National Hospice and Palliative Care Organization

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Palliative Care Resource Series

WHEN A PATIENT ASKS YOU TO PRAY: ADVICE FOR THE PALLIATIVE CARE PROFESSIONAL

Rev. Dr. Carla Cheatham

Research demonstrates that patients want to talk with their providers about R/S/E (religious, spiritual, existential) concerns but, most often, providers do not make space for them to do so (Williams, 2011). When spiritual support is provided, health outcomes and satisfaction are greater, there are lower rates of hospital deaths, higher rates of hospice enrollments, and persons are less likely to pursue unnecessary and aggressive end-of-life care. (Astrow, et al, 2007; Balboni, et al, 2010; Balboni, et al, 2011; Daaleman, et al, 2008; Flannelly, et al, 2012; Pargament et al, 2004; Wall, et al 2007).

Non-chaplain clinicians list multiple barriers to providing spiritual support, including a lack of time, discomfort with the prospect, and concerns about boundary issues. In at least one study (Balboni, MJ et al. 2014) of 112 nurses and 195 physicians, the greatest perceived barrier was the feeling they had not received adequate training (60% / 62%).

The purpose of this resource is to help address this perceived gap in training. It is important that we neither neglect persons' R/S/E needs nor abuse our positions of "power" in the caregiving relationship by overstepping boundaries. Either extreme is spiritual malpractice. Competent spiritual care is critical to patients' experiences and key to remain grounded in patient-driven care.

START WITH A PATIENT-DRIVEN VIEW

There is a sweet spot in spiritual care. It is that space in the middle, between those two extremes, from which we learn what patients and families believe, so we can help them access their beliefs to find meaning, peace, and comfort.

As the often used but anonymous saying goes, "We do not see things as they are, we see things as we are." It is easy to make assumptions about what persons want and need, projecting our own views and desires upon them without realizing we are doing so. Even as well-meaning, well-intended persons, we do this every day. Respecting a patient or family member's boundaries and honoring their views is essential to a patient driven view.

> One CNA at a hospice inpatient unit came to me, the chaplain, and excitedly shared that she had prayed for a patient who was non-responsive and felt that her praying had helped calm the patient. Taken aback, because I knew the patient's views were not Christian, I asked the CNA to tell me more about the language she had used and what she had prayed for.
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> The hospice worker described the experience and recited the prayer she had used; it contained language from one particular branch of Christianity. When I asked her why she had chosen to say a Christian prayer for the patient, the CNA expressed confusion, stating that the patient was "clearly Christian".
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> I asked how she knew that and the CNA responded, still confused, "Well, when she could still talk, she was just so nice and loving…I mean, she has to be Christian." I explained that I knew a great number of Muslims and Jews and Buddhists and Humanists and Atheists who were also "nice and loving", and then told her the belief system of the patient in question.

I could see the brain cells rearranging inside the CNA's head as her world view was challenged to expand. We talked more. She appeared crestfallen and even horrified at the thought of having imposed a Christian prayer on someone who was not. I acknowledged the compassion that led her to want to be loving and helpful and reassured her that this patient would probably understand and forgive her well-intentioned but misguided efforts.

The CNA asked about how to avoid making that kind of mistake again and how to be more respectful in the future. It led to a lovely conversation that I now use when training others about this topic.

We must learn to see patients and families as they are, not as we assume them to be, if we are to respond with care that is appropriate for their desires and needs. Rather than simply being patient-centered, we must be driven by what they communicate to us about what they want and how we can best care for them. As David Brandon in *Zen in the Art of Helping* wrote, "If only I could throw away the urge to trace my patterns in your heart, I could really see you." We must start by seeing and hearing them.

LET PATIENTS AND FAMILIES INITIATE

Many caregivers fear that not offering to pray may offend a person who is in distress, but there is another way. Even professional, clinically trained spiritual care counselors (SCCs) are taught to tread carefully when offering prayer. We are the member of the team most expected to offer prayer, but we also do not want persons to feel put on the spot or obligated to accept our offer because they don't feel comfortable telling us "No".

As an SCC, I'll simply state at the first visit, "Some persons want to talk, others want me to sing or read meaningful texts with them, some just want to sit quietly, some want me to pray, and others just want to play checkers. Whatever it is you would like, I'm happy to do."

From that point forward, before I leave each visit, I'll ask if there's anything else I can do for them. I ask in such a way as to indicate that I am not hinting that I want or need them to ask me to pray in order to think well of them. It is an honest, open, request, which means they have full room to answer honestly. At that point, some ask me to pray while others do not. I indicate my willingness to pray at the first visit, and they can choose whether or when to ask me to do so. What I am willing to give freely, I must be willing to never have requested.

Since this is their journey, their illness, their process, their life and it IS all about them, I get to have no ego invested here. If I have a need to pray for them, that's about me, not them; it calls into question my own boundaries and whether I'm looking to my professional work to fill some personal need. Those are always important questions to ask of ourselves.

We can trust patients to take the lead by asking for what they need. If I offer directly to pray, it can be very hard for them to refuse, even if they absolutely do not want me to do so. That is why I recommend non-spiritual care professionals allow the request to come from the patient or family. Patients and families may have never felt comfortable setting boundaries or being assertive.

Now, at perhaps the most emotionally and physically vulnerable time of their lives, they may be even more wary of telling the persons bringing the good drugs, help with bathing and Medicare forms, supplies, support for their families, etc. "No" and risk offending us. We must be mindful of the power differential in the caregiving relationship and tread very carefully. There are creative ways to be available without putting those for whom we care in an awkward position.

DETERMINE YOUR OWN COMFORT ZONE

Some professionals ask me the "do I pray" question with a deer in the headlights look! Praying aloud is not their thing, yet they don't want to feel as though they have abandoned someone in pain if the patient asks for prayer.

- If you do not feel comfortable praying aloud, here is a sample response that can be said with warmth and compassion: *"Praying out loud isn't something I'm (comfortable with / good at / experienced with, etc.) But I'd be happy to sit with you and hold your hand for a time in silence or while you pray. And, I promise, I'll definitely be holding you in my heart."*

  This type of response to the immediate request or need means that you are not abandoning or ignoring the request, you are just responding in the way that makes the most sense for you. I cannot administer medication for acute dyspnea, but I can hold a hand and breathe with the patient while we both wait for the nurse or physician to arrive.

- Another option may be to refer to the SCC on your team, "You know, this is what our SCC is trained to do. May I call on him/her and ask them to visit?" Those who decline spiritual care at one point in care may reconsider, when emotions intensify or as they begin to know and trust the team. You may need to reassure patients that the SCC is not coming to cast judgment or promote one particular religion. Have your elevator speech ready to describe what it is SCCs do and do not do in order to alleviate the fears some patients and families have about spiritual care.

- A favorite social worker I know is often heard to say, "They're not the Avon lady. They've nothing to sell." I often say, "We just want to know what you believe and how to help you access those beliefs to find as much peace, meaning, and comfort as possible."

- Sometimes, our best entryway is with someone they already know, trust, and with whom they feel comfortable. I encourage double-dating, which is other members of the team asking if they can bring the SCC with them the next time they visit.

We are not responsible for being able to resolve all the needs of patients and families, but we are responsible for screening for and noticing all forms of distress, offering at least an immediate acknowledgment and response, and facilitating the appropriate referrals.

FIND THEIR WORDS

If you do feel comfortable praying aloud, make sure you know how to pray in a way that honors the patient and/or family member's beliefs. The quickest and simplest way to do that is to ask, "How do you typically begin and end your prayers?" It really is that simple. If they do not understand, you can add,

"Everyone prays a little differently and I want to pray in the way that's most familiar and comforting to you. What words do you tend to use to start your prayers, and what are the very last words you tend to say?"

- Using the language that is comfortable for them, rather than what we are accustomed to using, is one more part of patients' right to refuse or accept treatment. This is, after all, a clinical intervention being performed in a healthcare setting with providers serving in a professional capacity; so it is a medical treatment.

- Even if we know that our own faith tradition matches theirs, we must not assume that our way of praying is the same as theirs. Some professionals I know who are Christian almost exclusively use masculine language for the divine, and the words fall into their prayers with regularity, which is completely fine for their own prayers. Others, however, have strong feelings of discomfort with such words and some even find it triggering. Why would I insist on using the word "Father" to pray for a person who still carries the scars of abuse from his/her own father and who struggles to relate to the divine in that way?

We use translation services as a means of creating access and equity in healthcare. Since the prayer is for patients, and not for us, and since it is in response to their need for support rather than our need to promote our religion, should we not want to use the language that will mean the most to them?

What are they praying for?
It is also important to ask them what they would like to pray for, rather than assuming what that might be. It's like imagining that the words they use to begin and end their prayers are two slices of bread and their request/s are inserted into the middle of the "prayer" sandwich. Equipped with words from their own heart, you can offer those words back to them as a prayer that respects their needs. They'll think it's the best prayer they've ever heard, because it will be of their own design.

Praying for physical healing
What if they ask you to pray for healing? The simple answer is to ask what healing looks like to them. Sometimes, simply asking that question can invite them to broaden their definition beyond a physical cure. We can affirm and even join them in the hope for physical healing, if that is the healing of which they speak, without setting up expectations that such a miracle is medically possible. This is an incredibly tricky area to navigate, and one with which even seasoned SCCs grapple. We do not want to stifle beliefs or hope, nor do we want to offer false expectations and leave patients unprepared if a physical cure does not occur.

Did I not pray hard enough? Did I not believe enough? Did G-d abandon or neglect me? These questions are all indications of spiritual distress that may arise if one asks for miracles and they do not come. We do not want to increase the risk of distress by mis-stepping around this topic.

If it seems appropriate, I will sometimes delicately ask, "I'm curious, if physical healing is not the miracle (insert their word for the divine, here) is going to provide in this circumstance, what other miracles do you want to ask for?" For many, this is the first time it has occurred to them that miracles can look like something other than their cancer going away. Inviting this dialogue has often led persons to go on to talk about emotional pain, relational wounds, family dynamics, and more issues that could use healing.

Patients can expand their prayers to include other forms of healing beyond the physical. This allows us to pray with them in a way that honors their desires with less of a chance of inviting spiritual distress or being medically unethical and perpetuating what is sometimes, at least medically, false hope.

Balancing personal faith/views and good patient care

Even if you fumble with the words you repeat back to them as you attempt to use their words, most people can tell when we are honestly trying to be respectful. They usually appreciate the heck out of our attempts to honor their views and can overlook imperfect attempts to meet them where they are.

It's important to note that I'm not asking you to deny your own faith or views. For some, the two are not mutually exclusive; they can pray for another as is needed without feeling as if they are betraying their own views.

For others, it is simply too big of a leap from what feels do-able for them. That's ok! That's why you have someone on the team who IS trained to be able to care for the needs of persons of all views and backgrounds. Part of our professional responsibility is knowing when to "refer out". There is no shame in doing so. The only shame would be to, even if well-intentioned, cause harm to those for whom we are committed to honor and care by abandoning them or disrespecting this aspect of their culture and coping.

FOLLOW UP

It is always good practice to touch base with the SCC with whom you work. If a patient tells me they're having a physical symptom, I call the nurse and let him or her know. If they're struggling with family dynamics, I contact the social worker.

It's no different if someone expresses spiritual symptoms. Coordinating care with the professional responsible for overseeing that aspect of a patient's treatment plan is important and respects boundaries and the transdisciplinary approach.

Information you have gleaned from your interaction with the patient and/or family member can be incredibly helpful to the SCCs plan of care. It also promotes interprofessional respect and understanding of and appreciation for one another's roles. It provides an opportunity for all members of the team to grow in their knowledge as the team discusses circumstances they face, how they responded, what worked, and what did not.

While the primary source for R/S/E support is usually the SCC, all members of the team can be involved. Providing an ethical, appropriate, coordinated response to those for whom we are committed to care will serve everyone well.

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