Ethical boundaries of spiritual care

Gerald R Winslow and Betty J Wehtje-Winslow

ABSTRACT

- In an age that features technologically sophisticated medical interventions, patients still desire spiritually nurturing health care.
- Attention to patients' spiritual needs and resources in the clinical setting may raise a number of ethical questions.
- Five ethical guidelines are offered as illustrations of norms that respect patients' preferences and preserve health care professionals' integrity.

MJA 2007; 186: S63–S66

When a patient is faced with a health crisis, he or she may seek spiritual sustenance, even if this has not been a typical part of the person's day-to-day life. Patients who are members of a particular faith tradition, and those who are not, may want prayer or other forms of spiritual practice to be part of the care they receive from health care professionals. Or they may not. Either way, health care professionals who want to provide spiritually nurturing and ethically sensitive care need to think carefully about the place of spiritual care in professional service.

The purpose of this article is to consider a set of normative principles that may guide health care professionals in setting ethical boundaries for the spiritual care of patients. What, if any, are the ethical responsibilities of caregivers who are attuned to patients' spiritual resources and needs? Answers to this question can be sought under two broad headings: the respectful care of the patient, and the essential integrity of the professional. Under these rubrics, we set forth a series of five guidelines that comport well with current understanding of professional ethics.

In recent years, the importance of spirituality in health care has gained broad currency. Researchers interested in the health-related effects of spirituality have generated a burgeoning literature, with numerous reports of empirical evidence for the positive benefits of practices such as prayer and meditation.[1-5] The current enthusiasm for attending to patients' spirituality heightens the need for ethical reflection.[6-8] The vulnerability of patients and their wide variety of religious and spiritual backgrounds raise important practical questions. For example, if spiritual care is believed to be genuinely beneficial, should health care professionals go beyond *offering* such care and *urge* patients to engage in such practices as meditation or prayer?

Two concepts require brief clarification: religion and spirituality. The concept of religion is generally associated with the teachings and rituals of various faith traditions. Spirituality, on the other hand, is more often viewed as a nearly universal human trait that arises from the human need for hope and meaning. For most people in the culture we know best, a strong connection exists between spirituality and religion.[9] However, there are many people who identify themselves as spiritual but not religious.

Respectful care of the patient

The essential ethical characteristic of professional health care is a relationship of trust with the patient (and the patient's family, if present). Patients, made vulnerable by their illnesses, count on their carers to be trustworthy. Trust is established when the health care professional makes a commitment to seek the patient's wellbeing and protect the patient from harm. Trust is lost when considerations other than the patient's wellbeing are allowed to take priority.

A crucial element of trust is respect for the patient as a person. One recent study of patients' attitudes to spiritual care found that patients must feel respected by their physician in order to risk discussing spiritual issues.[10] Such respect entails the recognition that patients arrive with their own distinctive values and life plans, which may be radically different from the values of the patients' caregivers. Respectful care begins with a willingness to learn about the needs and the resources of the patient as a whole person. In the memorable expression of Cohen and colleagues, health care professionals "are constrained to treat patients as whole persons — for those are the only kind there are".[7] Thus we are led to state the first ethical guideline.

1. In order to provide respectful care, health care professionals should seek a basic understanding of patients' spiritual needs, resources, and preferences

Just as it would be inappropriate to give physical care without an understanding of a patient's diagnosis and the goals of treatment, it would be inappropriate to proceed with spiritual care that does not take into account the distinctive beliefs and values of the patient. In the past, it was not uncommon for professional and institutional barriers to be established against health professionals asking patients about their faith.[7] More recently, the mounting evidence that spirituality can be significant in patients' recovery from illness and the evidence that most patients want to have attention to their spirituality included in their health care has begun to change the cultural environment for health professionals in the United States.[11] The organisation that accredits US hospitals (and those in many other countries) now includes a standard that requires accredited hospitals to document a "spiritual assessment" of patients.[12] At a minimum, this record must indicate "what spiritual practices are important to the patient".

This development has been accompanied by a variety of proposed approaches to obtaining a patient's spiritual history. The method developed by Puchalski and colleagues is an example that has gained wide acceptance.[8] They propose that patients be asked the following four questions:

- Do you consider yourself spiritual or religious?
- How important are these beliefs to you, and do they influence how you care for yourself?
- Do you belong to a spiritual community?
- How might health care providers address any needs in this area?

It is unlikely that everyone will agree that these are the best questions for obtaining a patient's spiritual history. However, regardless of the specific approach, those who care for patients' wholeness need to address at least two basic questions: What are the patient's spiritual needs and resources? What difference, according to the patient, should such information make to his or

her care? There are, no doubt, many ways to script the specific questions that will help patients to give whatever information they choose to share. Skilful professionals will find their own distinctive ways to broach the subject. The evidence from a number of studies is that most American patients favour being asked about their spiritual preferences by health care professionals.[13,14]

When seeking understanding of the patient's spiritual history, it is important to attend to more than an expression of needs. Patients typically bring many spiritual strengths and resources to the clinical setting. Puchalski's suggested questions for a spiritual history illustrate attention to such assets by asking about the importance of a patient's beliefs and membership in a "spiritual community".[8] Attention to the patient's spiritual resources, as well as needs, may open greater opportunity for genuine spiritual cooperation. Knowing, for example, that a patient wants the services of a particular spiritual leader or that the patient draws strength from a distinctive spiritual practice can be significant in the provision of respectful care.

2. Respect for the patient requires that health care professionals follow the patient's expressed wishes regarding spiritual care

The 20th century saw a remarkable shift in the attention of health care professionals towards patient autonomy. Despite the arguments of some that we have gone too far in this direction, there appears to be no turning back from the requirement that competent patients be told the alternatives for treatment and be asked what they will permit. Pellegrino, who has criticised too much reliance in health care ethics on a narrow view of patient autonomy, nevertheless offers these strong words: "To ignore, override, repudiate, or ridicule the patient's values is to assault the patient's very humanity. This affront aggravates the disintegration of the person already there as a result of illness."[15]

Another critic of an over-reliance on patient autonomy concludes: "[T]he responsibility of the healthcare provider is not so much to respect decisions, although that is surely the case, but to create an environment and a treatment plan that empowers the decision on the basis of the patient's values."[16] The point is that health care professionals should not rely on the momentary expression of a patient who may be a nearly total stranger and whose ability to express his or her authentically held values may be impaired in many obvious or subtle ways. The goal of respect for the patient's autonomy is to "empower" the patient to express the values he or she holds, and to understand autonomy as one feature of the patient's integrity or wholeness.[16]

The importance of patient autonomy raises the additional question of whether health care professionals should take any initiative regarding spiritual care or simply wait for the patient to introduce the possibility. According to the authors of one widely cited article, "It would ... be disrespectful and not beneficial or supportive of autonomy to encourage patients to 'get' religious or spiritual beliefs if they do not have them".[8] This normative statement makes sense if what is proscribed is foisting religious beliefs or practices on patients. But this justifiable caution should not prevent caregivers from finding gentle ways to ask patients about their spiritual preferences. It is likely that many patients who could receive significant benefit from spiritually attentive care will not receive this help unless their caregivers take the initiative to ask.

3. Health care professionals should neither prescribe spiritual practices nor urge patients to relinquish religious beliefs or practices

Respectful care requires refraining from using the clinical setting or professional authority to promote religion or particular spiritual practices. It is sufficient to be attuned to the patient's already established spirituality. The clinical setting is not the place for proselytising, and the health care professional role does not properly include such activity.

There may be little disagreement about refraining from pushing religion or spirituality on patients. But the question becomes more contentious when it comes to urging that patients relinquish beliefs or practices their caregivers consider detrimental to the patients' health or disruptive of their health care. Subtler still are the spiritual beliefs people hold that may be detrimental to their health, even though these beliefs do not interfere with conventional health care. Given the current enthusiasm for the positive health benefits of spirituality, it may be difficult to imagine that some spiritual beliefs could be harmful to one's health. However, Pargament and colleagues find evidence that patients' spiritual beliefs may be either helpful or harmful, depending on the nature of the beliefs.[17-19] In their words, "religious methods of coping are neither always positive nor always negative".[17] Their research suggests that some forms of religious coping are associated with greater distress and poorer patient outcomes. And they believe that a more comprehensive understanding of the relationship between spirituality and health requires that we study both the functional and the dysfunctional aspects of religious coping.

What, then, should health care professionals do if they believe that their patients' religious convictions or spiritual practices may be harmful to their health or disruptive of their health care? The third guideline proscribes pressuring patients to relinquish their spiritual beliefs or practices. Sometimes, however, the ministry of a spiritual care leader who is acceptable to the patient may assist the patient in finding a more helpful grasp on his or her beliefs. It is not uncommon to find that members of a particular faith community may benefit from a deeper understanding of their own religious tradition. As Cohen and colleagues observe, "Some patients, misunderstanding the tradition of their religious community, choose in idiosyncratic ways that could cause them injury".[7] Of course, it is not the proper role of the health care professional to provide specialised spiritual assistance in such cases. But securing the help of an acceptable religious leader can sometimes have a salutary effect. Hospital chaplains and other specialists in spiritual care may also be able to help patients explore their belief systems in ways that may reduce dissonance or dysfunctional forms of coping. But, if not, it is not the place of health care professionals to force patients to yield their religious convictions. They "are not free to coerce patients to change their informed religious convictions or to manipulate events in ways that conflict with those convictions".[7]

While many other guidelines for patient care could be listed, the three discussed above provide basic illustrations of the normative meaning of respectful care. We turn now to the integrity of caregivers who wish to care spiritually for their patients.

Preserving personal and professional integrity

An essential ingredient in relationships of trust is the virtue of integrity. The ethical ideal of integrity is to be a whole person who

has sincerity of purpose. Central to the pursuit of personal integrity is the examination of one's own convictions, including beliefs about what ultimately gives meaning to human life. A life of integrity is marked by actions that match well considered beliefs. If spirituality may properly be defined as a quest for ultimate meaning, then the development of integrity is linked to spirituality, as both have to do with the core of personhood. The connection between spirituality and integrity leads to the fourth guideline.

4. Health care professionals who care for the spiritual needs of patients should seek to understand their own spirituality

Comprehension of one's own spirituality, including spiritual weaknesses, opens the way for respectful caring for another's spiritual needs. Such awareness should include an understanding of the experiences that may have caused spiritual pain or loss in life. As difficult as this exploration may be, it prepares the way for more compassionate and respectful care because it helps caregivers to distinguish between their own spiritual needs and those of their patients.

Spiritual self-awareness can be especially important, for example, when a patient asks for prayer. One study of 476 American physicians found that 77% would be willing to pray with their patients if the patients requested prayer.[20] This level of willingness highlights the need to find appropriate boundaries. The following advice regarding prayer for clients in psychological therapy may also be appropriate for other health care professionals: "In the most unethical manner, therapists not guided by the principle of exploring and understanding their own beliefs, values, and needs might lead prayer in a manner which is unfamiliar and uncomfortable to the client, praying for the assumed needs of the client as well as a few of their own."[21] A professional's honest understanding of his or her own beliefs about spirituality, including an assessment of doubts or unresolved questions, can do much to ensure that the professional is effectively attentive to the spiritual needs of the patient. These reflections on the relationship of integrity to spiritual care lead to the fifth and final guideline.

5. Participation in spiritual care should be consonant with professional integrity

There is no place in a relationship of trust or in respectful care for inauthentic spirituality. Elsewhere we have argued that it is sometimes possible to negotiate ethical compromises in ways that preserve integrity.[22] This is often necessary in any culture where people with vastly different ethical visions live and work together and must find some middle way to resolve their differences. But we also recognise that the tactic of compromise has its limits. Feigning spirituality would be a regrettable failure of integrity and a breach of patients' trust.

There are a number of potentially effective strategies for caregivers who are not comfortable attending to patients' spiritual needs. An obvious one is to request the services of a chaplain or a spiritual care specialist of the patient's own choosing. There may also be other professionals who could, with integrity, help the patient. Creative exercise of integrity may find other useful approaches. For example, the caregiver who does not find prayer personally meaningful may still be respectfully supportive of patients who choose to pray.

Thus far, we have discussed integrity largely in terms of personal wholeness. But an important part of integrity is the harmony between one's personal convictions and one's professional and social roles. We have taken the stance that spiritual care for patients is commensurate with the role of health care professionals. Not all are in agreement with this. For example, Post and colleagues have argued that, when physicians encounter patients' requests for spiritual care, such as prayer, the requests should be referred to chaplains or other spiritual leaders if possible.[8] Our own sense of professional integrity leads us to conclude that health care professionals who believe in spiritual practices such as prayer may appropriately participate with their patients in such practices if the patients make the request and if the participation is driven by patients' needs and preferences.

Conclusion

In an age that features technologically sophisticated medical interventions, patients still desire spiritually nurturing health care. The value of providing whole-person care should lead health care professionals to offer care not only for physical needs but also for the needs of the human spirit in search of meaning. Guided by ethical reflection, health care professionals may better serve patients who desire spiritually nurturing health care. The five guidelines we have stated are offered as illustrations of what respectful care requires of caregivers with integrity.

Competing interests

None identified.

Author details

Gerald R Winslow, PhD, Professor of Ethics, Faculty of Religion
Betty J Wehtje-Winslow, PhD, Professor of Nursing, School of Nursing
Loma Linda University, Loma Linda, Calif, USA.
Correspondence: gwinslow@llu.edu

References

1 Koenig HG. Religion, spirituality, and medicine: research findings and implications for clinical practice. *South Med J* 2004; 97: 1194-1200.
2 Koenig HG, McCullough M, Larson DB. Handbook of religion and health. Oxford: Oxford University Press, 2001.
3 Levin JS. God, faith, and health: exploring the spirituality–healing connection. New York: John Wiley and Sons, 2001.
4 Dossey L. Prayer is good medicine: how to reap the healing benefits of prayer. San Fransisco: HarperCollins, 1996.
5 Benson H. Timeless healing. New York: Scribner, 1996.
6 McCord G, Gilchrist VJ, Grossman SD, et al. Discussing spirituality with patients: a rational and ethical approach. *Ann Fam Med* 2004; 2: 356-361.
7 Cohen CB, Wheeler SE, Scott DA, et al. Prayer as therapy. A challenge to both religious belief and professional ethics. The Anglican Working Group in Bioethics. *Hastings Cent Rep* 2000; 30: 40-47.
8 Post SG, Puchalski CM, Larson DB. Physicians and patient spirituality: professional boundaries, competency, and ethics. *Ann Intern Med* 2000; 132: 578-583.
9 Hill PC, Pargament KI, Hood RW, et al. Conceptualizing religion and spirituality: points of commonality, points of departure. *J Theor Soc Behav* 2000; 30: 51-77.
10 Ellis MR, Campbell JD. Patients' views about discussing spiritual issues with primary care physicians. *South Med J* 2004; 97: 1158-1164.
11 Kendrick K, Robinson S. Spirituality: its relevance and purpose for clinical nursing in a new millennium. *J Clin Nurs* 2000; 9: 701-706.
12 Joint Commission on Accreditation of Healthcare Organizations. Spiritual assessment. Revised 1 Jan 2004. http://www.jointcommission.org/AccreditationPrograms/Hospitals/Standards/FAQs/Provision+of+Care/Assessment/Spiritual_Assessment.htm (accessed Mar 2007).

13 Ehman JW, Ott BB, Short TH, et al. Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill? *Arch Intern Med* 1999; 159: 1803-1806.
14 McCauley J, Jenckes MW, Tarpley MJ, et al. Spiritual beliefs and barriers among managed care practitioners. *J Relig Health* 2005; 44: 137-146.
15 Pellegrino ED. The relationship of autonomy and integrity in medical ethics. *Bull Pan Am Health Organ* 1990; 24: 361-371.
16 Thomasma DC. Beyond autonomy to the person coping with illness. *Camb Q Healthc Ethics* 1995; 4: 12-22.
17 Pargament KI, Zinnbauer BJ, Scott AB, et al. Red flags and religious coping: identifying some religious warning signs among people in crisis. *J Clin Psychol* 1998; 54: 77-89.
18 Pargament KI, Koenig HG, Perez LM. The many methods of religious coping: development and initial validation of the RCOPE. *J Clin Psychol* 2000; 56: 519-543.
19 Pargament KI, Koenig HI, Tarakeshwar N, Hahn J. Religious struggle as a predictor of mortality among medically ill elderly patients: a 2-year longitudinal study. *Arch Intern Med* 2001; 161: 1881-1885.
20 Monroe MN, Bynum D, Susi B, et al. Primary care physician preferences regarding spiritual behavior in medical practice. *Arch Intern Med* 2003; 163: 2751-2756.
21 Magaletta PR, Brawer PA. Prayer in psychotherapy: a model for its use, ethical considerations, and guidelines for practice. *J Psychol Theol* 1998; 26: 322-330.
22 Winslow BJ, Winslow GR. Integrity and compromise in nursing ethics. *J Med Philos* 1991; 16: 307-323.

(Received 2 Oct 2006, accepted 22 Mar 2007) ❑