Should GPs provide spiritual care?

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Ethics
It was not necessary to obtain approval for the study and no ethics committee approval was sought.

Debate and Analysis

Should GPs provide spiritual care?

Spirituality and spiritual wellbeing

The World Health Organisation in 1948 defined health as a complete sense of physical, mental and social wellbeing and in 1998 the definition was revised to include the importance of spiritual wellbeing and the connection between mind and body in the healing process. The word spirit comes from the Latin “spiritus” meaning breath and spirituality has been described as a search for existential meaning regarding a power other than the self that is not necessarily called “God”. This search for meaning includes a need for identity and relatedness and sometimes is expressed as a need to feel loved or accepted and of having a sense of self-worth. Spirituality is about acceptance, integration and wholeness and is the essence of what it means to be human.

Spiritual care

Spiritual care can be defined as care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and includes the need for meaning and self-worth, to express oneself, for faith support or simply for a sensitive listener. It is usually given in a one to one relationship, is person centred and makes no assumptions about personal conviction or life orientation.

Spiritual needs assessment and assessment tools

Rumbold in a review of spiritual needs assessment suggested that it should include: respect for the patients’ perspectives and privacy, involvement of all members of the interdisciplinary team, clear documentation of needs and strategic responses to these needs, integration of strategies into an overall care plan, provision of a shared framework for continuity of care between community agencies and inpatient services and not conflating spiritual issues with religious practice (1).

Many assessment models or tools have been proposed mainly for use by healthcare professionals and chaplains and one of the most commonly used is the F(Faith), I (Importance), C (Community) and A (Address in care or action) or FICA/HOPE tool which was developed by a group of US primary care physicians and validated in the city of Hope by the George Washington Institute for Spirituality and Health. The FICA tool allows doctors to assess the severity of spiritual distress, identify a patient’s spiritual resources of strength and integrate that information into the clinical treatment plan (2). It is a model which could be readily adapted for use in UK general practice.

Arguments against using assessment tools

Arguments against using tools to assess spiritual needs include the view that the vocabulary of the spirit belongs to a language of depth and meaning which unfolds in the context of relationship rather than by dispassionate analysis and that the best way of obtaining information about spiritual needs is by listening to patients' stories and encouraging them to articulate their concerns. Spiritual care is not a set of prescribed and proscribed roles but a series of highly fluid interpersonal processes in the context of mutually recognised human values and experiences and sight, speech, touch and presence are the ways in which healthcare professionals impact on patients' spiritual well-being regardless of their awareness or intent.

Results of spiritual interventions

Several studies have demonstrated positive outcomes from spiritual interventions. Patients with type 2 diabetes and/or cardiovascular disease have been shown to incorporate spirituality into their self-management routines with a positive effect on their health and wellbeing (3) and patients receiving talking therapy from a chaplain have been shown to experience similar improvements in wellbeing as patients who were prescribed antidepressants (4). Good spiritual care of terminally ill patients has also been shown to be associated with less aggressive end of life care and greater quality of life near death (5).

Results of systematic literature reviews have been less convincing. A review of randomised controlled trials of faith-based psychological therapies for anxiety and depression found that the trials were typically small and susceptible to significant bias (6). Another review investigating spirituality as a complementary treatment in mental healthcare concluded that due to the diversity of protocols and outcomes and lack of standardisation of interventions it was not possible to give a definite answer one way or the other (7) and results from a review of five randomised controlled trials investigating if the presence of a spiritual care counsellor in palliative care teams helped patients feel emotionally supported were inconclusive (8).

Why are GPs and other healthcare professionals reluctant to provide spiritual care?

In a qualitative evidence synthesis Vermandere et al concluded that most GPs saw it as their role to identify and assess patients' spiritual needs but struggled with spiritual language and experienced feelings of discomfort and fear that patients would refuse to engage in the discussion (9) and although nurses have traditionally provided spiritual care reservations have been expressed regarding their involvement in spiritual assessment.

A recent hospital based study suggested there was strong agreement among clinical and non-clinical staff on the importance of delivering spiritual care but uncertainty in the ability to recognise and meet the spiritual needs of patients (10) and in a qualitative analysis healthcare professionals had difficulty in formulating descriptions of spiritual care which was in marked contrast to the importance they attached to this aspect of holistic care. The reasons given for being reluctant to

provide spiritual care included; lack of available time, lack of training and expertise and a sense that others could do a better job (11).

Do Chaplains have a role in general practice?

Chaplains act as spiritual care providers, emotion facilitators, grief counsellors and cultural and religious experts and are increasingly becoming involved in spiritual care in the community and in general practice. In a pilot study community clergy who received training with healthcare professionals and chaplains enhanced the quality of care they provided to patients dying at home who wished to receive spiritual support (12) and in a previously mentioned study it was suggested that primary care chaplaincy could be considered as an alternative to cognitive behaviour therapy (4). Perhaps in future the GP will be regarded as the generalist in spiritual care who refers appropriate patients to the chaplain who is the specialist in spiritual issues.

Recent NICE guidance on spiritual care

In 2014, an audit of end of life care by the Royal College of Physicians reported that nearly half of all deaths in England occurred in hospital and spiritual issues were documented in only one in 7 patients. The National Institute for Health and Care Excellence (NICE) has issued new guidance on spiritual care of dying patients which states that only by attending to a patient's spiritual, cultural, religious and social preferences can truly individualised care be delivered and all healthcare professionals should now include spiritual beliefs when discussing care with dying patients and those close to them.

Conclusion

Spiritual care is not religious (although religious care which is given in the context of the shared religious beliefs, values, liturgies and lifestyle of a faith community may be spiritual) and it is an important aspect of holistic patient care. There are two challenges; firstly, developing instruments which will more accurately assess the effectiveness of spiritual interventions (9) and secondly, persuading GPs and other healthcare professionals of the importance of providing good spiritual care.

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