# A SPIRITUAL AGENDA FOR DOCTORS?

***Eleanor Williams***

*Abstract: In this article the author addresses the ambivalence felt by doctors in the delivery of spiritual care. A number of issues are addressed including the place of spirituality within healthcare and holistic care, the role of the doctor in the delivery of spiritual care and the need for greater cooperation between disciplines in this area of healthcare. This is the first of two articles examining the relationship between doctors, spiritual care and healthcare chaplaincy.*

*Keywords: Spiritual Care, Holistic Care, Multidisciplinary Working, Spirituality*

## Prologue – a story

My first encounter with the role of a hospital chaplain was over 20 years ago. I was less than a year out of medical school, the junior house officer on a medical ward in a district general hospital in a South Wales valleys ex-mining town. It was the middle of a busy night, and earlier that evening I'd admitted two men to adjacent beds in a six bed unit.

The man in the bed next to the window was clearly very sick, I can't remember now, but I think it was his heart. The man next to him had come in with severe breathing difficulties, emphysema, probably smoking-related. The man by the window was a Roman Catholic, and his son was with him. It was clear that there was little we could do for him, and the very astute night sister had suggested that a chaplain be called. Impressively, he came very quickly, and administered "the last rites".

The man in the middle bed watched the comings and goings, through the gap in the curtains, which had been part drawn discreetly around his bed. He must have been aware of what was going on, particularly when the priest came, and a short time later the "crash team" was called, and unsuccessfully attempted to revive the man by the window, when he suffered a cardiac arrest.

I don't remember anyone going to the man in the middle bed to explain what was going on, or to see if he needed any help himself. We'd done all we could medically for him. All I remember is going backwards and forwards past the open gap in the curtains, and I do have a clear memory of seeing him sitting upright, struggling for breath, with an oxygen mask on, and with a look of fear on his face.

Both men died that night, and I've wondered since then whether we failed the man the man in the middle bed. Perhaps we were all too busy. Perhaps his religious affiliation was not clearly marked on his notes. Perhaps we didn't feel sure that it was our role to talk to him about matters of life and death, and besides, I don't think we expected him to die, or perhaps we would at least have thought about offering him the opportunity to talk to somebody.

It was the middle of the night and we were busy, but he died alone and afraid. From a 'medical' perspective he had all the care we could offer, but it seemed as if there was a dimension that we completely overlooked in our care for him. I think we sensed this, but too late to do anything else for him.

## Spirituality as Part of Holistic Care

A search for 'spirituality' is common among today's consumers, although church attendance has been in decline for many years. The huge rise in numbers of people seeking help from alternative and complementary practitioners may reflect this search for a spiritual dimension, evidence of an undercurrent of dissatisfaction with the current mechanistic medical models, which all too often neglect a fully holistic view of patient care.

The World Health Organization reported in 1998:

*Until recently the health professions have largely followed a medical model, which seeks to treat patients by focusing on medicines and surgery, and gives less importance to beliefs and to faith - in healing, in the physician and in the doctor-patient relationship. This reductionist or mechanistic view of patients is no longer satisfactory. Patients and physicians have begun to realise the value of elements such as faith, hope, and compassion in the healing process.(World Health Organisation 1998)*

*'Begun to realise'* is probably right. There is patchy and incomplete acknowledgement among doctors of the need for awareness of spiritual issues, with much being done in the USA, but considerably less in the UK, and mainly in the fields of palliative medicine, psychiatry and general practice, though considerably more work has been done from a nursing perspective.

The Royal College of Psychiatrists now has a Spirituality & Psychiatry Special Interest Group; several medical schools run courses on spirituality in healthcare; the British Medical Journal has published in recent years two editorials on inclusion of a spiritual dimension in patient care by doctors (Culliford 2002 and Speck 2004c); and there have been a number of UK research articles published. There are signs of an increasing openness in the UK to engage in discussion about the inclusion of a spiritual dimension to medical care, within a multi-faith NHS context, in which meeting the spiritual and religious needs of patients and staff is considered to be increasingly important.

NHS Scotland has taken this a step further by making it official policy that the provision of spiritual care should be addressed by all members of healthcare teams (Chisholm 2002). At the time of writing the General Medical Council is conducting a consultation exercise on *Personal Beliefs and Medical Practice*, which identifies the importance of taking into consideration patients' and doctors' beliefs and values.

*Discussing personal beliefs may, when approached sensitively, help you to work in partnership with patients to address their particular needs. For some patients, enquiring about or acknowledging their beliefs or religious practices will be an important aspect of a holistic approach to their care.* (GMC 2007)

The concern for more holistic models of medical care is not new, having developed in challenge to reductionist biomedical views, most notably beginning within general practice with those who sought to move from a doctor-centred paternalistic model to a more patient-centred model of care. (See work by pioneers in the UK such as Balint, Byrne and Long, Pendleton and others, and McWhinney in Canada ) We need to acknowledge the huge contribution that has been made towards establishing a more holistic framework for patient care, but there are limits to how patient-centred models have been able to be applied, in that a spiritual dimension has seldom been deliberately included, perhaps because the underlying philosophy has remained 'mechanistic and reductionist.' with the possible exception of McWhinney who writes about healing, the doctor as the Wounded Healer and the ability of anyone to become a healer in a spiritual sense for another (McWhinney 1981 pp 79-85)..

A limited amount of research has been conducted in the UK to investigate the role of doctors in spiritual care in a healthcare setting, finding that significant numbers of patients want spiritual and/or religious issues to be discussed. Murray conducted 149 interviews with 40 terminally ill patients and their carers, and found that there were often unexpressed and unmet spiritual needs in terms of seeking meaning and purpose. Most held back from raising spiritual concerns, but:

*many were able and willing to talk about them when asked open questions or allowed to tell their story by professionals who were willing to step beyond rigid professional boundaries* (Murray 2004).

These studies confirm the findings of much more research conducted predominantly in the USA.

Perhaps one of the consequences of the decline in church attendance is that spiritual issues which might have in the past led a person to consult their priest may now take them to their doctor, and that GPs in particular seem to have taken on some of the functions of the clergy (for more on this see Greaves 2004) The increasing openness to a spiritual dimension has come as a welcome surprise to some, but there have been other more mixed responses, with

significant questions and doubts raised, which will form the basis of the discussion to follow.

Who should provide spiritual care? Are doctors equipped to deal with spiritual issues? Is this part of their role? Do they have the time or expertise? What training should they have? Do our consultation models and current teaching frameworks go far enough? This first article will focus mainly on these areas.

What about the role of chaplains – the 'spiritual experts'? What care do they provide? Does it extend beyond the 'religious'? What do they contribute to holistic patient care that is distinct from what doctors can do? How can doctors & chaplains work better together? (See e.g. Murray 2003b, Doyle 1992, Handzo & Koenig 2004, Short 2003) The second article will focus mainly on these areas.

A primary purpose of these articles is to challenge both doctors and chaplains to engage in dialogue, asking how they can work together, acknowledging the different contributions that each can play in moving towards embracing a spiritual dimension, and an enriched and deeper understanding of patient care and the life of healthcare organisations.

## A Preliminary Consideration: The Distinction Between Spirituality and Religion

Clarifying the distinction between 'spirituality' and 'religion' is vital, as there remains much confusion among members of the health care team. Spirituality is a notoriously difficult concept to define, but various key concepts seem to recur: search for meaning, purpose, values, transcendence, relationships, identity, coping strategies, usually within a context of some belief in a 'higher power' (Speck 2004). In a contemporary multi-faith secularised context it is important to distinguish between religion and spirituality. Cobb (Cobb 2005, p. 21,22) describes religion as being the most obvious external and social way of expressing spirituality: the ritualised expression of beliefs usually within the context of a formalised religious group, but that there is not always a religious component to an individual's spirituality. In many ways religious needs are easier to define and to attend to, through completing assessment questions about religious belief, and then by specific rituals or liturgical contexts. Spiritual needs are harder to elucidate but are often of considerable significance for patients.

## Should Doctors Be Providing Spiritual Care?

A holistic patient-centred model of care is what we all aspire to, in primary and secondary care. Medical schools are now teaching undergraduates to make it a priority to discover the patient's agenda. However there is not usually an explicit spiritual component included in consultation models and frameworks.

When sufficient time and attention is given to the patient's agenda and their concerns, there can be a spiritual dimension, but it may not be explored fully because of lack of time, perceived expertise or other constraints. Doctors have clearly defined roles in healthcare, whether that is in clinical care, research, teaching or management, and spiritual care of patients is at best a secondary rather than a primary role. Most clinical care takes place under constraints of time and within bureaucratic contexts that militate against having sufficient time or energy to focus on being attentive to the deeper dimensions of patients' concerns, when there are Quality Frameworks to adhere to, opportunistic screening to be done and people clamouring for 'urgent' appointments (the Quality and Outcomes Framework (QOF) is a component of the new General Medical Services contract for general practices, introduced from 1 April 2004).

Even those who have trained recently and been exposed to intensive teaching about patient-centred communication skills, sometimes find it very difficult when an enquiry about the patient's *"ideas, concerns and expectations"* (Silverman et al 2004), to encourage exploration of psychosocial aspects of the patient's agenda comes dangerously close to existential questions about meaning. There is often, sadly, a reversion to a more traditional doctor-centred way of consulting when set loose in the 'real world' of medical practice because of time pressures, and when senior colleagues are observed still using a more doctor-centred approach.

In a study linked to his work cited earlier Murray conducted a study of patients with terminal illnesses one part of which was to interview their GPs. All of the 40 GPs interviewed felt that spiritual care was a part of their role, but felt constrained by not being

sure if the patient would want the subject raised. Time was also a significant issue, as one GP put it:

*I think it is a part of our job, you know, we try and…well most of us try and practise* [a] *fairly holistic approach, and it's difficult, it's frustrating when we can't spend time with people but you have to realise that, you know, you're a limited resource, and, you know, if we spend three-quarters of an hour with one patient, you're spending 5 minutes with the other three*. (Murray et al 2003 p. 958)

Murray concluded that GPs needed supportive working practices, training in identifying needs, possibly with appropriate assessment tools, training in providing appropriate interventions, and above all, time.

This is echoed in other research investigating the role of nurses and doctors in providing spiritual care where respondents felt that they were able to assess spiritual need to a certain extent, for example asking a patient's religion to 'tick the box' on admission forms, but there were greater levels of unease with the more 'difficult' areas, particularly when questions were asked by patients such as: "Why has this happened to me?", and also when asked to engage in prayer, or other rituals. In many ways focussing on assessing religious needs can be neater, more circumscribed, and easier than exploring existential questions of meaning, in a broader context of spirituality.

In *Hospital Chaplaincy – Modern, Dependable* Helen Orchard reports on interviews with nursing and other staff about who should be delivering spiritual care, and the results are interesting, that all can be involved in addressing spiritual needs of patients, particularly if 'spiritual' is defined broadly:

*the broader the definition one has of spirituality, the larger the crowd who can deliver it* (Orchard 2000, p. 138).

However Orchard found that many nurses felt that their role, and the role of other health professionals, was to build relationships where patients had the opportunity to express themselves, assess the need for spiritual care, but then pass on the responsibility for delivery of care to the chaplaincy team, because they did not have the training, the expertise, or the time to fully enter into provision of that spiritual care (Orchard p. 138).

In a similar vein Harold Koenig, a physician, and George Handzo, a chaplain, wrote a joint article in which they explored who should provide spiritual care and wrote:

*In general, the role of the physician is to assess spiritual needs as they relate to healthcare (i.e., briefly screen) and then refer to a professional pastoral caregiver as indicated (i.e., to address those needs). The chaplain is the spiritual care specialist on the healthcare team and has the training necessary to treat spiritual distress in all its forms. Seeing the physician as the generalist in spiritual care and the chaplain as the specialist is a helpful model."* (Handzo and Koenig 2004, p. 1242 – 1244)

This seems to be the position that a number of writers come to, after examining some of the hindrances and potential problems associated with doctors providing spiritual care.

One significant finding from research is that to a great extent the willingness and perceived ability to engage at deeper levels was determined by personal characteristics rather than just having sufficient time. Linda Ross reports this with nurses (Ross 1995), and Sheila Cassidy writes eloquently as a palliative care doctor about how engaging with those who are in pain is tough, and not everyone can do it, and those who can do it cannot do it all the time (Cassidy 1998 p. 18-19).

## The Unique Contribution of Chaplains

*The degree to which clinicians can address spirituality in the healthcare setting is limited by such factors as training, time, and the acceptance of their healthcare system. Even if they choose to investigate issues as part of the therapeutic process, there comes a point when the needs go beyond the capacity of the physician to meet them. Just as there are times when a clinician must refer to a specialist because of the complexity of the physical condition, so there are times when the clinician must refer to a specialty because of the spiritual condition* (Kliewer & Saultz 2006 p.185)

If doctors are to consider a more explicit inclusion into their consulting of enquiring about a spiritual dimension, with appropriate training, there will always be time constraints, and a need to be able to refer on to those who can spend longer with patients and have the self-awareness, expertise and experience to deal with deeper issues. This is perhaps where we look to chaplains to have a major role, and where there is an expectation of expertise.

We want chaplains who can cope with these kinds of demands. Speck and Drew both comment on the need for chaplains to have self-awareness of their own needs, and to have at least begun to wrestle with the issues themselves, so that they can be a support and resource to others (Kelly 2002, Speck 2004b).

However there is confusion about who chaplains are and what they do. Even among chaplains there seems to have been something of a lack of clarity about what makes the role of the chaplain unique, and a lack of self-definition, which can make it harder for other members of healthcare teams to know when to call in a chaplain, and for the 'powers that be' to make appropriate decisions about funding.

In a recent conversation with final year medical students the question of involvement of chaplains came up, and the misunderstandings were striking: "Oh, are they the ones who all wear those funny collars?" and "I'm not sure about involving them - I wouldn't want religion pushed down my throat".

The second article will consider in more detail the unique contribution of chaplains, and how chaplains and medical staff might work more closely together.

## Bibliography


AHPCC, CHCC & SACH (2005) *Health care chaplains code of conduct* 2ndedition

ALDRIDGE A. 2006 The unique role of a chaplain *Scottish Journal of Healthcare Chaplaincy* 2006: 9:1 p. 18-22

BALINT M. 1986 *The Doctor, the Patient and the Illness* Edinburgh: Churchill Livingstone

BUB B. 2006 *Communication skills that heal: a practical approach to a new professionalism in medicine* Oxford: Radcliffe Publishing

BYRNE P. S. and LONG B. E. L. (1976) *Doctors talking to Patients* London HMSO

CAPPS D. 1984 *Pastoral Care and Hermeneutics* Fortress

CARR W. 1997 *Handbook of pastoral studies London* SPCK

CASSIDY S. 1998 *Sharing the darkness: spirituality of caring* Darton, Longman & Todd

CHISHOLM M. 2002 Speech delivered at the 'Spiritual Care in the NHS' Conference on 16th November 2001 *Scottish Journal of Healthcare Chaplaincy* 2002: 5:1 pp 24-26

COBB M. 2005 *The hospital chaplain's handbook: a guide for good practice* Norwich: Canterbury Press

CROTON E. 2003 Spirituality and Health *Triple Helix* 2003; Summer:16 (Journal of Christian Medical Fellowship)

CULLIFORD L. 2005 Healing from Within: Spirituality and Mental Health in McCLURE, M. (ed). *Partners in Care Resource Pack*. London, Gaskell. Sep 2005

CULLIFORD L. 2002 Spirituality and clinical care. *BMJ* 2002: 325;1434-35

Department of health (2003) South Yorkshire Workforce Development Confederation, 2003. *Caring for the Spirit.* Sheffield: SYWDC

Department of health (2005) South Yorkshire Workforce Development Confederation *A minimum data set for spiritual healthcare* Sheffield: SYWDC

Department of Health, 2003. *NHS Chaplaincy: Meeting the Religious and Spiritual needs of Patients and Staff.* London: DoH

DOYLE D. 1992 Have we looked beyond the physical and psychosocial? *Journal of Symptom Management* July: 302

FABER H. 1971 *Pastoral care in the modern hospital* London: SCM

FINLAY I. 2006 Speech in House of Lords on 19th May 2006 by Baroness Finlay of Llandaff http://www.publications.parliament.uk/pa/ld200405/ldhansrd/pdvn/lds06/text/60519-09.htm#60519-09_spnew0

FOLLAND M. 2006 Opportunity and conflict: evidence-based practice and the modernization of healthcare chaplaincy *Contact* 149 p. 12-20

FRASER D. 2004 Clarity and cost effectiveness in chaplaincy *Scottish Journal Healthcare Chaplaincy*, 7:1 pp 26-30

General Medical Council (1993) *GMC Annual Report. Doctors' use of professional standing to promote personal interests or beliefs.* London: GMC, 1993:4
General Medical Council (2007) *Personal Beliefs and Medical Practice - A draft for consultation*. https://gmc.e-consultation.net/beliefs/consultation%20draft.pdf
GOODLIFF P. 1998 *Care in a confused climate* Darton, Longman & Todd
GREAVES D. 2004 *The healing tradition: reviving the soul of Western medicine* Oxford: Radcliffe Medical Press
HANDZO G., KOENIG H.G. 2004 *Spiritual Care: Whose Job Is It Anyway?*
HAY D., HUNT K. 2000 *Understanding the spirituality of people who don't go to church: a report on the findings of the adults' spirituality project.* Nottingham: University of Nottingham
KELLY E. 2002 Preparation for providing spiritual care *Scottish Journal of Healthcare Chaplaincy* 5:2 p.11
KING M., SPECK P., THOMAS A. 1995 The Royal Free interview for religious and spiritual beliefs: development and standardization. *Psychol Med* 1995; 25: 1125-1134
KINH M., SPECK P., THOMAS A. 2001 The Royal Free interview for spiritual and religious beliefs: development and validation of a self report version. *Psychol Med* 2001; 31(6): 1015-23
KIRKWOOD N 1998 *Pastoral care in hospitals* Australia: E.J. Dwyer
KLIEWER S.P., SAULTZ J. 2006 *Healthcare and spirituality* Oxford: Radcliffe publishing
KOENIG H.G., McCULLOUGH M.E., LARSON D.B. 2001 *Handbook of religion and health* Oxford University Press
KOENIG H.G., IDLER E, KASL S., HAYS J.C., and GEORG L.K. 1999 Editorial: Religion, Spirituality, and Medicine: A Rebuttal to Skeptics *International Journal of Psychiatry in Medicine;* 1999; 29(2); pg. 123 – 131
LAUNER J. 2002 *Narrative-based primary Care: a practical guid*e Oxford: Radcliffe Medical Press
LYALL D. 2001 *Integrity of Pastoral Care* London: SPCK
McWHINNEY I. R. 1981 *A textbook of family medicine* Oxford University Press
MOWAT H., SWINTON J. 2005 *Executive Summary - What do Chaplains do?* Report Number: CSHD/MR001 February 2005 ISBN 0-9549901-0-2 Aberdeen: Mowatt Research
MURRAY S. A., GRANT E., GRANT A., and KENDALL M. 2003a Dying from cancer in developed and developing countries: lessons from two qualitative interview studies of patients and their carers. *BMJ* 2003; 326:368-371
MURRAY S.A., KENDALL M., BOYD K., WORTH A. and BENTON T.F. 2003b General practitioners and their possible role in providing spiritual care: a qualitative study *British Journal of General Practice*, 2003; 53: 957-959.
MURRAY S.A., KENDALL M., BOYD K., WORTH A. and BENTON T.F. 2004 Exploring the spiritual needs of people dying of lung cancer or heart failure: a prospective qualitative interview study of patients and their carers *Palliative Medicine* 2004; 18: 39-45
NHS National Services Scotland 2004 *Provision of Spiritual Care in NHS National Services Scotland*
Office of Population, Censuses and Surveys. Census 2001 - Ethnicity and religion in England and Wales. London: OPCS
ORCHARD H. 2000 *Hospital chaplaincy: modern, dependable? A research report of the Lincoln Theological Institute, University of Sheffield*. Sheffield: Academic Press.
PENDLETON D., SCHOFIELD T., TATE P. and HAVELOCK P. 1984 *The Consultation: An Approach to Learning and Teaching* Oxford: OUP
POST S.G., PUCHALSKI C.M. and LARSON D.B. 2000 Physicians and patient spirituality: professional boundaries, competency and ethics *Annals of Internal Medicine* 4 April 2000 132:7 p.578-583
RHODES B. 2005 Send in the clowns *Nursing Management*; Oct 2005; 12: 6 p.13
ROSS L.A. 1995 The Spiritual dimension: its importance to patients' health, well-being and quality of life and its implications for nursing practice *Int J Nursing Studies* 1995; 32:5 pp. 457 – 468
SILVERMAN J., KURTZ S. and DRAPER J. 2004 *Skills for Communicating with Patients* Oxford: Radcliffe Medical Press (2nd edition)
SLOAN R.P., BAGIELLA E., and POWELL T. 1999 Religion, spirituality, and medicine *The Lancet*. London: Feb 20, 1999.Vol.353, Iss. 9153; p. 664
SPECK P. 1988 *Being there* London: SPCK
SPECK P. 2004a *A standard for research in health care chaplaincy*
SPECK P. 2004b Spiritual care in health care *Scottish Journal of Healthcare Chaplaincy* 7:1 p. 21
SPECK P., HIGGINSON I., ADDINGTON-HALL J. 2004c Editorial: Spiritual needs in health care *BMJ* 2004;329:123-124(17th July)

"Spirituality and Psychiatry" special interest group of the Royal College of Psychiatrists (www.rcpsych.ac.uk/college/sig/spirit)

STEWART M., BELLE BROWN J., WESTON W.W., McWHINNEY I.R., McWILLIAM C.L. and FREEMAN T.R. 2003 *Patient-centred medicine: transforming the clinical method* Oxford: Radcliffe Medical Press

SWINTON J. 2001 *Spirituality and mental health care: rediscovering a forgotten dimension.* London: Jessica Kingsley

VAUGHAN K. 2005 Taking a spiritual history *Triple Helix* 2005; Winter: 6,7 (Journal of Christian Medical Fellowship)

World Health Organization 1998 WHOQOL and spirituality, religiousness and personal beliefs: report on WHO consultation. Geneva: WHO

*The Revd Dr Eleanor Williams is a part-time GP in Cambridge, and was recently appointed Specialist in Clinical Communication, teaching communication skills in University of Cambridge School of Clinical Medicine. In 2007 she was ordained as a minister in the Church of England, serving a curacy in Ely diocese as a Minister in Secular Employment.*