FAITH: spiritual history-taking made easy

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INTRODUCTION

The incorporation of spirituality into medical practice is increasing as the mechanistic view of patients is no longer satisfactory.[1] It is being recognised and remembered that a patient needs to be treated as a 'whole person' and not just as a condition or disease.[2] A 'whole person' has physical, emotional and spiritual dimensions which interact with each other and account for personal well-being.[2] In the Dialogues of Plato the holistic principle is described:

... that 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 .... for the part can never be well unless the whole is well.[3]

Furthermore, in words that remain apt for the modern era, it 'is the great error of our day in the treatment of the human body, that physicians separate the soul from the body.' [3] FAITH provides a simple patient-centred framework for doctors and students to work through when taking a spiritual history.

Medical educators in the USA are aware that spirituality is an integral component of comprehensive and holistic patient care and are endeavouring to train doctors to be more compassionate.[4] In 1994 only 13 per cent of USA medical schools provided teaching on religious and spiritual issues and this figure is now over 75 per cent.[5] A recent study found that the proportion of medical schools in the UK that currently provide such teaching is significantly lower.[6]

In the UK 76 per cent of people admit to having a spiritual dimension in their lives and Murray et al found that many patients in their last year of life expressed spiritual needs.[7] During illness people tend to re-evaluate their belief systems and may utilise a spiritual dimension to help them cope.[8] Patients' spirituality may also influence decisions regarding treatment plans.

A patient needs to be treated as a 'whole person' and not just as a condition or disease

Patients' spirituality may ... influence decisions regarding treatment plans

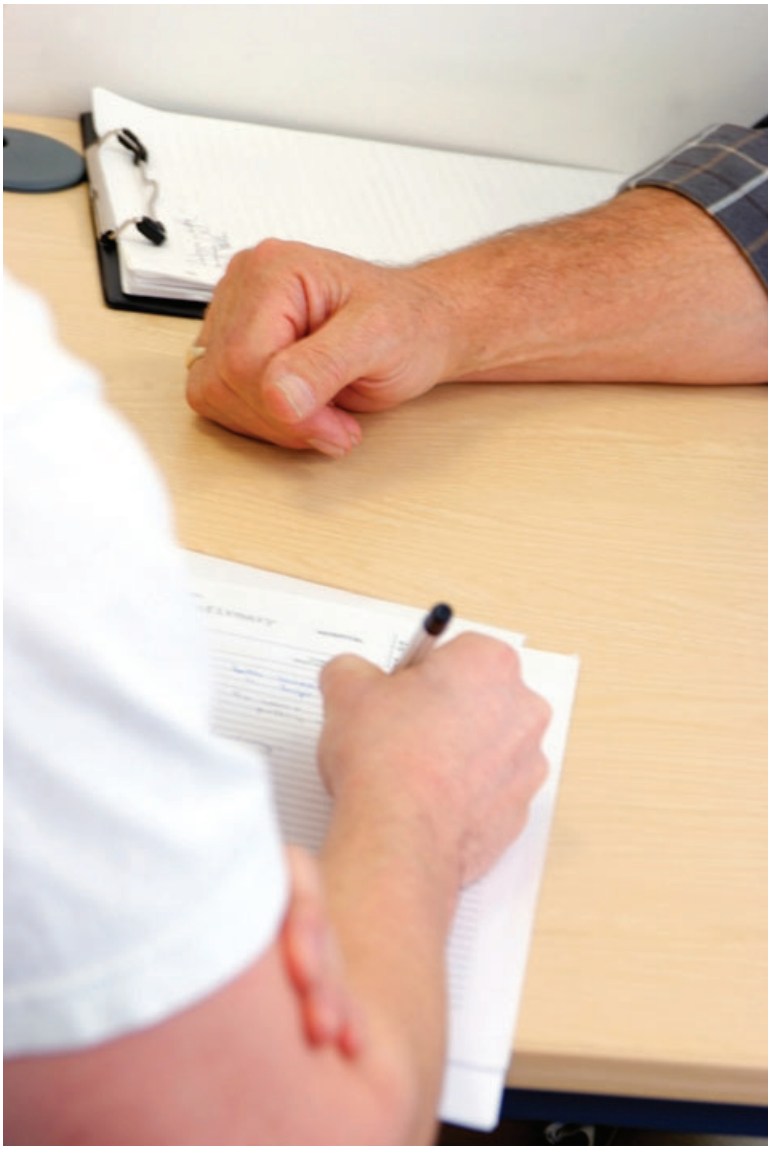
They may hold beliefs that are in conflict with certain medical interventions such as decisions regarding end-of-life management. It is important that doctors are aware of spiritual beliefs before difficult situations arise.

SPIRITUAL HISTORY

A spiritual history taken as an extension of the social history in the routine medical encounter is a practical first step to incorporating patients' spirituality into medical practice and providing some form of spiritual care.[1] A comprehensive spiritual history would establish a patient's spiritual needs, sources of support, application of spirituality in the patient's life and evaluate the influence of beliefs on life and medical decisions. It would identify any spiritual distress and those who may appreciate referral to a chaplain or spiritual counsellor.[8]

Several formats for spiritual history-taking already exist, including; HOPE,[1] FICA,[9] SPIRIT[10] and a set of four questions devised by the American College of Physicians[11] (see Appendix S1). Each one establishes if a patient has a faith or belief system and how it applies to both their everyday lives and to their health. A need still exists for a user friendly and brief measure to assess spiritual need in the presence or absence of religious faith.[12] Many people with important spiritual beliefs do not express them through religion, which is an organised system of beliefs, rituals and practices.[13] Spirituality is grounded in the lived experience of the human person and endeavours to encompass that which gives meaning, purpose, connection and value in life.

We propose that the mnemonic FAITH provides a simple patient-centred framework for doctors and students to work through when taking a spiritual history (Box 1). It is also applicable for patients whose spirituality lies outside the boundaries of traditional religion.



This system is easily memorised as the mnemonic is pertinent to the topic unlike some of the other existing formats. Sample questions are included in Box 2.

Box 1. FAITH: Patient-centred framework for taking a spiritual history

Faith/spiritual beliefs

Application

Influence/importance

Talk/terminal events planning

Help

This format is easily taught to both medical students and doctors alike. Lack of training is cited as one reason why doctors may not ask about spiritual beliefs.[14] Introducing this tool into the curriculum would help to address this. Preliminary work with medical students shows it is easy to recall and simple to work with and adapt. Being brief and potentially comprehensive it is more likely to be implemented into daily practice as part of the routine history-taking. FAITH equips doctors and students with a flexible patient-centered system

of questions which can be adapted to suit each individual patient. It is not prescriptive but is a framework where a few questions may be asked or it may provide the opportunity for a more in depth discussion. However, with use doctors may alter these questions as they develop their own personal spiritual history-taking style.

Case reports of FAITH in practice by medical students.

1. *A 68 year old lady was admitted for laparoscopic cholecystectomy. The patient had a strong religious faith and applied it in her every day life by praying and attending religious services. Her faith was very important to her during illness and helped her cope. She found prayer beneficial and felt that it helped her approach her forthcoming surgery, believing that she would do better if she prayed. She was able to discuss spiritual matters with her own priest but was also delighted to be asked if we (the health care team) could be of any help e.g. by referral to the chaplain. To this she gave immediate approval and the chaplain subsequently attended.*
2. *A 39 year old lady was admitted for panproctocolectomy and ilesotomy for ulcerative colitis. She felt that the absence of any specific religious or spiritual belief had not been detrimental in her life. She suffered from depression, at times felt alone and had difficulty coping. Her illness had rendered her housebound and this exacerbated her depression. She drew strength and support from her family and from the Ileostomy Association. Forming new friendships and connections through the association helped her to 're-find' herself and enabled her to cope better. She found a new source of 'inner-strength' and a new appreciation for life which was aided by music and alternative health therapies.*

Box 2. FAITH: sample questions for taking a spiritual history

Faith/spiritual beliefs

Do you have any particular faith, religious or spiritual beliefs?

What gives your life meaning?

What helps you cope in times of stress or illness?

Application

In what ways do you apply your faith in your daily life?

Do you belong to a particular church or community?

Is prayer or meditation important to you?

Influence/**I**mportance of faith in life, in this illness and on health care decisions.

How do your faith and spiritual beliefs influence your life? Are they important to you?

How do your faith and spiritual beliefs influence you in this illness? Have they altered your attitude or behaviour?

Has this illness influenced your faith?

Do your beliefs influence or affect your health care decisions that would be helpful for me to know about?

Talk/**T**erminal events planning

Do you have anyone you can trust to talk to about spiritual or religious issues?

Do you have any specific requests if you were to become terminally ill? (E.g. terminal care options, living will or end of life requests.)

Help

Is there any way I or another member of the health care team can help you?

Do you require assistance or help with prayer? (E.g. facilities or accompaniment)

Would you like to speak to a chaplain?

Would you like to discuss spiritual issues or your beliefs with your doctor?

In the first example it was clear to the student that the patient greatly appreciated the enquiry around her faith. In the second example the student gained a deeper understanding of the patient and identified stressors and coping strategies. In each case information was elicited that would not otherwise have been obtained and the opportunity to provide spiritual care as part of the overall holistic care of the patient would have been missed. The students also developed an appreciation for the multi-dimensional nature of health care and the importance of harmony in the body-mind-soul complex. These two pre-operative cases highlight the un-mined potential for spiritual care to be provided as part of routine patient care.

There are many potential outcomes and benefits of taking a spiritual history and a few are outlined in Box 3.

DISCUSSION

FAITH provides a flexible and comprehensive tool to aid spiritual history-taking which is applicable in a wide variety of

FAITH is a practical and efficient way of incorporating patients' spiritual perspectives into their medical care

Showing a concern for the 'whole patient' strengthens the patient-doctor relationship

Box 3. Potential outcomes and benefits of taking a spiritual history

Outcomes

- Deeper understanding of patient
- Modified management/care plan
- Referral to chaplain
- Provision of literature
- Prayer opportunities
- No further action

Benefits

- Enhanced:
  - Trust within doctor-patient relationship
  - Coping skills
  - Well-being
- Holistic care: feeling valued, heard and empowered
- Greater compliance
- Altered course of illness

medical settings including general practice, hospital and hospice. FAITH is a practical and efficient way of incorporating patients' spiritual perspectives into their medical care, identifying spiritual needs and providing the opportunity for therapeutic intervention. Utilisation of the FAITH tool acts as an intervention through caring and listening, bringing us back to the compassionate and care giving roots at the core of medicine. Initial work shows it is a simple tool that is easy to recall and could be readily incorporated into the medical history by medical students, doctors and other members of the health care team e.g. nursing staff.

A spiritual history forms a starting point for the provision of spiritual care by the health care team. This involves engaging with and responding to an individual's expressions of spirituality, which may or may not involve any discussion of God or religion.[1,12] If a doctor feels unable to personally respond to a patient's spiritual needs he or she should ensure that they are addressed by an appropriate person. The initial enquiry about spiritual issues would let patients know that they could be discussed in the future if required.[15] It is necessary to respect the patients' rights to autonomy in beliefs and practices, confidentiality and privacy. Doctors are advised not to impose their own beliefs or culture on patients but to be open and accepting of their patients' beliefs if appropriate.[9]

It may be argued that taking a spiritual history may upset some patients as it is unexpected, too personal or because they are not spiritual. It has been said that patients seek doctors' advice to have their medical problems addressed and not their spiritual lives assessed.[16] However, if the history is taken in a sensitive and respectful manner, patients without such beliefs are unlikely to be offended and if the doctor's rationale for performing such an assessment is made clear this would help avoid misinterpretation of the doctor's motive.[8]

Another misperception is that taking a spiritual history may induce feelings of guilt in patients.[8] A sick patient may feel that his illness is a punishment resulting from a lack of faith. Research has shown that patients who feel punished or abandoned by God have diminished life expectancy compared to those without such feelings.[17] However, these complex issues need to be addressed to avoid a state of spiritual distress for the patient. The fear of inducing guilt does not stop doctors from enquiring about other aspects of patient health such as: alcohol consumption, recreational drug use and smoking status and neither should it deter them from taking a spiritual history.

Sloan et al suggest that it may still be premature to promote spirituality and religion as 'adjunctive medical treatments'.[18] However, showing a concern for the 'whole patient' strengthens the patient-doctor relationship by instilling more trust and may increase the therapeutic effect of medical interventions.[8] It has been shown that spirituality can improve the quality of life of many individuals by subjective well-being through enhanced coping strategies and social support, providing systems of meaning and integration within a community.[15,19]

CONCLUSION

Spirituality may be regarded as the forgotten dimension in modern medicine. Spirituality is fundamental to whom one is as a person and its importance in health care management is gaining momentum. It is therefore necessary to have a simple and flexible structure for taking a spiritual history and FAITH fulfils all the necessary criteria.

REFERENCES

1. Anandarajah G, Hight E. Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment. *American Family Physician* 2001;**63**(1):81–89.
2. Koenig HG. Religion, spirituality and medicine: application to clinical practice. *Journal of the American Medical Association* 2000;**284**(13): 1708.
3. Plato. Charmides, or temperance. [Online] 2005 [cited 2008 June 30]; Available from: URL: http://infomotions.com/alex2/authors/plato/plato-charmides-645/plato-charmides-645.shtml
4. Tang TS, White CB, Gruppen LD. Does spirituality matter in patient care? Establishing relevance and generating skills. *Acad Med* 2002;**77**(5): 470–471.
5. Pulchalski CM. Spirituality and medicine: curricula in medical education. *Journal of Cancer Education* 2006;**21**(1):14–18.
6. Neely D, Minford EJ. Current status of teaching on spirituality in UK medical schools. *Med Educ* 2008;**42**:176–182.
7. Murray SA, Kendall M, Worth A, Benton TF. 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.
8. Koenig HG. *Spirituality in patient care- Why, How, When, and What?* 1st ed. London: Templeton Foundation Press; 2002.
9. Puchalski C, Romer AL. Taking a spiritual history allows clinicians to understand patients more fully. *Journal of Palliative Medicine* 2000; **3**(1):129–137.
10. Maugans TA. The SPIRITual history. *Archives of Family Medicine* 1996;**5**: 11–16.
11. Lo B, Quill T, Tulsky J. Discussing palliative care with patients. *Annals of Internal Medicine* 1999;**130**: 744–749.
12. Speck P, Higginson I, Addington-Hall J. Spiritual needs in health care. *BMJ* 2004;**329**:123–124.
13. King M, Speck P, Thomas A. The Royal Free interview for spiritual and religious beliefs: development and validation of a self-report version. *Psychol Med* 2001;**31**: 1015–1023.
14. Ellis MR, Vinson DC, Ewigman B. Addressing spiritual concerns of patients, family physicians' attitudes and practices. *Journal of Family Practice* 1999;**48**:105–109.
15. Koenig HG. An 83-year-old woman with chronic illness and strong religious beliefs. *Journal of the American Medical Association* 2002; **288**(4):487–493.
16. Scheurich N. Reconsidering spirituality and medicine. *Acad Med* 2003;**78**(4):356–360.
17. Pargament KI, Koenig HG, Tarakeshwar N, Hahn J. Religious struggle as a predictor of mortality among medically ill elderly patients: a two year longitudinal study. *Archives Internal Medicine* 2001;**161**: 1881–1885.
18. Sloan RP, Bagiella E, Powell T. Religion, spirituality and medicine. *New England Journal of Medicine* 1999;**353**:664–667.
19. Rosner F. Religion and Medicine. *Archives of Internal Medicine* 2001; **161**(15):1811–1812.

Supporting Information

Appendix S1. Alternative Spiritual History Tools.

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