

# Spirituality in General Practice

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*In a pluralist and secular society, as well as in a medical world which is becoming increasingly evidence-based, making a case for consideration of spirituality in general practice may seem futile and irrelevant. Notwithstanding such an apparent paradoxical proposal, developments occurring in other specialties<sup>1</sup> as well as in general practice abroad reveal that it is high time that this theme is addressed academically and implications applied in local practice.*

For decades and in recent years, nurses<sup>2</sup> and psychologists<sup>3</sup> have discussed the role of spirituality in their professions, and psychiatrists have proposed therapies such as logotherapy<sup>4</sup> which addresses problems related to themes of a spiritual nature. General Practice as a specialty has not lacked behind, with the relationship with spirituality explored since at least the 1980s,<sup>5</sup> studies on the subject appearing in relevant journals in the United States<sup>6</sup> and Australia,<sup>7</sup> and a paper dealing with spirituality in medicine winning the RCGP registrar award as recent as 2008.<sup>8</sup>

## **Definitions**

With the meaning of spirituality considered to depend on individual interpretation, socio-cultural background and life experiences<sup>9</sup> as well as the rapidly evolving nature of the subject, coming to a universal definition of the spirituality is problematic. Yet most of the available literature can be considered to relate spirituality to a person's search for meaning, values and purpose in life.<sup>10</sup> A recent review acknowledges wholeness as another important aspect, whether it is wholeness within one's own life, interconnectedness with others or wholeness with the transcendent.<sup>11</sup> In definitions and research papers dealing with spirituality numerous themes often feature and these include hope, strength, comfort, meaning, peace, love, connection,<sup>12</sup> happiness, trust,<sup>13</sup> coping in illness,<sup>14</sup> positive outlook to life,<sup>15</sup> and fulfillment. Anandarajah conveniently categorised these themes into three categories, reflecting the cognitive (such as beliefs and values), the experiential (love, energy and connection) and the behavioural (prayer and meditation) aspects of spirituality, alternatively known as the 3H model as these categories respectively describe

what can be considered as the *head, heart and hands* aspects of spirituality<sup>16</sup>

Consequently, spiritual distress can be described to occur when a person's values, purpose or meaning in life are threatened, whether by disease process, familial circumstances, social problems or otherwise. As these situations often surface during consultation with the general practitioner, the importance of addressing such spiritual distress emerges, together with the need for appropriate approaches that parallel and compliment other modalities of care. One way to address these issues is to include spirituality in the biopsychosocial model of care transforming it into biopsychosocial-spiritual model.<sup>17</sup> The BMSEST model expands further these four dimensions<sup>18</sup> within a person's life to include further his/her environment and any relationship with the transcendent. In her well written paper, Anandarajah, continues by exploring the relationship between these different dimensions within a person, illustrating the complexity and mapping the therapeutic channels available during the doctor-patient relationship. She also formulates two variations of the BMSEST model that takes into account the different western and eastern religious traditions. By acknowledging that 'spirituality is a dynamic creative force that keeps a person growing and changing' Baldacchino provides a different model whereby spirituality integrates the biological, psychological and social dimensions in a person, as well as the religious dimension in believers.<sup>19</sup> These dimensions must be addressed for holistic care to be delivered. This is in line with the definition of healing provided by Dossey et al. whereby healing is defined as 'the process of bringing together aspects of one's self,

body-mind-spirit, at deeper levels of inner knowing, leading toward integration and balance with each aspect having equal importance and value.<sup>20</sup>

Even though related, spirituality is distinct from religiosity and religion. While spirituality, according to Wullf, often connotes and expresses a sense of meaning, purpose, or power either from within or from a transcendent source, religiosity can be viewed as the various organized, individual, and attitudinal manifestations of different faith traditions.<sup>21</sup> Meaning, values and purpose in life may be specifically religious, but even non-believers or those not members of an organised religion may have their own belief systems by finding meaning and purpose through connection to nature, music, the arts or a quest for scientific truth.<sup>22</sup> In a sense, spirituality addresses universal human questions and needs, in contrast to religion which often attempts to provide specific and differing answers to those questions, and ways of meeting those needs.<sup>23</sup> This differentiation is essential and needs to be distinguished. Indeed in one study, physicians who were highly spiritual were more likely to report practice among the underserved, as opposed to those who were more religious in general (as measured by intrinsic religiosity or frequency of attendance at religious services).<sup>24</sup> The present article will focus mainly on spirituality, and the reader is referred elsewhere to the implications of religion in modern medical practice.<sup>25</sup>

### **Evidence Based Practice**

Addressing issues of spirituality in General Practice should follow the same academic rigour adopted in studying other aspects of practice, particularly by being grounded on a reliable evidence base. In other words research on spirituality will need to engage in the apparent paradox of treating what traditionally has been associated with the transcendent through the tools of modern evidence based methods.

There is growing evidence that spirituality is associated with positive health outcomes. In HIV-patients, positive meaning was associated with a higher level of psychological well-being and a lower level of depressed mood.<sup>26</sup> In other studies, spiritual well-being was found to be associated with a reduced incidence and a significantly quicker recovery from depression<sup>27</sup> and is inversely related to suicide risk.<sup>28</sup> Indeed, a comprehensive literature review supported spirituality as a coping method among individuals experiencing a variety of illnesses ranging from hypertension, pulmonary disease, diabetes, chronic renal

failure, rheumatoid arthritis, multiple sclerosis, AIDS, polio to surgery and addictive illnesses.<sup>29</sup> The enhancement of mental health, together with the propensity to adopt a healthier lifestyle and cope with adversity, may also explain why people reporting positive spiritual coping behaviour are associated with reduced risk for physical illnesses such as hypertension, heart disease and cancer.<sup>30</sup> Secondary analysis of cross-sectional data from a large cohort study revealed that the geriatric population which reported greater spirituality (but not greater religiosity) were more likely to appraise their health as good, revealing how spirituality is an important explanatory factor of subjective health status in older adults.<sup>31</sup>

The relationship between spirituality and health has also been studied on a biochemical level. Indeed, high-quality social relationships have been shown to modulate brain function in specific, predictable, and beneficial ways to alleviate or prevent anxiety,<sup>32</sup> while meditation has been shown to modulate lung inflammatory processes in asthmatics.<sup>33</sup>

One, however, must be cautious in generalising such studies and the need remains to investigate the role of spiritual coping mechanisms in individual diseases, as benefit is not extendible to all aspects of illness. Indeed, in a study by Rosenkranz et al. spiritual beliefs were not linked with a favourable recovery from spinal surgery.<sup>34</sup>

Rigourously tested research tools are also essential for results to be evidence based. Although spiritual well-being (SWB) is essentially a subjective concept, reliable tools have been developed for research purposes. Baldacchino and Buhagiar<sup>35</sup> discuss issues in three American tools namely the Moberg's Social Indicators of SWB, the Ellison and Paloutzian SWB scale and the Jarel SWB scale. Concluding that the Jarel SWB scale was the most useful as it amalgamates existential and religious aspects they proceeded to study a Maltese translation of this scale and found it to be 'a reliable tool to measure the level of SWB on nursing students making it convenient to adopt locally in future studies. Another index, namely the Spirituality Index of Well-Being, was studied by Daaleman and Frey, the index having the additional benefit of having been found to be a valid and reliable instrument in a primary care setting.<sup>36</sup>

### **Practical applications**

In view of the evidence provided above, the need to include spiritual issues in primary care consultations emerges as an important challenge. This need is even more pressing as patients desire such discussions, as

revealed in a study by McCord et al. where the majority of respondents wanted physicians to ask about spiritual beliefs, particularly in life threatening illnesses, serious medical conditions and bereavement.<sup>37</sup> Our reaction as physicians does not always encourage such engagement. Some doctors argue that spirituality should not be routinely included in the consultation. This has been shown in a study by Ellis et al., with these authors also outlining that upbringing and culture, resistance to exposing personal beliefs, and belief that spiritual discussions will not have an impact on patients' illnesses or lives as some of the reasons behind this situation. Lack of time, inadequate training for taking spiritual histories, and difficulty in identifying patients who want to discuss spiritual issues emerged as other problematic factors.<sup>38</sup> The result is that often spiritual issues are only rarely discussed between patients and their primary care physician.<sup>39</sup>

With a commitment to develop appropriate approaches that allows the identification and addressing of spiritual issues, much of these problems can at least be addressed. Ellis et al. suggest patient centered reflection, an approach to spiritual discussion with 'gentleness and reverence' and avoidance of imposing one's beliefs as some of the basic principles for addressing spiritual issues.<sup>40</sup> Being physically present and open towards the patient's life and individuality is considered by physicians to go a long way to help in this dimension,<sup>41</sup> with the doctor in this relationship effectively serving as a supportive resource for the patients when listening, validating spiritual beliefs, and remaining with them during times of need.<sup>42</sup>

Spiritual self understanding and assessment, as well as a good patient-doctor relationship are identified by Anandarajah and Hight as other prerequisites for spiritual care. Appropriate detection and response to verbal and non-verbal cues as well as a basic knowledge of the Maslow's theory of hierarchy of needs may identify the moment to intervene.<sup>43</sup> Murray et al. suggest that simple questions such as 'What are the things that keep you going?' or 'What is important to you' are helpful in opening up a discussion on spiritual needs,<sup>44</sup> while Anandarajah and Hight describe a more formal approach through the use of the HOPE questions. Here a tool is provided to formally identify the sources of hope, meaning, and connection, reveal the role of organized religion, personal spirituality and practices on the illness, as well as determine how these effect medical care and end-of-life decisions.<sup>45</sup>

Once these are determined, various modalities and degrees of intervention are available. Together with the patient one may opt for no intervention, incorporate spiritual care as an adjuvant to care or modify the health care plan.<sup>46</sup> At each moment the doctor has to judiciously exercise the need to involve other members of the interdisciplinary team, and the response may vary from encouragement of the patient's spiritual self-care or general spiritual care<sup>47</sup> to referral to specialised spiritual care.<sup>48</sup>

## Medical Education

Medical education is increasingly being recognised in helping doctors discuss patients' beliefs and spiritual concerns in a respectful and caring manner.<sup>49</sup> According to Roger Neighbour's model in *The Inner apprentice*, the trainee's autonomy may be considered as the last and final goal of a successful training programme, a phase whereby the trainee 'discovers, chooses and pursues his/her own interests' and gains a 'sense of overall purpose, worth and direction'.<sup>50</sup> This highlights the importance (and possibly also proposes the timing) of preparing for an effective teaching programme that also addresses purpose and values, two concepts inherent in the above noted definition of spirituality. The BMSEST model provides one theoretical framework which can prove useful to communicate the role of spirituality in personal professional development and patient care, offering an opportunity to include the spiritual dimension in seeking complexity during a general practice consultation.<sup>51</sup>

Davidson suggests that primary care physicians should undergo contemplative training to cultivate qualities, such as sensitive attention, compassion, and positive intention.<sup>52</sup> While not questioning the validity of such training, one has to seriously consider practical ways of teaching them. To this regard, Anandarajah claims that educators have successfully used a small group exercise whereby learners are sequentially asked to define spirituality and organize answers according to the 3 H model (see above). According to this author this can serve trainees to learn from each other about the variety of world views present in their own learning community, provided a safe environment and appropriate small group facilitation skills are provided. This according to Anandarajah may than be used to explore trainee's encounters with patients' spiritual issues in the hope of addressing challenges and propose appropriate approaches in care.<sup>53</sup> One way of facilitating such work is outlined by Neighbour who identifies stories (particularly

of a greek mythological nature) as a suitable way of raising moral and spiritual agenda in a non-threatening way,<sup>54</sup> such techniques that increase non-judgmental awareness of values considered by this author as effective teaching tools.<sup>55</sup>

With a more general approach, the *Curriculum for Specialist Training in Family Medicine for Malta*<sup>56</sup> provides guidelines on how to address spirituality in the training of the Maltese specialist general practitioner. In line with achievements abroad, the curriculum promotes an educational philosophy that acknowledges the complexity of human beings and places the spiritual alongside the physical and psychological dimensions of care.<sup>57</sup> The curriculum recognises that this can only be achieved by a professional attitude during the consultation that 'respects the appropriate socio-cultural and spiritual context according to the patient's perspective.'<sup>58</sup> Indeed Falzon Camilleri singles out spirituality as an essential component to provide a 'humanely effective and compassionate dialogue in consultations'. This is not attained automatically or serendipitously but only through committing oneself to cultivate a healthy personal and professional development that promotes the cognitive, emotional and spiritual dimensions.<sup>59</sup> The teaching of values, attitudes and ethics is essential in the journey of personal development and is thus given high priority in this curriculum.<sup>60</sup>

In contrast to the general principles provided above and probably congruent with research abroad, the curriculum highlights issues of spirituality in specific areas of training, namely complementary and alternative medicine, palliative care as well as paediatric and adolescent health. Complementary and alternative medicine provides an opportunity to include the spiritual dimension in holistic care, not only by complimenting mainstream medicine but also by giving scope to explore diverse and alternative frameworks to the subject.<sup>61</sup> By definition patients in palliative care cannot be cured of their physical illness, but still may experience healing in psychological, social and spiritual matters. Thus according to the curriculum spirituality should form part of the definition and client assessment in palliative care as well inspire the acquisition of the necessary skills to co-ordinate care with other relevant members of the interdisciplinary team.<sup>62</sup> In paediatric and adolescent health the curriculum acknowledges the United Nations Declaration of the Rights of the Child by considering the spiritual dimension essential as part of normal development.<sup>63</sup>

Implementing these principles into practice will certainly be a challenge in the future. The work involved is justified by the reality that addressing spiritual issues in medical care helps transform the physician from "curer of disease" to "healer of the sick."<sup>64</sup>

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