

M.E.D.S. —A Strategy for the Spiritual Support of Patients by Health Care Providers

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This strategy focuses on the dynamics of meaning, emotion, distress and spirituality for patients and...

...can work across lines of spiritual/religious diversity

...takes very little time in the clinical encounter, while potentially bringing clinically pertinent benefits

...does not necessarily require a large knowledge base about spiritual/religious issues

...does not blur professional roles/boundaries, and especially does not ask health care providers to act as spiritual counselors

M = acknowledge statements of meaning/quest/relationship

Patients may make overtly religious/spiritual statements of meaning, quest, and relationship; but often the expression is more subtle and indirect. Examples: “God has a plan,” “I know God’s with me,” or “God didn’t bring me this far to let me down now”; *but also*, “I’m sure learning a lot,” “Something like this changes your priorities,” or “I’m so thankful for my family.”

Acknowledgement can be made as simply as reflecting or paraphrasing the patient’s statement or by saying, for instance: “I appreciate your perspective,” “You’re finding your way ahead through this,” “You’re in touch with what’s important,” or “This is a journey.” —*Such statements generally open up communication.*

E = affirm the emotionality nature of our humanity

Emotion may be said to be the “heart” of spirituality, and an affirmation of emotion can help patients express spiritual need. For instance: patients who are ashamed of their anxiousness or tears may be blocked from expressing or exploring spiritual issues, or emotional lability may be experienced as a spiritual problem.

Affirmation of emotion can occur through acknowledgement and normalization. For example: “Your tears show how deeply you feel, how important things are to you,” “There’s so much about what’s happening that’s scary,” “Illness and treatment can be such an emotional rollercoaster,” “Your spirit feels heavy; I want to affirm how well you’re managing in all of this,” or simply “I honor your feelings.” —*Listen for spiritual content in patients’ responses.*

D = look/listen for indications of possible distress that may have spiritual connections

Any sign of physical or psychological distress *may* have connections to a patient’s spirituality, including unexplained or unmanaged pain, trouble sleeping, anxiety or agitation. Spiritual distress can have mundane indicators.

Conversational hints of *possible* spiritual distress

- 1) Interruption of religious practices / rituals of every kind (e.g., congregational or social religious activities, prayer)
- 2) Issues of meaning amid change (e.g., questions/statements about the meaning or purpose of his/her pain or illness or of life in general, expressions about a sense of injustice, overwhelming salience of loss, hopelessness, or abandonment/withdrawal from relationships or groups)
- 3) Religiously associated expressions (e.g., mentions illness as “deserved” and/or “punishment,” talks of “evil” or “the enemy,” describes self as “bad” or “sinful,” uses colloquial expressions with religious overtones like “this is hell,” repetition of “forgiveness” language, refers to death as “judgment day,” or wonders about “God’s plan”)

Think of how a patient’s physical challenges may be problematic to spiritual activities, causing distress:

- Barriers to attending congregational activities (including treatments or check-ups over religious holidays)
- Inability to kneel [—also a falling hazard]
- Difficulty using hands (e.g., to make religious gestures or to hold religious objects or scriptures)
- Trouble seeing (e.g., to read religious material)
- Trouble hearing (e.g., to listen to music or religious broadcasts or speak on the phone with friends/clergy)
- Pain and medication issues (e.g., affecting meditation/prayer/concentration)
- Body image and hygiene issues affecting a sense of “cleanliness” (including difficulty washing)

S = express a respectful, professional interest in the patient’s spirituality *per se*: particular patient resources/issues pertinent to the provider-patient relationship

Health care provider inquiries about spirituality should...

...implicitly or explicitly indicate that the purpose is to provide health care that honors patients’ beliefs and values (and that the question is not a judgment about the patient’s values)

...give patients an “easy way out” if they don’t want to talk about their spirituality

For example: “Do you have any religious or spiritual concerns that might affect your medical care?”

If patients want to discuss spiritual matters, or there are issues of spiritual distress, refer to a trained chaplain or their own clergy.