

VIEWPOINT

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Health and Spirituality

For centuries, physicians and other healers have witnessed how illness focuses attention on “ultimate meaning, purpose, and transcendence, and ... relationship to self, family, others, community, society, nature, and the significant or sacred.”¹ Patients often discover strength and solace in their spirituality, both informally through deeper connections with family and friends, and formally through religious communities and practices. However, modern day clinicians regularly overlook dimensions of spirituality when considering the health of others—or even themselves.

This relative neglect represents a departure from the substantial history linking health, religion, and spirituality within most cultures.² However, accumulating evidence that highlights the richness of the interconnection can inform future strategies for population health as well as individualized, patient-centered care. According to a 2016 Gallup Poll of 1025 adults in the United States, 89% believe in God or a universal spirit, and 75% consider religion of considerable importance.³ The potential ramifications of these perspectives are substantial, especially given that increasing numbers of people in an aging society may be facing difficult end-of-life decisions.

Research

Recent studies suggest a broad protective relationship between religious participation and population health. A report from the Nurses' Health Study, which followed

characteristics), sensitivity analysis suggested that the association was moderately robust to such unmeasured confounding. Another report from the Nurses' Health Study noted that attendance at religious services was associated with a reduction in depression risk (adjusted relative risk, 0.71) and a 6-fold reduction in suicide risk (from 6.5 to 1.0 per 100 000/y).⁵

Possible mechanisms include that religious service participation may enhance the social integration that promotes healthy (eg, tobacco-free) behaviors and provides social support, optimism, or purpose. A recent meta-analysis of 10 prospective studies with more than 136 000 participants showed having higher purpose in life was associated with a reduction (relative risk, 0.83) in all-cause mortality and cardiovascular events.⁶ Because randomized trials are not possible (assignment of behaviors such as service attendance and life purpose is infeasible), these population-based studies represent the strongest available evidence.

Additional investigations suggest the value of spiritual approaches to medical care within the clinical realm, particularly in the end-of-life setting. In a multisite, prospective study⁷ of 343 patients with advanced cancer, those whose medical teams (eg, clinicians, chaplains) attended to their spiritual needs had quality-of-life scores at life's end that were 28% greater on average than those who did not receive such spiritual care (20.3 vs 15.8; highest possible score, 30). In addition, patients reporting high support of their spiritual needs by their medical teams (26%) compared with the large majority who did not receive such care (74%) had a higher odds of transitioning to hospice care (adjusted odds ratio, 3.5).

In contrast, when religious communities supplied spiritual care in the absence of the medical team (43%), patients with terminal illness had a lower odds of receiving hospice services (adjusted odds ratio, 0.37) together with a higher odds of receiving aggressive medical interventions (eg, resuscitation and ventilation) during the last week of life (adjusted odds ratio, 2.6).⁷ Other studies indicate that most patients with serious illness experience spiritual struggles, such as feeling punished or abandoned by God, associated with decrements in patient well-being.⁷ All these findings suggest the need for clinicians to integrate spiritual care into end-of-life settings for patients who wish to receive it.

More explicit focus on spirituality, often considered outside the realm of modern medicine, could improve person-centered approaches to well-being long sought by patients and clinicians.

up more than 74 000 study participants for 16 years, found that women who attended weekly religious services had a lower mortality rate compared with those who had never attended religious services (actual rates of 845 vs 1229 per 100 000/y, respectively; adjusted hazard ratio, 0.74),⁴ and those who attended religious services more than once per week had an even lower mortality rate (actual rates of 740 vs 1229 per 100 000/y; adjusted hazard ratio, 0.67), suggesting a possible dose-response relationship.

Multivariable adjustment for extensive confounders did not substantially attenuate the association, suggesting that some of the association might be causal. Although the findings may still be subject to unmeasured factors and residual confounding⁴ (eg, personal, social, psychological, and socioeconomic

Patient and Clinician

Since the 1990s, national and global health organizations (including the Association of American Medical Colleges, the American Medical Association, the American College of Physicians, and the Joint Commission) have increasingly called for attention to various aspects of

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spiritual challenges as part of whole-person, culturally competent care. The National Consensus Project for Quality Palliative Care has established standards for clinical practice that include the spiritual, religious, and existential aspects of care as 1 of 8 core domains. The World Health Organization has recognized spirituality as a core dimension of palliative care to improve quality of life for patients and families.

However, response to these calls has been limited. More than 80% of US medical schools currently offer training in spiritual care but most physicians have not received such training, which is usually delivered as an elective course. Despite evidence associating chaplain involvement with improved patient satisfaction in the hospital setting,⁷ formal systems of collaboration between spiritual leaders and clinicians remain limited.

Moreover, studies suggest that even though most patients desire spiritual care, few receive it. One multisite study⁸ that included 75 patients with advanced cancer and 339 nurses and physicians showed that even though 86% of patients viewed spiritual care as important to cancer care, 90% never received any form of such care from their oncology nurses or physicians. Another study² with 100 patients with advanced lung cancer and 257 medical oncologists indicated that of 7 possible factors in medical decision making, patients rated faith in God as the second most important factor, whereas physicians rated this factor as the least important.

Clinicians can begin to address the need by acknowledging spiritual health as part of obtaining a routine social history. Asking questions such as "Do you have a faith or spirituality that is important to you?" and "Do you have a religious or spiritual support system to help you in times of need?" signals respect for such issues while eliciting critical information to inform future care. Without overstepping bounds, clinicians can also implement formal models for spiritual history taking such as the FICA model (attention to *faith* or spirituality, its personal *importance* in health and illness, and the role of the patient's spiritual *community* and the health care team in *addressing* these issues).⁷ As appropriate, clinicians can also inquire about communal involvements, including religious services, and how they affect patients' well-being.

Clinicians might also benefit from attending to their own spiritual health. Pressing professional issues related to burnout, avoidable medical errors, attrition, and higher suicide rates among physicians than among the general population are of increasing concern.

Access to spiritual resources and practices could build resilience in both medical students and practicing clinicians. The act of providing such care to patients may help clinicians draw on their own internal spiritual resources. One study⁸ demonstrated that physicians (n = 204) who provided such care to patients with terminally ill cancer better integrate their religion or spirituality into their profession; therefore, providing spiritual care to patients may derive from or facilitate the clinician's own spiritual well-being. Another study⁹ of more than 1500 physicians found that those who regarded medicine as a calling experienced more career satisfaction and less burnout.

Community Resources

Clinicians can better connect patients with health-related resources offered by faith-based organizations in communities. Some of these organizations provide accessible settings for a wide range of health promotion activities with respect to smoking cessation, nutrition education and intervention, vaccination programs, cancer screening, and partnerships to address issues related to human immunodeficiency virus and AIDS. Federal agencies have encouraged such collaboration provided that inherently religious activities (eg, prayer, worship) are not funded by the government and that other conditions outlined in the First Amendment's Establishment Clause are not violated. This collaboration theme has had bipartisan support through the White House Office of Faith-Based and Community Initiatives (established by the Bush Administration in 2001) and later known during the Obama Administration as the Office of Faith-Based and Neighborhood Partnerships.

Conclusions

More explicit focus on spirituality, often considered outside the realm of modern medicine, could improve person-centered approaches to well-being long sought by patients and clinicians. Because most research has involved predominantly US and Christian populations, future work should examine these dimensions within broader ethnic and religious contexts. More attention to such spiritual matters could bring medicine closer to the World Health Organization's longstanding definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."¹⁰

ARTICLE INFORMATION

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