March 2013 Article of the Month

This month's article selection is by Chaplain John Ehman,
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Shin, J. H., Yoon, J. D., Rasinski, K. A., Koenig, H. G., Meador, K. G. and Curlin, F. A. "**A spiritual problem? Primary care physicians' and psychiatrists' interpretations of medically unexplained symptoms**." *Journal of General Internal Medicine* 28, no. 3 (March 2013): 392-398.

SUMMARY and COMMENT: "Medically unexplained symptoms (MUS) are symptoms that present with no physiological abnormalities" and "[t]hey account for 20-30 % of primary care consultations..." [p. 392]. This study explored how physicians may understand the role of spirituality in such cases, especially in light of physicians' own religious/spiritual characteristics. The authors are well known to those who follow the spirituality & health literature, with the probably exception of the lead author, Jiwon Helen Shin. She is a graduate student in theological studies at Westminster Seminary California (Escondido, CA) who at the time of the study at hand was a Research Intern in Religion and Medicine at the University of Chicago Hospitals. For health care chaplains, results here may help illuminate larger questions of physician attitudes and -- potentially -- referrals for spiritual care, though the article does not address chaplaincy referrals per se.

Data were analyzed from a 12-page, 42-item questionnaire mailed to 1,504 primary care physicians (PCPs) and 512 psychiatrists, between September 2009 and June 2010. The stratified random sample was generated from the American Medical Association Physician Masterfile of all US physicians. The survey included clinical vignettes like the following:

> A 41-year-old woman presents for her seventh clinic visit complaining of generalized muscle pains, fatigue and headaches. She has had the symptoms for several years. Prior physicians have diagnosed her with fibromyalgia and chronic fatigue syndrome. Physical exam is unremarkable except for tenderness over multiple areas of her body. Diagnostic workups have not found any physiological abnormalities. Regular exercise, NSAIDS, and muscle relaxants have not provided relief. She denies depression. [p. 393]

Participants were then asked a series of questions, such as: "In general, how much do you think patients with these symptoms would benefit from each of the following? a) paying more attention to their relationships; b) paying more attention to their spiritual life; c) taking medications" [p. 393]; and "Please indicate whether you agree or disagree with the following statements about patients who have multiple chronic symptoms for which there is no clear physiological abnormality after a thorough medical workup: Such patients 1) are usually experiencing the normal ups and downs of life; 2) have medical conditions that scientific research will one day be able to explain; 3) tend to have a root problem that is spiritual in nature; and 4) often get better with treatment by physicians" [p. 393]. There were a number of personal demographic items as well. The

questionnaire is well described in the Methods section [pp. 393-394], and a detailed report of the instruments themselves is at available online.

The response rate was 63% for PCPs and 64% for psychiatrists. Characteristics of the sample are given in a table on p. 394. Results address Interpretation of MUS, Differences by Physician Religiosity and Spirituality, and Differences Between Primary Care Physicians and Psychiatrists [pp. 394-396]. Among the findings:

> ...one in three PCPs and psychiatrists believes that patients with MUS have root problems that are spiritual in nature, and two out of three believe that such patients would benefit from paying more attention to their spiritual lives. Physicians who are more religious and/or spiritual were more likely to interpret MUS as resulting from spiritual problems and more confident that MUS patients would benefit from paying attention to their spiritual life. Being a psychiatrist is independently associated with believing that MUS are medical conditions that will one day be explained by science, and with being confident that patients with MUS will benefit from paying more attention to relationships, taking medications, and being treated by physicians; being a psychiatrist is inversely associated with believing that MUS are indicative of a spiritual problem. [p. 396]

The authors further note that "[w]hile two out of three physicians endorsed attention to spiritual life, however, only half as many interpreted MUS as reflecting a spiritual problem" and they speculate that "[m]any of the former may believe attention to one's spiritual life can help patients to cope with problems that are not necessarily spiritual in origin" [p. 396]. They also offer a particular caution: "Patients should be aware that their physicians' responses to MUS will likely reflect the physicians' particular personal and professional background" [p 397]; and they emphasize the importance of good physician-patient communication to avoid "misunderstanding and conflict in the clinical encounter" [p. 397].

Chaplains interested in factors that may affect interaction with -- and referrals from -- physicians should find this research thought-provoking. However, the very patterns by which physicians associated unexplained symptoms with spirituality may be a challenge for chaplains to consider how spiritual/religious characteristics and specialties may affect our own thoughts about *the unexplained* in patients and whether we generally tend to see spiritual problems as "root" issues or involvement in religious communities or closer attention to one's spiritual life as pretty much always good ideas. Medically unexplained symptoms may be an especially productive topic for discussion between chaplains and physicians, precisely because the medical assessment is admittedly insufficient here. Though the authors call for great attention to physician-patient communication [--see p. 397], this research may additionally imply a greater need for chaplain-physician communication about assumptions and interpretations of patients' symptoms that are medically unexplained ...and perhaps even those that are medically explained.

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

The article may be best suited for students in the second half of a residency, when they've had some time to get a sense of medical perspectives on spirituality and become somewhat familiar with the health care literature. It's easily readable, though as with many articles, the Discussion section should be a more narrative and contextual report of results than the actual Results section. The Methods section explains nicely the use of scenarios in the questionnaire, and students interested in this aspect of the study will want to access the online supplementary material. The authors relate their findings to previous research well [--see esp. p. 396], and the medium-sized endnotes provide good leads for follow-up. Discussion could address students' sense of their own assumptions about spiritual problems affecting physical and psychological symptoms, and whether spirituality may be helpful to symptoms that might not be rooted in a spiritual problem. Can they offer any examples? If a patient asked them for help in light of a medically unexplained symptom, how might they proceed? What sort of chaplain-physician consultation might be in order?

Related Items of Interest:

I. We have highlighted studies of physician attitudes and beliefs before on our site. See especially July 2011, October 2005 (for more work by Farr Curlin), and September 2004.

II. The present study follows a long line of research from the University of Chicago's Program on Medicine and Religion, co-directed by Farr Curlin. See especially the project titled the Chicago Atlas of Religion and the Practice of Medicine, and Dr. Curlin's 2008 essay, "A case for studying the relationship between religion and the practice of medicine." Many publications are available for downloading from the Program on Medicine and Religion site.

III. Among the voluminous works of the members of the team that produced this month's article, chaplains may be interested in the following sample of more recent articles addressing physicians and spirituality:

Bekelman, D. B., Parry, C., Curlin, F. A., Yamashita, T. E., Fairclough, D. L. and Wamboldt, F. S. "**A comparison of two spirituality instruments and their relationship with depression and quality of life in chronic heart failure**." *Journal of Pain & Symptom Management* 39, no. 3 (March 2010): 515-526. [(Abstract:) Spirituality is a multifaceted construct related to health outcomes that remains ill defined and difficult to measure. Spirituality in patients with advanced chronic illnesses, such as chronic heart failure, has received limited attention. We compared two widely used spirituality instruments, the Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being (FACIT-Sp) and the Ironson-Woods Spirituality/Religiousness Index (IW), to better understand what they measure in 60 outpatients with chronic heart failure. We examined how these instruments related to each other and to measures of depression and quality of life using correlations and principal component analyses. The FACIT-Sp measured aspects of spirituality related to feelings of peace and coping, whereas the IW measured beliefs, coping, and relational aspects of spirituality. Only the FACIT-Sp Meaning/Peace subscale consistently correlated with depression ($r=-0.50$, $P<0.0001$) and quality of life ($r=0.41$, $P=0.001$). Three items from the depression measure loaded onto the same factor as the FACIT-Sp Meaning/Peace subscale ($r=0.43$, -0.43, and 0.71), whereas the remaining 12 items formed a separate factor (Cronbach's alpha=0.82) when combined with the spirituality instruments in a principal component analysis. The results demonstrate several clinically useful constructs of spirituality in patients with heart failure and suggest that psychological and spiritual well-being, despite some overlap, remain distinct phenomena.]

Curlin, F. A., Lawrence, R. E., Odell, S., Chin, M. H., Lantos, J. D., Koenig, H. G. and Meador, K. G. "**Religion, spirituality, and medicine: psychiatrists' and other physicians' differing observations, interpretations, and clinical approaches**." *American Journal of Psychiatry* 164, no. 12 (December 2007): 1825-1831. [(Abstract:) OBJECTIVE: This study compared the ways in which psychiatrists and nonpsychiatrists interpret the relationship between religion/spirituality and health and address religion/spirituality issues in the clinical encounter. METHOD: The authors mailed a survey to a stratified random sample of 2,000 practicing U.S. physicians, with an oversampling of psychiatrists. The authors asked the physicians about their beliefs

and observations regarding the relationship between religion/spirituality and patient health and about the ways in which they address religion/spirituality in the clinical setting. RESULTS: A total of 1,144 physicians completed the survey. Psychiatrists generally endorse positive influences of religion/spirituality on health, but they are more likely than other physicians to note that religion/spirituality sometimes causes negative emotions that lead to increased patient suffering (82% versus 44%). Compared to other physicians, psychiatrists are more likely to encounter religion/spirituality issues in clinical settings (92% versus 74% report their patients sometimes or often mention religion/spirituality issues), and they are more open to addressing religion/spirituality issues with patients (93% versus 53% say that it is usually or always appropriate to inquire about religion/spirituality). CONCLUSIONS: This study suggests that the vast majority of psychiatrists appreciate the importance of religion and/or spirituality at least at a functional level. Compared to other physicians, psychiatrists also appear to be more comfortable, and have more experience, addressing religion/spirituality concerns in the clinical setting.]

Curlin, F. A., Rasinski, K. A., Kaptchuk, T. J., Emanuel, E. J., Miller, F. G., and Tilburt, J. C. "**Religion, clinicians, and the integration of complementary and alternative medicines**." *Journal of Alternative & Complementary Medicine* 15, no. 9 (September 2009): 987-994. [(Abstract:) OBJECTIVE: The aim of this study was to compare religious characteristics of general internists, rheumatologists, naturopaths, and acupuncturists, as well as to examine associations between physicians' religious characteristics and their openness to integrating complementary and alternative medicine (CAM). DESIGN: The design involved a national mail survey. The subjects were internists, rheumatologists, naturopaths, and acupuncturists. MEASURES: Physician outcome measures were use of and attitudes toward six classes of CAM. Predictors were religious affiliation, intrinsic religiosity, spirituality, and religious traditionalism. RESULTS: There was a 65% response. Naturopaths and acupuncturists were three times as likely as internists and rheumatologists to report no religious affiliation (35% versus 12%, $p < 0.001$), but were more likely to describe themselves as very spiritual (51% versus 20%, $p < 0.001$) and to agree they try to carry religious beliefs into life's dealings (51% versus 44%, $p < 0.01$). Among physicians, increased spirituality and religiosity coincided with more personal use of CAM and willingness to integrate CAM into a treatment program. CONCLUSIONS: Current and future integrative medicine will be shaped in part by religious and spiritual characteristics of providers.]

Curlin, F. A., Sellergren, S. A., Lantos, J. D. and Chin, M. H. "**Physicians' observations and interpretations of the influence of religion and spirituality on health**." *Archives of Internal Medicine* 167, no. 7 (April 9, 2007): 649-654. [(Abstract:) BACKGROUND: In spite of a substantial body of empirical data, professional disagreement persists regarding whether and how religion and spirituality (hereinafter "R/S" and treated as a single concept) influences health. This study examines the association between physicians' religious characteristics and their observations and interpretations of the influence of R/S on health. METHODS: A cross-sectional survey was mailed to a stratified, random sample of 2000 practicing US physicians from all specialties. Physicians were asked to estimate how often patients mention R/S issues, how much R/S influences health, and in what ways the influence is manifested. RESULTS: The response rate was 63%. Most physicians (56%) believed that R/S had much or very much influence on health, but few (6%) believed that R/S often changed "hard" medical outcomes. Rather, most physicians believed that R/S (1) often helps patients to cope (76%), (2) gives patients a positive state of mind (75%), and (3) provides emotional and practical support via the religious community (55%). Compared with those with low religiosity, physicians with high religiosity are

substantially more likely to (1) report that patients often mention R/S issues (36% vs 11%)(P<.001); (2) believe that R/S strongly influences health (82% vs 16%) (P<.001); and (3) interpret the influence of R/S in positive rather than negative ways. CONCLUSION: Patients are likely to encounter quite different opinions about the relationship between their R/S and their health, depending on the religious characteristics of their physicians.]

Fitchett, G., Rasinski, K., Cadge, W. and Curlin, F. A. "**Physicians' experience and satisfaction with chaplains: a national survey**." *Archives of Internal Medicine* 169, no. 19 (October 26, 2009): 1808-1810. [This is actually a letter in the journal, reporting a survey of 1102 physicians. Among the findings: "[m]ost physicians (89%) reported experience with chaplains," and "[a]mong these, most (90%) reported being satisfied or very satisfied with chaplains" [p. 1108]. Data showed that "higher levels of satisfaction were associated with practicing medical or other subspecialties, working in teaching hospitals, endorsing positive effects of R/S on patients, and believing it is appropriate to pray with patients whenever the physician senses it would be appropriate" [p. 1108]. In the geographic regions of the Midwest, West, and South, satisfaction with chaplains was similarly strong, but it was significantly lower in the Northeast. This research builds particularly upon earlier work: Curlin, F. A., Lantos, J. D., Roach, C. J., Sellergren, S. A. and Chin, M. H., "Religious characteristics of US physicians: a national survey," *Journal of General Internal Medicine* 20, no. 7 (July 2005): 629-634; which our Network featured as an Article-of-the-Month in October 2005.]

Lawrence, R. E., Rasinski, K. A., Yoon, J. D., Koenig, H. G., Meador, K. G. and Curlin, F. A. "**Physicians' beliefs about faith-based treatments for alcoholism**." *Psychiatric Services* 63, no. 6 (June 2012):597-604. [(Abstract:) OBJECTIVE: The study examined physicians' beliefs about faith-based alcohol treatments vis-a-vis Alcoholics Anonymous, pharmacologic treatment, and residential treatment. METHODS: A survey was mailed to a national sample of U.S. primary care physicians and psychiatrists. It included a brief vignette of a nominally religious 47-year-old man hospitalized for acute alcohol poisoning who requested addiction treatment. Physicians rated the likely effectiveness of three treatment methods: Alcoholics Anonymous, pharmacological therapy by an addiction specialist, and a residential program. Physicians were asked whether they would refer the patient to a faith-based program (beyond Alcoholics Anonymous) and whether an emphasis on spirituality is critical to 12-step program success. RESULTS: The response rate was 896 of 1,427 (63%) for primary care physicians and 312 of 487 (64%) for psychiatrists. Psychiatrists were more likely to rate Alcoholics Anonymous as very effective (64% versus 57% of primary care physicians), more likely to rate residential treatment as very effective (47% versus 38% of primary care physicians), and more likely to rate pharmacologic therapy as very effective (31% versus 22% of primary care physicians). Psychiatrists and primary care physicians were equally likely to consider referring the patient to a faith-based program (71% and 79%) and equally likely to believe that an emphasis on spirituality is critical to the success of 12-step programs (81% and 85%). CONCLUSIONS: Psychiatrists were more optimistic than primary care physicians about all three treatments. Physicians in both specialties would refer even nominally religious patients to explicitly faith-based programs (beyond Alcoholics Anonymous). Physicians' enthusiasm for faith-based treatments highlights the need for scientific study of these treatments to determine which elements are most helpful for patients seeking recovery.]

Rasinski, K. A., Kalad, Y. G., Yoon, J. D. and Curlin, F. A. "**An assessment of US physicians' training in religion, spirituality, and medicine**." *Medical Teacher* 33,

no. 11 (2011): 944-945. [(Abstract:) This study examined US physicians' training in religion and medicine and its association with addressing religious and spiritual issues in clinical encounters. Reports of receiving training were higher for highly spiritual physicians, psychiatrists, and physicians with high numbers of critically ill patients. Discussing religion or spirituality with patients was associated with having received training through a book or CME literature or during Grand Rounds, through one's religious tradition and from other unspecified sources but not with having received such training in medical school.]

Stern, R. M., Rasinski, K. A. and Curlin, F. A. "**Jewish physicians' beliefs and practices regarding religion/spirituality in the clinical encounter**." *Journal of Religion & Health* 50, no. 4 (December 2011): 806-817. [(Abstract:) We used data from a 2003 survey of US physicians to examine differences between Jewish and other religiously affiliated physicians on 4-D of physicians' beliefs and practices regarding religion and spirituality (R/S) in the clinical encounter. On each dimension, Jewish physicians ascribed less importance to the effect of R/S on health and a lesser role for physicians in addressing R/S issues. These effects were partially mediated by lower levels of religiosity among Jewish physicians and by differences in demographic and practice-level characteristics. The study provides a salient example of how religious affiliation can be an important independent predictor of physicians' clinically-relevant beliefs and practices.]

Williams, J. A., Meltzer, D., Arora, V., Chung, G. and Curlin, F. A. "**Attention to inpatients' religious and spiritual concerns: predictors and association with patient satisfaction**." *Journal of General Internal Medicine* 26, no. 11 (November 2011): 1265-1271. [(Abstract:) BACKGROUND: Little is known about how often patients desire and experience discussions with hospital personnel regarding R/S (religion and spirituality) or what effects such discussions have on patient satisfaction. OBJECTIVE, DESIGN AND PARTICIPANTS: We examined data from the University of Chicago Hospitalist Study, which gathers sociodemographic and clinical information from all consenting general internal medicine patients at the University of Chicago Medical Center. MAIN MEASURES: Primary outcomes were whether or not patients desired to have their religious or spiritual concerns addressed while hospitalized, whether or not anyone talked to them about religious and spiritual issues, and which member of the health care team spoke with them about these issues. Primary predictors were patients' ratings of their religious attendance, their efforts to carry their religious beliefs over into other dealings in life, and their spirituality. KEY RESULTS: Forty-one percent of inpatients desired a discussion of R/S concerns while hospitalized, but only half of those reported having such a discussion. Overall, 32% of inpatients reported having a discussion of their R/S concerns. Religious patients and those experiencing more severe pain were more likely both to desire and to have discussions of spiritual concerns. Patients who had discussions of R/S concerns were more likely to rate their care at the highest level on four different measures of patient satisfaction, regardless of whether or not they said they had desired such a discussion (odds ratios 1.4-2.2, 95% confidence intervals 1.1-3.0). CONCLUSIONS: These data suggest that many more inpatients desire conversations about R/S than have them. Health care professionals might improve patients' overall experience with being hospitalized and patient satisfaction by addressing this unmet patient need.]