February 2006 Article of the Month

This month's article selection is by Chaplain John Ehman,
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Steinhauser, K. E., Voils, C. I., Clipp, E. C., Bosworth, H. B., Christakis, N. A. and Tulsky, J. A. "**'Are you at peace?': one item to probe spiritual concerns at the end of life**." *Archives of Internal Medicine* 166, no. 1 (January 9, 2006): 101-105.

COMMENT and SUMMARY: While chaplains have long sought efficient ways to engage patients in explorations of spirituality, researchers and medical care providers have in recent years joined in a roughly similar pursuit for *key questions* by which to inquire about a patient's spirituality that could be pertinent to health. Some questionnaires have been developed with the help of chaplains [--see, for example the articles by Galek and by Peterman, highlighted in the June 2005 and the February 2004 Articles-of-the-Month pages, respectively], but most instruments entail quite a number of questions, and that may be a disadvantage for their incorporation into the everyday clinical setting. This chaplain was involved in research that essentially piloted a clinically-friendly, single-item assessment: "Do you have spiritual or religious beliefs that may influence your medical decisions?" [--see, Ehman, J. W., Ott, B. B., Ciampa, R. C., Short, T. H. and Hansen-Flaschen, J., "Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill?" *Archives of Internal Medicine* 159, no. 15 (August 9/23, 1999): 1803-1806], but the quest for just the right question--one that is easily asked by any health care provider and that works across diverse populations--has continued. The authors of this month's featured article propose an inquiry about a patient's sense of peace, perhaps simply: "Are you at peace?"

Karen E. Steinhauser, Ph.D., and colleagues found from previous studies [--see Items of Related Interest, below] that the concept of "being at peace" appeared to hold special value for patients at the end of life, and though it was often "related to a religious notion of 'being at peace with God,'" it also had non-theological meanings [p. 102]. " …[W]e were struck by the extent to which the concept of being at peace applied to multiple contexts and with varied meaning yet held a common, vital impact. …[S]uch a construct might serve as a brief, non-threatening gateway to eliciting patient and family concerns" [p. 102]. The wording in the present study--"Are you at peace?"--was chosen for inclusiveness.

Data were collected from 248 patients (a 78% response rate from a total sample of 320 patients approached), all of whom had at least one of four life-threatening conditions: stage IV cancer, congestive heart failure, end-stage renal disease, and/or chronic obstructive pulmonary disease. The "breadth of applicability of the construct of being at peace" was tested by examining "the relationship between the extent to which patients felt 'at peace' and demographic categories" [p. 103]. No significant relationship was found to exist with "ethnicity, education, sex, diagnosis, site of recruitment, or marital status," though "a small but positive correlation between age and feeling at peace (r=0.24)" [p. 103] was detected.

Next, the "conceptual underpinnings" of feeing at peace were explored through correlational analysis--the patients having completed the QUAL-E measure of quality of life at the end of life, the instrumental and affective support scales from the Duke University EPESE survey, and (most notably for chaplains) the FACIT-Sp. [For more on the FACIT-Sp, see the February 2004 Articles-of-the-Month page.] Among the findings: "peacefulness was most strongly associated with the emotional and spiritual well-being subscales (r=0.52 and 0.60, respectively)," and in terms of the FACIT-Sp's two subscales of *faith* and *purpose*, there were "significant associations between feeling at peace and both dimensions (purpose: r=0.47, P<.001; faith: r=0.51, P<.001), suggesting similar construct resonance for religious as well as meaning-making components of spirituality" [p. 103].

The research would seem to support the clinical usefulness of an inquiry about a patient's sense of peace, but the authors caution:

> The purpose of these analyses is not to reduce spiritual, religious, or emotional concerns to a construct of peace, nor does use of the item constitute a full spiritual history. Rather, we liken its use to the single question, "Are you depressed?", which works well as a screening tool that indicates when there is a need for a fuller psychological assessment. These data indicate use of the concept of peacefulness as a gateway to larger discussions, framed according to patients' values, preferences, and life experiences.

To illustrate, the practical value of an inquiry about peace, two brief examples of dialogue between a physician and a patient are presented. One is as follows:

> **Physician:** How have you been doing?
> **Patient:** Okay, I guess.
> **Physician:** I'm wondering how you're doing living with your illness. I sometimes hear people talk about whether or not they're at peace. Do you feel that you are at peace in your life right now?
> **Patient:** Well, when you ask it that way, no.
> **Physician:** Tell me more.
> **Patient:** I just can't seem to get a handle on all of this….

This vignette shows that the authors are not wedded to the precise wording of their study question, "Are you at peace?"--yet implicitly the research supports that formulation.

Steinhauser and colleagues are focused on physicians here, but chaplain researchers may be interested in further investigation along these lines, with special attention to how giving explicit and high priority in *pastoral* conversation to a patient's sense of peace may influence the trajectory of pastoral interaction and the effectiveness of pastoral intervention. Though such research would probably be largely qualitative, some quantitative measures could be incorporated. The FACIT-Sp, after all, emphasizes peacefulness, and the new comprehensive spiritual assessment by Galek, et al. [--see again the June 2005 Articles-of-the-Month page], coming out of The HealthCare Chaplaincy in New York, includes peace as a core construct (grouped with positivity, gratitude, and hope). Among other measures worth considering would be the Ironson-Woods Spirituality/Religiousness Index, whose first subscale is "Sense of Peace" [--see the February 2003 Articles-of-the-Month page]. Also, the Serenity Scale is cited in the current article [--see Roberts, K. T. and Aspy, C. B., "Development of the Serenity Scale," *Journal of Nursing Measurement* 1, no. 2 (Winter 1993): 145-164].

Suggestions for the Use of the Article for Discussion in CPE:

This month's article well-written and, while not aimed at chaplains, should be engaging to CPE students. (The authors do note referrals to chaplains on p. 104.) Discussion could turn on the potential value of the question, "Are you at peace?" per se, and whether the concept of peacefulness figures into students' pastoral assessment practices. The language of peacefulness could also be explored: How do patients tend to talk about their sense

of peace or their lack of it? Are there roundabout or euphemistic ways of talking about peace? Furthermore, do there seem to be barriers to the subject coming up in pastoral conversation, and do patients tend to think mainly about the concept in relation to God or in relation to other things? For advanced students, the article could be discussed in light of the research process by which the concept of peace has here been identified and analyzed. The article could also set up an interesting discussion with a guest physician, and the topic of physician inquiry and pastoral referral could additionally be explored.

Related Items of Interest:

Other recent articles by Karen E. Steinhauser, together with various co-authors from this month's study:

Bosworth, H. B., Steinhauser, K. E., Orr, M., Lindquist, J. H., Grambow, S. C. and Oddone, E. Z. "**Congestive heart failure patients' perceptions of quality of life: the integration of physical and psychosocial factors**." *Aging and Mental Health* 8, no. 1 (January 2004): 83-91. [In this focus group study, spirituality is noted briefly in the results: "Spirituality was reported to be an important mechanism for coping with CHF and improving quality of life" (p. 87).]

Steinhauser, K. E., Bosworth, H. B., Clipp, E. C., McNeilly, M., Christakis, N. A., Parker, J. and Tulsky, J. A. "**Initial assessment of a new instrument to measure quality of life at the end of life**." *Journal of Palliative Medicine* 5, no. 6 (December 2002): 829-841. [The article describes the QUAL-E, a 31-item questionnaire having, as its core, 24 items covering 5 domains that focus groups and a national survey indicated to be import to dying patients: 1) sense of life completion, particularly through contributions to others, 2) relationships within the health care system, 3) preparation or anticipatory concerns about dying, 4) symptom impact, and 5) connectedness and affective social support (--see especially, pp. 833-834). Chaplains were included in the focus group and national survey phases (--see p. 831). The full QUAL-E is presented in an appendix on pp. 839-841.]

Steinhauser, K. E., Clipp, E. C., McNeilly, M., Christakis, N. A., McIntyre, L. M. and Tulsky, J. A. "**In search of a good death: observations of patients, families, and providers**." *Annals of Internal Medicine* 132, no. 10 (May 16, 2000): 825-832. [This focus group study of 75 participants (including physicians, nurses, social workers, chaplains, hospice volunteers, patients, and recently bereaved family members) identified six process-oriented themes integral to the concept of a "good death": pain and symptom management, clear decision making, preparation for death, completion, contributing to others, and affirmation of the whole person. (This study was also noted under Related Items of Interest, in the October 2002 Article-of-the-Month.)]

Steinhauser, K. E., Clipp, E. C. and Tulsky, J. A. "**Evolution in measuring the quality of dying**." *Journal of Palliative Medicine* 5, no. 3 (June 2002): 407-414. [The authors critique current instruments used to measure quality-of-life in dying patients, and they suggest that further instrument development focus on expanding conceptual domains, attending to future concerns of patients, considering diverse understandings of spirituality, accommodating better those patients for whom illness is a barrier to response, and better measuring change over time.]

Steinhauser, K. E., Christakis, N. A., Clipp, E. C., McNeilly, M., Grambow, S., Parker, J. and Tulsky, J. A. "**Preparing for the end of life: preferences of patients, families, physicians, and other care providers**." *Journal of Pain and Symptom Management* 22, no. 3 (September 2001): 727-737. [This focus group study, subsequently paired with a quantitative national survey, identified the importance of "naming someone to make decisions, knowing what to expect about one's physical condition, having financial affairs in order, having treatment preferences in writing, and knowing that one's physician is comfortable talking about death and dying" (--from the abstract, p. 727). Chaplains were included in both the qualitative and quantitative phases, and particular input from chaplains is noted on pp. 730 and 732.]

Steinhauser, K. E., Christakis, N. A., Clipp, E. C., McNeilly, M., McIntyre, L. and Tulsky, J. A. "**Factors considered important at the end of life by patients, family, physicians, and other care providers**." *JAMA*

284, no. 19 (November 15, 2000): 2476-2482. [This is a report of a 1999 national survey of seriously ill patients, bereaved family members, physicians and other health care providers (including 120 chaplains), exploring attributes of quality of life at the end of life. Among the many interesting findings, were that patients rated as much more important than did physicians the items of "Be at peace with God" and "pray." "Patients highly valued attention to spirituality; in particular, coming to peace with God and praying. Rank ordered responses showed that coming to peace with God and pain control were nearly identical in importance for patients and bereaved family members" [p. 2481]. Also, physicians gave less importance than did patients to the item of "Meet with clergy member," but bereaved family members actually gave that same item *more* importance than did patients.]

NOTE: Also see the October 2002 Article-of-the-Month page for more on spiritual needs at the end of life.
