

Spirituality in history taking

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Andrew Taylor Still, MD, DO, included in his founding postulates of osteopathy the concept that a patient's health includes the health of a patient's spirit. In the recent past, medicine as a whole, and osteopathic medicine specifically, has neglected this postulate. Recent research has confirmed the validity of Still's postulate, and many medical training institutions have received grants and established programs to incorporate spirituality into their curriculum. As with any patient evaluation, the history and physical examination is the starting platform. This article describes several tools that can be easily incorporated into the history and physical examination, along with some of the obstacles in evaluating the health of the patient's spirit.

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As far back as Plato's time, physicians were encouraged to care for the whole person. Plato admonishes, "As you ought not to attempt to cure the eyes without the head, or the head without the body, so neither ought you to attempt to cure the body without the soul. The part can never be well unless the whole is well."¹ Andrew Taylor Still, MD, DO, expanded on this concept in laying the foundations for osteopathic medicine. Still recognized that man comprises body, mind, and spirit. Dysfunction in any one of these areas affects the health of the others. Corrections of the dysfunctions in any of these components will help the body to heal itself.²⁻⁴ There-

fore, physicians should not neglect a patient's spirit if they are to maximize their healing ministrations. Yet for too long, we physicians have been doing just this—ignoring the spirit while trying to heal the body.

According to a 1990 Gallup poll, 95% of Americans believe in God, 57% pray daily, and 42% attended a place of worship in the past week.⁵ Recent surveys indicate that more than 75% of patients want their physicians to pray with them; however, only 10% or fewer of the patients were actually prayed for by their physicians.⁶⁻⁹ One of the strengths of family medicine is the patient-physician relationship. Simply inquiring about a patient's spiritual status produces a strong, positive response. If physicians would engage the spiritual arena, the patient-physician relationship would increase by a quantum leap.

Data support the need for and the benefits of including spiritual aspects in physicians' interactions with their patients.^{6,10-13} To interact with patients, physicians need to learn the means of assessing patients' spiritual status, the tools used to do this, and how to recognize obstacles that need to be avoided or overcome to make spirituality a nor-

mal part of the complete history and physical (H&P) examination.

Medicine continues to discard various taboos that encumber the assessment of patients' well-being. In the 1950s and 1960s, most physicians did not discuss the sexuality of their patients. The "S" word (sex) was not considered an appropriate subject to discuss, even in the private setting of the doctor's office. Physicians were not trained in or were not comfortable with discussing patients' sexuality or related issues. Physicians were either embarrassed by the subject or afraid that they would embarrass their patients, or both. If the patient's condition demanded that his or her sexuality be addressed (for example, if the patient had a sexually transmitted disease), the physician treated the disease with minimal discussion or intervention into surrounding issues such as sexual practices. Of course, physicians had been dealing with many of the consequences of their patients' sexual activities for centuries, but this was usually done covertly, retrospectively, and with minimal education. As a result of the sexual revolution and subsequently available sexual education, physicians are now better trained to address sexuality and its many surrounding issues (practices, preferences, etc). Physicians can now intervene proactively and not just retroactively in their patients' sexual health, and they are expected to include a sexual history in their complete history and physical examination.

Today, spirituality is the new "S" word. Spirituality and religion are in the analogous position that sex and sexuality were in the 1960s. Medicine has realized that not addressing patients' spirituality detracts from the healing process. But recognition is only the beginning. There are many barriers to discussing spirituality with patients, including the unease of physicians in dealing with spiritual matters; lack of physician training with regard to spiritual health; the need of physicians to support spiritual concepts with which they disagree; physicians' concern that they may be considered to be proselytizing; confusion between religion and spirituality; and the

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perceived conflict between science and spirituality.

One of the biggest barriers to discussing spirituality with patients is the comfort level of the physician with his own spirituality, or the status of the physician's own spiritual health. Open discussion of spirituality with a patient may cause the physician to reveal what he considers personal and private issues. If physicians are not prepared or not capable of dealing with personal spiritual matters, they will be reluctant to address those of the patient because it would force them to address their own concerns. It is often difficult to discuss an alternate spiritual lifestyle if one is threatened by that lifestyle, if one is ignorant about that lifestyle, or if one is opposed to that lifestyle. To openly discuss or question spirituality (or any subject, for that matter) in a nonthreatening, inviting manner requires the physician to be comfortable and confident in his or her own knowledge and feelings about spiritual matters. So the first step in dealing with the patient's spiritual health is for the physician to assess his own spiritual health—a topic not addressed in any medical school's curriculum.

Inadequate training presents several obstacles to dealing with patients' spiritual health. In antiquity, the spiritual was not separated from the physical, and the priest was also the doctor. In modern, politically correct terms, the spiritual leader was also the healthcare provider. Then, as man became more understanding of the physical world, the metaphysical realm was denigrated and separated from the treatment of the body. Physical healing, medicine, was relegated to the physician. Soul and spirit remained under the realm of the priest. With the advent of psychology, care of the soul was extracted from the responsibility of the priest and delegated to the psychologist. The division of man was complete. Man, who used to be cared for by one person—the priest-physician—is now cared for by three persons—physician, psychologist, and theologian. This division failed to yield complete understanding and control of the wellness of man. So now, the original concept—that man is

one whole being with three interactive parts—is the working paradigm.

Unfortunately, the training of the care providers has been and continues to be fragmented. All have been trained only in the realm associated with their discipline. The theologian deals with spiritual matters, the psychologist deals with matters of the soul (mind, will, and emotions), and the physician deals with physical matters. For this reason, most physicians are not adept at dealing with spiritual matters and hence are reluctant to broach the subject with their patients. With the new insight, that spiritual health influences physical health, physicians are having to (re)learn spiritual matters.¹⁴⁻¹⁶

There is also the pressure not to proselytize patients. This pressure has several aspects, the most obvious aspect being that, as physicians, we want to know the truth of a matter. We obviously accept our own spiritual parameters as truth, or else we would change them. When patients express concepts that are different from our own beliefs, or when they express concepts that are harmful (according to our beliefs), we want to change their beliefs. Because we have access to patients at their vulnerable moments, our urge to correct their belief system needs to be curtailed until the patient gives us permission to address these differences. This requires tact and is often time-consuming.

Another aspect of the pressure not to proselytize our patients is the concept of tolerance. This concept supposes that each of us has an equal right to believe what we believe and that each belief system is equally valid. This has two consequences. The first consequence is that the concept of absolute right or absolute wrong is removed from any dealings with the patient. The physician should not evaluate the patient's belief system. If the physician forms an opinion that the patient has a wrong belief system, then the physician is seen as judgmental and intolerant (this is as deadly as being accused of being racist or sexist). This forced tolerance leads to the second consequence, that the physician may be forced to function within a framework that is in opposition to the physician's

own spiritual health. The physician must lay aside his spiritual beliefs and function within the beliefs of the patient. It becomes too easy to avoid the whole discussion of spiritual matters and stay within the realm of the physical, where appropriate and inappropriate concepts are better defined and better understood—the exact error that the resurgence of inclusion of spiritual matters in medicine is struggling to correct.

Separation of the biological from the spiritual or the physical from the metaphysical is another barrier to addressing spiritual matters. Modern physicians are trained in the scientific method and not in ways of incorporating the metaphysical aspects of a patient into the physical “reality.” If the physician concerns himself with patients' spirituality, he is believed to have lost his “objectivity” and is no longer deemed to be a competent physician. If the physician cannot see, feel, measure, or manipulate the issue, then that issue is not real and is considered to be irrelevant. If the physician accepts that there is a metaphysical aspect to healing, then he is admitting that his training is incomplete, that he is lacking, that he may not be in control. These are all anathemas to the traditional, modern, training of physicians.¹⁷ Physicians are therefore often reluctant to open the Pandora's box of spirituality.

Misunderstanding of the differences between religion and spirituality creates another problem. *Spirituality* is defined as having to do with the spirit and is often thought of as the better or higher part of man. Spirituality has to do with man's search for a sense of meaning or purpose to life, and it is that part of a person's psyche that strives for transcendental values, meanings, and experiences. The spirit is that aspect or essence of a person that gives power and energy and motivates the pursuits of virtues such as love, truth, and wisdom.

Religion is any specific system of belief, worship, conduct, etc, often involving a code of ethics and a philosophy. It may include doctrine, dogma, metaphors, myths, and a way of perceiving the world. Organized religion is one way of expressing one's spirituality. Common

themes to many religions include purity of life, peace, and beliefs in immortality and a supreme being. The wide variety of religions attests to the importance of spirituality to humans.¹⁵ Therefore, it is all the more important for a physician to provide medical skills to aid in the healing of the spirit as well as to use the spirit to aid in the healing of the body. The physician of today is faced with treating patients not only in the biomedical model, not in a biopsychosocial model, but in a biopsychosocial-spiritual model.^{18,19}

Medicine and spirituality intersect in at least four areas: (1) meanings of health and illness; (2) relation of health to other human values; (3) attitudes toward the aged, the incurable, and the weak; and (4) attitude toward nature.²⁰ Nine specific ideas embodied in most religious systems that provide an ethical basis for medical practice are stewardship, creation, human dignity, freedom, love, covenant, justice, vocation, and finitude.²¹

Five aptitudes that physicians should have to meet the spiritual needs of their patients are to (1) be trustworthy, (2) treat the patient as a person, (3) be kind, (4) maintain hope, and (5) assist in determining what it means to live.²² With these aptitudes, physicians can approach their patients' spirituality. The first step in healing the spirit is to determine the status of the patient's spiritual well-being. The goal of including spirituality in history taking is to assess the patient's spiritual health. A patient who has spiritual health (1) attaches meaning and purpose to life events, including the illness; (2) has hope, faith, and relative absence of guilt; (3) is able to love and forgive self and others; (4) participates in laughter and celebration; and (5) is involved in a community of faith and practices worship, prayer, and meditation.¹⁹

Including an evaluation of the patient's spiritual well-being in the complete H&P requires that the patient be at ease, that there is a rapport established between the physician and patient, and that there is a working relationship between the physician and patient. The physician needs to discern and follow

up on verbal and nonverbal clues. These are the applications of the five aptitudes listed previously. Unfortunately, most history taking is done by junior physicians who machine-gun questions at patients, prevent patients from talking in their own terms, and avoid asking questions about mood, reaction to illness, or the impact of the illness on patients' families. Many aspects of medical training, such as performing the H&P, are undertaken by junior physicians. These aspects are expected to develop and improve as their experience increases. The distressing aspect of this is that physicians do not improve in establishing rapport with patients or in letting patients talk.²³ Many experienced physicians do not demonstrate these aptitudes.

As in most history taking, the aspects of spirituality are best broached using open-ended questions: "Do you belong to a particular church, fellowship, or practice?" "Do you consider yourself religious or spiritual?" These questions give the patient permission to talk about the subject without being judged. Because spirituality is an intimate subject, it must be approached gently and nonjudgmentally. As this is a new aspect of history taking, several guides/acronyms have been proposed to help physicians obtain the necessary information quickly and efficiently. Three examples follow.

The first is a series of 26 questions to which the patients scale their agreement. The Spiritual Involvement and Beliefs Scale²⁴ is purported to allow assessment of four factors involved in spirituality.* Factor 1 (External/Ritual) typically addresses spiritual activities/rituals that are consistent with belief in an external power. Factor 2 (Internal/Fluid) includes items that refer to evolving beliefs and items that focus on internal beliefs and growth. Factor 3 (Existential/Meditative) clusters items dealing with meditation

and other more existential issues. Factor 4 (Humility/Personal Application) contains items that deal with humility and application of spiritual principles in daily activities. The goals of the Spiritual Involvement and Beliefs Scale are to provide physicians with a quantitative, credible method of spiritual inquiry that allows integration of spiritual assessment into traditional medicine (much the way mental status exams such as the Beck's Depression Scale²⁵ are used) and to provide an objective measurement of spirituality to aid in research into the role of spirituality in medicine.²

The next tool is designed not for objective data gathering, but for aiding physicians in inquiring into all the aspects of spirituality that are understood to be appropriate, as listed previously. The developers of this tool formed it into the mnemonic *SPIRIT*.²⁶ The letters of this mnemonic remind physicians to ask about the different factors of spirituality and spiritual health: *S* = spiritual belief system; *P* = personal spirituality; *I* = integration with a spiritual community; *R* = ritualized practices and restrictions; *I* = implications for medical care; and *T* = terminal events planning. To use this tool, a physician has to develop a safe, comfortable relationship with the patient. A suggested style of questioning may be similar to this: "Many people have strong spiritual or religious beliefs that shape their lives, including their health and experiences with illness. If you are comfortable talking about this topic, would you please share any of your beliefs and practices that you might want me to know, as your physician?"

Once patients are prompted to talk about their beliefs, they will share important detailed information. Specific suggested questions for each of these six areas include the following: *S*, What is your formal religious affiliation? *P*, Describe the beliefs and practices of your religion that you do not personally accept; *I*, Do you belong to any spiritual or religious group or community? *R*, Are there specific practices that you carry out as part of your religion/spirituality? *I*, What aspects of your religion/spirituality would you like for me to keep in mind

*The factor analysis used to establish the scales of this tool were completed using small sample sizes. Evaluations using larger sample sizes and factor analyses may yield different factor loadings than has been previously published.²⁴ Therefore caution must be used in applying this instrument in everyday practice. Anyone interested in using this tool is encouraged to contact the author, as cited in Hatch et al.²⁴

as I care for you? *T*, Are there any particular aspects of care that you wish to forgo or have withheld because of your faith? There are also other questions that can be used to assess patients' spiritual beliefs.^{26,27}

Another mnemonic, *FICA*, was developed by Puchalski²⁸: *F* = faith and belief; *I* = importance and influence; *C* = community; and *A* = address in care. Sample questions for each follow: *F*, Do you consider yourself spiritual or religious? *I*, What role do your beliefs play in regaining your health? *C*, Is there a group of people you really love or who are important to you? *A*, How would you like me, your doctor, to address these issues in your healthcare? No matter how the patient answers, the physician should encourage the patient to elaborate and to pursue any topics that would be of help to the patient. This is being sensitive to the patient's needs—being a physician instead of a technician.

Comment

The spiritual history, or spiritual health evaluation, can be taken annually or at any follow-up visits as appropriate. A close study of the two mnemonics, *SPIRIT* and *FICA*, shows that they each cover the components that make up spiritual well-being. To successfully incorporate spirituality into the H&P, physicians need to answer these questions for themselves and thus be able to meet the spiritual needs of their patients. The heritage passed on to us by Andrew Taylor Still is now being used by all of medicine. As osteopathic physicians, we should be in the vanguard of applying the concept of spirituality to medicine. To do this, our training programs and trainers need to become adept at evaluating the spiritual condition of our patients and at using these strengths in our treatment.

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