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The importance of spirituality in caring for patients

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Corresponding Author:	John Wattis University of Huddersfield Huddersfield, UNITED KINGDOM
Corresponding Author Secondary Information:	
Corresponding Author's Institution:	University of Huddersfield
Corresponding Author's Secondary Institution:	
First Author:	John Wattis
First Author Secondary Information:	
Order of Authors:	John Wattis
	Stephen Curran
Order of Authors Secondary Information:	
Additional Information:	
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'The importance of spirituality in caring for patients'

Key points:

According to the GMC, attention to spiritual issues is expected as part of a medical assessment.

1. Spirituality is hard to define precisely but it can be understood as what gives meaning and purpose and a sense of connectedness to life.
2. Religion and spirituality overlap but are distinct and there are non-religious as well as religious approaches to spirituality.
3. Serious illness and injury may challenge patients' spirituality and clinicians need to be sensitive to this and provide or arrange support as appropriate to meet their spiritual needs.
4. Training to address these issues is in its infancy in the UK, though nursing research has identified key competencies than can be applied to medicine, too.
5. The present challenges in the NHS mean we need to pay particular attention to organisational issues related to spirituality.

How many doctors know that the General Medical Council (GMC) expects them to include spiritual as well as psychological, social and cultural factors when assessing patients (1)? At first sight this may seem a strange requirement and provokes a string of questions. What does "spiritual" mean in this context? How does "spirituality" differ from "religion"? Where is the evidence that it makes any difference?

Spirituality can be broadly understood as what gives meaning and purpose to life, a sense of connectedness and a source of hope. It at least includes the possibility of transcendence in the sense of moving beyond physical needs and realities. In an important paper, written from a North American point of view, Post et al (2) discussed the ethical obligation for physicians to address spirituality. They believed this obligation was rooted in the principle of beneficence, on the grounds that addressing spirituality facilitates patient engagement with the physician and that spiritual and religious coping have a beneficial effect on patient outcomes (in part mediated by *psychoneuroimmunology*). There is an overlap between spirituality and religion and, particularly in American research, religious practice is sometimes used as a rough surrogate for spirituality. Much of this research shows significant health benefit from religiousness/spirituality (3). Though this indirect measurement is convenient for research purposes, since spirituality is notoriously hard to "measure", it is less appropriate in clinical practice (4). In post-modern, multi-cultural societies many non-religious people, too, claim their own spirituality.

The sense of meaning and purpose in life is often challenged by serious illness (and injury). Serious illness can be experienced as life-threatening and can also be life-changing. People with serious and/or chronic illness may need help coping with these challenges. A focus on the purely bio-medical aspects of care can fail to recognise these needs but doctors are not always well prepared to assess or address spiritual needs. The palliative care movement in the UK has taken a lead in addressing these needs and the Joint Royal College of Physicians Training Board Specialty Training Curriculum for Palliative Medicine has a standard: "To have the knowledge and skills to elicit spiritual concerns, recognise and respond to spiritual distress and demonstrate respect for differing religious beliefs and practice and accommodation of these in patient care" (5). There is no reason why this standard should be reserved for end of life care!

In medical undergraduate training, most of the initiatives have been in the USA. By 2006 four fifths of US medical schools included teaching on religious and spiritual issues applied to medicine (6). Less is known systematically about undergraduate teaching concerning spirituality in the UK (7). Other healthcare disciplines are leading the way in the UK. The Royal College of Nursing (RCN) conducted a large scale survey of nurses' understanding of spiritual issues (8) and subsequently published guidance (9). There has also been a lot of work on defining spiritual competencies for nurses (10) though paradoxically the latest Nursing & Midwifery Council (NMC) "code" (11), unlike Good Medical Practice (1), does not specifically mention spirituality (though it can be assumed to be contained within the rubric of "holistic care").

Nursing research (10) has identified three clusters of spiritual competencies:

- Spiritual self-awareness and use of self
- Spirituality in practice
- Quality assurance and improvement

The six competencies under these headings include self-awareness, cultural sensitivity, the identification of spiritual needs, discussion with the patient and the team about spiritual care provision and planning, provision and evaluation of care and contributing to quality assurance and improvement of spiritual care within the organisation. Again, there seems to be no reason why these competencies should be reserved for nurses; they appear of equal value to all clinical professions.

Spiritually competent practice requires compassionate engagement with the whole patient in ways which foster a sense of meaning and purpose. This includes supporting connections with family and community, addressing suffering and supporting patients' coping strategies to improve their quality of life. This also includes the practitioner accepting a person's beliefs and values, whether they are religious in foundation or not, and practising with cultural competency (12). For most NHS organisations in the UK, mandatory diversity and inclusion training at least addresses the last of these. Undergraduate and postgraduate medical education would benefit from attention to spiritual care competencies and compassionate engagement requires personal commitment from staff. Spiritually competent practice also requires an organisation that values personal, compassionate care and provides staff with the time and facilities to deliver this. Some, patient-centred and well-led organisations foster a spirit of co-operation and do their best to deliver these prerequisites. Other organisations, motivated by fear about financial performance and driven by targets, fail to do so.

In the present state of the NHS (perhaps particularly in England), personal self-awareness and organisational issues are especially important. What is our meaning and purpose as clinicians? How well do we connect with each other and other health care disciplines? In an NHS subjected to increasing demand, restricted finances and repeated reorganisation, what (or who) are *we as doctors* here for? What are *our professional values* and how far can we allow them to be compromised if at all? The recent junior doctors' industrial action has challenged unrealistic expectations from politicians about how far limited funding can be stretched. There has been a sense of solidarity within the profession and with other clinical (and even managerial) disciplines in standing up to unrealistic expectations and inappropriate imposition. The once strong corporate spirit of the NHS, battered by repeated reorganisations and political pressures, now seems to be reviving, re-asserting itself and finding its purpose. As doctors, we need to contribute to this by paying attention not only to the technical aspects of our profession but also by attention to the meaning, purpose and values of the profession and to the spiritual needs of our patients and our organisations.

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8-10 references (12 at present)

5-8 key points (6 at present)

No conflicts of interest. Approx. 1100 words excluding references but including key points, 1400 words including references