An 83-Year-Old Woman With Chronic Illness and Strong Religious Beliefs

Harold G. Koenig, MD, Discussant

Dr Burns: Mrs A is an 83-year-old woman who has multiple medical problems and, despite numerous medical interventions, chronic progressive pain and weakness. She feels that her faith offers the most help for coping with her illness. She lives in a senior residence near Boston and has 3 daughters, 2 sons, and many grandchildren. Mrs A attends church regularly and has a strong social support network through church. She has Medicare insurance, and her primary physician is Dr M, who practices at Beth Israel Deaconess Medical Center.

Mrs A has a history of hypertension, diabetes, and goiter. In the late 1980s, she developed diffuse body pain. An evaluation found that she had polymyositis and sensory neuropathy, most likely secondary to diabetes. Initially, she was treated with intravenous gamma globulin without improvement in her symptoms. She was subsequently treated with gabapentin, topiramate, mexiletine, tramadol, rofecoxib, celecoxib, acetaminophen with codeine, oxycodone/acetaminophen, and fentanyl patch without improvement. Mrs A has also tried acupuncture and massage without benefit. The consulting neurologist does not have any further therapy to offer her.

In 1999, Mrs A began experiencing worsening right lower extremity pain and weakness and was found to have spinal stenosis with L5-S1 radiculopathy. She underwent multiple lumbar epidural steroid injections without improvement in her symptoms. She has had recurrent episodes of right hip and bilateral shoulder pain from trochanteric and subacromial bursitis. She also had multiple local steroid injections with either no or short-term benefit.

Her medications include losartan potassium, felodipine, hydrochlorothiazide, levothyroxine, metformin, omeprazole, and acetaminophen. She is allergic to penicillin, aspirin, and angiotensin-converting enzyme inhibitors. She lives alone and has a daughter who lives nearby. She is able to perform all her activities of daily living and independent activities of daily living and refuses any assistance from a homemaker or visiting nurse.

On a recent examination, her blood pressure was 140/88 mm Hg, and she had mild restriction of motion of the left shoulder, pain with any motion of the right shoulder, pain to palpation of the small joints, and pain over the trochanteric bursa on the right. On neurologic examination, grip strength was decreased, sensation to pinprick was decreased in the digits bilaterally, and motor strength of the lower extremities was 2/5 proximally and 3/5 distally. Her reflexes were intact.

Mrs A continues to have diffuse body pain as well as increasing weakness of her lower extremities. During the course of her illness, she has steadfastly maintained her independence and good spirit. She has consistently stated that her faith in God has enabled her to endure her chronic pain. She looks to praying and the Holy Spirit to offer her comfort and strength. The role this should play in her ongoing medical care remains a question.

Mrs A: Her View

They said it’s kind of a rare pain. Not everybody has it. I don’t dwell on the pain, you know. Some people are sick and have pain, and it gets the best of them. Not me. Praying eases the pain, takes it away. Sometimes I pray when I am in deep, serious pain; I pray, and all at once the pain gets easy. Praying helps me a lot. I feel that has helped me more than the medication.

A doctor is a doctor. Not everybody is bound to believe in God. It’s your own mind, your thought, and your belief. The doctor gives you the medicine. God works through the doctor. He is a great physician and He heals, but you have to believe. I believe in God. He’s my guide and my protector.

Whenever you pray, you will get healing from God. You will. But you must have that belief. Because if you don’t believe in God and turn your life over to Him, it’s nothing doing. You can’t just pray, “God, I’m suffering, and I ask You to heal my body.” It don’t work like that. You have to really be a child of God.

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Dr M: Her View
She continues to have chronic, diffuse pain from her polymotor and sensory neuropathy, and she is beginning to develop some lower extremity weakness. She now has to walk with a cane and even with that is somewhat unstable at times.

She is a very impressive patient in that, throughout the 15 years that I have known her, she has continued to live with a chronic, progressive, and debilitating illness and has done so with incredible spirit, particularly in light of the lack of traditional medicine to offer her a lot of hope. She very much relies on her belief in God and her own prayers to get her through what have been some really tough times.

Most of our visits consist of her telling me where she hurts and my telling her that I understand that and then having to acknowledge that there is not a lot that I can do to help that pain go away.

I would like to ask Dr Koenig what should I be asking her about her beliefs? To what extent should I be encouraging or discouraging those beliefs? What is appropriate for me to bring into the context of a medical visit? Is it appropriate for me to use that as part of a therapeutic treatment plan for this patient?

AT THE CROSSROADS:
QUESTIONS FOR DR KOENIG

What is the role of spirituality in helping patients cope with serious medical illness? What data exist to support such a role? What is the pathophysiology explaining a benefit? How does spiritual coping affect quality of life for a patient with serious medical illness? What are the risks vs benefits of promoting a focus on spirituality? How should physicians ask patients about spirituality? Should a patient seek a physician with similar spiritual beliefs? What are the professional boundaries between physicians and chaplains? What do you recommend for Mrs A?

Dr Koenig: Mrs A has a lot to deal with. She has chronic progressive pain secondary to diabetic neuropathy, spinal stenosis, recurrent bursitis, and arthritis. The pain has been resistant to narcotic and nonnarcotic analgesics, acupuncture, and massage, and her neurologist says there is nothing more he can do for her. She lives alone and receives no formal assistance. She copes by using religion.

At least 60 studies have now examined the role of religion in medical conditions such as arthritis, diabetes, kidney disease, cancer, heart disease, lung disease, HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome), cystic fibrosis, sickle cell disease, amyotrophic lateral sclerosis, and chronic pain and in severely ill adolescents, with the majority finding high rates of religious coping. Religion is used more often to cope in the United States than in other areas of the world such as northern Europe, where weekly church attendance is 2%. Religious coping is about 1%, and even among cancer patients, 43% do not believe in God and 45% receive no comfort from religious beliefs. Compare this with the 90% of Americans who turned to religion in response to the September 11th terrorist attacks. Even the baseline rate of religious coping in the United States before those events was high (78% of Americans indicate that they receive comfort and support from religious beliefs).

Do Religious Beliefs Make a Difference?
Mrs A certainly thinks so. But what is the objective evidence that such persons cope better with illness? To answer this, our team examined religious coping in 850 consecutively admitted hospitalized patients to determine whether those depending on religion coped better than those handling stress in other ways. Those depending on religion coped better independent of demographic characteristics, social support, economic resources, psychiatric history, and physical health status. In the cross-sectional analysis, a significant inverse correlation was found between religious coping and depressive symptoms, whether self-rated (partial $F_{1,798}=19.8; P=0.001$) or observer-rated (partial $F_{1,308}=12.2; P=0.001$). An interaction appeared between physical disability and religious coping, with the most disabled patients experiencing the most benefit (partial $F_{1,798}=3.9; P=0.05$). In the prospective portion of this study, 202 patients were followed up for an average of 6 months to determine what baseline characteristics predicted change in depressive symptoms over time. Only 2 characteristics predicted later depressive symptoms: kidney disease predicted more symptoms and religious coping predicted fewer (partial $F_{1,75}=10.4; P=0.002$).

To determine whether religious attitudes are related to speed of recovery from depression, we used the National Institute of Mental Health Diagnostic Interview Schedule to interview 87 medical inpatients (from consecutive admissions to general medicine, cardiology, and neurology services). Depressed patients were prospectively followed up for an average of 47 weeks after discharge, during which weekly change in depressive symptoms was measured. Of nearly 30 baseline characteristics, intrinsic religiosity was 1 of only 5 independent predictors of speed of remission. For every 10-point increase on the intrinsic religiosity scale (with scores ranging from 10-50), there was a 70% increase in the speed of remission from depression (hazard ratio [HR], 1.70; 95% confidence interval [CI], 1.05-2.75) after controlling for social support, changes in physical health, psychiatric history, and other covariates. The speed of remission in patients whose physical functioning was either stable or worsening more than doubled for every 10-point increase on the scale (HR, 2.06; 95% CI, 1.02-4.15).

In both studies, religious beliefs were particularly important for patients whose physical condition was not improving despite medical treatments. Mrs A eloquently summarizes it: “Some people are really sick, really sick and going to doctors and hospitals, and still they stay the same way. So I think praying helps a lot, but praying without belief is no good. I believe in God. He’s my guide and my protector.”
The Duke studies above are not the only ones finding a connection between religion and better coping with medical illness.22-27 In fact, a systematic review of research published during the 20th century identified 724 quantitative studies, of which 478 (66%) found a statistically significant relationship between religious involvement and better mental health, greater social support, or less substance abuse.1 Even in Europe where religious involvement is low, studies find that those who are less religious experience more depression28,29 and recover more slowly from depression.30 For example, a 12-month prospective study of 177 older adults in the Netherlands found that low religiosity predicted persistent depression (odds ratio, 5.83; 95% CI, 1.52-22.6). In that study, no depressed women with low religiosity recovered from depression compared with 50% of those with high religiosity.30 Religious involvement may also postpone the development of physical disability in later life.31 and chronically ill persons who are religious may perceive themselves as less disabled than they really are.32,33 Mrs A, for example, remains independent despite her pain and multiple medical problems.

The relationship between religion and chronic pain such as Mrs A experiences is particularly complex. Of the 5 studies in our systematic review that evaluated religious activity and pain, all 5 found that prayer is associated with greater severity of pain when examined cross-sectionally (individuals tend to pray more as pain worsens).3 In the only prospective study, 74 patients with low back pain lasting at least 6 months were followed up for 8 weeks. At baseline, scores on a prayer subscale were positively related to pain severity (F1,68=8.28; P<.01). Over time, however, increased use of prayer predicted decreased reports of pain intensity (r = −0.21; P<.05).34 Only 1 intervention study has examined the effects of prayer and meditation on chronic pain; 10 of 14 (71%) subjects receiving the intervention experienced at least a one-third reduction in chronic pain compared with 2 of 19 (11%) in the comparison group (P<.005, based on unpaired t test corrected for multiple testing).35

**Mechanisms**

How does religion facilitate coping with chronic pain, disability, and serious illness? Mrs A’s comments again provide key insights: “I don’t dwell on the pain. Some people are sick and have pain and it gets the best of them. Not me. . . . Prayer helps me a lot—I give God my heart and soul—and you don’t have to worry about nothing. He leads you and directs you, and he takes care of you. That is my belief.”

Many patients have little control over their health conditions, which creates anxiety and, in some cases, furious attempts to regain control. When such attempts fail, anxiety worsens and depression develops as the person feels increasingly overwhelmed. Religious beliefs and practices provide an indirect form of control that helps to interrupt this vicious cycle. They enable a patient to turn a health situation over to God and stop worrying and obsessing about it. Prayer gives patients something to do so they don’t feel as helpless: by praying to God, they believe that they can influence the outcome. As Mrs A demonstrates, prayer may also result in a deep state of relaxation that reduces muscle tension and improves function.36

For Mrs A, belief is a very important part of the process. Beliefs are the basis for a worldview, which is how individuals interpret and make sense of reality, especially the reality of pain, suffering, and tragedy. The Western religious worldview is an optimistic one that gives hope, purpose, and meaning to negative life circumstances. Mrs A’s strong belief frames her entire situation. Her trust and confidence are in God, with whom she is in constant communication: “I pray every day. I walk and talk with God. I read my Bible and I pray. . . . I hold onto that for no man can take that away from me.” Whether an illness gets better or not, having such a powerful ally and companion can have an enormous impact on relieving loneliness and isolation and, again, regaining a sense of control. As long as God is with her, leading and directing her, she can rest.

Note that Mrs A also attends church regularly, despite pain and multiple health problems. This provides her not only with socialization but also with opportunities to support and encourage others. She is a member of a prayer group, where she prays for others and they pray for her. She even visits and prays for those who are sick—and says she sees results: “I was praying for a lady and she was very sick, could barely sit up in her bed. And we went and prayed for her, and she prayed with us . . . and now she’s feeling all right; she comes to church now.” Praying for others likely helps to distract her from her pain and gets her mind on something outside of herself. In a cross-sectional survey of 577 medically ill older adults, providing “religious help” to others predicted less depression (β =−1.3; P<.01), higher quality of life (β = 2; P<.001), and greater personal growth resulting from life stressors (β =.5; P<.001), independent of controls.37

**Health Consequences**

Relationships between mental health and strong faith, devout prayer, and religious socialization may have consequences that are far-reaching and perhaps greatly underestimated. Religious involvement is associated with improved attendance at scheduled medical appointments,38 greater cooperation,37 better compliance,39-41 and improved medical outcomes.42,43 A number of well-designed prospective studies have found that those who are more religious or spiritual have lower blood pressure,44 fewer cardiac events,45 possible regression of coronary artery obstruction,46 better results following heart surgery,43 and longer survival in general.47,48

Pathways exist to help explain why religious beliefs and practices like prayer could influence physical as well as mental health. Sympathetic and parasympathetic nerve tracks
connect thoughts and emotions in the brain to the circulatory system, coronary arteries, lymph nodes, bone marrow, and spleen. If religious beliefs and prayer help patients cope better with illness and result in less stress, anxiety, and depression and greater social support, then they may counteract stress-related physiological changes that impair healing. Preliminary evidence suggests that religious involvement may be related to stronger immune functioning and lower cortisol levels. Religious involvement is also associated with less substance abuse, exercise, and smoking. Less cigarette smoking is also associated with less substance abuse. Although randomized clinical trials that demonstrate causality are lacking, such studies are now under way among patients with breast cancer and will soon be undertaken in patients with congestive heart failure.

Promoting Spirituality

When Mrs A was asked what kind of advice she had for patients, she responded, “I think doctors should tell the patient they must read their Bible and pray to help with the medicine.” I am impressed by her enthusiasm, but I must disagree. Although there is growing evidence that prayer and other religious activities are associated with better coping, less depression, more social support, and better health outcomes, recommending religious beliefs to nonreligious patients is premature. Religion is an intensely personal and private affair for many people, and no matter how much data accumulate, there will probably never be enough to justify imposing religious beliefs on patients. There is a lot that physicians can do, however, short of prescribing religion.

Least controversial among these is taking a spiritual history, although less than 10% of physicians routinely do so. A spiritual history inquires about the role that religion or spirituality plays in the patient’s ability to cope with and make sense of illness. Perhaps the most powerful rationale for taking a spiritual history is not the positive effects of religion on health, but the potential negative effects. Are religious beliefs a source of comfort and support for the patient, as they are for Mrs A, or are they a source of stress and emotional turmoil? Beliefs indicating religious struggle predict worse mental and physical health outcomes after hospital discharge. In a prospective study of 595 hospitalized patients, those who believed that God was punishing them, had abandoned them, didn’t love them, or didn’t have the power to help or felt their church had deserted them experienced 19% to 28% higher mortality during a 2-year period following hospital discharge (relative risk for death ranging from 1.19 [95% CI, 1.05-1.33] to 1.28 [95% CI, 1.07-1.50]). This effect was statistically significant and independent of physical health, mental health, and social support. Such patients may refuse to speak with clergy because they are angry with God and have cut themselves off from this source of support.

Would religious beliefs influence medical decisions if the patient becomes seriously or terminally ill? One cross-sectional survey of 177 outpatients attending a university-based pulmonary clinic found that nearly half of patients (45%) indicated that religious beliefs would influence their medical decisions if they became gravely ill. End-of-life decisions are often influenced by religious beliefs, especially do-not-resuscitate or discontinuation-of-treatment decisions. Patients or families with strong beliefs may not agree to a do-not-resuscitate order or withdrawal of life support because they are praying for a miracle and determined not to give up faith.

Are there religious beliefs that might conflict with medical care? Patients may stop taking their medications or fail to seek medical care on religious grounds. Religious activities like prayer may be used instead of traditional medical care to treat illness. For example, religiousness is associated with lower use of physician services in type 2 diabetes and less use of antiretroviral medications in HIV infection. In the latter study of 202 HIV-positive patients, those indicating that prayer was the most important influence on their decisions about HIV medication were significantly less likely than other patients to be taking antiretroviral medications (7.1% vs 23.0%; P = .003 by Fisher exact test). Even if beliefs conflict with medical care (as those of Jehovah’s Witnesses or Christian Scientists), however, physicians should be cautious about rejecting them. Instead, they should try to understand the patient’s worldview by beginning a dialogue that shows respect for the beliefs and a willingness to work with the patient. Unless patients feel as though they can talk to their doctors about such issues, they will simply conceal noncompliance.

Is the patient a member of a spiritual community and is that community supportive? The answer will help determine how much support patients have when they return home. According to a survey of 106 consecutive older patients treated at a university-based clinic in Springfield, Ill, more than half (52%) reported that 80% or more of their closest friends came from their church congregations. Religious congregations often serve as extended families for older adults, especially those who live alone or have limited support from relatives. Church members may check on

CLINICAL CROSSROADS

Box. Taking a Spiritual History

Do your religious or spiritual beliefs provide comfort and support or do they cause stress?
How would these beliefs influence your medical decisions if you became really sick?
Do you have any beliefs that might interfere or conflict with your medical care?
Are you a member of a religious or spiritual community and is it supportive?
Do you have any spiritual needs that someone should address?
such patients, monitor their health, provide rides for office visits, and render many other practical services.

Does the patient have any other spiritual needs? A cross-sectional survey of 50 medical-surgical inpatients and 51 psychiatric inpatients at Rush-Presbyterian-St Luke’s Medical Center in Chicago found that 76% of medical-surgical and 88% of psychiatric inpatients had 3 or more religious needs during hospitalization. Does the patient wish to speak with a chaplain or other clergy? Would the patient like an opportunity to attend a hospital worship service? And Would the patient (or family) like spiritual reading materials or someone to pray with? Although physicians may not be able to personally address these spiritual needs, they should ensure that someone does.

Once a spiritual history has been taken, the physician may decide to support religious beliefs the patient finds helpful, particularly if they do not conflict with medical care. Mrs A reported that when she told her physician about her religious beliefs, the doctor said, “Keep it up.” Brief encouragement from the physician like this may help to reinforce religious beliefs that are relied on for comfort and hope. The existing beliefs of the patient should always be supported and encouraged; this is not a time to introduce new or unfamiliar spiritual beliefs or practices.

What about the patient who is not religious or who doesn’t wish the physician to address religious issues? Willingness to participate in spiritual discussions with doctors is closely tied to the patient-physician relationship. Although most patients want physicians to ask about coping and support mechanisms, a survey of 83 inpatients in Pennsylvania and 120 inpatients in North Carolina found that one third to one half felt uncomfortable about physicians discussing religious beliefs with them. If the patient resists such inquiry, the physician should not persist but rather should redirect the conversation to a discussion of what enables the patient to cope or gives life meaning and purpose in the setting of illness. The initial inquiry about religion will let the patient know that such issues can be discussed in the future if needed.

Taking a spiritual history or addressing spiritual issues must be done in addition to competently and completely addressing the patient’s medical concerns (“competence is the first act of kindness”). Therefore, it will take additional time. Where does a busy physician find the time? There is no easy answer, particularly in a health care system that rewards productivity and numbers over compassion and caring. Here are a few suggestions. Not every patient needs a spiritual history on every visit. A 5-minute spiritual history can be taken during an initial evaluation of patients with serious or chronic medical illness or at the time of hospital admission as part of the social history. Spiritual issues may be addressed during a health maintenance evaluation when there is a little more time to talk about social and personal concerns. Interestingly, only about one quarter (26%) of physicians indicate that they don’t have time to discuss religious issues with patients. Space precludes a more detailed discussion of integrating spirituality into patient care, which can be found elsewhere.

Should a patient seek a physician with similar beliefs? That depends on the patient. In Mrs A’s case, the religious beliefs of her physician did not seem to matter that much. When asked whether she would prefer to have a physician who believes in God, she answered: “A doctor is a doctor. Not everybody is bound to believe in God.” For most medical patients, even very religious ones, the beliefs of the physician are less important than the patient-physician relationship and the respect and support that the physician shows for the patient’s beliefs.

Professional Boundaries

What professional boundaries separate the responsibilities of the physician from those of the chaplain? Most physicians do not have the training to address religious or spiritual issues in the setting of medical illness. More than half of US medical schools now have courses on religion and medicine that introduce medical students to these issues.

Attending such a course is useful. However, a couple of lectures or even a more intensive course throughout a semester or 2 is no match for the training a chaplain receives. Whenever anything but the most simple and uncomplicated spiritual issues come up, chaplains or pastoral counselors should be consulted.

Not all patients, however, wish to talk to unfamiliar chaplains about deeply personal religious issues laced with feelings of anger and guilt. Alternatively, the patient may be willing to discuss these issues with a caring physician who is known and trusted. In those cases, the physician should take a few minutes to listen to the patient’s spiritual concerns. Caring and listening is the intervention, not giving advice or trying to fix the spiritual problem.

Prayer with patients is a more controversial activity that many physicians (at least one third) sometimes engage in. Certain conditions should be met before such activity is considered: a spiritual history has been taken, the patient is religious, the patient requests prayer, the physician’s religious background is similar to that of the patient, and the situation calls for prayer (significant patient distress). Prayer should be physician-initiated only if the physician is certain the patient would want it and be comforted by it; otherwise, physician-led prayer has the potential to be coercive. Prayer or any other religious activity should not be prescribed.

Recommendations for Mrs A

To Mrs A, I would say, “Keep it up!” Despite disabling, unrelenting chronic pain and multiple other complex medical problems, she is optimistic, cooperating with her treatment, functioning independently, and staying socially active. Mrs A’s physicians should respect and support the beliefs that help her cope, ensure that her spiritual needs are met.
when she is hospitalized, and be aware that religion is likely to influence her medical decisions. Because of her strong faith, Mrs A may rely more heavily on her religious beliefs and activities than on her medical treatments, so it is important to keep lines of communication open on this subject and periodically gently explore how her beliefs are influencing compliance. Finally, religious patients like Mrs A sometimes see their declining health status or need for assistance as a spiritual failure and should feel free to talk with their physicians about such feelings should they arise.

QUESTIONS AND DISCUSSION

A PHYSICIAN: Can you elaborate on your statement that it would be unethical to prescribe prayer, even where the data support it?

DR KOENIG: The risk in prescribing prayer—the doctor imposing this on the patient—is that it goes from being patient-centered to being physician-centered. When you move the center away from the patient, you run into the risk of coercion, particularly for a nonreligious patient who is not praying.

A PHYSICIAN: When people’s religious beliefs conflict with medical treatment, what is the extent to which you believe that we should respect and support them, or is it legitimate to criticize?

DR KOENIG: If patients’ beliefs are conflicting with their medical care, the important thing to do is not to criticize the beliefs but to try to better understand them. Learn more about their view, show respect for it, and stay in communication with the patient on it.

A PHYSICIAN: Has the relationship between level of education and religious beliefs been studied?

DR KOENIG: Education level does seem to have an effect, although not a great one. A few studies have looked at this relationship,19,47-48 They found that the effects on mental and physical health are independent of education.

A PHYSICIAN: When some religious people have a life-threatening illness, they bring to their view a sense of having done this to themselves. How do you respond to this?

DR KOENIG: People’s behavior does influence their illnesses. The question is how do you deal with that in a compassionate manner. Some people feel that they are being punished, and many of our patients are probably asking the question, Why me? It is helpful if a physician allows them to talk about that and does not dismiss it outright. If such concerns persist, then having the patient speak with a chaplain or certified pastoral counselor can be very helpful.

A PHYSICIAN: What advice would you give physicians, especially in critical care settings, when they encounter patients or families who say, “I’m praying for a miracle”? DR KOENIG: When a patient or family is praying for a miracle in medically futile circumstances, the physician should respect that belief and join in a supportive dialogue with the patient or family on the subject. Sincerely try to understand their worldview and the important role that such beliefs are serving. Doing this demonstrates to the patient and family that the physician cares about what may be their last anchor of hope. It also helps keep open avenues of communication that will allow the physician to gently convey important medical information that can be heard more easily than if that dialogue is based on criticism and confrontation, which could elicit a need to defend their faith against the physician. If patients feel that they can talk to the physician about these issues and know their religious beliefs are valued, they will be better able to trust and accept what the physician is saying, ie, sometimes God answers our prayers for healing in psychological, interpersonal, and spiritual ways that may ultimately be even more important than physical healing.

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