

# Integrating Spirituality into Primary Care

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## 1. Introduction

Spirituality has been associated with medical care for centuries. Hospitals and universities originally were based on religious tenants and grounded by religious temples or societies. Nevertheless, in the early part of the 20<sup>th</sup> century there was a separation between religion, spirituality and medicine as the emphasis of medicine shifted to a more scientific focus(1).

However, since the 1960's, epidemiological studies started to show the impact of religiosity and spirituality to the patient health and triggered research on this subject. Religion was seen by many as beneficial and responsible for clinical outcomes, which motivated the creation of the term "Evidence Based Spirituality"(2, 3).

Since then, thousands of articles have been published in scientific databases showing the impact of religiosity/spirituality in mental and physical health(4, 5). Spirituality has been associated with quality of life, better mental health, survival, less hospitalization and better coping (6-8).

In addition, patients believe their doctors should ask about spiritual matters which could improve the doctor-patient relationship. According to recent studies, 99 percent of family physicians believe that religious beliefs can heal, and 75 percent believe that others' prayers can promote healing(9).

Nevertheless, physicians usually are not trained for addressing spiritual beliefs and reported many barriers for that evaluation such as: lack of time, lack of knowledge, lack of training, fear and being not comfortable to address it(10).

Spirituality is defined by Koenig(11) as "a personal search for understanding final questions about life, its meaning, its relationships to sacredness or transcendence that may or may not lead to the development of religious practices or formation of religious communities".

Religiosity(11) is understood as the "extension to which an individual believes, follows, and practices a religion, and can be organizational (church or temple attendance) or non organizational (to pray, to read books, to watch religious programs on television)".

In fact, many arguments support the teaching and practice of these basic spiritual/religious skills to physicians(3, 12, 13):

1. Religious beliefs and spiritual needs are common among patients, and many patients would like their doctors to address these issues
2. Religious beliefs influence medical decision making
3. There is a relationship between spirituality and health.
4. Supporting a patient's spirituality can enrich the patient-physician relationship.

In this chapter, we aim to investigate the role of spirituality and religiosity in primary care, reviewing the following topics (Box 1).

1. scientific evidence of the relation between spirituality and health
2. primary care patients and physicians' opinions
3. reasons for addressing
4. barriers
5. how to address spiritual issues in clinical practice
6. religious struggle
7. ethical issues
8. the role of primary care physician.

Box 1. Topics addressed by this chapter

## **2. Scientific evidence of the relation between spirituality and health**

There is a huge amount of evidence regarding the impact of spirituality/religiousness in health.

For instance, a search conducted in the beginning of 2011 showed that 4.42 articles per day were published on Pubmed concerning spirituality or religion. Furthermore, the most important and high quality journals in the World have been publishing these articles such as New England Journal of Medicine(14), The Journal of the American Medical Association (15) and Lancet (9).

Most American Universities have departments dealing with this kind of issue such as "The George Washington Institute for Spirituality and Health from George Washington University", "Center for Spirituality, theology and health from Duke University" and Center for the study of Health, Religion and Spirituality from Indiana State University among others. In addition, most American medical schools have spirituality courses in their curriculum (16).

In "Handbook of Religion and Health"(11, 17), authors analyzed all articles published in scientific databases before the year 2000. From those, more than 700 studies examined the relation between religion, well-being, and mental health. They found that religious beliefs and practices were associated with significantly less depression and faster recovery from depression (60 of 93 studies), lower suicide rates (57 of 68), less anxiety (35 of 69), and less substance abuse (98 of 120). They were also associated with greater well-being, hope, and optimism (91 of 114), more purpose and meaning in life (15 of 16), greater marital satisfaction and stability (35 of 38) and higher social support (19 of 20).

A summary of the research on physical health outcomes(11, 17) found that religious beliefs and activities have been associated with better immune function (5 of 5 studies); lower death rates from cancer (5 of 7); less heart disease or better cardiac outcomes (7 of 11); lower blood pressure (14 of 23); lower cholesterol (3 of 3); and better health behaviors (23 of 25, less cigarette smoking; 3 of 5, more exercise; 2 of 2, better sleep).

Some other studies have studied the relation between spirituality and religiousness (S/R) and survival. Three meta-analysis(5, 18, 19) found that patients with higher levels of spiritual/religious beliefs have a lower mortality (varying from a 18 to 25% decrease) and a recent study(7) found that S/R plays a considerable role in mortality rate reductions, comparable to fruit and vegetable consumption and statin therapy.

Recently, some studies have been addressing the impact of a spiritual intervention for treatment of some conditions such as anxiety(20), depression(21),cancer(22), including others.

### **3. Primary care patients and physicians' opinions**

According to recent surveys, most patients want their doctors to ask about their religious and/or spiritual beliefs.

McCord et al.(23) evaluated 921 patients and found that 83% of respondents wanted physicians to ask about spiritual beliefs. The most acceptable scenarios for spiritual discussion were life-threatening illnesses (77%), serious medical conditions (74%) and loss of loved ones (70%). Among those who wanted to discuss spirituality, the most important reason for discussion was desire for physician-patient understanding (87%). Patients believed that information concerning their spiritual beliefs would affect physicians' ability to encourage realistic hope (67%), give medical advice (66%), and change medical treatment (62%).

Ehman et al.(24) also evaluated patient acceptance of including a spiritual beliefs question in the medical history of ambulatory outpatients. They found that forty-five percent of patients believe religious beliefs would influence their medical decisions if they become gravely ill. Further, ninety-four percent of individuals agreed that physicians should ask them whether they have such beliefs if they become gravely ill. Altogether, two thirds of the respondents indicated that they would welcome a spirituality question in a medical history, whereas 16% reported that they would not. Only 15% of the study group recalled having been asked whether spiritual or religious beliefs would influence their medical decisions.

In other countries, these results are similar. Lucchetti et al.(6) evaluated rehabilitation Brazilian patients and found that more than 87% of patients wanted their physicians to ask about their religious beliefs. Nevertheless, only 8.7% recalled have been asked about their religion by their doctors.

Primary care physicians have been asked several times about these issues. Luckhaupt et al.(25) evaluated the opinions of primary care residents and found that 46% felt they should play a role in patients' spiritual or religious lives, especially when the gravity of patient's condition increased.

In 2003, Monroe et al.(26) evaluated primary care physicians and found that 84.5% of them thought they should be aware of patients' spirituality. However, most would not ask about spiritual issues unless a patient was dying. They also found that family practitioners were more likely to take a spiritual history than general internists.

Another study conducted by Ellis et al.(27) showed that 96% of 231 family physicians interviewed considered spiritual well-being an important health component, 86% supported referral of hospitalized patients with spiritual questions to chaplains, and 58% believed physicians should address patients' spiritual concerns. According to the authors, fear of dying was the spiritual issue most commonly discussed, and less than 20% of physicians reported discussing other spiritual topics in more than 10% of patient encounters.

#### 4. Reasons for addressing

Many reasons are pointed up for addressing spirituality in clinical practice. Table 1 shows the most common reasons pointed and their explanation.

In addition, the JCAHO(13) (Joint Commission on Accreditation of Healthcare Organizations) requires that a spiritual history be taken and documented on every patient admitted to a hospital, nursing home or home health care agency.

| Reasons for addressing  | Explanation (According to recent surveys)   |
|---|---|
| Religious beliefs and spiritual needs are common among patients                                 | 90-99% of patients believe in God and 70% are church/temple members(3, 13)  |
| Many patients would like their doctors to address these issues                                  | More than 80% of patients want physicians to ask about spiritual beliefs and more than 94% if they become very ill(23, 24)  |
| Religious beliefs influence medical decision making   | Near half of the patients believe religious beliefs would influence their medical decisions if they become gravely ill. In addition, religious beliefs could influence diet, blood transfusion, use of contraceptive methods, including others(13, 24). |
| Many patients depend on religion to cope  | More than 80-90% of the population usually turn to religion in order to cope with stressful events(13, 28)  |
| Religious/spiritual beliefs can impact mental and physical health                               | Spirituality and religiousness have relation to almost every aspect of the human being. These evidences were extensively discussed earlier in this chapter.(11)   |
| Supporting a patient's spirituality can enrich the patient-physician relationship.              | 66 to 81% would have greater trust in their physician if he asked about their religious beliefs, including an improvement of patient-physician relationship(13)   |
| Religious involvement may affect the kind of support and care patients receive in the community | Religious organizations could play a role in early disease prevention (education), early disease detection (screening) and provision of health care (trained volunteers).(13)   |

Table 1. Reasons for addressing spiritual issues

## 5. Barriers

Many barriers are pointed up by health professionals for not including spirituality and religiousness issues in their daily routine.

Ellis et al.(27) found in primary care physicians that the most common barriers were: lack of time (71%), inadequate training for taking spiritual histories (59%), and difficulty identifying patients who want to discuss spiritual issues (56%).

The same author(29) also divided the barriers in four parts: Physician Barriers, Mutual Physician-Patient Barriers, Physician-Perceived Patient Barriers and Situational Barriers (Table 2).

| Barriers                             | Types of Barriers   |
|--------------------------------------|---|
| Physician Barriers                   | Lack of comfort or training<br>Lack of spiritual awareness or inclination<br>Fear of inappropriately influencing patients                                     |
| Mutual Physician-Patient Barriers    | Discomfort with initiating discussions<br>Lack of concordance between physician and patient spiritual or cultural positions<br>No common “spiritual language” |
| Physician-Perceived Patient Barriers | Fear that it’s wrong to ask doctor spiritual questions<br>Belief that spiritual views are private<br>Perception of physician time pressure                    |
| Situational Barriers                 | Time<br>Setting (examination room)<br>Lack of continuity or managed care  |

Table 2. Most common barriers for incorporating spirituality in clinical practice(29).

A recent survey evaluated the barriers pointed up by medical teachers from a Brazilian medical school regarding integrating spirituality in clinical practice and found that the most prevalent barriers cited by medical teachers were: lack of time (11.3%), lack of knowledge (9.3%), lack of training (9.3%), fear (9.3%) and being not comfortable to address it (5.6%).

## 6. How to address spiritual issues in clinical practice

Health professionals experience difficulties assessing this issue in clinical practice(26). In order to facilitate the addressing of spirituality in clinical practice, several authors have created instruments to obtain a spiritual history (30-32).

Anandarajah et al. suggested that a spiritual assessment should include "determination of spiritual needs and resources, evaluation of the impact of beliefs on medical outcomes and decisions, discovery of barriers to using spiritual resources and encouragement of healthy spiritual practices"(31).

According to the Joint Commission on Accreditation of Healthcare Organizations JCAHO(33), practitioners should conduct an initial, brief spiritual assessment with clients in many settings, including hospitals and behavioral health organizations providing addiction services. The same framework, however, is used in all settings. At minimum, the brief assessment should include an exploration of three areas: (1) denomination or faith tradition, (2) significant spiritual beliefs, and (3) important spiritual practices.

Table 3 shows some important instruments to facilitate spirituality addressing in clinical practice by primary care physicians.

| Instrument   | Opinion  |
|--|--|
| SPIRiTual History(34)  | This instrument is very broad, evaluating key questions such as medical practices not allowed and terminal events. Nevertheless, it takes a relatively long time to apply which can hamper its use in certain settings, especially those involving 15 to 20 minutes primary care (general practitioner) consultations.         |
| FICA (30)  | Easy to remember and to apply, and was well suited for those physicians that want to address patients' spirituality but do not have enough time for a consultation. It covers the social aspect as well as treatment action. It also constitutes a good instrument for those beginning in this field and with little training. |
| HOPE (31)  | Good instrument that is easy to remember and which addresses important questions such as medical practices not allowed and personal spirituality   |
| FACT - Spiritual history tool (35)                           | a straight-forward instrument which is quick to apply, has a treatment plan, and includes a question about coping  |
| CSI-MEMO Spiritual History (32)                              | Easy to remember, easy to use, fast to apply, and address important questions such as coping (comfort), the negative side of religion (stress) and the influence of spiritual beliefs on medical decisions   |
| Spiritual history of the American College of Physicians (36) | Fast to apply and easy to address. Nevertheless, some important questions pertaining to palliative care such as medical practices not allowed due to religion and terminal events, are not included.   |

Table 3. Some instruments to facilitate spirituality addressing in clinical practice by primary care physicians.

## 7. Religious/spiritual struggles

Religious/spiritual struggles refer to expressions of conflict, question, doubt, and tension about matters of faith, God, and religious relationships that occur as an individual attempts to conserve or transform a spirituality that has been threatened or harmed (37). Spiritual struggles can be triggered by a variety of stressors. For example, a single unexpected event, such as the untimely loss of a loved one, may overtax the orientation system and trigger a spiritual struggle.

It is important for the primary care physician to differ the religious coping (positive) from the religious struggle (negative) because the first has positive outcomes on patient's health. Nevertheless, the later has extremely negative impacts.

In 2001, Pargament et al.(38) evaluated 596 patients aged 55 years or older and found that higher religious struggle scores at baseline were predictive of greater risk of mortality (risk ratio [RR]: 1.06) during a two-year follow-up.

McConnell et al.(39) investigated the relationship between spiritual struggles and various types of psychopathology symptoms in individuals who had and had not suffered from a recent illness. The authors found that negative religious coping was significantly linked to various forms of psychopathology, including anxiety, phobic anxiety, depression, paranoid ideation, obsessive-compulsiveness, and somatization, after controlling for demographic and religious variables.

Ai et al.(40) examined spiritual struggle related to plasma interleukin-6 (IL-6) in 235 adult patients undergoing cardiac surgery and showed that spiritual struggle ( $p = .011$ ) were associated with excess plasma IL-6, even after controlling for medical correlates.

## 8. Ethical issues

Many ethical issues emerged with the incorporation of spirituality in patient care. According to Daaleman (41), "the ethical challenge of intersecting patient and physician spiritualities lies in how both negotiate these movements across health and illness".

The most common ethical issues regarding spirituality, religion and health are (for a deeper reading, see the following references) (23, 42):

- Respect for patients' opinion: Autonomy requires that physicians respect the decisions of competent patients, which are often based on religious and spiritual beliefs
- Not impose physicians' religion: Nonmaleficence ("do no harm") requires that physicians not proselytize.
- End-of-life care and decisions: some end-of-life care decisions as well as life-support decisions were influenced by religious traditions(43).
- Contraception and abortion: Most religions have taken strong positions on abortion and ethical issues are very common on these situations.
- Acceptance of hemocomponents and hemoderivatives: Some religious traditions such as Jehovah's Witnesses refuses to accept hemoderivatives essentially based on the Bible(44).

- Praying with the patient: physicians should not impose their religious beliefs on patients nor initiate prayer without knowledge of the patient's religious background and likely appreciation of such activity(15).

Finally, according to Curlin et al.(45) "Physicians who engage patients in discourse regarding religion should do so in an ethic of friendship, marked by wisdom, candor, and respect. Whether a particular conversation is ethical will depend on the character of those involved and the context of their engagement."

## 9. The role of primary care physician

Thousands of studies have been showing that just the biological model is not enough for treating the whole patient(46).

According to the World Health Organization (WHO): "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (47).

The WHO definition has been submitted to revision at the end of last decade, under the impulse of Dr Halfdan Mahler, WHO Director-general at that time. The executive board submitted a new definition of health including the spiritual dimension of health in the following way "Health is a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity." This modified WHO health definition was to be presented to the 1st World Assembly of Health in 1998 as it requested a revision of the WHO Constitution. Finally, this proposal slipped away from endorsement and has not yet been brought back on the agenda(47). Although not approved yet, this definition is widely use in this new paradigm of integrative medicine.

Integrative medicine represents a higher-order system of systems of care that emphasizes wellness and healing of the entire person (bio-psycho-socio-spiritual dimensions) as primary goals, drawing on both conventional and CAM approaches in the context of a supportive and effective physician-patient relationship(46).

The aims of primary care are to provide the patient with a broad spectrum of care, both preventive and curative, over a period of time and to coordinate all of the care the patient receives(48). In other words, primary care physicians have the responsibility of providing the best care available for their patients and, if their patients have a spiritual issue they need to know how to act. Further, most available studies dealing with this issue have been conducted in primary care settings and by primary care researchers (49).

According to Walter Larimore(50): "Just as 'obstetrics is just too important to be left to obstetricians' I believe the practice of basic spiritual skills is just too important to be left solely to pastoral professionals." The authors of this chapter share this view.

## 10. Conclusion

In conclusion, spirituality and its interface with medicine have been extensively discussed and considered by health professionals, including those responsible for primary care.

The patient care, previously limited only to the biology dimension, is now being expanded to other dimensions (social, psychological, spiritual) in a more integrative and complex view.

Health professionals should be aware of the spiritual beliefs/needs of their patients in order to treat them as fully as possible.

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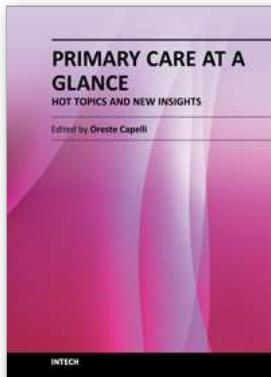
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## Primary Care at a Glance - Hot Topics and New Insights

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"Both among scientists and clinical practitioners, some find it easier to rely upon trivial explanations, while others never stop looking for answers". With these surprising words, Augusto Murri, an Italian master in clinical medicine, reminds us that medical practice should be a continuous journey towards knowledge and the quality of care. The book brings together contributions by over 50 authors from many countries, all around the world, from Europe to Africa, from Asia to Australia, from North to South America. Different cultures are presented together, from those with advanced technologies to those of intangible spirituality, but they are all connected by five professional attributes, that in the 1978 the Institute of Medicine (IOM)<sup>1</sup> stated as essentials of practicing good Primary Care: accessibility, comprehensiveness, coordination, continuity and accountability. The content of the book is organized according to these 5 attributes, to give the reader an international overview of hot topics and new insights in Primary Care, all around the world.

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