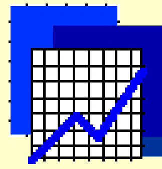

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May 2013 Article of the Month

This month's article selection is by Chaplain John Ehman,
University of Pennsylvania Medical Center-Penn Presbyterian, Philadelphia PA.

Balboni, T. A., Balboni, M., Enzinger, A. C., Gallivan, K., Paulk, M. E., Wright, A., Steinhauser, K., VanderWeele, T. J. and Prigerson, H. G. "**Provision of spiritual support to patients with advanced cancer by religious communities and associations with medical care at the end of life**." *JAMA Internal Medicine* 173, no. 12 (June 24, 2013): 1109-1117.

SUMMARY and COMMENT: We have featured before the work of Tracy Balboni, Michael Balboni and the team of investigators based largely at Harvard (see especially June 2011, January 2010 and also April 2009). These authors continue to build an impressive body of work around spirituality & health, and their renown helps attract media coverage of their research. The present article became the topic of news reports internationally as soon as it was posted online *ahead of print*. Regrettably, news coverage tends to give a poor and partial account of such studies, yet this is the means by which a "take home message" seems often to be formed for many people even in health care circles. For this reason, chaplains may be well served by a close familiarity with the original work.

Our authors state their rationale and purpose at the outset, in light of how patients with advanced illness are frequently unable to receive sufficient spiritual support from medical teams (including chaplains):

> Understanding the impact of religious community spiritual care on patient [End of Life] outcomes is critical to characterizing optimal spiritual care provision. Furthermore, given the salient role that religious communities often play among racial/ethnic minority and high religious coping patients--patients at risk for greater aggressive EoL care--understanding associations of religious community spiritual care with EoL outcomes is of particular relevance in these populations. [p. 1110]

Data were collected from seven major outpatient clinics in Massachusetts, New Hampshire, Connecticut, and Texas between September 1, 2002 and August 28, 2008. Of 940 eligible patients with an advanced cancer refractory to first-line chemotherapy, 670 (71%) agreed to participate, but the final sample was 343 patients who had died at the end of the data collection phase. The methodology is very well laid out in the article [--see pp. 1110-1112], but the baseline spiritual care variables are worth special note here:

> Spiritual support from religious communities was assessed by the question, “To what extent are your religious/spiritual needs being supported by your religious community (eg, clergy, members of your congregation)?” Spiritual care from the medical team was assessed with the question, “To what extent are your religious/spiritual needs being supported by the medical system (eg, doctors, nurses, chaplains)?” ....Patients were also asked whether they had received chaplaincy services.... [p. 1110]

Also, the Brief RCOPE coping measure was among the instruments used. Patients' Quality of Life near death was assessed by caregivers in terms of psychological distress, physical distress, and overall QoL near death. "Receipt of aggressive EoL care was defined as receipt of care in an intensive care unit (ICU), ventilation, or resuscitation in the last week of life" [p. 1110].

Among the findings:

> ...[P]atients receiving high levels of spiritual support from religious communities are less likely to receive hospice care and are more likely to receive aggressive medical interventions at the EoL and die in an ICU setting. These findings remained after controlling for potential confounding factors, such as race and advance care planning. Furthermore, these findings were strongest among racial/ethnic minority and high religious coping patients.... Among patients receiving high levels of spiritual support from religious communities (43% of our sample), provision of spiritual support by the medical team and EoL discussions were associated with reduced aggressiveness of EoL care. [p. 1113]

Highlighting the latter finding: "...[A]ssociations between spiritual support from religious communities and EoL outcomes [i.e., receipt of hospice care, receipt of aggressive medical interventions, and days on the ICU --see Figure 1, p. 1113] were significantly different from, and in the opposite direction of, spiritual support from medical teams" [p. 1112]. Remember, for the purposes of this study, the "medical team" is identified in the question asked of patients as "eg, doctors, nurses, *chaplains*" [p. 1110, italics added]. While baseline patient information included receipt of "chaplaincy services" [p. 1110 and Table 1 on p. 1111], the contribution of chaplains was not tracked separately over the course of EoL care. An invited commentary on the study [--see Related Items of Interest, #I (below)] suggests that an analysis of chaplains' documentation in the medical records could offer valuable additional insight in future studies.

Chaplains should also be interested in the authors' discussion and speculation about "the disparate influences of spiritual care from religious communities compared with spiritual care provided by medical teams" [pp. 1113-1114], including:

> In contrast to medical teams, religious congregations may be unaware of the biomedical realities surrounding terminal illness and hence may not be addressing issues of death and dying owing to lack of clarity regarding when or whether death will occur. In addition, within many religious traditions including Christian traditions...there is a strong belief in miracles. Religious communities, in supporting their ill congregants, may be emphasizing and reinforcing a belief in the potential for miraculous healing. ...[R]eligious congregations may view choosing to withhold medical technologies as curtailing the principal avenue by which divine healing can take place or even taking the trajectory of the person’s life out of "God’s hands." [p. 1113]
>
> Another possible mechanism by which religious community spiritual support may result in greater aggressive care is that religious communities may frequently emphasize perseverance through and hope found within suffering. Coupled with a strong belief in the potential for miraculous healing, religious communities’ emphasis on hope, meaning, and perseverance in illness may not only uphold but also may constrain patients’ spiritual approach to terminal illness to fighting their disease. [p. 1114]

One curious finding in the mix is that good spiritual support from religious communities was associated with better Quality of Life at baseline *but not* near death. The authors propose that this may be a factor in the contrast between support provided by religious communities and by medical teams:

> ...[R]eligious communities’ focus on spiritual support in fighting disease...may uphold QoL earlier in the course of advanced illness when combating illness remains feasible but may become increasingly incongruent or even in conflict with patients’ spiritual needs as death becomes imminent. Conversely, medical teams providing spiritual support may be better addressing spiritual

> needs that become increasingly central to patient QoL as terminal illness progresses, such as finding acceptance and spiritual peace in dying. [p. 1114]

Moreover:

> The findings suggest that by addressing EoL decisions in a manner that embraces patients' spiritual values and goals, the medical team is assisting patients in avoiding aggressive interventions at the EoL. Mechanisms for these associations may be that medical teams are engaging those religious/spiritual factors influencing EoL medical decisions (eg, belief in miracles) and that this engagement is encouraging patients to adopt less-intensive approaches to EoL care.

The authors raise much that should be fodder for further research, especially in their thoughts on possible mechanisms that could play into health care strategies, say, targeting patients who receive strong support from religious communities [--see p. 1114]. They also implicitly suggest practical tensions between sources of spiritual support for patients with advanced illness --tensions that may directly affect chaplains.

Note: Kathleen Gallivan is the Director of the Chaplaincy Services Department at Brigham and Women's Hospital, and Michael Balboni holds degrees in Divinity and Theology.

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

This month's article should be useful for all students, though perhaps it's best suited for those who have had at least some experience reading in the medical literature. It might be paired with the very short invited commentary also published by the journal [--see Related Items of Interest, #I (below)]. Discussion could focus on two aspects: the formal findings and speculation about the mechanisms behind those findings. The basic findings are presented on pp. 1113-1114 but are reiterated for the most part in the first paragraph of the Discussion section on p. 1113. More advanced students may want to concentrate on this and discuss the methodology laid out on pp. 1110-1112 (printed in smaller type). Students newer to research, in contrast, may be most engaged by the Discussion section alone, and the authors' thoughts on the mechanisms behind the findings should naturally generate energy in the group. Students might be challenged to look closely at Figure 2 [p. 1115], graphing data on differences between spiritual support from religious communities and medical teams. Have students talked much with patients who have advanced illness about their support by religious communities? How might patients experience that religious community support as a constant as their own medical circumstances have changed? Has any such sense of constancy been experienced as rigidity or as being out of sync with patients' changing needs? Do patients experience support from the medical team as in sync with changing needs or as rigid and out of touch with the lived experience of illness? Have students ever found themselves as mediators between other members of the medical team and members of a patient's religious community? Do students conceive themselves as on the "side" of the other members of the medical team? Finally and generally, how do students believe the findings here may be helpful to their professional practice?

Related Items of Interest:

> **I.** This month's article is paired with a brief invited commentary: Ellison, C. G. and Benjamins, M. R. "**Advancing research on spiritual influences at the end of life**." *JAMA Internal Medicine* 173, no. 12 (June 24, 2013): 1117-1118. The authors point up methodological areas they believe need attention. They note, among other things, the value of "decades of work within the pastoral care field concerning the conceptualization and assessment of spiritual needs among medical patients" [p. E1] and give the particular example of George Fitchett's work.* They also indicate the potential

that lies in analysis of chaplains' documentation in the medical record [--and for more on chaplains' access to the medical record, see the November 2011 Article-of-the-Month].

*Ellison and Benjamins cite Fitchett's *Assessing Spiritual Needs: A Guide for Caregivers* (Lima, OH: Academic Renewal Press; 2002), but his 7x7 model of spiritual assessment is summarized, and a case study is offered, conveniently on the Rush University's Religion, Health & Human Values website.

II. Our authors cite a telephone survey in which "80% endorsed a belief that God acts through physicians to cure illness" [p. E6]. For more, see:

Mansfield, C. J., Mitchell, J. and King, D. E. "**The doctor as God's mechanic? Beliefs in the Southeastern United States**." *Social Science and Medicine* 54, no. 3 (February 2002): 399-409. [(Abstract:) Spiritual practice and beliefs related to healing are described using data from a telephone survey. Questions in the survey address the practice of prayer and spiritual beliefs related to healing. Questions explore belief in miracles, that God acts through religious healers, the importance of God's will in healing, and that God acts through physicians. Questions also ask whether people discuss spiritual concerns with their physician and whether they would want to if seriously ill. We create a composite index to compare religious faith in healing across race, gender, education, income denomination, and health status. Logistic regression predicts types of patients who believe God acts through physicians and those inclined to discuss spiritual concerns when ill. The most important findings are that: 80% of respondents believe God acts through physicians to cure illness, 40% believe God's will is the most important factor in recovery, and spiritual faith in healing is stronger among women. African-Americans, Evangelical Protestants, the poorer, sicker, and less educated. Those who believe that God acts through physicians are more likely to be African-American than White (OR = 1.9) and 55 or older (OR = 3.5). Those who discuss spiritual concerns with a physician are more likely to be female (OR = 1.9) and in poor health (OR = 2.1). Although 69% say they would want to speak to someone about spiritual concerns if seriously ill, only 3% would choose to speak to a physician. We conclude that religious faith in healing is prevalent and strong in the southern United States and that most people believe that God acts through doctors. Knowledge of the phenomena and variation across the population can guide inquiry into the spiritual concerns of patients.]

III. The first two authors of our featured article are Tracy A. Balboni and Michael J. Balboni. For a select bibliography of their earlier work, much of which is with other co-authors from this month's article, click HERE.

IV. Further research along similar lines [added 7/15/14]:

Shinall, M. C., Jr., Ehrenfeld, J. M. and Guillamondegui, O. D. "**Religiously affiliated intensive care unit patients receive more aggressive end-of-life care**." *Journal of Surgical Research* 190, no. 2 (August 2014): 623-627. [(Abstract:) BACKGROUND: Previous studies among cancer patients have demonstrated that religious patients receive more aggressive end-of-life (EOL) care. We sought to examine the effect of religious affiliation on EOL care in the intensive care unit (ICU) setting. MATERIALS AND METHODS: We conducted a retrospective review of all patients admitted to any adult ICU at a tertiary academic center in 2010 requiring at least 2 d of mechanical

ventilation. EOL patients were those who died within 30 d of admission. Hospital charges, ventilator days, hospital days, and days until death were used as proxies for intensity of care among the EOL patients. Multivariate analysis using multiple linear regression, zero-truncated negative binomial regression, and Cox proportional hazard model were used. RESULTS: A total of 2013 patients met inclusion criteria; of which, 1355 (67%) affirmed a religious affiliation. The EOL group had 334 patients, with 235 (70%) affirming a religious affiliation. The affiliated and nonaffiliated patients had similar levels of acuity. Controlling for demographic and medical confounders, religiously affiliated patients in the EOL group incurred 23% (P = 0.030) more hospital charges, 25% (P = 0.035) more ventilator days, 23% (P = 0.045) more hospital days, and 30% (P = 0.036) longer time until death than their nonaffiliated counterparts. Among all included patients, survival did not differ significantly among affiliated and nonaffiliated patients (log-rank test P = 0.317), neither was religious affiliation associated with a difference in survival on multivariate analysis (hazard ratio of death for religious versus nonreligious patients 0.95, P = 0.542). CONCLUSIONS: Compared with nonaffiliated patients, religiously affiliated patients receive more aggressive EOL care in the ICU. However, this high-intensity care does not translate into any significant difference in survival.]

If you have suggestions about the form and/or content of the site, e-mail Chaplain John Ehman (Network Convener) at john.ehman@uphs.upenn.edu .
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