

Spiritual Discussion: Relevance, Benefits and Application to Primary Care Consultations

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Introduction

Spiritual discussion, offering successful communication of the patient's ideas to the clinician is not a routine component of medical consultations in the United Kingdom. Views regarding the value, relevance and appropriateness of discussing spirituality are mixed. This review will introduce spirituality, provide a historical context, comment on personal reflection and discuss the benefits of successfully communicating spiritual concerns to the patient and clinician. It will also outline perceived barriers and risks, comment on changes needed to current practice and propose methods to do so.

Historical context

Historically religion shared an intimate relationship with healing and medicine. Initially, medicine and religion were coupled, with healthcare evolving from religious teachings, and ancient priest-physicians healed the body by curing and attending to spiritual ills. Seminal changes included the Hebrew Bible's proclamation as God the only healer, contrasting with Jesus the soter (saviour and healer [1]), Greek medicine favouring secular practice, and religion and sciences impasse in Renaissance Europe cumulating in separation during the twentieth century [2]. Subsequently, religious concerns were variously omitted, viewed as irrelevant or bothersome, and patients' spiritual needs ignored, ridiculed, and in extremis pathologised by Freud as universal obsessional neuroses [3]. This transition resulted in the gradual erosion of spiritual discussion within the consultation, cumulating in almost complete absence during the early twentieth century, characterised by a biomedical [4] approach with little emphasis on psychological or social components.

Spirituality and religion

Spirituality is an experiential process, looking for meaning, purpose, transcendence, connectedness and values, through relationship with the divine, nature, music, arts or science. Religion organises the collective experiences of many into a communicable system of beliefs and practices [5], whereas religiosity is the degree of participation. Does a consultation satisfy the World Health Organisations health definition of "...physical, mental and social well-being, not merely the absence of disease..." [6] if it excludes spirituality? If healthcare reflects societal norms [7] and values, does the omission of spirituality reflect patient preference? The United Kingdom supports numerous beliefs, from atheism and agnosticism to the devout. Taking spirituality as a search for meaning and connectedness, everyone, secular or religious contends with spiritual questions, which pose individual challenges to sensitive discussion especially during illness [2,8]. Does the missing spiritual reference impact on consultation outcome?

Personal reflection

Prior experience suggests that many patients derive significant comfort and benefit from religion. Additionally, it seems that the public's interest in the interplay of spirituality and health is not matched by medical practice, posing the questions: Does this affect patients? Do they feel isolated? Are clinicians neglecting human dilemmas? A memorable patient who suffered with severe depression and psychosis requiring numerous detentions under the mental health act and failure of medical treatments is enjoying a prolonged period of remission that she ascribes to renewing her faith. This view was not uncommon amongst psychiatric outpatients reviewed during a recent rotation, who appreciated opportunities to discuss spiritual concerns. It is clearly apparent that towards the end of life and during other significant life events, religious care is valued. But what roles, if any, should religious discussion have in less acute settings? Furthermore, what part should the clinician play? And how should spirituality be discussed? This review discusses the evidence regarding spirituality's role in the consultation, assessed against patient preference, satisfaction, impact on clinical decision making and health outcomes. Religion's interplay with mental health will be looked at in greater detail.

Methods

Search Strategy

A literature search strategy was developed and refined after consultation with a professional healthcare research librarian and applied to seven key databases. The NICE Healthcare Databases engine (www.library.nhs.uk) was searched using the advanced search facility. The seven key databases were AMED, BNI, CINAHL, EMBASE, Medline, HMIC & Psyc INFO. These databases were chosen to allow a comprehensive search of various fields including medicine, nursing, community healthcare, health and social care services, allied health, public health, sociology, psychology and gerontology.

Studies were identified by searching the electronic databases and scanning references of review articles and eligible studies for additional relevant studies. The search was restricted to English language articles and published studies.

The main terms were spirituality, religion, consultation, primary care, health outcomes and benefits. Numerous general background sources were identified by colleague recommendation and internet searches. A narrative review allowed a broad and abstract topic to be tackled with the integration and discussion of sources with various methodologies, to evaluate the relevance, benefits and application of spiritual discussion to primary care consultations.

Discussion

Spiritual demographics

Spirituality is not discussed during most consultations, thereby promoting secularism [9] and failing to satisfy patients' wishes as demonstrated by evidence from the United States and Australia [8]. Prevalence varies according to setting, with between 33% and 77% of patients interested in having clinicians attend to their spiritual needs [10]. Maugans research in the US notes that 72% of the general public agreed that *"my whole life is based upon my religion"*, only 39% of psychiatrists agreed [11]. Science fails to address personal spiritual thoughts surrounding meaning, value and relationships. Subsequently if spirituality is not discussed the patient may become a scientific curiosity as per the biomedical model.

It seems reasonable to expect these values to be broadly applicable to the UK where Christianity is the main religion, accounting for 48% of the total population, Islam being the second largest religion, 3% of the total population, Hinduism covering 1% of the total population. Whilst 46% of the British population says they don't belong to any religion [12], they may still be spiritual, and therefore still desire spiritual discussion.

Sadly, when physical or emotional insults occur spiritual concerns become more prevalent, as patients consider purpose and meaning. The fastest population increase in the UK is amongst those 85 and older, the so-called 'oldest old' [13], many of whom suffer with chronic disease, and may have spiritual concerns that are not met. Questions such as "why to me?" and "why now?" as described in Helman's Folk Model [14] become harder to answer in purely medical terms.

Implications of consultation models

The traditional model of doctor patient communication regards the doctor as an expert, communicating knowledge to the patient. The doctor is the authority figure. Some clinicians may not have evolved to more patient centered care, whilst others may feel uncomfortable communicating on matters outside their expertise. Patient shared and centered communication styles improve the communication process [15], with greater interaction leading to more commitment to advice given [16], improved compliance and better patient satisfaction [17].

Consultations and clinical decisions should aspire to be a partnership, being patient centered to improve outcomes as per Neighbour [18] and Pendleton [19]. Identifying patients' ideas, concerns and expectations as described by the Health Belief Model [20], makes acceptance of advice, diagnosis and treatment more likely. Doctors should also treat the patient as a whole person (Engel Biopsychosocial model [21]), satisfying the fundamental meaning that patients search for in suffering, healing, life and death [10], which enhances the relationship and increases the impact of therapy [3]. Consequently, Puchalski recommends adding the domain 'spiritual beings' to Engel's model [22]. These models require receptiveness by the doctor to the patient's opinions and expectations, and an effort to see the illness through the patient's eyes.

Ley's cognitive hypothesis model proposes that compliance can be predicted by a combination of patient understanding, recall and satisfaction with the consultation. Will patients be satisfied if their spiritual concerns are not discussed, will this omission prejudice their care? Studies by Haynes et al. [23] and Ley [24] concluded that satisfaction came from the affective aspects of the consultation

(emotional support and understanding), behavioural aspects (adequate explanation and prescribing) and competence (appropriate referral or diagnosis). These criteria are unlikely to be met if burning spiritual concerns are not addressed. Stanton's [25] adherence model of communication emphasises patients' beliefs, the patient's locus of control, perceived social support, and effects of adherence on lifestyle, again necessitating discussion of the patient's agenda.

Berry et al. [26] showed that a more personalised style was related to greater satisfaction, reinforcing the value of addressing individual spiritual needs. Balint emphasised transference and counter transference, necessitating that clinicians are aware that their behaviour and beliefs may impact on their patients. Psychological problems often manifest physically, care should therefore be taken before excluding spiritual discussion [27].

Poignantly, religious physicians were less likely to refer patients presenting with ambiguous symptoms of psychological distress to psychiatrists than non-religious physicians, preferring to refer to clergy members or religious counsellors [28]. Evidently health professionals have lay beliefs (spirituality) that vary as much as their patients. These beliefs influence diagnosis following the hypothetico-deductive model (Newell and Simon's) [29]. The clinician may wrongly assume he understands the nature of the problem. Compounding the initial error, evidence shows that doctors questioning and interpretation to confirm original hypotheses is biased [30]. Clearly, accurate assessment of the underlying issue is essential.

It seems prudent to elicit and follow patients' wishes, rather than risk ignoring or superseding them. When spirituality is not discussed parties are ignorant of each other's views, a meeting of experts is unlikely [31], and the consultation is biased towards the practitioner making concordance improbable and the delivery of substandard care likely. O'Donovan comments that "equality as human agents" is needed [1]. Clinicians are often best placed to identify patients' spiritual concerns as patients may for numerous reasons (fear, guilt, cognitive impairment) fail to contact a chaplain [10], necessitating an advocative role.

It is evident that spiritual communication between the clinician and patient is an interaction in the context of preconceived ideas, prejudices, stereotypes, lay beliefs and professional beliefs. Lessons learnt during cancer screening note that effective communication requires assessment of patients' personal health beliefs, which can have a spiritual component, and tailoring of communication method and content to suit the target audience. Unsurprisingly scripted or rigid communication inhibits disclosure of patients' personal concerns, and many patients feel such information should be solicited rather than volunteered. Patients may feel uncomfortable disclosing information during consultations lacking in rapport, especially if they believe clinicians from different cultures wouldn't understand their concerns [32].

Negative effects

Hassed notes that religion can have negative influences through [3] excess guilt, delayed access to treatment or abstinence from treatment. Detractors argue that religion should not be discussed as it may burden patients at an already sensitive time. However, these problems could be mitigated by open conversation [3], addressing concerns and referral to religious practitioners. It is unlikely that sensitive discussion will exasperate the situation and avoiding discussion fails to offer

resolution of concerns. Others have argued that personal religiosity can increase the religious content of delusions, and it is therefore inappropriate to discuss spirituality with mental health patients, this notion is refuted by research [33].

Some clinicians worry that routine discussions regarding spirituality violate patients' autonomy, or promote religion. Moral decisions are never made in a vacuum [34], by neglecting spirituality until major conflicts arise clinicians may impose their own values disproportionately. Doctors' risk allowing bias to mask that spirituality is important to their patients, ignoring Kleinman's [35] explanation of illness with its cultural interpretation giving value and meaning, and only treating the disease.

Benefits

Religiosity's association with less cigarette smoking, more conservative sexual practices, lower cortisol, catecholamine, blood pressure, cholesterol, and colon cancer [36] incidence is well documented. An increasing body of evidence purports that religiosity is associated with reduced morbidity and mortality, regardless of denomination [2,37]. Hypothesised mechanisms include improved social support, social capital, integration and better psychological resources. However behavioural associations are not a justification for spiritual discussion as cited by proponents. Religious commitment is inversely related to suicide risk [38-40], and may protect against depression [41,42]. Summarising, the literature suggests that spirituality has positive effects on social, mental and emotional health.

The nature of the alleged causal relationships makes research challenging. Sloan et al. argument that the empirical evidence has numerous methodological challenges, and confounders often not controlled for, thereby introducing bias into the assessment, is compelling [43]. The weaknesses may reflect an emerging field of research, however advocating clinical interventions (i.e. prescribing religiosity) as recommended by certain groups is without evidence. Most accept that spirituality is qualitatively different from other health behaviours even if associated with health benefits [2,43]. Claiming spirituality as an intervention misses the crux of why spirituality should be discussed, trivialises religion and practising religiosity for other reasons apart from its own sake may not accrue the same benefits [10]. The only relevant Cochrane review focused on prayer as an intervention, commenting that research shows no beneficial or harmful effect, but noting that the quality of trials was poor [43]. Another review concluded that religious activity may improve health outcomes, again highlighting methodological failures [44].

Barriers

Barriers to spiritual discussion include; the diversity of beliefs, multicultural societies, 'safety' of science, time pressures, concern regarding privacy, lack of training, risk of coercion [2,5], inappropriate counselling and prescriptive care [45], as well as the perception that religion opposes science [2].

Communication strategies

The literature supports spiritually oriented psychotherapy for individuals with anxiety disorder, eating disorders, and depression [46]. NICE recommends humanistic therapy (incorporating the body, mind, emotions, behaviour and spirituality) for children and young people with depression and some cases of schizophrenia [47], as well as advocating use for anxiety and addiction. Astrow et al. recommend

that the 'false dichotomy' of religion and healing be abolished and spirituality addressed routinely in the consultation [2]. Sloan et al. counter, claiming "... a lack of evidence that religious faith contributes to better health", and concern regarding spiritual coercion [48], and abuse of professional position. Accommodating patients' needs by providing access to services that the patient desires seems reasonable.

Regardless of the evidence true respect for patient autonomy necessitates that some spiritual assessment is made, the form of which should be in keeping with the situation, and the doctor-patient relationship, set in the middle ground between proponents who advocate religion as an adjunctive treatment and skeptics who reject the premise that faith can bring comfort. Silvestri et al. report that for some cancer patients faith is a more decisive factor in clinical decision making than efficacy of treatment [49]. American doctors conduct spiritual assessments and integrate findings into clinical decision making, hoping that this increases patient satisfaction, compliance and health outcomes [5]. Current UK care is variable.

Discussing spirituality routinely could prevent conflicts, and involving appropriate religious experts to discuss alternative treatments or interpretations with the patient may promote consensus [50]. The ideology of the patient supersedes that of the doctor [9]. Advocating for patients may also be required if they are subject to family or religious pressures.

Guidance

The United Kingdom's National Health Service guidance is exhaustive "requiring NHS staff and clinicians to be aware of and sensitive to the many perspectives that patients bring to ethical decision making" [51]. From a clinician's perspective, it is advisable to:

1. Conduct a spiritual history [8], or ask a simple open question such as "what role does religion play in your life?"
2. Supply or provide access to appropriate services
3. Value and support patient beliefs [2]
4. Orchestrate the meeting of spiritual needs

Plante describes thirteen tools for enhancing psychological health[52], distinguishing between internal religious spiritual tools (providing internal benefits e.g. nurturing individual spiritual and psychological growth), and external religious spiritual tools (help benefit the community and nurture external engagement) though this is beyond what is necessary for clinicians to provide. The General Medical Councils (United Kingdom organization that protects, promotes and maintains the health and safety of the public by ensuring proper standards in the practice of medicine) guidance is clear "Trust and good communication are essential components of the doctor-patient relationship. Patients may find it difficult to trust you... if they feel you are judging them on the basis of their religion, culture, values, political beliefs or other non-medical factors. For some patients, acknowledging their beliefs or religious practices may be an important aspect of a holistic approach to their care. Discussing personal beliefs may, when approached sensitively, help you to work in partnership with patients to address their particular treatment needs. You must respect patients' right to hold religious or other beliefs and should take those beliefs into account where they may be relevant to treatment options. However, if patients do not wish to discuss their personal beliefs with you, you must respect their wishes [53].

Conclusions

Claiming that spirituality is irrelevant to the consultation without causative evidence fails to take account of patient centered care. Medicine bases decision making on scientific discipline, value neutral and affect free interpretation of data, however scientific method is crude with qualitative data. Sloan et al. argue that mingling faith with science serves neither and weakens both [43], whereas Astrow et al. promote ending the 'false dichotomy'[2]. Medicine is an art and a science, a combination of intuitive practice and methodological discipline. Spirituality relies on faith rather than scientific rigour. Science offers patients 'a 25% chance of recovery', whereas spirituality provides hope, support and comfort. Current provision does not reflect patient preference, does not always satisfy the WHO health definition and when lacking impacts negatively on consultation outcomes.

It seems clear that spiritual care increases social integration, promotes relaxation, offers social support, engenders positive thinking, and provides discipline, hope and better compliance. Discussion enriches the doctor patient relationship, builds trust, provides patient centered practice and offers better outcomes. However, the size of these effects is arguable. Commonly proposed deleterious effects such as obsessive behaviour and guilt, prohibition of the use of diagnostic or therapeutic agents and undue influence are only exacerbated by refusing discourse. Healthcare professionals can meet the spiritual needs of their patients without sacrificing the gains of scientific medicine by discussing spirituality, acknowledging its importance, and referring as required [10] to other members of the wider healthcare team (counsellors, chaplains or other religious figures). This satisfies the tenet that questions of meaning, value and relationship are inseparable from illness. If "...to care for a person one must first learn to be a person"..., it would be sensible that professionals cultivate their own spirituality [2], become aware of their own beliefs, to better empathise with patients and accept, understand and compensate for different ideals.

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