

Physicians' attitude towards patients' spirituality at a tertiary-care health facility in Southern Nigeria.

ABSTRACT

Background: It has been shown that patients would like to discuss their spiritual beliefs with their physicians and that they have spiritual needs which are often under addressed by health care professionals. Whereas, addressing those needs in clinical practice is a component of the holistic care that every patient deserves, the attitude of physicians towards addressing them has not been ascertained in our environment.

Objectives: To explore physicians' attitude and self-reported behavior towards patients' spirituality in clinical practice at a tertiary health facility in Southern Nigeria.

Methods: In this cross-sectional survey carried out between August and November 2020, a semi-structured and self-administered questionnaire was completed by the participating physicians which were of various ranks and working in various departments of the hospital. Their attitude towards their patients' spirituality in clinical practice and self-reported behavior were analyzed using SPSS version 25.0.

Results: A total of 200 physicians participated in the study, 90% of them were residents of various cadres, two-third (n=122; 61%) had less than 10 years work experience. Majority of respondents (n=163; 81.5%) considered it appropriate to make inquiries about their patients' spirituality and less than half of them (n=98; 49%) were aware that there is a religious leader in the hospital who offers pastoral care. Half of the respondents (n=104; 52%) reported they rarely take spirituality history of patients, 18 (9%) often pray with the patient while 100 (50%) rarely refer patients for pastoral care. Insufficient time was the most frequent barriers to discussing spiritual issues with patients. However, only 5 (2.5%) respondents were able to name 3 common tools a health worker can use to assess patients' spiritual needs.

Conclusion: Physicians enquiry into the R/S of patients was inconsistent, and there were gaps between their attitudes to discussing these issues with their patients and its practice. Incorporating spiritual care courses into physician training is recommended to overcome the barriers to both patient and physician R/S inquiry.

Key words: Patients' spirituality; Clinical practice; Physicians; attitude and behaviour; Southern Nigeria

INTRODUCTION

Religion and spirituality (R/S), which many authorities have used interchangeably, have been associated with many aspects of patients' health and health behaviors, the disease process, medical decisions, provision of social support, and physician-patient relationship [1-3].

Besides, studies have shown that patients would like to discuss their spiritual beliefs with their physicians and that they have spiritual needs which are often under addressed by health care professionals [4-7]. Consequently, the World Health Organization (WHO) and other relevant organisations recommended that spiritual issues be addressed in clinical care and education of health professionals [3]. Thus, most medical schools in US and UK have already included spirituality and health content in their curriculum, teaching students how to take a spiritual history, how to deal with religious conflicts, and when to refer to **religious leaders**, among others [3].

Spirituality is defined as a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose of life, and experience relationship **with self, family, community, nature and the sacred**, and is expressed through beliefs, values, traditions and practices [8]. Whereas **spiritual well-being**, the balance between the physical, psychosocial and spiritual aspects of an individual, is a major element in his/her holistic care [8-10]. Religion/spirituality is an important part of people's lives and provides a sense of connectedness and comfort during times of illness and distress [11].

In many instances, the experience of illness or hospitalization is an affliction that is both physical, emotional, psychological as well as spiritual. And to many patients, not only those at the end of their life but also to those confronted with long-term chronic illnesses, R/S is an important resource for coping. Addressing the spiritual needs of a patient at such time, as part of his/her holistic and comprehensive care, has been shown to improve stress responses, tolerance of the disease/discomfort and improve his/her interpersonal relationships as well as general well-being [5,7-10]. Besides, research has emphasized the necessity to identify the needs for spiritual care and evaluate spiritual/moral distress, which can be achieved with the conduct of a spiritual assessment or taking a patient's spiritual history [12-14]. However, literature has shown that there is a significant weakness in the medical model as practiced today, as it lacks in the capacity to fulfil the quest for spirituality [15,16].

In Nigeria however, there is a dearth of literature on the impact of spiritual care on health outcomes on one side, and on the other, the position of healthcare professionals towards spirituality issues in the delivery of healthcare services. Thus, this study was conducted to explore physicians' attitude and self-reported behavior towards patients' spirituality in clinical practice at a tertiary health facility.

MATERIALS AND METHODS

This study was conducted at the University of Port Harcourt Teaching Hospital (UPTH), an 800 beds tertiary-care health institution, with a clientele of over 400,000 outpatients and over 10,000 in-patients per annum [17]. It is a major referral centre in Port Harcourt, the capital of Rivers State, which has a 2016 projected population of 7,303,924, serving also the neighbouring states in the southern part of Nigeria [18].

The UPTH has a Palliative Care (PC) unit that was established in 2013 and renders in- and out-patient care and occasionally home care. Its clientele is made of patients referred from the various clinical departments of the hospital as well as those referred from other health

facilities in Port Harcourt. The PC unit is run by a multidisciplinary team of healthcare professionals, including physicians, nurses, social workers, a pharmacist and a religious leader.

This was a cross-sectional survey carried out between August and November 2020. Participants of the study were physicians of various ranks (consultants, senior registrars and registrars) working in various clinical service departments, including Paediatrics, Internal Medicine, Surgery, Obstetrics & Gynaecology, Haematology, Family Medicine and Community Medicine.

The instrument used to obtain information was a semi-structured and self-administered questionnaire written in English, which was adapted from other related studies (Religion and Spirituality in Medicine: Physicians Perspective (RSMPP) questionnaire) [2,19-22].

In addition, we included few questions relevant to what is obtained in our hospital.

Information obtained included the participants' demographic data, their attitude and self-reported behaviors regarding spirituality in the clinical encounter, and their knowledge about what can be obtained locally. When appropriate, provision was made for adding an option in case the ones presented did not reflect the respondent's response. Spirituality was classified into high, moderate and low, depending on the extent to which respondents considered themselves to be a spiritual person.

Several tools have been developed to assess spiritual needs of patients. Commonly used ones include FICA, HOPE and Open Invite, which are practical and constitute a simple approach for taking a spiritual history within the context of clinical practice [12,13].

Respondents were asked to fill out the questionnaires at the end of their day's work and a 1-week period was established for the questionnaires to be returned. A pilot study with the questionnaire was first carried out to ensure that the questions would be easily understood by the respondents.

Approval for the study was obtained from the Ethics Committee of the hospital and consent for participation was sought and obtained from the respondents.

Data were entered into a Microsoft Excel Spread Sheet and analyzed using SPSS version 20.0.

RESULTS

A total of 200 physicians participated in the study. Demographic distribution of respondents is presented in Table 1. Table 2 presents physicians' attitude towards discussing Spiritual matters in clinical consultation.

Physicians' self-reported behaviors towards spiritual issues in clinical consultation is shown in Table 3. Barriers to discussing R/S with patients and source of knowledge of taking spiritual history at a clinical encounter are shown in Table 4. Respondents' knowledge of common tools to assess patients' spiritual needs is shown in Figure 1.

DISCUSSION

In this study, most physicians (81.5%) were open to discussions on R/S matters during clinical encounter, which is consistent with previous reports [6,23-25]. This is encouraging as openness towards discussing spiritual matters has been shown to be of great value for patients whereas by integrating the spiritual dimension in patient's care, physicians practice patient-centered compassionate and holistic care [25,26]. However, a lesser proportion of respondents (72.5%) considered such discussion as appropriate only when initiated by the patient. This is not in keeping with several series that reported a higher proportion (91% to 96%) being open to such discussion when the patient brings them up [12,19]. The reason for this difference is not clear.

Spiritual care involves among others, practicing compassionate presence; listening to patients' fears, hopes, pain, and dreams; obtaining a spiritual history; incorporating spiritual practices as appropriate and when necessary, involving religious leaders as members of the interdisciplinary health care team [23]. In this study, majority of responders (57%) reported that they rarely/never take spiritual history, which uncovers coping mechanisms and support systems, provides an opportunity for spiritual care, and helps the physician recognize when cases need referral to the religious leader [27]. This trend has been previously reported, though in those reports the frequency of taking spiritual history was found to increase with terminal illnesses, while prior training and increased physician religiosity/spirituality facilitated such discussions [6,28].

Recently, spiritual care has become increasingly recognized as part of a holistic management approach and the responsibility of all health care professionals, and no longer regarded as the sole domain of religious leaders [28]. Notwithstanding, while addressing simple issues of spirituality, physicians should be aware of their limitations in training and expertise in the area of spiritual care, and refer more complex matters to trained persons in that field [29].

In the present study, majority of responders (51%) were not aware of the availability of a religious leader in our hospital. It is thus not surprising that 67% of respondents rarely/never refer patients for pastoral care, which is of great concern as healthcare professionals are expected to provide holistic care to their patients [12,20,28]. It is possible that they considered spiritual care as being of low priority or irrelevant to their patients' assessment/care, which portrays a gap in knowledge about the subject. Besides, in an analysis of the pastoral caregiving in the Nigerian hospital context, it was proposed that the Nigerian health care facilities and hospitals will benefit from collaboration or the integration of pastoral care givers into patient care for a holistic quality hospital care [15]. On the other hand, clinical chaplaincy/religious leader remains an underutilized resource in health care, as patient spirituality continues to be an area that clinicians do not discuss as often as they should [26,30]. This calls for increased awareness for healthcare professional on the benefits of pastoral care, moreover, incorporating spiritual care into patient care has been found to significantly enhance patients' satisfaction with hospital experiences [7].

Several tools exist to help physicians conduct an organized, open and non-biased spiritual history/assessment, which is often a powerful intervention in itself [13,23,31,32]. Commonly used ones include: 1- the FICA Spiritual History Tool which uses an acronym to guide health professionals through a series of questions designed to elicit patient spirituality and its potential effect on health care; 2- the HOPE questions which leads the physician from general concepts to specific applications; 3- the Open Invite, which encourages a spiritual dialogue as it is structured to allow patients who are spiritual to speak further, and to allow those who are not to easily opt out [2,13,23,32]. Identified spiritual needs may then be incorporated into patient care. In the present study however, only 5 respondents were able to name 3 tools that can be used to take a spiritual history, while 95% of could not name any. This is also of great concern.

Research has demonstrated that prayer, which has also been referred to as a potent healing force, has a positive influence on the sick and helps to restore their health [1,14]. In this survey, opinions were divided about appropriateness of praying with a patient, as many would do so at the patient's request (48.5%), whereas others would when they sense the need (38.5%). In practice however, 9% of them reported praying often with patients, and these were the ones who identified themselves as highly spiritual.

Previous surveys have revealed several barriers to discussing R/S with patients, commonly reported ones include insufficient time, lack of adequate training, lack of knowledge to address R/S issues, concerns about offending the patient and concern that colleagues will disapprove [2,6,7,24,28]. These were also found in the present study. In addition, in a survey at a District General Hospital in UK, 20% of doctors thought it was not their job to ask [28]. But, surprisingly, only 6.5% of respondents mentioned insufficient knowledge/training. These barriers could be overcome by training at both under- and post-graduate levels, which focus on healing illnesses and physical management, producing doctors who are poorly equipped to respond to R/S issues [2,12]. Likewise in a multicenter survey involving 12 medical schools in Brazil, authors found that though medical students (58%) wanted to address spiritual issues, they were not prepared to do so (48.7%) [2]. Most of them (81%) reported they had never received any training during medical school on "spirituality and health" and that medical faculty had never or only rarely addressed the issue in clinical practice (78.3%), suggesting a gap between students' attitudes/needs in this area and the training they received. Furthermore, in a national survey of family medicine residents in the US, authors found that training in addressing spirituality may make residents more likely to discuss the topic in clinical practice [12]. They postulated that teaching residents the skills, knowledge, and attitudes required to have a thoughtful, supportive, and non-prejudicial discussion of a patient's beliefs and practices was the first step for family medicine educators to enable residents translate willingness to address spirituality into action [12]. In the light of this, it is rather unfortunate that only few respondents (14.5%) in the present study acknowledged residency training as a channel for learning how to take a spiritual history.

Understanding the complex relationship between R/S, medical practice, and medical education, could open new perspectives for a different, more compassionate and more integrated approach to patient care [2]. Moreover, R/S will continue to influence health care on both patient and community levels. It thus becomes imperative for the medical community

to appreciate this fact and educate trainees on religion and spirituality's role in health care [30].

Conclusion:

This survey found that physician enquiry into the R/S of patients is inconsistent, and there are gaps between their attitude to discussing these issues with patients and their practice. Incorporating spiritual care courses into physician training in undergraduate and residency programs is recommended, because of its potential to overcome the barriers to both patient and physician R/S inquiry, and improve patients' satisfaction with hospital experiences.

Limitations to the study

The sample size was small. The study was conducted in a single center and results may reflect local rather than national practice.

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UNDER PEER REVIEW

Table 1. Demographic distribution of respondents

Variable	Frequency	Percent
Gender		
Male	102	51
Female	98	49
Age group		
25 - 29	8	4
30 - 34	65	32.5
35 - 39	80	40
40 - 44	32	16
45 - 49	5	2.5
50 and above	10	5
Work experience		
<5 years	60	30
5 - 9 years	62	31
10 - 14 years	50	25
>15 years	28	14
Rank		
Consultants	15	7.5
Senior Registrar	84	42
Registrar	96	48
No response	5	2.5
Religious affiliation		
Christianity	167	83.5
Islam	24	12
Traditionalist	4	2
Others	5	2.5
Spirituality		
High	78	39.0
Moderate	106	53
Low	16	8

Table 2. Physicians' attitude towards discussing Spiritual matters in clinical consultation

	Frequency	Percent
Is it appropriate to inquire about a patient spirituality?		
Appropriate	163	81.5
Not Appropriate	37	18.5
Is it appropriate to discuss spiritual issues when a patient brings them up?		
Appropriate	145	72.5
Not Appropriate	55	27.5
Is it appropriate for a physician to talk about his/her own religious beliefs/experiences with a patient?		
Never	38	19
Only when patient asks	98	49
Whenever physician senses	59	29.5
Other	5	2.5
Is it appropriate for a physician to pray with a patient?		
Never	21	10.5
Only when patient asks	97	48.5
Whenever physician senses	77	38.5
Other	5	2.5
Is there a religious leader in the UPTH who offers pastoral care?		
Yes	98	49
No	21	10.5
I don't Know	81	40.5
Do you know any religious leader you can refer a patient to if need be?		
Yes	52	26
No	148	74

Table 3. Physicians' self-reported behaviours towards spiritual issues in clinical consultation

	Frequency	Percent
How often do you take spirituality history of patients?		
Often	40	20
Sometimes	46	23
Rarely	104	52
Never	10	5
How often do you share your own religious ideas and experiences with the patient?		
Often	12	6
Sometimes	149	74.5
Rarely	39	19.5
Never	0	0
How often do you pray with the patient?		
Often	18	9
Sometimes	87	43.5
Rarely	80	40
Never	15	7.5
How often do you refer patients for pastoral care?		
Often	13	6.5
Sometimes	52	26
Rarely	100	50
Never	35	17.5

Table 4. Barriers to discussing religion/spirituality with patients and source of knowledge of taking spiritual history at a clinical encounter.

	Frequency	Percent
What discourages you from discussing religion/spirituality with patients?		
Insufficient time	73	36.5
Concern about offending patient	57	28.5
Concern that colleagues will disapprove	47	23.5
Insufficient knowledge/training	13	6.5
General discomfort	5	2.5
Others	5	2.5
Source of knowledge of taking a spiritual history during patient clerking		
Self-development	89	44.5
Undergraduate training	77	38.5
Residency	29	14.5
Others	5	2.5
Should taking spiritual history be incorporated into the training of doctors?		
Yes	72	36
No	58	29
I don't Know	70	35

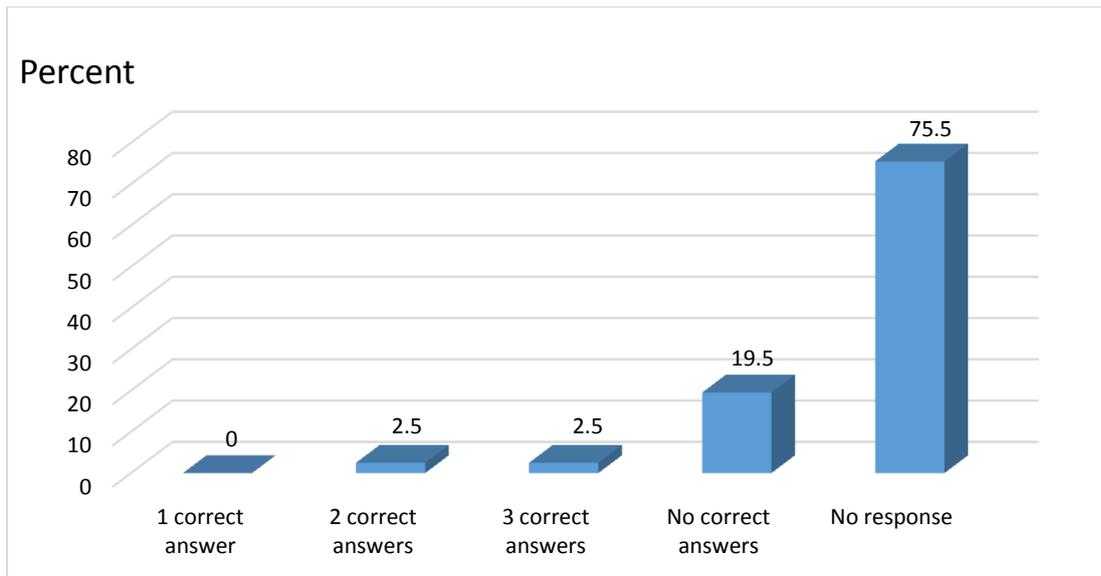


Figure 1. Respondents' knowledge of common tools to assess patients' spiritual needs

UNDER PEER REVIEW