Original Article

Limits and Responsibilities of Physicians Addressing Spiritual Suffering in Terminally Ill Patients

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Abstract

Context. Many patients experience spiritual suffering that complicates their physical suffering at the end of life. It remains unclear what physicians' perceived responsibilities are for responding to patients' spiritual suffering.

Objectives. To investigate U.S. physician opinions about the impact patients' unresolved spiritual struggles have on their physical pain, physicians' responsibilities for treating patients' spiritual suffering compared with patients' physical pain, and the number of patients in the past 12 months whose suffering the physician was unable to relieve to an acceptable point.

Methods. The study was based on a mailed survey to 2016 practicing U.S. physicians from clinical specialties that care for significant numbers of dying patients.

Results. Of 1878 eligible physicians, 1156 (62%) responded. Most physicians agreed that patients with unresolved spiritual struggles tend to have worse physical pain (81%) and that physicians should seek to relieve patients' spiritual suffering just as much as patients' physical pain (88%). Compared with physicians who strongly disagreed that physicians should seek to relieve patients' spiritual suffering just as much as patients' physical pain, those who strongly agreed were less likely to report being unable to relieve patients' suffering to a point the physician found acceptable (27% vs. 54% reported three or more such patients in the previous 12 months, adjusted odds ratio [95% CI] = 0.3 [0.1, 0.8]).

Conclusion. Most physicians believe that spiritual suffering tends to intensify physical pain and that physicians should seek to relieve such suffering. Physicians who believe they should address spiritual suffering just as much as physical pain report more success in relieving patient's suffering. J Pain Symptom Manage 2014;■:■−■.

Key Words

Religion, spiritual suffering, end-of-life care, suffering

Introduction

Within the profession of medicine, the past two decades have witnessed growing emphasis on comprehensive treatment of patient suffering.[1] In addition to the suffering caused by physical pain, physicians are often encouraged to attend to other forms of suffering during all phases of care and not just palliative care.[2] One specific form of suffering that patients experience has been described as *existential* or *spiritual*. Although some have sought to distinguish the latter two terms, they continue to be used interchangeably[3] to refer to what Jansen and Sulmasy[4] call "agent-narrative suffering"—the suffering that is "belief-dependent, bearing, at most, an indirect relationship to the patient's underlying medical condition." The lack of consensus regarding terminology reflects deeper professional perplexity regarding who should respond to spiritual suffering and how.[3–6]

How physicians respond to spiritual suffering would seem to be clinically important because clinicians

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often observe that spiritual suffering makes patients' pain more refractory to treatment, and patients often cite existential suffering as a reason they want to die.[2,3] Some have proposed that dying patients whose suffering is refractory to treatment should be offered what has come to be called palliative sedation to unconsciousness.[3,7–11] Although Putman et al.[7] found that two of three U.S. physicians oppose using sedation to unconsciousness to treat "psychological and spiritual suffering of terminally ill patients," it is unclear how physicians otherwise respond to and experience success in relieving spiritual suffering. Prior data suggest that lack of time,[12] a paucity of training, and the belief that addressing spiritual matters is ultimately the domain of chaplains[3,13] all militate against physicians addressing spiritual suffering.

This study sought a preliminary look at physicians' attitudes toward and experiences with trying to relieve patients' spiritual suffering. Because spiritual suffering is hard to treat and highly variable from patient to patient,[4,6] we hypothesized that physicians who believe they are responsible for treating spiritual suffering would report higher numbers of patients whose suffering could not be relieved to a point the physician found acceptable. It may be that a collaborative team approach, led by chaplains, is the best strategy, but this study begins with physicians, assessing their beliefs concerning the effects of spiritual suffering on physical pain, their responsibility for relieving patients' spiritual suffering, and how often they have faced patient suffering that was refractory to the best available treatment. Because this was part of a broader study of how physicians' religious characteristics shape their clinical practices, we included measures of physicians' religious characteristics in our analysis.

Methods

Survey

In 2010, we mailed a confidential self-administered questionnaire to a stratified random sample of 2016 practicing U.S. physicians aged 65 years or younger.[14] The sample was generated from the American Medical Association (AMA) Physician Masterfile, a database intended to include all U.S. physicians, regardless of membership in the AMA. We selected 1248 physicians from the specialties of internal medicine, family medicine, general practice, cardiology, and nephrology. We then selected an oversample of 768 physicians in specialties that care for disproportionate numbers of patients at the end of life (hospice and palliative care, geriatrics, oncology specialties, and pulmonary/critical care). In addition, to increase the power of other analyses that investigate the association of physicians' self-reported religious affiliation with medical practice and end-of-life issues, we used validated lists of Asian, Arabic, and Jewish ethnic surnames to increase the number of Hindu, Muslim, and Jewish physicians in the study.[15–17] Physicians received up to three separate mailings, with a $20 cash incentive in the first and an offering of $30 for participation in the third. All data were double-keyed, cross-compared, and corrected against the original questionnaires. The study was approved by the University of Chicago Institutional Review Board.

Criterion Variables

All criterion variable measures underwent cognitive pretesting before inclusion in the survey. To evaluate physician attitudes concerning pain and spiritual suffering, we asked the respondents to indicate to what extent they agreed (strongly agree, agree somewhat, disagree somewhat, and strongly disagree) with the following three statements: 1) patients with unresolved spiritual struggles tend to have worse physical pain symptoms, 2) physicians should seek to relieve patients' spiritual suffering just as much as patients' physical pain, and 3) pain and suffering are often means of spiritual growth.

To evaluate physicians' experiences with refractory suffering, we asked 1) in the past 12 months, approximately how many *terminally ill* patients have you taken care of whose pain and suffering, despite the best available treatment, could not be relieved to a point that *you* found acceptable? (no. of patients) and 2) in the past 12 months, approximately how many *terminally ill* patients have you taken care of whose pain and suffering, despite the best available treatment, could not be relieved to a point that *the patient* found acceptable? (no. of patients).

Predictors

We asked all physicians to estimate how many of their patients had died during the previous 12 months. We categorized clinical specialties as internal medicine, family medicine/general practice, cardiology/nephrology, hospice and palliative care/geriatrics, oncology specialties, and pulmonary/critical care. Religious affiliation was categorized as None, Hindu, Jewish, Muslim, Roman Catholic/Eastern Orthodox, evangelical Protestant, non-evangelical Protestant, and other religion. The importance of religion in physicians' lives was categorized as not very important (for analysis, this includes "not applicable. I have no religion"), fairly important, very important, and most important. Gender, age, race/ethnicity (white non-Hispanic, black non-Hispanic, Asian, Hispanic/Latino, other), and immigration history (U.S. or foreign born) were included as controls.

Statistical Analysis

Stratum weights were included to account for the oversampling of ethnic surnames and stratification by specialty, as well to account for modest differences in