

“Are You at Peace?”

One Item to Probe Spiritual Concerns at the End of Life

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Background: Physicians may question their role in probing patients' spiritual distress and the practicality of addressing such issues in the time-limited clinical encounter. Yet, patients' spirituality often influences treatment choices during a course of serious illness. A practical, evidence-based approach to discussing spiritual concerns in a scope suitable to a physician-patient relationship may improve the quality of the clinical encounter.

Methods: Analysis of the construct of being “at peace” using a sample of patients with advanced cancer, congestive heart failure, or chronic obstructive pulmonary disease. Descriptive statistics were used to compare response distributions among patient subgroups. Construct validity of the concept of being “at peace” was evaluated by examining Spearman rank correlations between the item and existing spirituality and quality-of-life subscales.

Results: Variation in patient responses was not explained by demographic categories or diagnosis, indicating broad applicability across patients. Construct validity showed that feeling at peace was strongly correlated with emotional and spiritual well-being. It was equally correlated with faith and purpose subscales, indicating applicability to traditional and nontraditional definitions of spirituality.

Conclusions: Asking patients about the extent to which they are at peace offers a brief gateway to assessing spiritual concerns. Although these issues may be heightened at the end of life, research suggests they influence medical decision making throughout a lifetime of care.

Arch Intern Med. 2006;166:101-105

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CLINICAL EXPERIENCE AND research reveal the importance of emotional and spiritual issues for patients facing the end of life.¹⁻¹¹ Acknowledging these needs constitutes compassionate, comprehensive palliative care.^{1,11-14} Some physicians may question the appropriateness of their role in probing patients' spiritual distress, as well as the practicality of addressing such issues in the time-limited setting of the usual clinical encounter. Yet, a patient's spirituality often influences treatment choices and endows personal resources during serious illness. Thus, a practical and evidence-based approach to discussing spiritual concerns in a scope suitable to a physician-patient relationship may improve the quality of care for patients at the end of life.

In a recent qualitative study¹⁰ of patients', bereaved family members', and health care providers' perceptions of what is important at the end of life, we asked participants to discuss attributes of “good”

and “bad” deaths. Of the 70 attributes generated, participants frequently reported that a positive end-of-life experience was associated with having “come to peace” or “being at peace.” Further conceptual analyses¹⁵ showed that for many respondents, this sense of peacefulness was related to a religious notion of “being at peace with God.” For others, it was a nontheological sense of tranquility. A sense of peacefulness may have resulted from a clear decision about whether to continue a course of chemotherapy or assurance that a patient's pain and symptoms would be managed. In other circumstances, patients had resolved a conflict with a family member or loved one, within themselves, in their relationship with God, or in spiritual reflection on the meaning of illness in their lives. Thus, resolution within the biomedical, psychosocial, or spiritual domains of patients' experiences often preceded the subjective experience of peacefulness. Furthermore, for these patients at the end of life, attention to issues of peacefulness was related to an antecedent, broader theme of “completion” or life closure.

To explore the statistical generalizability and breadth of applicability of the concept of peacefulness among wider groups, we translated qualitatively generated attributes of what was important at the end of life into quantitative survey items and distributed them to nationally representative samples of bereaved family members and patients with advanced serious illness.¹⁴ Respondents were asked to rate the extent to which they agreed with the importance of items on a 5-point Likert scale. Eighty-nine percent of patients and 91.5% of families agreed with the importance of “coming to peace with God.” Next, we evaluated patients’ endorsements as a function of age, sex, ethnicity, marital status, education, religious affiliation, depressed mood, and self-rated health and found no statistically significant differences in endorsement across patient groups. In addition, we asked respondents to rank-order 9 prespecified attributes of the end-of-life experience. Patients and families ranked as most important (and statistically equal to each other) “freedom from pain” and “being at peace with God.” This reinforced the equal footing of biomedical and emotional or spiritual issues we had earlier observed for dying patients and their families.¹⁰

Finally, in a subsequent sample of patients with advanced illness, we found that items measuring peacefulness correlated highly with having a chance to say good-bye; making a positive difference in the lives of others; giving to others in time, gifts, or wisdom; having someone with whom to share their deepest thoughts; and having a sense of meaning in their lives.¹⁶ These correlations suggested that peacefulness was most strongly associated with items assessing emotional and spiritual well-being.

In reviewing these qualitative and quantitative data, we were struck by the extent to which the concept of being at peace applied to multiple contexts and with varied meaning yet held a common, vital impact. Therefore, we explored further the construct’s breadth of applicability and conceptual significance. If widely accepted and conceptually sound, such a construct might serve as a brief, nonthreatening gateway to eliciting patient and family concerns.

The purpose of this study was to explore the construct of being at peace using quantitative data collected from patients with advanced, life-limiting illness. Our goal was to examine correlations with other assessments of spirituality and quality of life to identify constructs associated with the experience of being at peace.

METHODS

This study used a cross-sectional sample of patients with advanced serious illness.¹⁶ The sample comprised patients with stage IV cancer, congestive heart failure with an ejection fraction of 20% or less, chronic obstructive pulmonary disease with a forced expiratory volume of 1.0 L or less, or dialysis-dependent end-stage renal disease who were receiving care at the Durham Veterans Affairs (VA) or Duke University Medical Centers, Durham, NC.¹⁷ To identify potential patients, we reviewed weekly rosters from the oncology, heart failure, pulmonary, and dialysis clinics at both medical centers. We randomly assigned a recruitment order to all eligible patients and

enrolled as many as time allowed for each clinic half-day. Written informed consent was obtained at the time of recruitment. We administered the Short Portable Mental Health Status Questionnaire (SPMSQ) at enrollment and excluded patients with scores lower than 8 of 10 correct.¹⁸ A total of 248 patients were enrolled.

ITEM DEVELOPMENT

In the national survey, Factors Considered Important at the End of Life,¹⁴ the item wording was “coming to peace with God.” However, qualitative work has shown that peace is associated with relationships with others and oneself as well as with God. For some individuals, these were overlapping interpretations; for others, they were distinct. We were curious about whether these interpretations were performed distinctly, psychometrically. Therefore, in a subsequent study¹⁶ (data not reported herein), we examined distributions of several religious and non-religious alternative wordings: “at peace with God,” “at peace in my personal relationships,” “at peace with myself.” Both correlations with other items and within-item distributions were not significantly different; therefore, to promote inclusiveness, the final item employed wording in which respondents answered a question about the extent to which they were “at peace.”

COMPARISON MEASURES

Patients completed several instruments to assess quality of life at the end of life as well as social support. First, they completed the QUAL-E, a 31-item assessment of quality of life at the end of life representing 4 domains: life completion, relationship with health care provider, symptom impact, and preparation for the end of life.¹⁶ The instrument exhibits strong validity and reliability and is acceptable to seriously ill patients. Within the QUAL-E, 1 item asks patients about the extent to which they are “at peace.” Second, patients completed the Functional Assessment of Chronic Illness Therapy–Spiritual (FACIT-SP), a 27-item, 5-domain, expanded version of the Functional Assessment of Cancer Therapy–General (FACT-G) quality-of-life scale with a 12-item spiritual well-being subscale.¹⁹ The other 4 subscales are physical well-being, functional well-being, social and family well-being, and emotional well-being.²⁰ It was not designed specifically for use with terminally ill patients but remains a broadly used, well-validated, and reliable general quality-of-life assessment tool. The spirituality well-being subscale contains 2 dimensions, faith and purpose, and has been validated for patients with cancer and human immunodeficiency virus. Questions focus on 2 dimensions: the extent to which patients feel a sense of meaning and purpose in their life and the extent to which they find comfort or strength in their faith and spirituality. Finally, patients completed the 13-item social support subscale from the Duke University Established Population for Epidemiologic Studies of the Elderly (EPESE) survey, which includes instrumental and affective support subscales.

STATISTICAL ANALYSIS

We conducted correlational analyses to examine the relationship between the extent to which patients felt “at peace” and demographic categories, diagnoses, and site of recruitment. To explore construct validity, we examined Spearman rank correlations between patients’ assessments of the extent to which they were “at peace” and the FACIT-SP and EPESE subscales. Statistical analyses were performed with SAS software (version 8; SAS Institute, Cary, NC). The institutional review boards of the VA and Duke University Medical Centers approved both studies.

RESULTS

A total of 320 potential subjects were approached; 53 refused to participate, and 19 demonstrated significant cognitive impairment, yielding a response rate of 78%. We enrolled 100 patients from the VA and 148 from the Duke University Medical Centers. All 248 patients completed the interview. Twenty-two did not report any symptoms; compared with the full sample of 248 subjects, they were more likely to be female (50%), slightly older (mean age, 64 years), and not married (55%), and a higher percentage (27%) had congestive heart failure.

Participants had at least 1 of 4 life-threatening conditions: stage IV cancer (56%), congestive heart failure (21%), end-stage renal disease (14%), and chronic obstructive pulmonary disease (8%). Approximately 59% of subjects were male; 59%, white; and 34%, black. The sample showed a broad educational distribution, and a majority (62%) were married. The median age of patients was 61 years (range, 28-88 years) (**Table**).

First, we examined the relationship between the extent to which patients felt "at peace" and demographic categories. We found no significant relationships with ethnicity, education, sex, diagnosis, site of recruitment, or marital status. We observed a small but positive correlation between age and feeling at peace ($r=0.24$). Thus, in 2 samples,^{14,16} with the exception of age, the notion of being "at peace" was not explained by demographic variables.

After testing the breadth of applicability of the concept of being at peace, we conducted correlational analyses to examine its conceptual underpinnings. Our goal was to understand what elements of patient experience this single item may be tapping. Therefore, we analyzed associations between being at peace and existing subscales, namely, the FACIT quality of life subscales: emotional, social, physical, functional, and spiritual well-being. We also examined its association with both instrumental and affective social support given by patients.

Analyses showed that peacefulness was most strongly associated with the emotional and spiritual well-being subscales ($r=0.52$ and 0.60 , respectively). We observed small and moderately significant relationships with other dimensions of quality of life: physical well-being ($r=0.28$), functional well-being ($r=0.35$), and social well-being ($r=0.41$). We did not observe significant associations with either instrumental or affective support given by patients ($r=0.06$ and -0.08 , respectively).

To explore the relationship between the indicator of peacefulness and spirituality more specifically, we assessed correlations between peacefulness and the 2 dimensions within the FACIT spirituality subscale: faith and purpose. We found significant associations between feeling at peace and both dimensions (purpose: $r=0.47$, $P<.001$; faith: $r=0.51$, $P<.001$), suggesting similar construct resonance for the religious as well as meaning-making components of spirituality.

COMMENT

Dying patients confront complex spiritual concerns that influence the course of their illness, treatments chosen,

Table. Sample Profile of 248 Patients

Variable	Percentage
Sex	
Men	59
Women	41
Ethnicity	
Black	34
White	59
Native American	2
Other	5
Education*	
<High school	13
High school diploma	44
Associate's degree	23
Bachelor's degree	13
Graduate/professional degree	8
Marital status*	
Married/living with partner	62
Widowed	8
Divorced/separated	23
Never married	8
Diagnosis*	
Cancer	56
COPD	8
CHF	21
ESRD	15
Recruitment Site	
VAMC	40
DUMC	60
Age, y	Median, 61; range, 28-88

Abbreviations: CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; DUMC, Duke University Medical Center; ESRD, end-stage renal disease; VAMC, Veterans Affairs Medical Center.

*Does not equal 100% due to rounding.

relationships with loved ones, and overall quality of life. Despite the importance of spiritual issues during serious illness, these fundamental issues may not be readily elicited in a usual clinical encounter. Furthermore, clinicians may struggle to initiate such a discussion in a non-threatening, inclusive manner, particularly when patients' religious affiliations and preferences may differ from physicians' or are unknown.^{1,11-13,21-23}

The literature shows variation in patient preferences for discussing religious and spiritual issues with their physicians. In one survey²⁴ of hospital inpatients, 77% said their physicians should consider their spiritual needs, 37% wanted their physician to discuss religious beliefs with them, 48% wanted their physicians to pray with them, and 68% said their physician had never discussed religious beliefs with them. Other studies²⁴⁻²⁶ from outpatient settings reported lower percentages of patients who welcomed such questions (21%-40%). In a subsequent study of outpatient pulmonary clinic patients, Ehman and colleagues¹¹ showed that 94% believed that if patients were gravely ill, their physicians should ask if they "had religious or spiritual beliefs that would influence their medical decisions." These authors hypothesize that variation in endorsement may be associated with different wording of questions. For example, they suggest that direct open-ended questions such as "What are your religious or spiritual beliefs?" may evoke mistrust about the personal boundaries of such a conver-

sation or cause patients to question physicians' motivation. To summarize, research suggests that religious and spiritual concerns are important to many patients and influence their decision making, yet patients may feel awkward entering conversations about spiritual matters. Such conversations may be perceived variably among patient subpopulations.

The results of this study suggest that the concept of patients' sense of being at peace may be a point with which to initiate a conversation about emotional and spiritual concerns in a nonthreatening, nonsectarian manner. Data from the national survey reported by Steinhäuser et al¹⁴ show broad endorsement for this item's importance from patients and family members. Variation in the strength of their agreement was not explained by demographic categories, diagnosis, mood, or self-reported health, which suggests that use of the construct is applicable to patients with varied backgrounds and illness courses.

Our tests of distributions and subsample differences according to varied wording (ie, "at peace with God," "at peace with my personal relationships," and "at peace with myself") revealed broad applicability of concepts or an intertwining of concepts into a whole, more general notion of peacefulness. Our subsequent use of the concept was worded generally as feeling "at peace." When assessing associations with the extent to which patients were "at peace," demographic categories other than age exhibited no explanatory power. It is not surprising that younger patients (<50 years) with advanced serious illness report lower levels of peacefulness. Again, these analyses showed applicability of the concept of being "at peace" across patient subgroups.

Spirituality has been defined as the search for or attention to the ultimate meaning and purpose in life, often involving a relationship with the transcendent.²⁷ That relationship may be expressed in the context of human interactions or in terms of belief in a higher being.²⁷ Construct analyses revealed emotional and spiritual well-being underpinnings of the broadly worded construct of being at peace. Subanalyses involving comparisons of the item with the FACIT spirituality subscale showed equal strength of association for both faith and purpose dimensions, suggesting that the concept may be useful to patients who discuss spirituality in more or less traditionally religious terms. Clinicians may note the frame of reference most suitable to particular patients. However, a reference to being at peace may cue patients to discussions about and beyond spiritual issues.

The purpose of these analyses is not to reduce spiritual, religious, or emotional concerns to a construct of peace, nor does use of the item constitute a full spiritual history. Rather, we liken its use to the single question, "Are you depressed?," which works well as a screening tool that indicates when there is a need for a fuller psychological assessment.²⁸ These data indicate use of the concept of peacefulness as a gateway to larger discussions, framed according to patients' values, preferences, and life experiences.

The specific language patients choose to use in response to the question "Are you at peace?" reveals their frame of reference, dimensions of distress, and acceptable terminology for discourse. If a patient's response connotes a spiritual frame, physicians may continue with a

more in-depth spiritual assessment in which he or she asks more specifically about what role faith or spirituality plays in the life of the patient and in the role of health and decision making. Furthermore, the physician may inquire about the role of a faith community as support and about how the patient would like his or her spiritual needs to be addressed in the health care context.^{27,29,30} Alternatively, if patients respond to questions of peacefulness using an affective frame of reference, the physician may probe mood and emotional well-being. Although clinicians and researchers may divide patients' emotional and spiritual concerns into separate domains, previous studies^{10,31} suggest that patients and families initially experience these concerns as a part of a larger whole of suffering or disruption. The construct presented in this article, as shown in the following 2 examples of dialogue, is offered as a bridge to those concerns.

Physician: We've talked a lot about the decisions you're making from a medical perspective. I'm wondering whether you feel at peace with those decisions.

Patient: Well, I wish I didn't have cancer and didn't have to make these choices in the first place.

Physician: I wish that too . . .

Patient: But, given that I am where I am, I think I've made the best choices I can.

Physician: How have you been doing?

Patient: Okay, I guess.

Physician: I'm wondering how you're doing living with your illness. I sometimes hear people talk about whether or not they're at peace. Do you feel that you are at peace in your life right now?

Patient: Well, when you ask it that way, no.

Physician: Tell me more.

Patient: I just can't seem to get a handle on all this . . .

In his presentation of a bio-psychosocial-spiritual model for care of patients at the end of life, Sulmasy³² offers a framework of "right relationships" as building blocks of physical, psychological, social, and spiritual well-being. Patients' end-of-life experiences are constructed by multidimensional layers of relationships of physiological and biochemical processes, cognitive understandings, interpersonal connections, and bonds to the transcendent. Suffering is associated with relationship disruption or conflict. Asking patients about the extent to which they are at peace may initiate discussions that reveal suffering in any of the 4 dimensions.

However, clinicians may fear, often appropriately, that theological discussions rest outside the purview of their role or expertise. Using inquiries about the extent to which a patient or family members are at peace (with choices and decisions, for example) offers a straightforward approach to exploring spiritual concerns. Physicians and other health care providers may then refer patients and their families to specialized care professionals, such as chaplains, while appreciating the kinds of distress with which patients struggle as they traverse the course of serious illness. Physicians seeking more extended assessment tools for research purposes may explore recently developed spirituality scales.^{33,34}

This study has several limitations. Most of the 100 patients recruited from the VA Medical Center were male. However, we oversampled women at Duke University

Medical Center to permit sufficient statistical power to detect differences between men and women. Patients were predominantly white and black. Patients at the VA Medical Center resided predominantly in 1 geographic region. However, Duke University Medical Center draws from both regional and national patient pools.

Although this study's samples included patients with advanced serious illness, the construct of being "at peace," or peacefulness, and the discussions and communication techniques described may be applicable to patients and families at many stages of health and illness. Although a patient at the end of life has a heightened awareness of the importance of nonbiomedical dimensions, research suggests spiritual concerns affect a patient's choices throughout a lifetime of care.

Accepted for Publication: June 26, 2005.

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Financial Disclosure: None.

Funding/Support: This study was based on work supported by the Office of Research and Development Health Services Research and Development Service, Department of Veterans Affairs (IIR No. 98-162), and the Duke Institute on Care at the End of Life. Dr Steinhauser is supported by a VA Career Development Award.

Role of the Sponsor: Funders provided general support for the projects but did not have any role with regard to design or conduct of the study; collection, management, analysis, or interpretation of the data; or preparation, review, or approval of the manuscript.

Disclaimer: The views expressed in this article are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs or Duke University.

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