

**Dr Ross Bryson**

It gives me enormous pleasure to welcome you to today's conference on meeting spiritual needs in General Practice. I have been asked to introduce the day and then tackle the question, "What are spiritual needs?"

I consider myself privileged to work in British General Practice. I say that in the full knowledge of the very turbulent days in which the health service, and particularly general practice, finds itself. However, in the midst of this turbulence, we have the opportunity -- and the necessity -- to define and safeguard those features of health care which we believe we must maintain. General Practice, as we have known it, has aspired towards personal care for the whole person.

What do we mean by personal care? In 2003 the British Medical Journal published an article that sought to answer this question: It was called a "Qualitative study of the meaning of personal care in general practice" (1). One of its conclusions was that "Human communication and individualised care are critical in making care personal whatever the context" and they noted that "Many patients' accounts centred on dealing with the "whole person" in the context of their life and illness, rather than just treating the presenting illness. Patients often referred to the importance of professionals knowing about them and their family history"

What does it mean to care for the whole person in General Practice? In 2005 the British Journal of General Practice had an article seeking to define "whole person health care" or holism (2). It quotes the Oxford English dictionary definition of holism as "the tendency in nature to form wholes that are greater than the sum of its parts". It says that General Practice, as defined by the European Academy of Teachers of General Practice, is described as a discipline of medicine that "deals with health problems in their physical, psychological, social, cultural, and existential dimensions". This body of GP academics considered that it was important to add both "cultural" and "existential" to the familiar bio psycho social model which is widely accepted. Their view is that the concept of "existential" includes what others term as "the spiritual". The word existential pertains to the meaning of our existence. As we will see this search for meaning is a key element in an understanding of the concept of spirituality, and as such I have no argument with those who prefer to use that term.

In this article it is argued passionately -- and I quote "an approach to health and medicine that is not reductionist is an implicit part of the comprehensive care provided by GPs. We are not doctors for particular diseases, or particular organs, or particular stages in the life cycle -- we are doctors are people. People are complex, and live in complex communities in a complex world. All aspects of this world have an impact on the health of the people in it". This means that "everything affects health,

and as physicians dedicated to maintaining and improving health we must understand and honour the whole". "As physicians we cannot treat all of these areas, but we must guard against defining health problems only as things we can treat". "The hope of an holistic approach is that we can employ many allies in the effort to bring better health to people."

### **So why don't we address spiritual needs in health care?**

In 2003, in the British Journal of General practice there was a report entitled "General Practitioners and their possible role in providing spiritual care: a qualitative study (3). In this study they interviewed GPs who had had patients with life threatening illnesses over the previous year. They asked the GPs to identify their patient's holistic needs and to discuss whether they considered that they had a role in providing spiritual care. The GPs varied greatly in their understanding of their patient's experiences and needs. Most said that they had a role in providing spiritual care, but hesitated to raise spiritual issues with patients, mentioning lack of time, a feeling that they should wait for a cue, or being unprepared or unskilled. The authors concluded that GPs and other health care professionals require supportive working practices and training to enable them to explore spiritual needs, handle uncertainty, and provide appropriate interventions.

The reasons why we don't address spiritual needs in health are suggested as:

- Education (lack of training, resulting in lack of knowledge or insight or confidence)
- Economics (lack of staff or time or resources)
- Personal obstacles (sensitivity or own belief systems)

So then, we have identified an aspect of health care which we acknowledge is important. The challenge is therefore to review our working practices; to consider needs for training, and to be able to implement appropriate interventions. As we consider our need for training, I wonder how honest we are prepared to be about our lack of knowledge. Let me give you an analogy from another area of my working life.

Last Friday morning a patient came in to see me complaining of tingling in his fingers. I have to admit that I have never loved neurology! But, as his GP I need to be able to manage his complaint of tingling in his fingers. Perhaps he had been playing rugby and injured his neck. Perhaps he has nerve compression in his wrist known as carpal tunnel syndrome. Perhaps this is the beginning of a serious neurological disease such as multiple sclerosis or syringomyelia. As a GP I am obliged to know enough about the anatomy, physiology, and the pathology that relates to tingling in the fingers, so that I can make an initial assessment, decide on the first steps of a management plan and when and to whom I should refer him. As a GP, am I not therefore also obliged to know enough about the nature of man, so that I can make the same kind of initial assessment about spiritual needs, how to

begin to address these needs and when and to whom I should refer him? Here is another story from my work which illustrates the importance of including spirituality in our understanding of our patients in order to make an accurate diagnosis.

This is the story of a lady who came to see me one Friday afternoon. I had never met her before but she struck me as being a competent and articulate young Afro-Caribbean woman. She was however very tentative in describing her concerns. As the story unfolded I realised she had problems with a housing situation and was requesting a letter from a doctor which could facilitate a move of accommodation. This is a frequent request where I work and one which has a tendency to irritate me. However this situation was unusual. She had no complaints about the physical surrounds or the decor of her flat. What she hesitatingly described to me was a series of events which had no apparent explanation. She had seen crockery flying across the kitchen and smashing when she was alone in a flat. She had heard sounds as if there were other people in the flat when there were not. She could no longer live there because of fear. Having made enquiries she had been told that three people had committed suicide in the flat in previous years. She had been reluctant to tell me these details for fear that I should label her as mentally ill. But as I talked to her I could find no evidence of psychiatric illness. I conveyed the fact that I accepted her story and was willing to write a letter, but then suggested there could be another course of action. My diagnosis was that the events occurring in her flat that caused her such fear were not in her imagination but were spiritual phenomena which could be addressed by appealing to a more powerful spiritual force. She was initially surprised at my suggestion, but very rapidly told me that she had friends who attended church and they had offered the same explanation. As it happened, she had moved to a flat very near a church I knew well. I explained that there were Christians who lived near her who believed that Jesus Christ had the power to deal with what was happening in her flat. At my suggestion she did contact them and they came and prayed with her in her flat. The outcome of this was that all these paranormal phenomena ceased. A great sense of peace was experienced in her flat and she was able to remain there. Some weeks later she attended an inter-church event where she dedicated her life to following Christ.

I suspect that part of the reason that you have come to this conference today -- and I know that some have come from far a field as London and Glasgow -- is that you recognize your own need for training. Training in understanding the nature of man and what we mean by spirituality and spiritual needs. There is an increased awareness of this need training -- for example our local hospice is offering a training session tomorrow entitled "Where the Sky Meets the Earth- Spiritual Care Competency" and I know that some of you are planning to attend that.

We have several speakers who are going to help us learn more about spirituality, spiritual needs and how the role of a chaplain can be a specialist resource to which we can refer. I have the fortunate position of being able to make my contribution first! As a GP and generalist I am also well used to

having a little knowledge on a subject, plus a lot of exposure to ordinary people which can allow me to sound like an expert!

And so for the rest of my session I want to:

- offer my observations and experience on an understanding of the nature of man
- I want to begin to tackle the concept of what we really mean by spirituality and spiritual needs
- I want to touch on some of the evidence base for the relevance of spirituality in healthcare
- and I want to outline the journey and history of what we have done so far in this field to my place of work at the Karis Centre.

I would like, if I may for a moment, to describe something of my personal journey as a physician who has sought to understand and honour the whole, and to grapple with a Biblical view of the nature of man. Before I became a physician I became a Christian. My Christian faith is profoundly important to me and throughout my training and my practice of medicine I have sought to understand how this all relates to what we learn about God and the world through the Bible. As a medical student, while I was grappling with anatomy and physiology and pathology I was attending a church where there was an openness to the move of the Holy Spirit and a longing for evidence of a supernatural God in physical healing and what was termed "emotional healing". I had neither the wisdom nor the humility to acknowledge that we do not really understand the nature of human beings. Of course I understood -- I was a medical student! However, what I saw happening in the life of my church fortunately confronted my arrogance. One particular story is worth re-telling.

A man approached the church pastor requesting prayer. His problem was of severe back pain. He was under the care of the orthopaedic surgeons at Dudley Road Hospital. Due to significant nerve root compression, he was scheduled for spinal fusion surgery. During a time of prayer the church pastor had the clear impression that this man's problems were related to his relationships. He sensed that the man had three very draining relationships in his life and the man readily acknowledged that. The prayer was then focused on freeing this man from unhealthy emotional bondages in these relationships and while they prayed to this effect, there was a visible and palpable movement in his lower back and the pain resolved. He then requested an additional outpatient appointment with the surgeon as he was no longer sure he needed surgery. Reluctantly this was granted and an additional x-ray was performed which showed his vertebrae to be entirely normal. The somewhat bemused surgeon discharged him and had the graciousness to write in his medical records "healed through prayer".

Even at that stage in my life, I had no problem with the theoretical concept that an all-powerful God could intervene in the world in miraculous ways. What disturbed me about that story was the

interrelationship between the emotional and physical. Why should a divine power need to first address damaged relationships and then cause miraculous physical healing? My understanding of the nature of man was far too compartmentalised to handle this.

As I tussled with this I came across the concept of a world view. This is the definition which I read: "A world view is a set of assumptions which are held consciously or subconsciously about the basic make up of the world, and which influence or control one's thinking about any given subject" (4). I began to realise that indeed I did have a worldview which subconsciously determined the way I analysed the world. My values did indeed affect the outcome of my evaluation.

Over the next few years I sought to understand what were the factors in my western and scientific worldview that prevented me from seeing the bigger picture and grasping a more profound truth. I had some theological training. I spent a year studying the Hebrew Scriptures and considering every reference to disease, illness and other descriptions where health was impaired, as well as all the terms where health and healing are referred to. I began to realise how profoundly Greek philosophy had influenced the birth of science and modern contemporary thought. In absorbing dualism, materialism and rationalism we had lost an understanding of the holistic nature of the world as revealed in the Hebrew Scriptures. Perhaps more importantly, we had lost the notion that God was intimately involved in every aspect of his creation, and have tried to confine him to the religious or the mystical.

In 1987 I wrote this in the conclusion to my dissertation:" The challenge which the Hebrew Scriptures present to Christians in contemporary medicine is to understand where our assumptions, our worldview, depend on human tradition and the basic principles of this world rather than on Christ. The challenge is also to seek ways of developing whole person medical practices where medical knowledge is used in submission to, and in harmony with, this omniscience and omnipotent God. These medical practices would aim for the highest standards in the research and application of medical science, but would not be bound by materialist or rationalist assumptions. Thus they would also be open to God's transrational revelations and miraculous demonstration. In the final analysis, our response to God's truth as revealed in the Hebrew Scriptures will reveal to what extent we are prisoners of our profession, or, how much we are able to respond to our Lord's prayer and cause His Kingdom to come."(5)

Moving on from my personal story but staying with our search for understanding about man's nature, let me quote from a Bible dictionary about man's structure.

### **Man's Structure**

Various words are used to describe man in his relationship to God and to his environment, and in the structure of his own being. Here are the main ones:

spirit (Hebrew ruah Greek pneuma),  
soul (Hebrew nepes, Greek psyche),  
body (only in New Testament Greek, Soma),  
flesh (Hebrew basar, Greek sarx).  
heart (Hebrew leb, Greek kardia)

These words are used according to the different aspects of man's activity or being which it is intended to emphasise, but they must not be regarded as describing separate or separable parts which go to make up for what man is. Neither Old Testament law nor New Testament usage justifies the conception of the human constitution as a trichotomy (6) – i.e. constructed of a 3 separate parts – body+ mind+ spirit.

It has been described to me in this way:

Imagine you are visiting a stately home and in the garden was a summer house. The summerhouse is circular in construction and has numerous windows but inside only one room. On the walls of this room are variety of pictures and the furniture is arrayed neatly inside the room. As you wander round the summerhouse you glance in through the different windows and each window gives you a different perspective on the room. Man is like that summerhouse. He is a unity, indivisibly whole. He can be viewed from different perspectives with each perspective offering a different but complementary understanding of who he is.

-Looking through the window created by the word soul we find an emphasis on his individuality and vitality with emphasis on his inner life and feeling, personal consciousness, and an association with the will and moral action.

-The view created through the word body emphasises the historical and outward associations that affect his life. But the soul is, and must be, the soul of his body and vice versa.

- When we contemplate man through the window of his spirit we see the animating principle and dominant disposition; the seat of perception, feeling, will, a state of mind. This window shows us that man is also in such a relation to the Spirit of God that he has spirit, and yet not in such a way that he can be described as spirit, or that the spirit can be regarded as a third aspect of his identity.

- Viewing man through the window of his flesh shows him in his connection with the realm of nature and with humanity as a whole, not only in its weakness but also in its sinfulness and opposition to God.

- The window of the heart, gives us a large view of the room. The heart is the governing centre for the whole of man, with all his attributes – physical, intellectual and psychological.

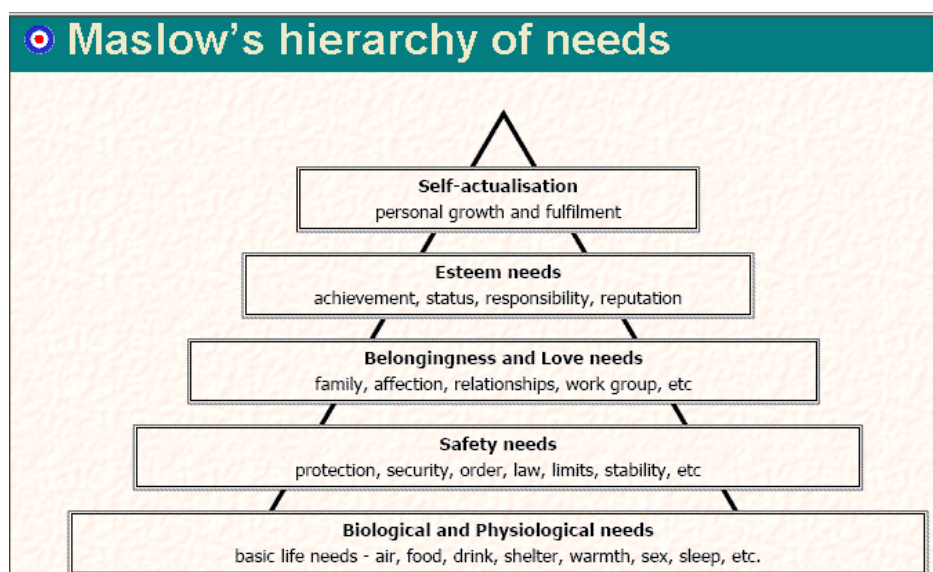
I hope that this explanation of how the Bible views the nature of man may prove useful. Now I want to try and define a contemporary understanding of spirituality and spiritual needs.

### **What we really mean by spirituality and spiritual needs?**

One of the features that I enjoy most about being a GP is the opportunity to get to know, and closely observe people who come from a whole range of life's experiences. Because I have a deep interest in people I have developed an interest in what you might call psychology and spirituality.

As a generalist, I want to give you some of my own thoughts on psychology and spirituality which I have found firstly, to be within my ability to understand them, and secondly to be useful in my daily interaction with people.

In the 1940s a psychologist Abraham Maslow presented his concept that human beings have a hierarchy of need (7).



As you can see from the table, this concept is hardly rocket science. Nevertheless, in its simplicity it communicates a lot of truth about the way we live. It is still highly regarded today. (In fact I took this table of a GP training website)(8). Having attended to our basic biological and safety needs, we find within ourselves the need for love and esteem and personal growth and fulfilment. Maslow persuasively argued that psychological health implies an impulse toward wholeness (9) -- or moving up the pyramid.

In the last few years, some British psychologists, Joe Griffin and Ivan Tyrrell, developed Maslow's concept into what has become known as the Human Givens approach. They describe this as the first bio-psycho-social model of psychotherapy. It is stated that "the starting point to understanding human givens is to first realise the significance of a profound truth: that all living things have to take nutriment from the environment to develop and sustain themselves. We are all born with essential physical and emotional needs. Moreover, Nature has incorporated innate resources – guidance systems – to help us fulfil them. It is because these needs and resources are incorporated into human biology that they are called 'givens' "(9)

Our emotional needs include:

*The need for security (stable home life and a safe territory to live in);*

*the need for intimacy and friendship;*

*the need to give and receive attention;*

*the need for a sense of autonomy and control;*

*the need to feel connected to others and be part of a wider community;*

*the need to feel competent which comes from successful learning and effectively applying skills (the antidote to 'low self-esteem');*

*the need for privacy (to reflect on and consolidate our experiences) and*

*the need to be 'stretched' in what we do, from which comes our sense that life is meaningful.*

The Human Givens approach does not use the term "spiritual needs", but their view is that spiritual needs refer to the need to find meaning in life through being challenged and stretched. It is claimed that "those whose needs are well met do not have mental health problems. Those whose needs are not fulfilled, or whose innate resources are damaged or being used incorrectly, suffer distress". The human givens approach enables professionals to focus more powerfully on helping clients identify unmet emotional needs in their lives and empower them to meet these needs by activating their own natural resources in new ways.

The human givens approach is becoming increasingly respected in a wide variety of fields -- in psychiatry, in General Practice, and in education. I will later describe how we have used it at the Karis Centre.

However I want to return again to Maslow and his hierarchy of needs. As well as arguing that psychological health implies an impulse toward wholeness; Maslow also believed that human beings have an impulse towards self transcendence (10). He argued that mature, well integrated individuals have experiences which seemed to transcend or go beyond the limitations of our individuality. He called them peak experiences. This view has led to the development of a whole new school of

psychology known as transpersonal psychology. The British Psychological Society gives this definition of transpersonal psychology: "Transpersonal Psychology might loosely be called the psychology of spirituality and of those areas of the human mind which search for higher meanings in life, and which move beyond the limited boundaries of the ego to access an enhanced capacity for wisdom, creativity, unconditional love and compassion. It honours the existence of transpersonal experiences, and is concerned with their meaning for the individual and with their effect upon behaviour" (11).

It has been suggested that deep within all of us lies a desire to transcend ordinariness and connect with lasting joy and a spiritual reality. Unfortunately, we rarely understand or cooperate with this subconscious desire, and so we land up substituting it for other things, such as seeking temporary experiences of pleasure, including sexual pleasure, and looking for security in finite things.

That reference, from transpersonal psychology, to seeking sexual pleasure fits with an observation from my work as a GP. One does not have to be working for long in General Practice before you are confronted with the reality that people's sexuality seems to be a very powerful force which influences and often drives their behaviour. Is there then a connection between sexuality and spirituality?

As I have pondered this question, and considered some views on this from those of no religious faith and those influenced by Eastern religions, I became aware that those describing spirituality and those describing sexuality were both referring to a deep human awareness of alienation, and at the same time a deep longing for connectedness.

A psychoanalyst, Eric Fromm claims that our deepest need is the need to overcome separateness, the prison of aloneness (12).

**G Feuerstein PhD** in his book **Sacred Sexuality**.

He suggests that a fundamental feature of human nature is a universal experience of alienation and imperfection which does not express the wholeness of being.

What most of us today are crying out for, he says, is intimacy and respect for our individuality. Our post-modern civilisation is strangled by a lack of intimacy.

The same author then goes on to claim "Sometimes, the "peak experiences" which Maslow describes happen as a kind of breakthrough when we are in love, and during or as a result of sexual intimacy. Sexual love, it is claimed, is the most intense and tangible way in which ordinary men and women strive for a union that transcends the boundaries of their everyday experience. Sexual love can be a hidden window onto the spiritual reality. And so it is concluded, that because of our deep and often

unconscious psychological yearning for transcendence, that sex is substitute for a spiritual way of life. (13)

I found that the same view expressed by a contemporary American Christian writer that many of you may have heard of -- Rob Bell. Writing in his recent book *Sex God* he states:

We are severed and cut-off and disconnected in a thousand ways, and we know it, we feel it, we are aware of it every day. It is an ache in our bones that won't go away.

And so from an early age we have this awareness of this state of disconnection we were born into, and we have a longing to reconnect.

Scholars believe that the word sex is related to the Latin word *secare*, which means "to sever, or to disconnect from the whole". This is where we get words like sect, section, dissect, bisect.

Sexuality, then, has two dimensions. First, our sexuality is our awareness of how profoundly we are severed and cut-off and disconnected. Second, our sexuality is all the ways we go about trying to reconnect (14).

What I have suggested so far is that spirituality at its simplest, but perhaps also at its most profound, is about the search for meaning and connectedness.

There is another concept which I want to introduce this stage, which not only relates to the concept of connectedness, but helps us understand why both health care professionals and patients struggle with the issue of spirituality.

I want to quote from Richard Rohr -- in his book "Adams Return":

I think that our lack of training in grief work and letting go, our failure to entrust ourselves to a bigger life, is the basis of our entire spiritual crisis. All great spirituality is about letting go. True spirituality mirrors the paradox of life itself. It trains us in both detachment and attachment, detachment from the passing so that we can attach to the substantial (15).

All great spirituality is about letting go - detachment from the passing so that we can attach to the substantial.

I wanted to give you two case studies which I hope will illustrate this important principle.

Last week I was called out urgently to see one of my patients who has advanced metastatic carcinoma of the colon. His pain had been much worse overnight and both he and his wife were distressed. Coincidentally, the day before I had received a request from the hospice nurse to refer him to the chaplain. As I was talking to him and his wife it struck me how much they needed the

doctor to provide the answers; they were hoping, against hope, that the increased pain was not evidence of the cancer's progression. I realised that they had a false attachment to the medical profession and the belief that it could prevent the inevitable, and that I had a false attachment to my image as a doctor who could diagnose and resolve people's problems. On that occasion I chose to stay with those false attachments, to do the appropriate investigations and to review the situation very shortly. I did not have the time, and perhaps the courage at that moment, to help us break free of these false attachments and, as Richard Rohr describes, to help them entrust themselves to the bigger life and attach to the substantial.

The second case study is about a 10-year-old girl who was suddenly found to have a large malignant brain tumour with spinal secondaries. As the parents began to absorb the fact that without treatment their daughter would imminently die, and with treatment there was a moderate chance that she would not die, but a certainty that there would be numerous significant and permanent health damaging consequences, they too had to let go of the attachment to the false concept that the medical profession could give them back their healthy daughter; the attachment to the false belief that a healthy child would automatically develop into a healthy adult; the attachment to the false hope that their family life would once again be normal, and that their other children would not themselves be damaged by the cancer in their sibling. The parents struggled to understand what it meant to entrust themselves to the bigger life and attach to the substantial, both for themselves and their suffering daughter. They taught her -- as she went through prolonged hospital treatment with serious complications and urgent re-admissions -- the simple phrase that, "home is where Jesus is". And one night, during which she had been seriously ill, their understanding of this bigger life, this substantial life, was enlarged through the insight of a child, when, as she surfaced she said "Mummy, I thought I was going home to be with Jesus last night".

And so we see that in this detachment and attachment, spirituality is beckoning us towards the substantial, towards finding a lasting and secure sense of home.

### **Definitions of spirituality in health care**

I want to look now in the healthcare literature where we find some helpful definitions of spirituality. But before I do so, to clarify, as some of you who know me will have already deduced, that the second case study was not about a patient of mine, but was my daughter.

Nurses have traditionally had a more person centred approach to health care, so it is not appropriate that the first reference to spirituality in healthcare is from a book: Nursing Concepts of Health Promotion.

“In every human being there seems to be a spiritual dimension...that strives for inspiration, reverence, awe, meaning and purpose...and comes essentially into focus in times of emotional stress, physical illness, loss, bereavement and death.” (16)

In the Health Service Journal of 2001 there is a very succinct and helpful definition:

“Spirituality is associated with the human quest for meaning, purpose, self transcending knowledge, meaningful relationships, love and also a sense of the holy”(17).

In November 2003, the Department of Health issued the following guidance: NHS Chaplaincy: Meeting the religious and spiritual needs of patients and staff (18). In the guidance is the following advice:

“It is helpful to distinguish between religion and spirituality. Spiritual needs may not always be expressed within a religious framework. It is important to be aware that human beings are spiritual beings who have spiritual needs at different times of their lives”. It is significant to note that the NHS is making a clear statement about patients and their needs here, i.e. “that human beings are spiritual beings who have spiritual needs”.

A year later the National Institute of Clinical Excellence produced a very significant document about palliative care. These specialists have described what excellent care for the dying should look like, and what we should all be aiming to provide. One whole section of this document is about spiritual support (19). I want to give you several quotes from this section.

“Formal religion is a means of expressing an underlying spirituality, but spiritual belief, concerned with the search for the existential or ultimate meaning in life, is a broader concept and may not always be expressed in a religious way. It usually includes reference to a power other than self, often described as ‘God’, a ‘higher power’, or ‘forces of nature’. This power is generally seen to help a person to transcend immediate experience and to re-establish hope”.

So what advice is there regarding how to meet the needs which arise from our spirituality? The NICE Guidance on Palliative Care from 2004 - Spiritual Support Services, provides a very useful reference point and resource in answering this question.

“Spiritual care should be seen as a responsibility of the whole team, while recognising that an individual may hold specific responsibility for ensuring its provision  
staff working within supportive and palliative care services have access to basic training in understanding the spiritual needs of patients and ways of assessing spiritual need”.

“Assessment of spiritual needs does not have to be structured, but should include core elements such as:

- exploring how people make sense of what happens to them,
- what sources of strength they can draw upon, and whether
- these are felt to be helpful to them at this point in their life”.

“Key issues in delivering effective spiritual and existential support to people experiencing illness or treatment or who are approaching death are:

listening to the patient’s experience and the questions that may arise

affirming the patient’s humanity

protecting the patient’s dignity, self worth and identity”.

The over arching advice is that service delivery must ensure “ that spiritual care is offered as an integral part of an holistic approach to health, encompassing psychological, spiritual, social and emotional care, and within the framework of the patient’s beliefs or philosophy of life”.

So we have here a description of the kind of health care we should be offering to those with terminal conditions. Should we not also be offering it to others, indeed to all whose health we have the privilege to care about? At what point do people *not* have spiritual needs?

So if spiritual needs are relevant to other areas of health care delivery, what is the evidence?

### **The evidence base for addressing the spiritual needs in healthcare**

We have dedicated a whole session this afternoon to looking at this important topic. It is essential that we leave this conference confident that there is strong evidence base for what we are aspiring to do. I will refer briefly to a few of the significant texts in this field.

In December 2002 the British Medical Journal gave editorial space the following paper:

Spirituality and clinical care, with the sub heading: Spiritual values and skills are increasingly recognised as necessary aspects of clinical care (20).

This is well worth reading and has numerous references you may wish to follow up.

It makes a reference is to a book by Koenig, McCullough and Larson, entitled 'Handbook of Religion and Health' (21), which has been highly acclaimed by a number of scientists in this field.. This book "offers a critical, systematic, and comprehensive analysis of empirical research, examining relations between religion or spirituality and many physical and mental health conditions, covering more than 1200 studies and 400 reviews.

Spirituality and religion had a statistically significant benefit on a whole range of conditions:

- heart disease, hypertension, cerebrovascular disease, immunological dysfunction, cancer, mortality, pain and disability, and health behaviours and correlates such as taking exercise, smoking, substance misuse, burnout, and family and marital breakdown.

- Psychiatric topics covered include psychoses, depression, anxiety, suicide, and personality problems.

The benefits are threefold: aiding prevention, speeding recovery, and fostering equanimity in the face of ill health.

There is one more reference I would like to mention -- mainly because the title always makes me smile when I consider how I viewed things 30 years ago. It comes from the Royal College of psychiatrists in Britain, from their special interest group in spirituality and psychiatry and by a psychiatrist Peter Fenwick. It is entitled the Neuroscience of Spirituality (22)!

Having acknowledged the undoubted benefits of spirituality and religion on health, this article seeks to explain some of the neurological and immunological mechanisms which have been discovered and that go some way towards explaining these benefits.

### **The Karis Centre**

A final brief word about how we have developed the concept of addressing spiritual needs in primary health care at the Karis centre. Over several years we have developed a broad primary health care team, similar to many across the country. Where we differed perhaps, was an open recognition that we did not have the skills within this team to adequately address spiritual needs. We were aware of our obligations under the General medical Council to be responsible and confident about where we referred patients. We did not have the necessary knowledge and relationships with the numerous faith organisations that existed within our large city catchment area, in order to refer people to local churches. More importantly, we were very aware that for many people who were expressing their spiritual needs, going to a church would be the last thing that they would consider. Having discussed this within our team, a team consisting of Christian doctors and other staff who are not all Christians, it was uniformly agreed that we needed additional personnel with the skills and the time to address spiritual needs.

In our discussion we used the following definition of spiritual needs:

"Everyone of us has, at the centre of our beings, spiritual needs that have to be met if we are to fully function as persons. Though many and varied these can be stated as three basic needs: a need to love and be loved; a need to feel worthwhile and a need for meaning and purpose (23).

We were able to use the Department of Health circular of 1992 (24) to persuade Birmingham Health Authority in 1997 that this was a valid appointment within primary care.

Perhaps if the NICE guidance from 2004 had been published 10 years previously, we might have called the post "a spiritual support service provider"! As it was, we decided upon the term chaplain, and drew up a job description based on what we felt was necessary in a primary care setting as distinct from what chaplains do in other settings.

Our concept of spiritual needs was, as I have described, something which embraced the whole of a person's life, and not just religious needs. The chaplain's role was therefore not simply to meet all spiritual needs but to complement an aspiration which the whole team held. In order to facilitate this, one of the first tasks of the chaplain was to network with all local faith organisations. Out of this came a steering group and subsequently an established charity called Karis Neighbour Scheme. This draws on the picture of the parable of the Good Samaritan, and we provide a few employed staff and dozens of volunteers -- who are mainly from local churches. They address unmet needs that the primary health team become aware of, through befriending and practical help to disadvantaged individuals and communities. Their focus has been mainly on families with young children, asylum seekers and refugees, and the isolated elderly. The chaplain remains an integral part of Karis Neighbour scheme as well as the work which we will hear about later, of talking and praying with individual patients of the Karis Medical Centre.

In addition to the annual comprehensive patient survey about the care at Karis using the nationally validated GPAQ Survey, a few years ago we also conducted a separate "Whole Person Survey" patient questionnaire. In this we were trying to gauge if patients had an understanding of "spiritual needs" - as defined earlier.

The surveys showed that by and large, patients were treated in a person centred way, with care, dignity and respect as individuals. The person operating the questionnaire felt that we needed to define what we meant by "whole person care" more clearly. It was also noted from patients' free text answers that patients do not separate "religious needs" from "spiritual needs". When we say "spiritual needs" we mean the needs of the human spirit. Patients hear something to do with religion, which may have nothing to do with them.

So we tried to redefine what we meant in ways that reduce ambiguity and gave us a useful tool to use during consultations. We drew from the "Human Givens" approach which I referred to earlier and decided to use the phrase deepest human needs. Using a variety of definitions of spiritual needs we came to the following conclusions.

- Our deepest human needs are for security and significance.
- Our security comes from our environment, relationships, health and transcendence.

- Our significance comes from having a sense of purpose, being challenged, being approved, being valued and transcendence.

This is portrayed in a leaflet which uses the picture of a house built on stilts. When it is appropriate during a consultation, we use this to help people understand what the necessary supports are for their life and health. It very quickly becomes clear to them which of these supports are lacking in their life and how that relates to their own awareness of lack of well-being. Using the questions on the leaflet, we encourage patients to consider the issues further at home. There may be actions they can take that will begin to meet some of their deepest human needs; they may be helped to accept that some of these needs cannot be met. It is hoped that we can help patients detach themselves from the temporary, limited and sometimes unhelpful sources from which they have sought to have their needs met, and attach themselves to more positive and secure sources to meet their needs. As ultimately, all human resources to meet these needs are limited, we try and draw them towards God by discussing the human need for transcendence. This can occur over several consultations and our experience has been that using this leaflet can make the consultation more time efficient. A referral to the chaplain is obviously one possible outcome from this process.

Let me close with a reminder that our values do determine our evaluation. We need to value patients as unique human beings with a spiritual nature which is integral to who they are and part of all of their life. Helping them to understand their spiritual nature and what their spirituality means can be one of the most rewarding aspects of working in General Practice. It is part of good health care, and may be of eternal benefit to your patients.

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