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Toward Comprehensive Medicine: Listening to Spiritual and Religious Needs of Patients

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Abstract

Although great progress has been made in medicine, the spiritual and religious needs of patients have been slow to be acknowledged as a core principle of professional practice and care at end of life. Spiritual care, once regarded as the sole province of chaplains, has recently become increasingly recognized as part of a holistic management approach and the responsibility of all health care professionals. Almost two decades after the appearance of first recommendations, doctors still find it difficult to initiate discussions on religion and spirituality with their patients. In a local survey we conducted among junior doctors and nursing staff, only 2% of doctors would regularly enquire, whereas more than 50% never asked about religion. It appears that doctors are generally poorly prepared to tackle this issue, both during their medical student years and later as trainees. We present a case study that illustrates the intricacies of trying to deliver comprehensive care to an elderly patient with a potentially life-ending condition where the cultural, personal, and religious opinion of the relatives have played an important role in the patient's management. We then discuss the results of our survey and explore the literature as to why doctors, in particular, tend not to enquire about the religion and spirituality of their patients.

Keywords

medical training, competencies, religion, spirituality, faith, end of life care, comprehensive medicine, medical education

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Case Study

An 80-year woman was admitted with a history of recurrent seizures. She was unconscious on admission and experienced two further seizures while in the accident and emergency department. On examination she was noted to have developed aspiration pneumonia.

She had a history of ischemic heart disease and previous disabling stroke 4 months earlier leaving her bedbound and requiring all care. She lived with her younger son and his family.

The consultant in charge met up with the son to provide an update and discuss the management plan. The consultant maintained that given his mother's poorly state, it was best to keep her comfortable, withdraw antibiotics, and stop intravenous fluids.

The patient was of Muslim religion. She was also the matriarch for the family who were practicing Muslims. The son, who was a consultant anesthetist, maintained that he did not want his mother to suffer pain or be exposed to invasive diagnostics or treatments. However, he wished to discuss the plan with the other members of the family before formally agreeing.

Soon after, he returned to the ward explaining that the whole family was unhappy about withdrawing fluids or stopping antibiotics. The family felt that the patient should not be starved to death and would like a feeding nasogastric tube placed. He explained that the family felt strongly that their mother should go peacefully if that was her fate but should not be deprived while alive. This difference in view caused disagreement and the consultant in charge very sensibly requested a second opinion from a colleague who was more knowledgeable in the patient's religion. The second opinion recommended that the patient should not be starved and that she should continue on antibiotics for 48 hr and if no improvement was noted, then the antibiotics should be withdrawn. The family agreed with the care plan. He

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also suggested taking over her care if the first consultant was agreeable.

Introduction

Few would disagree that quality care is achieved not only by meeting the patient's physical needs but also by attending to the social, psychological, spiritual, and religious aspects of care. Patients generally welcome it. Although the prevalence varies, studies have reported that between 33% and 77% of patients are interested in having clinicians attend to their spiritual needs (Sulmasy, 2009) and this becomes especially important in end of life situations when religion and spirituality often become more prominent. In a U.S. study among adult patients (mean age 56.8 ± 12 years) with advanced cancer, who have failed first-line chemotherapy and had an expected prognosis of less than 1 year, 88% of the 230 individuals in the population studied considered religion to be at least somewhat important (T. A. Balboni et al., 2007). Nonetheless, the medical profession has been slow to respond; in the same study, the majority (72%) reported that their spiritual needs were either not supported or minimally supported by the medical system. This has led to the perception that the current dualistic approach to modern medicine, which separates care of the body from care of the soul, has resulted in physicians not always being able to achieve an in-depth understanding of patient needs, and therefore reduced holistic healing, compassion, and care (Singh & Ajinkya, 2012).

It is therefore essential that doctors and other health care professionals are competent in discussing spiritual and religious issues with their patients. Many organizations have recommended attention to the spiritual and religious needs of patients as an ethical obligation and an essential aspect of clinical practice (Lo et al., 1999). Furthermore, the physician's duty of beneficence requires respect for patient spirituality. Training medical students and junior doctors to address these needs of their patients is becoming increasingly important in the current context of striving toward delivering comprehensive medical care.

One of the important starting points is understanding the difference between religion and spirituality. Although the two terms are often used to mean the same thing, in academic circles it has become increasingly common to accept spirituality and religion as distinct but overlapping entities. Religion can be understood as a set of beliefs and practices shared by a community, whereas spirituality is commonly defined as a person's existential relationship with God or the Transcendent. Spirituality relates to the way in which people understand and live their lives in relation to their core beliefs and values and their perception of ultimate meaning. Spirituality, however, is not confined to religion alone; it may also be attained through interaction with nature, the arts, or a humanist approach especially in non-believers.

In the United States, physicians are more likely to describe themselves as spiritual and distinct from religious thus making a clear difference between the two (Anandarajah, 2005). In a more recent survey among clinician educators (McEvoy, Burton, & Milan, 2014), nearly 31% of respondents were spiritual not religious and 4.4% were religious not spiritual. This highlights a difference in perspective among doctors. In the general population, however, this distinction especially in the older religious person is, in reality, quite blurred and the two terms are in fact used interchangeably (Musick, Traphagan, Koeing, & Larson, 2000).

Another important point is appreciating the role of the doctor's faith. The cultural and religious backgrounds of doctors should not be dismissed when discussing issues around end-of-life care. Curlin (2005) found that 55% of physicians stated that religious beliefs influenced their practice of medicine (Curlin, Lantos, Roach, Sellergren, & Chin, 2005). This was highlighted in a national survey among U.S. doctors (McEvoy et al., 2014), which reported that physicians who have no religious affiliation were more willing to provide assistance with euthanasia than those with a religious affiliation, and to have complied with the patient's request for assisted suicide. The situation was similar, not only in the United Kingdom where a study reported that non-religious doctors were more likely to provide continuous deep sedation until death (Seale, 2010), but also multinationally among non-religious doctors who were more likely to administer drugs with the explicit intention of hastening death (Cohen et al., 2008). In contrast, religious doctors in European countries are more likely to be opposed to agreeing to patients' request for non-treatment, or to allow patients to decide on hastening their deaths (Miccinesi et al., 2005). Not surprisingly, very religious Israeli doctors are less likely to agree to withdrawing life-sustaining treatment or providing pain medication that may shorten life (Wenger & Carmel, 2004). Similarly, Muslim and Hindu doctors in the United States are more likely to object to assisted suicide or terminal sedation.

The religious and cultural background therefore influences individual practice and is associated with the willingness to take certain, and occasionally controversial, end-of-life decisions. Furthermore, a higher level of spirituality among physicians is more likely to lead to a discussion around the subject with their patients (Rasinski, Kalad, Yoon, & Curlin, 2011).

In a society where diversity of opinion is a doctrine, awareness of one's own decision-making determinants and the ability to contrast them with the patient's concerns and expectations is important. Physicians must avoid being judgmental when the patient's beliefs and values conflict with their own. Relevant dialogue with the patient and relatives should clarify some core issues and aid in discussing ethically and legally acceptable management options. Training is important as accidental

intersection of opposing views might break the evolving rapport between patient and doctor. In situations where a resolution cannot be reached, a second opinion should be sought.

Current Practice

In 1999, the Association of American Medical Colleges (AAMC) recommended that physicians bring up and discuss religion and spirituality with their patients (AAMC, 1999). However, by 2006, half of U.S. physicians surveyed (psychiatry not included) never brought the subject up with patients and majority would only feel comfortable talking about it if patients themselves initiated the conversation (Curlin et al., 2007). A more recent study of 297 American physician trainees revealed that discussions on religion and spirituality in palliative care required communication skills that were more advanced than other usual topics on the subject like DNACPR discussion (Ford, Downey, Engelberg, Back, & Curtis, 2012).

In the United Kingdom, the General Medical Council advises that all doctors must take into account spiritual and cultural preferences when taking a clinical history (17—Good Medical Practice [2017]). However, a survey in Scotland confirmed that Foundation year 1 doctors (intern first year graduates) were less prepared to deal with the spiritual distress of palliative patients in comparison with other domains such as pain control and speaking with families (Bowden, Dempsey, Boyd, Fallon, & Murray, 2013). This, in all likelihood, is related to the poor education and training given to the subject. In a previous questionnaire survey sent out to 32 medical schools in the United Kingdom, looking at the state of teaching on spirituality (Neely & Minford, 2008), 10 (59%) of the 17 medical schools that responded stated that they provide some teaching on spirituality. Furthermore, there was no uniformity on content or form and there is little practical evidence that this is translated into patient care. In 2011, in the United States, 30% of medical schools did not have spirituality and religion on their curriculum (Young, 2011).

In our District General Hospital, we conducted a questionnaire survey in 2014 looking at the attitudes of junior doctors and nursing staff in relation to their patients' religious views. We enquired about the frequency they asked patients about their religion, if they felt it was important, their knowledge of different religions and whether they would like religious support for themselves if they were patients. Finally, we asked for views on the usefulness of a seminar on religious and ethical considerations.

Fifty doctors and 50 nurses were invited. The doctors were at different stages of their training (Foundation—Years 1 and 2 postgraduate [$n = 26$]; Continuing Medical Training level, Years 3 and 4 of training [$n = 16$]; and subspecialty trainees [$n = 8$]). The nurses were all ward based at different stages in their careers and levels of experience from first year post qualification ($n = 20$, 40%), to ward matrons with more than 8 years of experience ($n = 5$, 10%). Twenty percent had not specified their grades.

The questionnaire was in paper format, given by hand to participants by one of the authors (C.B.) and collected shortly thereafter. Only one nurse declined to participate.

Interestingly, only 2% of doctors would regularly ask their patients, 50% never asked, and 48% did so infrequently. In contrast, 50% of nurses always or very often asked their patients. Only 6% of nurses never asked.

A third of doctors felt that time restraints and being busy were the main reasons. Surprisingly, 20% of doctors thought it was not their job to ask and 43% felt it was not important for them to prioritize such discussions. A few felt it was either "embarrassing" to ask or their lack of knowledge about religions as reasons for shying away from asking. In contrast, virtually all nurses ($n = 49$) considered religious and spiritual support important to patients. This contrasted to 70% of doctors.

Although 54% of doctors considered themselves religious, only 33% considered religious support to be important for themselves if they were patients. Among the nurses, 64% considered themselves religious and 78% felt religion important to them in time of illness. 14% of doctors and 16% of nurses felt they did not know very much about different religions, 98% of both groups considered training on these issues as useful or very useful.

Discussion

Our survey revealed, the majority of doctors did not enquire about their patients' religious views. Two thirds either did not appreciate its relevance or acknowledge it as part of patient assessment. They reported finding it difficult to initiate discussions with patients about their spirituality mainly because these discussions were felt to be either intrusive to the patient or embarrassing for the doctors due to lack of knowledge on such topics. Time restraint was another important factor reported. More surprisingly however is the fact that a significant proportion did not see it as within their role or scope as doctors. Similar issues have been highlighted in previous studies as well. In a U.S. survey of about 350 physicians and nurses, the nurses considered "lack of private space" and doctors "lack of time" as the key barriers preventing discussion of these topics (Richardson, 2014). However, neither of these was found to be correlated with discussion in practice, one of the main barriers being inadequate training. In the United Kingdom, the Foundation year's curriculum includes some training on these issues. The discussion of spirituality with relevant patients is part of the Foundation training syllabus

(Foundationprogramme.nhs.uk, 2017), yet junior doctors bring up these subjects very sporadically when dealing with patients as shown in our study and earlier (Bowden et al., 2013).

Our study is limited by its small sample size and being conducted in a single center. The results may therefore be a reflection of current local rather than national practice. It does nonetheless show that the assessment of the patient spiritual and religious needs remains unsatisfactory.

The lack of teaching and training extends beyond undergraduate years to include postgraduate training. Until recently, postgraduate medical training has especially focused on healing illness and physical management with the result that specialty doctors have come to believe that it is not their role to get involved in spiritual and evangelical discussions with patients. This traditional training has resulted in a lack of confidence to the extent that doctors fear being overwhelmed and out of their comfort zone, unsure how to respond to the spiritual matters raised by the patient.

The lack of appropriate training in end-of-life care has called for more emphasis in training and given rise to changes in the medical school and postgraduate curricula, through which medical students and residents learn to address spiritual and religious issues of patients in the context of providing holistic, patient-centered, and compassionate care (AAMC, 1999; Puchalski & Larson, 1998; Puchalski & Romer, 2000).

How to Do It? A Proposal

As discussed earlier, the majority of patients are not offended by gentle non-judgmental questioning on their religious and spiritual beliefs. Therefore, given the evidence, clinicians should be able to elicit a spiritual history from the patient. However, as shown in our study and others earlier (M. J. Balboni et al., 2014; Richardson, 2014), doctors are generally not comfortable asking such questions. A notable gap in education and training is therefore apparent not only in appreciating and understanding patient needs but also on how to execute the task. A multilayered approach is therefore needed. To start with, efforts should focus on raising awareness to spiritual and religious issues by highlighting its significance predominantly through relevant case studies demonstrating that attention to these issues is part of holistic medicine, and also by reflecting on real life experiences of the clinician teacher with patients. This should be started at an early stage of medical education and can be delivered in the undergraduate curriculum through an educational module on spirituality and religion. The module can incorporate a multitude of educational tools from lectures, to small group teaching, to facilitator-led case studies. Group teaching should facilitate dialogue and engage trainees to explore possible spiritual perspectives individual group members may have come across and reflect on the experience as a group. The module should also include at least an introduction to some of the essential differences between the various religions.

The next level is teaching the important competencies and skills necessary in dealing with issues of spirituality and religion. This, in our view, can be achieved through the implementation of workshops to stimulate exploratory discussions, or small group teaching to encourage trainees to enquire from patients without feeling embarrassed. Alternatively, simulation courses to teach communication skills in relation to sensitive topics, through enacted case scenarios in the form of OSCE can be organized for postgraduates or establishing a comprehensive physician training program as suggested by Puchalski and Larson (1998). Whichever the format, a balance between pedagogy and andragogy should be sought.

The third level of training is learning how to best to practically implement the acquired knowledge; translating the knowledge acquired into clinical practice. Clinicians should be trained to explore patient spirituality with sensitivity and skill and in a timely efficient manner. This is probably the most difficult part.

All trainees and most senior doctors involved in the acute medical or surgical take and general medical/surgical wards will appreciate the intense workload and demand for rapid throughput of patients. This imposes time restraints on the assessment of patients as they come through the front door and /or shortly following admission. It is therefore not difficult to see how certain aspects of the time-honored history taking can be missed out by the admitting doctor especially if the general impression is that this part of patient history is "non-essential" in the acute management setting. This view can be changed, as teaching about spirituality and religion becomes more embedded from the early days of medical training. For now, one way to ensure that it has not been left out of the history taking is by designating a certain area of the standardized patient clerking proforma. This should serve as an aide memoire and also document the discussion that takes place with the patient about spirituality.

Several assessment tools have been developed to address the subject of religion and spirituality in patients (see Lucchetti, Bassi, & Lucchetti, 2013, for a systematic review) (Lucchetti et al., 2013) although in our view, the narrative approach is probably the most likely to consolidate good rapport with the patient and, in certain instances, their family. Given the constraints of time, a simple process should be advocated. Simple open-ended questions may provide a less formal approach to obtain the necessary information. Examples of such questions are shown in Box 1.

Box 1. Examples of Questions When Enquiring About Spirituality and Religion.

- What role does religion play in your life?
- Are you a religious person?
- Do you practice your religion?
- Do you have any spiritual or religious requirements that the hospital can arrange for you?
- Do you have any spiritual beliefs that might affect your stay here at the hospital?
- Are there any spiritual beliefs that you wish to discuss with me?
- Would you like to see a chaplain or someone from pastoral care?

The information can be acquired either during the initial history taking, in the context of breaking bad news, or during a medical crisis, for example, deterioration in clinical condition. Respect for patients requires attention to detail and careful listening and the choice of words is important when talking to the patient or their relatives.

Finally, the importance of multidisciplinary approach to spiritual needs cannot be overstated especially in cases of spiritual distress when appropriate referral should be made to spiritual care providers (e.g., chaplain, other clergy), who can address these issues in depth.

The doctors and nurses should also reassure the patient on the availability of religious and spiritual input locally, as part of the multidisciplinary approach.

Conclusion

Attitudes toward illness and death are determined by the beliefs and culture in which one lives. Today in the developed world, medical institutions are relying on the scientific method to achieve better understanding of the patient's illness and the outcomes of various therapeutic approaches. However, patients often have culturally determined religious and spiritual views. These views may play an important role in the understanding and decision-making processes of the patients. In the case of doctors and health care workers, the professional regulations require sound evidence-based advice and treatment to be delivered to their patients. The differences between these contradictory standpoints should be clarified earlier on in the doctor–patient dialogue.

We recommend that sensitivity should be employed for the patients and relatives with strong views as well as those with mental issues. Patients without strong support from family and friends deserve perhaps more careful and thorough enquiry regarding their spiritual and religious needs as they might benefit more from these services' input. By not tackling these issues, the team may fail to address these often important needs of their patients even when the local services are readily available and very effective.

The role of the clinician is to clarify the patient's concerns, beliefs, and spiritual needs, and attempt to establish trust with both patient and family. Thus, they can be at ease to share their deepest concerns and not feel embarrassed to ask for help. The inclusion of spiritual and religious needs of patients as part of history taking and assessment remains unsatisfactory and should be fully incorporated into all undergraduate and postgraduate medical training.

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Author Contributions

AA conceived and designed the survey and wrote the manuscript, MH did the literature search and reviewed the manuscript, and CB conducted the survey and reviewed the manuscript

Ethical Approval and Consent to Participate

The manuscript does not include patient study; therefore, no ethical approval sought. The survey questionnaire (results included as part of the manuscript) contained a section on consent/agreement to participate in the form given to participants.

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References

Association of American Medical Colleges. (1999). *Report III: Contemporary issues in medicine: Communication in medicine. Medical school objectives project*. Washington, DC: Author.

Anandarajah, G. (2005). Doing a culturally sensitive spiritual assessment: Recognizing spiritual themes and using the HOPE questions. *Virtual Mentor*, *7*, 371-374. doi:10.1001/virtualmentor.2005.7.5.cprl1-0505

Balboni, M. J., Sullivan, A., Enzinger, A. C., Epstein-Peterson, Z. D., Tseng, Y. D., Mitchell, C., . . . Balboni, T. (2014). Nurse and physician barriers to spiritual care provision at the end of life. *Journal of Pain and Symptom Management*, *48*, 400-410.

Balboni, T. A., Vanderwerker, L. C., Block, S. D., Paulk, M. E., Lathan, C. S., Peteet, J. R., & Prigerson, H. G. (2007).

Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. *Journal of Clinical Oncology*, *25*, 555-560. doi:10.1200/jco.2006.07.9046

Bowden, J., Dempsey, K., Boyd, K., Fallon, M., & Murray, S. A. (2013). Are newly qualified doctors prepared to provide supportive and end-of-life care? A survey of Foundation Year 1 doctors and consultants. *The Journal of the Royal College of Physicians of Edinburgh*, *43*, 24-28.

Cohen, J., van Delden, J., Mortier, F., Löfmark, R., Norup, M., Cartwright, C., . . . Eureld Consortium. (2008). Influence of physicians' life stances on attitudes to end-of-life decisions and actual end-of-life decision-making in six countries. *Journal of Medical Ethics*, *34*, 247-253. doi:10.1136/jme.2006.020297

Curlin, F. A., Lantos, J. D., Roach, C. J., Sellergren, S. A., & Chin, M. H. (2005). Religious characteristics of U.S. physicians. *Journal of General Internal Medicine*, *20*, 629-634. doi:10.1111/j.1525-1497.2005.0119.x

Curlin, F. A., Lawrence, R. E., Odell, S., Chin, M. H., Lantos, J. D., Koenig, H. G., & Meador, K. G. (2007). Religion, spirituality, and medicine: Psychiatrists' and other physicians' differing observations, interpretations, and clinical approaches. *American Journal of Psychiatry*, *164*, 1825-1831. doi:10.1176/appi.ajp.2007.06122088

Ford, D. W., Downey, L., Engelberg, R., Back, A. L., & Curtis, J. R. (2012). Discussing religion and spirituality is an advanced communication skill: An exploratory structural equation model of physician trainee self-ratings. *Journal of Palliative Medicine*, *15*, 63-70. doi:10.1089/jpm.2011.0168

Foundationprogramme.nhs.uk. (2017). *The foundation programme curriculum*. Retrieved from http://www.foundationprogramme.nhs.uk/sites/default/files/2018-07/Reference%20Guide.pdf

Lo, B., Quill, T., Tulsky, J., Abrahm, J., Block, S., Breitbart, W., . . . Kroenke, K. (1999). Discussing palliative care with patients. *Annals of Internal Medicine*, *130*, 744-749. Retrieved from https://www.acponline.org/system/files/documents/clinical_information/resources/end_of_life_care/palliative_care.pdf

Lucchetti, G., Bassi, R. M., & Lucchetti, A. L. G. (2013). Taking spiritual history in clinical practice: A systematic review of instruments. *Explore*, *9*, 159-170. doi:10.1016/J.EXPLORE.2013.02.004

McEvoy, M., Burton, W., & Milan, F. (2014). Spiritual versus religious identity: A necessary distinction in understanding clinicians' behavior and attitudes toward clinical practice and medical student teaching in this realm. *Journal of Religion and Health*, *53*, 1249-1256. doi:10.1007/s10943-014-9844-0

Miccinesi, G., Fischer, S., Paci, E., Onwuteaka-Philipsen, B. D., Cartwright, C., van der Heide, A., . . . Mortier, F. (2005). Physicians' attitudes towards end-of-life decisions: A comparison between seven countries. *Social Science & Medicine*, *60*, 1961-1974.

Musick, M. A., Traphagan, J. W., Koeing, H. G., & Larson, D. B. (2000). Spirituality in physical health and aging. *Journal of Adult Development*, *7*, 73-86.

Neely, D., & Minford, E. J. (2008). Current status of teaching on spirituality in UK medical schools. *Medical Education*, *42*, 176-182. doi:10.1111/j.1365-2923.2007.02980.x

Puchalski, C. M., & Romer, A. L. (2000). Taking a spiritual history allows clinicians to understand patients more fully. *Journal of Palliative Medicine*, *3*, 129-137.

Puchalski, C. M., & Larson, D. B. (1998). Developing curricula in spirituality and medicine. *Academic Medicine*, *73*, 970-974. Retrieved from http://journals.lww.com/academicmedicine/Fulltext/1998/09000/Developing_curricula_in_spirituality_and_medicine_.15.aspx

Rasinski, K. A., Kalad, Y. G., Yoon, J. D., & Curlin, F. A. (2011). An assessment of US physicians' training in religion, spirituality, and medicine. *Medical Teacher*, *33*, 944-945. doi:10.3109/0142159X.2011.588976

Richardson, P. (2014). Spirituality, religion and palliative care. *Annals of Palliative Medicine*, *3*, 150-159. doi:10.3978/j.issn.2224-5820.2014.07.05

Seale, C. (2010). The role of doctors' religious faith and ethnicity in taking ethically controversial decisions during end-of-life care. *Journal of Medical Ethics*, *36*, 677-682. doi:10.1136/jme.2010.036194

Singh, D. K. M., & Ajinkya, S. (2012). Spirituality and religion in modern medicine. *Indian Journal of Psychological Medicine*, *34*, 399-402. doi:10.4103/0253-7176.108234

Sulmasy, D. P. (2009). Spirituality, religion, and clinical care. *Chest*, *135*, 1634-1642. doi:10.1378/chest.08-2241

Wenger, N. S., & Carmel, S. (2004). Physicians' religiosity and end-of-life care attitudes and behaviors. *Mount Sinai Journal of Medicine*, *71*, 335-343.

Young, C. K. C. (2011). *Spirituality, health, and healing: An integrative approach* (2nd ed.). Sudbury, MA: Jones & Bartlett.