Spirituality and Religion in Health Care Practice

A person-centred resource for staff at the Prince of Wales Hospital
Spirituality and Religion in Health Care Practice: a person-centred resource for staff at the Prince of Wales Hospital was prepared by the Spirituality and Health Project team:

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The purpose of this resource

Staff at POWH recognise the importance of spirituality/religion in person-centred health care, and are willing to incorporate patients’ beliefs and practices into their treatment planning and care. However, staff acknowledge that they seldom ask patients about spirituality/religion, they lack confidence in responding to patients’ comments on the subject, and they do not currently have strategies for integrating spirituality/religion into their practice.

This resource has been developed in response to these needs. It is based on an extensive literature review and two phases of research at POWH.

Key findings from POWH research

- Spirituality/religion is important to the majority of POWH patients
- Rituals and practices associated with beliefs are important to POWH patients
- Beliefs and practices are not easily categorised – they are eclectic, individualised and evolving
- Respecting the diversity of beliefs and practices is extremely important to POWH patients and staff
- Patient-centred care requires health care professionals to acknowledge and accommodate patients’ beliefs, practices and wishes
- A patient-centred assessment of needs requires patient/staff engagement, attention to patient cues and, when appropriate, sensitive strategic questioning

Spirituality in health care: why is it important?

There is increasing recognition within contemporary western medicine of the significant links between spirituality/religion and health, and the need for health professionals to understanding their patients’ spiritual/religious beliefs and practices because they can affect:

- the way people understand health, illness, diagnoses, recovery and loss
- the strategies they use to cope with illness
- their resilience, resources and sense of support
- decision-making about treatment, medicine and self-care
- people’s expectations of and relationship with health service providers
- day-to-day health practices and lifestyle choices
- overall health outcomes

Spirituality/religiosity per se is not necessarily an indicator for better health outcomes because the relationship between beliefs, practices and health can be negative or neutral as well as positive. The critical factor is not if someone is spiritual/religious, but how they are spiritual/religious. This may be influenced by a myriad of factors including culture, family ties and social networks, and life events such as health crises, trauma and loss of a loved one.
Understanding religion and spirituality

Religion
Religion is usually seen as the institutionalisation of shared beliefs and customary practices. It is often integrated into a community’s cultural life and can be a framework for understanding and decision-making. Most religions have traditional beliefs and practices relating to healthy living, illness and death.

Spirituality
Spirituality means something different for everybody and consequently there can be no single all-encompassing definition. It relates to how we find meaning and connection, and the resources we use to replenish ourselves and cope with adversity. Spirituality may be part of religious beliefs or another shared belief system, or something entirely personal and self-developed.

Based on these definitions religion is considered to be more structured, formal and rooted in tradition; while spirituality is perceived as more fluid, eclectic and individual.

Spiritual Worldview
The concept of a ‘spiritual worldview’ incorporates religion and spirituality, as well as many other philosophical or popular beliefs and reference points that make assumptions about the larger context of human existence. It may include fatalism (“It wasn’t meant to be”); an unspecified universal design (“Everything happens for a reason”); ‘New Age’ concepts which encompass a diverse range of beliefs; advocacy of holistic approaches to health and ecology; astrology; non-theist spiritual practices such as Buddhism, Taoism and Paganism; ethical philosophies such as Humanism and Utilitarianism; and Agnostic and Atheist positions.

For many people, their worldview is the most important thing in their lives with a deciding role in directing behaviour; guiding attitudes to health, work and relationships; and strongly influencing how they regard themselves and others.

Why should we try to understand a patient’s spiritual worldview?
Thinking about religion and spirituality as dimensions of a person’s ‘spiritual worldview’ helps us to be responsive to the complex and diverse ways in which people personalise their beliefs. This means we are less likely to make assumptions about their needs, wishes and practices based on a generalised term on their admission sheet. It also:

• helps us to develop a better understanding of the patient and their context
• assists in the development of informed and comprehensive treatment plans
• contributes to the collaborative dialogue that encourages patients to commit to treatment regimens and healthy-living practices
• lets patients know that we are concerned with the whole person
• helps us to support spiritual patients to tap into resources that may contribute to improved coping and wellbeing
Customs, Rituals and Practices

“Ritual is a marking of an ordinary person’s journey which tells them their experience is significant and that it is connected with the wider community of universal life and existence.”

Customs and rituals may be religious, cultural or personally defined. People use them to connect with each other, with their faith, and their traditions: with whatever framework they have for meaning in their lives. Rituals and rites provide comfort and assistance when dealing with illness, anxiety, pain, confusion, misfortune, death, and the fear of these events. They can enhance quality of life, provide critical reassurance, offer a vehicle for therapeutic communication, enable a sense of purpose and control, and facilitate mutual support and solidarity with family, friends and community members.

Peer-reviewed studies have shown ritual practices such as meditation, prayer and social religiosity to have a positive impact on specific physical and mental health indicators. It is widely accepted that rituals can directly affect patient wellbeing and quality of life by impacting upon stress/relaxation, hope, coping, and perceived recovery, which in turn affect overall health outcomes. Therefore, it is important that health professionals recognise the importance that rituals have for many patients and families, respect their practice, and support them whenever possible.

“A patient on my ward was dying. Apparently the family requested a chaplain but, for some reason, staff delayed making the call and the patient died before the chaplain could attend. The family was very upset because certain rituals hadn’t been administered. They felt guilty and concerned that their relative’s spirit would not be able to rest. It had a huge impact on their ability to grieve and move on.” — POWH Nurse

Spirituality and religion in Australia

Spirituality is an important aspect of life for many Australians, with two thirds of people stating that spirituality is significant in their lives, and nearly three quarters of the population (74%) professing some form of religious affiliation. These figures are higher in rural (86%) and elderly (83%) populations, and tend to increase when people experience illness or injury.

Trends suggest that traditional religiosity is in decline, but that spirituality may be growing, as Australians increasingly turn to a range of eclectic beliefs and self-developed practices. For example, a feeling of deep connection to the land/nature, which may in part have been inspired by indigenous Australians, is becoming an increasingly significant dimension of spirituality across Australian society.
Spirituality and religion at the Prince of Wales Hospital

In-depth interviews with patients and clinical staff, followed by a hospital wide survey of 228 Prince of Wales patients and visitors\(^a\) found that:

- **Most of our patients are spiritual/religious**
  Three quarters of people surveyed (74%) said they had spiritual or religious beliefs of some kind.

- **Patients feel there is a relationship between spirituality/religion and health**
  Over 80% of respondents stated that health is affected by religious or spiritual beliefs, and that these beliefs become more important when a person is ill. Whether it is “God’s healing”, “providing comfort”, “inner strength”, “living right” or “a placebo effect”, nearly 74% agreed that spirituality and religion has an impact on the way that people view health and illness.

- **Patients want staff to know about their beliefs and practices**
  Over 70% of those surveyed felt it was helpful for hospital staff to know their patients’ beliefs, and confirmed it was all right for staff to ask them. Respondents indicated they want staff to understand their beliefs and practices so appropriate support can be offered. This accords with international research which finds the majority of patients want clinicians to consider their beliefs\(^{11,40,41}\) and would trust them more if they made this enquiry.\(^42\) These findings contradict the misconception that patients tend to find religious/spiritual questions intrusive\(^43\).

- **Spirituality and Religiosity are not synonymous**
  Of those who identified as spiritual/religious, one third (24% of all respondents) saw themselves as spiritual but not religious; while another 21% said they were religious but not spiritual.

- **People’s beliefs are fluid and eclectic**
  When asked to select a religious/spiritual category that best described them, 22% of participants selected multiple categories. In many cases, this eclecticism overlapped significantly with traditional religious affiliations.

- **People’s beliefs change**
  Over half those surveyed said their beliefs had changed over time. Changes included a ‘deepening’ faith or spirituality based on personal development or life experience; or rejected faith due to disillusionment. Life events were a strong influence, both positively and negatively: loss of health, lifestyle, or a loved one either enhanced or confirmed beliefs or caused people to question them.

- **Spirituality/religiousness does not necessarily mean church attendance**
  Although 74% of those surveyed said they were spiritual/religious, only 43% indicated they attended a place of worship or spiritual group.

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Religious/spiritual rituals and traditional practices are important
81% of POWH surveyed patients and visitors said that rituals and customs can help people when they are ill or suffering. Half (54%) of the respondents observed rituals on a daily or weekly basis. 74% felt their rituals were of moderate or strong importance and, of this group, 68% said they wished to continue their practices while in hospital.

Spiritual/religious beliefs and practices can provide crucial support
In-depth interviews (n13) revealed that spiritual/religious beliefs and practices help people to cope during health crises, treatment and care, end-of-life and the bereavement process, offering comfort, guidance, meaning and connection.43

Chaplains are important
Nearly 40% of respondents said they would like to speak to a chaplain. A further 17% thought they might like to depending on their situation or on the attributes of the chaplain.

Respect is paramount
Patients and their families consistently told us that staff should acknowledge and respect their beliefs and practices, and those of other patients - whatever they are.

Incorporating spirituality in the hospital context
“The degree to which religious/spiritual beliefs and practices are important in health care depends on each individual patient. The safest starting point for discussion is to expect it might be important.”
POWH doctor

The predominant biomedical position has been to leave spirituality out of medicine. However, the research, together with the increasing emphasis on a biopsychosocial model, strongly suggests that this is no longer acceptable in contemporary patient-centred health care. Indeed, the findings in the section above clearly show that the majority of our patients:

- are spiritual/religious
- feel that spirituality/religion is more important during illness
- believe that rituals can help
- feel it is helpful for health professionals to know about a patient’s beliefs
- are willing to be asked about their beliefs.

These findings are supported by national studies which indicate that patients want clinicians to incorporate spirituality into their treatment and care.45 Therefore, we can conclude that patients and their families are likely to have some spirituality/religiosity that is significant to them in the health context, and that we should ask them about it so that we can respond appropriately.

The core spiritual issues that are likely to affect patients relate to meaning (how we make sense of what is happening to us, eg. how we tackle questions like “Why?”) and coping (spirituality is a resource that transcends personal, social and material circumstances and so can offer sustenance in the face of all mortal adversity). Understanding and supporting these needs is not an addition to clinical care but an integral part of it.
Identifying needs

“One of my patients was going to pass away. Neither she nor her family had mentioned spiritual needs. I happened to say to the daughter that one of the chaplains was on the ward. She burst into tears and said “Oh, please get him”. It seemed that neither she nor her mother were able to vocalise their needs, perhaps they weren’t even aware of the service, but it made a real difference to them. So now I make a point of asking people rather than assuming they will tell us what they want. Even when people say ‘No’, they often say they appreciated being asked. I think it shows them we care.”

POWH nurse

What are we trying to identify?

In identifying ‘spiritual/religious needs’ in the hospital context we are attempting to gain an understanding of two broad issues:

1. Beliefs or practices which are significant to the patient’s health in that they affect decision-making, coping, support networks, commitment to treatment regimens, complementary health practices and general wellbeing.

2. Patients’ wishes about the way their beliefs and practices are acknowledged and supported while they are in hospital. This may include referrals to chaplains or other services.

Limitations of our current methods

In most cases at POWH the matter religion/spirituality is addressed only at admission in response to a question on the admission form which asks patients to state their “Religion/denomination”. This is followed by an option, “If you want your religion withheld from the chaplaincy service, please tick this box”.

How do we identify spirituality?

The phraseology of the admission form fails to identify patients who see themselves as spiritual but not religious - nearly a quarter (24.1%) of those surveyed. The significant and increasing numbers of Australians in this group are well documented, yet they are excluded by our data collection instruments.

How do we identify religion?

The question on the admissions form will generally capture patients who associate with a traditional religion/denomination providing (a) they are asked / able to read the question, (b) they understand the question, and (c) they feel able to answer honestly. However, an answer does not necessarily denote religiosity. Research indicates a proportion of patients regard religion as a way to identify their cultural heritage or family background rather than as an expression of beliefs and practices, eg. “I was baptised in a Catholic Church so I guess that makes me Catholic”. Furthermore, some people who do not see themselves as religious, and therefore leave this question blank on the admission form, return to the cultural /religious practices of their upbringing when facing a serious illness or death.

b Prince of Wales Hospital & Community Health Services Recommendation for Admission Form Perioperative Health Questionnaire S1258 (March 2005). Still in use at the time of writing.
Consequently, the information on the admission form does not tell us:

- To what extent patients’ beliefs are important and are likely to play a part in health-related decision-making. For example, do they have deep religious convictions, or do they view their religion primarily as an inherited label?
- What their practices are and how these might affect medical treatment, rehabilitation and their overall health and wellbeing.
- How diagnosis may affect their spiritual worldview.
- What their needs and wishes are while in hospital, including if they would actively like to see a chaplain.

Therefore, we may be able to use admission form information as a potential starting point for talking with in-patients about spirituality/religion, but we need to engage in conversation to understand their worldview and its implications for health care.

‘Spiritual assessment’ versus patient engagement

“One size does not fit all. We need to talk to people as individuals. There are cases where deeply spiritual patients are neglected because they don’t identify as religious so nothing is recorded on their record. I also know of a case where staff were trying to be non-prescriptive and asked an elderly Italian man “do you have any particular spirituality?” . Although the patient had good English he didn’t understand the question and said ‘No’, despite being a devout Catholic. Sadly, this wasn’t discovered until after he died.”

Hospital Chaplain

Some of the literature, particularly in the American context, advocates using a standardised spiritual assessment tool or inventory. However, the quantifiable instruments that medical science favours employ a theoretical framework that sits uncomfortably with spirituality/religion. People’s spiritual worldviews and practices are eclectic, fluid and individualised; they cross paradigms and have different emphases and meanings; they are evolutionary – shifting in response to life changes and events; and the words, concepts and imagery used to express them vary from person to person. It is highly unlikely that any instrument using prescribed questions could capture this diversity and present it to staff practically. Furthermore, this topic has profound meaning (even ultimate meaning) for many patients and families, and raises concerns for some of them. We know that formal administrative processes are not the best option for sensitive questioning because people respond more openly when they feel they have a connection with the person asking the questions.

If we want meaningful answers we have to ask meaningful, appropriate questions. This requires an emphasis on engagement rather than the employment of routine screening tools. Therefore, instead of viewing spiritual assessment as a discrete activity using instruments that may be experienced as presumptuous, impersonal and invasive, staff are encouraged to integrate the consideration of spiritual matters into their everyday practice, using the same person-centred communication skills they employ when talking with patients and families about other issues. In this way, identifying and responding to needs becomes individualised, allowing staff to approach and respond sensitively to each patient in their context.

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*This presents challenges for research in the field, an issue addressed in: Hilbers et al 2007, *Spirituality and Health at the Prince of Wales Hospital (phase two)*, Prince of Wales Hospital, SESIAHS, Sydney. Available at: http://sesiweb/powh/diversityhealth/PDFs/spirituality_report_2007*
The patient and their context

As busy professionals working in an often rushed health care system, we do not have the luxury of engaging with every patient we meet. However, we are usually aware of a patient’s medical context: issues such as pain, trauma, loss, increased dependency, the seriousness of diagnoses and prognoses and their associated psycho-social impacts are part of the clinical assessment and record. This knowledge can inform the degree to which we judge spirituality may be significant. In cases of serious illness and aged decline, major medical or surgical interventions, catastrophic injury, palliative care, and illness with significant implications (eg. affecting mobility, fertility, cognitive capacity, lifestyle), spirituality is likely to be highly relevant to the patient and their family and should be addressed as part of holistic treatment and care.  

This does not mean there is a simple equation - greater health needs equate to greater religious/spiritual needs - but our professional understanding of the circumstances provides a context for considering how to deal with each patient as a whole person. When it comes to spirituality, this may mean the difference between asking patients about their spiritual worldview, or simply being attentive to the cues they give and being prepared to respond sensitively. This is the same for other dimensions of health and wellbeing such as social or psychological factors – some contexts indicate an increased likelihood of need, and some patient/staff relationships are more appropriate than others for raising the issues. However, regardless of the circumstances we must maintain our ‘spiritual radar’ so we are open to identifying and addressing the topic if the patient or their family give us reason to.

The next section offers some practical ideas about how to identify and respond to patients’ and families’ spiritual worldviews.

Responding to cues

“The skill is to be attuned to what a person’s spiritual needs might be. Recognising cues and clues, the signs that spirituality/religion is an issue. It’s about being attentive and having a ‘spiritual radar’.” Hospital Chaplain

Patients and families often tell us about their beliefs and practices without being asked. Some cues are implicit, such as statements which suggest that a person’s worldview is significant to their health situation, eg:

- I keep wondering why this is happening to me
- What has she done to deserve this?
- Perhaps it was meant to be
- He knows his time has come

Other cues are more explicit, especially overtly religious signs such as crossing oneself; holding rosary beads; praying; wearing faith-specific insignia or dress such as the Muslim hijab, Seikh turban, Christian crucifix, the Hindu tilaka (forehead dot) or Jewish kippah; and making statements which suggest a religious connection, eg:

- I pray that I won’t have to make that decision
- My friends from church will take me home
- It’s in the hands of God
Such cues give us an easy opening to ask further questions so that we can understand the person’s spiritual worldview and give them the opportunity to express their feelings and tell us of any way in which we can support them.

Depending on the context, in cases where no cues are proffered we still have a responsibility to ask strategic questions in order to invite patients to explore this issue with the professionals who will be treating and caring for them.

**Asking Questions**

“Don’t be afraid to ask. Don’t assume you understand what people mean by the words they use, unless you have already discussed it. Eg. people may use words like meditation, God, prayer or fate in a way that might differ greatly from how you use them. This is not an invitation to ‘probe’ because any exploration should be gentle and voluntary, but it’s OK to ask them to tell you more.”

POWH Doctor

The questions provided in this resource are not a checklist, they are examples which may or may not be appropriate to particular patients in particular contexts. Use your professional judgement and communication skills to develop suitable questions for your treatment context, and to select one or two which gently facilitate discussion and avoid a feeling of ‘interrogation’. Questions should be used sensitively and supportively, and prefaced with a rationale which puts them in context, eg. *It can help us to provide better treatment and care if we understand your point of view, or Religion or spirituality is important for many people when they are in hospital, so I would like to ask you a question about it if I may.*

**Indirect questions**

There are many questions which invite patients to express significant beliefs which may be philosophically, culturally and/or spiritually based. The examples below are cross-culturally sensitive and do not assume a spiritual dimension so they can be used in any conversation, particularly in cases of serious illness where some of the questions could be considered as part of an holistic assessment and treatment plan.

The core ‘open’ question used by many staff to gently explore a patient’s coping and meaning-making context is:

- **Where do you get your strength from?**
  or
- **Who or what supports you in life?**

Other questions are:

- **What do you think might have caused your illness?**
- **How would you describe what is happening to you?**
- **Why do you think it started when it did?**
- **What kind of treatment do you think you should receive?**
- **What are the most important results you hope to achieve from his treatment?**
- **What are the main problems your illness has caused for you and your family?**
- **What are your main worries about your illness?**

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Direct questions
Direct questions may be used in any context, but become particularly pertinent when the clinician considers that spirituality or religious belief is likely to play a significant role in their patient's health.

- Are you a religious or spiritual person?*
- Is faith/religion/spirituality important to you?
- Do you have any religious or spiritual beliefs that you would like staff caring for you to be aware of?
- Spiritual or religious belief sustains many people in times of distress. What is important for us to know about your spiritual needs or faith?
- How can we support your beliefs and practices?
- Do you have anyone to talk to about religious/spiritual matters?
- Would you like to talk with someone about religious/spiritual matters?*
- How can we best support you?

These questions facilitate improved understanding by staff and thereby enable more accurate assessment, better treatment planning and more responsive service provision; all of which are crucial to positive outcomes.

Responding to Needs

“Nurses, doctors, allied health and ward clerks are there to support. Spirituality is part of that. It isn’t medical treatment, but it is something that nourishes and helps to heal a person’s spirit”

POWH Nurse

Having engaged with and listened to patients in order to understand their spiritual worldview and associated needs, the task for staff is to:

- acknowledge their beliefs and consider how they relate to their health
- take account of beliefs and practices in treatment planning and care
- support rituals and other valued practices
- coordinate a team response to needs, eg. ensure they are documented and that colleagues understand them
- work with chaplains or representatives from the patient’s faith community where appropriate

POWH Case Study: Rebecca

At her request, Rebecca had her family, friends and priests in the room praying with her. There was incense burning, rose petals and rosary beads. Rebecca had a very strong connection to her Maronite faith; this was a spiritual connection, but also important culturally. Rebecca has always been comfortable with an Australian way of life, but she seemed to identify more with her Lebanese heritage as she realised she was seriously ill. Staff consulted with her about how they could support her faith and practices, and how they could most appropriately continue to administer care while prayer and rituals were in progress.

* Note: the reply “not really” may be a way of telling you that there is an aspect of religiosity/spirituality that might usefully be explored. Mirroring back “not really?” is a non-invasive starting point.

* Responding to needs will often include asking patients and/or their families if they would like to talk with a hospital chaplain or social worker, or if they would like a religious/spiritual representative from their community to visit them (chaplains can arrange this).
Using resources and making referrals

“There are many misconceptions about chaplains: that we prey on the sick to convert them, or that we’re only there for death/dying. In fact, we negotiate with patients and families about what they want, we have connections across all aspects of their lives, we adapt rituals and traditions to meet people’s needs, we facilitate connections with family and friends, and we listen and support. We not only accompany people on spiritual journeys but across their life journeys due to our long associations with people from hospital, back to their home, and often through other major life events.”

Hospital Chaplain

Chaplains are a valuable resource for POWH staff. Indeed, as Post et al note, “Referrals to chaplains can be critical to good health care for many patients, and can be as appropriate as referrals to other specialists.”

Chaplains can be used by health professionals to:
- provide a caring, listening ear for patients, their families and carers
- offer support across whole-of-life, not just end-of-life
- facilitate rituals and services
- participate in team meetings and case conferences
- arrange visits from religious representatives from the patient’s faith community
- support staff and provide religious/spiritual services for them
- provide consultation on a breadth of spiritual/religio-cultural beliefs and practices

When staff introduce the idea of using the Chaplaincy service it may be useful to provide some reassurance about the pastoral care model used by SESIAHS chaplains. This model emphasises an holistic, non-judgemental, non-directive and supportive approach that is open to the diversity of lifestyles, practices and beliefs. This is important because POWH research found that some patients were interested in speaking with a chaplain but had concerns such as being preached to, being judged due to their sexuality or lifestyle, being regarded as undeserving because they had ‘lapsed’, or the worry that chaplains would administer according to doctrine rather than exploring on the patient’s own terms. Others believed chaplains only tend to patients when they are dying. Therefore, it is good practice to let patients and family members know that chaplains are available for a range of services, including their main work which is simply to be with patients, listen to them and provide support.

POWH Case Study: Shen

After Shen’s death his family wanted to know what would happen to his body. How would staff care for him after they left? Where would he be taken? Would his body go stiff or smell? Would he look the same? Would the hospital make them take his body before the funeral was arranged? Shen’s wife, Amy, explained, “We don’t know what’s meant to happen”. Like many people, Amy had never arranged a funeral before, let alone her husband’s. Furthermore, having grown up in Australia without a particular connection to the Chinese community, she didn’t know what a Chinese funeral entailed; however, she was clear that the funeral should be respectful of Chinese traditions. The social worker listened and offered reassurance and discussed options with her. They supported Amy to find a Chinese funeral director who could offer advice about cultural traditions as well as make practical arrangements. Having met with the funeral director Amy passed information on to staff so they could treat Shen’s body appropriately before it left hospital.
What skills do health professionals need?

Incorporating spirituality into health care requires the same skills that competent practitioners already use in their delivery of person-centred care:

- Basic communication skills that allow you to engage with people and establish an accepting, empathic relationship
- The ability to ask appropriate, encouraging, open-ended questions
- Good listening skills and attention to non-verbal communication
- A appreciation for the importance that people’s beliefs and practices play in their lives and the impact they may have on their health, their quality of life, their decision-making and their coping abilities
- Some familiarity with culturally related values, beliefs, and practices that are common among our patient populations
- Comfort in talking about worldview issues with patients and their families
- A willingness to seek information from appropriate professionals and coordinate any spiritual/religious support
- A commitment to teamwork which includes colleagues from a range of disciplines (including chaplains) as part of the care team

These skills are underpinned by the principle of respect. In practice, this does not mean we always have to feel respect for all patients and their beliefs and practices, but that we should always act respectfully towards them.

Professional roles and boundaries

Hospital staff, other than chaplains, should not feel a need to answer spiritual/religious questions, nor to resolve a patient’s spiritual/philosophical crises or concern. Our task is to enquire, acknowledge, take account of and support where possible. We are not here to:

- proselytise or direct spiritual/religious discussion down a particular theological path
- suggest to patients or families that their beliefs are incorrect or misinformed
- assert our own beliefs in a way that contradicts or causes discomfort to others
- infringe privacy by asking interrogative questions

Good practice means that staff should clearly document patient needs, response to needs and outcomes; and should work collaboratively with the multidisciplinary team (and link with other agencies when required) to ensure needs are met. If in doubt, consult with the Chaplaincy Service.

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9 While this information can be useful, it is important to remember that it is a general overview of religious/cultural traditions which may or may not be relevant to the individual patient. You can use it as a starting point, but it is essential to ask the patient what their personal wishes are rather than make assumptions, eg. “I believe that at this time (certain practices) often occur, is this the case for you?”

This practice is responsive and consistent with what staff report they feel most comfortable doing – letting patients lead the way in any spiritual/religious discussion, and offering support where they can.

Beliefs and practices which may be detrimental to patients’ health

POWH Case Study:
A Jehovah’s Witness patient was admitted to POWH for surgery. He was anxious about how his blood product requirements would be managed, and how staff would view his religious beliefs. He was pleasantly surprised to find that staff consulted with him as a real partner in his care. They asked him questions to clarify his wishes and ensured they understood exactly what was permitted, and they advised him of their plans and gave him time to ask further questions. He felt that his hospitalisation had been a positive experience not only for himself, but also for staff who learnt from him.

Most of the time patients’ beliefs are congruent with medical intervention, particularly when staff have engaged the patient in collaborative discussion which takes account of their wishes and beliefs. However, sometimes patients and their families hold beliefs or employ cultural or religious practices which clinicians judge to be obstructive or damaging. For example, patients may refuse certain treatments or resist making decisions because they believe outcomes will be determined by a higher power. Similarly, families may refuse to accept a patient will die because they anticipate a divine intervention, or they may reject clinician guidance due to perceived incompatibility with religious or cultural practices.

The valued beliefs of patients and families should not be refuted; this will only widen the chasm between clinician and patient, leading to greater tensions and increased likelihood of entrenched, polarised positions. The goal is to engage in exploratory conversation which elicits better understanding of the beliefs, and encourages expression of the ambiguity and dilemmas that many people experience when trying to reconcile their beliefs with the demands of secular contexts. In these cases clinicians may find it helpful to move away from absolute or factual statements such as She has a 50/50% chance of recovery, or He will suffer without X…, or The recommended course of treatment is… Instead, use phrases which patients and families can relate to from their position such as I hope…, I’m worried about…, We don’t know if…, We think it’s likely that…, Perhaps we could consider…

Try to explore the belief and its relationship to the situation, How will you know when God would like us to intervene? or You talked before about ‘unnecessary suffering’, do you think we may be approaching that point? Questions like these recognise the expertise of patients and families to determine what is right for them within their belief system; and they help the parties to explore options collaboratively.

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1 Note that patient autonomy can be compromised in these cases when relatives are asked to interpret for non-English speaking patients and may change or omit information according to their beliefs. Always use professional health care interpreters when possible.
Barriers to integrating spirituality into health care

The literature, and research at POWH, addresses the obstacles that staff experience in incorporating spirituality into health care. These are some of the most prevalent:

“Spirituality and religion isn’t relevant to my work with patients and families”

Research at POWH shows that over 80% of patients and families believe that spirituality/religion has an impact on health, and that it is useful for health professionals to know about their patients’ beliefs (74%). Broader Australian and International literature supports these findings.34

“Spirituality and religion is personal, I’d feel I was intruding if I asked about it”

The overwhelming majority of patients tell us they are willing for staff to ask them about their beliefs and practices.43 Furthermore, we routinely make other sensitive enquiries, eg. about sexual functioning and practices, drug and alcohol use, bowel movements and psychological health. Some patients would prefer not to answer such questions, but we ask them because it is important. It follows that if we feel patients’ beliefs and practices are important, we will ask about them too. In the event that a patient says they are unwilling to disclose the information, we simply accept their wishes respectfully and move on.

“It’s not my role to ask questions or respond to cues about religion/spirituality”

Spiritual/religious/philosophical beliefs and practices are an integral part of what it is to be human. These beliefs and practices influence our patients’ understanding of their condition, their acceptance, decision-making, commitment to treatment regimens, coping strategies and their selection of complementary health practices. If you have more than a passing role in admitting, treating or caring for patients, or communicating with family members, and you believe in patient-centred care, it is definitely your role to take account of this dimension. eg 9, 10, 12, 16, 22, 43

“I don’t have enough knowledge to talk with someone about their beliefs”

You don’t need any knowledge, just an ability to engage with people and show a respectful interest in their experience and point of view. You are not facilitating a religious debate, you are simply acknowledging an issue that may be important to them and their health. It may be helpful to think about your response as ‘interested’ rather than ‘knowing’. In fact, asking naïve questions can sometimes be the best way of supporting someone to explore an issue and talk freely.

“I don’t know what words to use; do I say ‘religion’ or ‘spirituality’?”

Australian research suggests that the term spirituality has more resonance with the majority of our community (a) because it embraces people who are unaffiliated with or alienated from organised religion,34 and (b) because it “is vague enough to allow patients themselves to define the playing field”.15 However, there are many people, particularly those who are older or from non-English speaking backgrounds, who will not understand this term and need to hear the word ‘religion’ (see the quote on page 7 for an example of this). Therefore, it is safest to
use both terms, eg. Is religion or spirituality important to you? Do you have any religious or spiritual needs that we should be aware of while you are in hospital?

“What if I don’t share their beliefs, or interpret things differently to them?”
You don’t have to agree with someone’s spiritual beliefs anymore than you have to agree with their political views or taste in music. Simply show an interest in their perspective. If you are asked about your views it is up to you whether you share them or not. It is OK to say that you’d rather not disclose them, or to say that you have a different way of seeing things - as long as you return the focus of the conversation to the patient and don’t dwell on your perspective.

“I’m uncomfortable talking about religion/spirituality in case I impose my beliefs on patients”
It is important for all staff to appreciate that our role is to listen, not to preach; but you can ask someone about their views and show an interest without imposing yours. Even if you are asked about your beliefs you can give general or vague answers, or simply state that you hold different views. By maintaining a respectful focus on the patient’s perspective you will avoid imposing your views.

“I’m worried that if a patient and I talk about religion/spirituality we might get into some really deep or sticky issues”
Patients and their families are often already dealing with deep and sticky issues such as pain, fear, anger, confusion, loss and death. Spirituality/religion may offer meaning and comfort, or may be part of the issue they are struggling with. It is not your job to resolve spiritual/religious questions, but you can help by listening, or gently asking if they would like to explore the question further with a hospital chaplain or social worker, or someone from their religious/spiritual community.

“What if they try to convert me?”
Some patients may wish to talk about their beliefs in the hope that you will come to share them. If so, try to gently return the focus of the conversation to the patient - what do they value about their beliefs? If necessary you can let the patient know you see things differently, or thank them for their thoughts but remind them that work is not the place for you to be exploring your personal beliefs.

“How can I differentiate between cultural and religious/spiritual needs?”
You don’t have to. We are not trying to label patients or tick off items on a checklist; we are trying to engage with each person as an individual so we can respond to their unique perspective and needs. All we need to know is what is important to the patient, and how they would like us to support them.

“I haven’t got time to address this issue”
It is hard to make time for all the tasks we need to complete, but the way you prioritise your time depends on what you regard as important. Patients and their families tell us that spirituality/religion is important to them and they want it to be included as part of their health care. Since patient-centred practice demands that we try to be as inclusive of patients’ wishes as possible, it is part of our job to consider their spiritual worldview when appropriate.26, 44
Resources and further Information

General information on major religions and their customary practices
www.abc.net.au/religion

Hospital chaplains
Any member of staff, patient or family member may contact the chaplains at any time, day or night, via the POWH switchboard: 938 2222

Spirituality/religion at End-of-Life
www.pallcare.asn.au/mc/mccontents.html
Leaflets about palliative care and what to do when a relative dies in hospital are available in multiple community languages from www.mhcs.health.nsw.gov.au/mhcs/topics/Death_and_Dying.html

Jehovah’s Witnesses: medical and legal advice relating to blood transfusion

Organ Donation
www.healthinsite.gov.au/topics/organ_donation
www.australiansdonate.org.au
www.organdonor.com.au
Spirituality and Religion at Prince of Wales Hospital
An action summary

The majority of patients at POWH:

- Have some religious affiliation or spiritual connection (74.1%)
- Feel that spirituality/religion becomes more important when a person is ill (81.6%)
- Believe that rituals can help people when they are ill or suffering (81.1%)
- Say it is helpful for health professionals to know about a patient’s beliefs (73.7%)
- Agree it is all right for health professionals to ask them about their beliefs (72.8%)

Staff at POWH:

- Respect the significance of people’s beliefs and practices and want to support them
- Believe staff should not impose their own beliefs
- Are uncertain about how to integrate spiritual/religious issues into their practice

What health staff need to know

- Any beliefs or practices which affect decision-making, coping, commitment to treatment, use of complementary health practices and general wellbeing
- The patients’ wishes about the way their beliefs and practices are acknowledged and supported while they are in hospital.

Incorporating spirituality/religion into health practice

- Engage with and listen to patients (and their families)
- Acknowledge their beliefs and consider how they relate to their health
- Take account of beliefs and practices in treatment planning and care
- Support rituals, customs and other valued practices
- Ensure needs are documented and that colleagues understand them
- Refer to and work with chaplains or representatives from the patient’s community (chaplains can arrange this). Contact chaplains day or night via the switch x 22222.

How to engage with patients in relation to spirituality/religion

- Be attentive to clues about spiritual/religious beliefs and practices. Clues may be comments, actions, possessions or clothing with a spiritual/religious significance.
- As part of patient engagement you can ask: *Where do you get your strength from?* or *Who or what supports you in life?* These are non-intrusive ‘open’ questions.
- Gently ask patients specific questions:
  - *Do you have any spiritual or religious beliefs that we should know about in order to care for you properly?*
  - *Is faith/religion/spirituality important to you?*
  - *How can we support your beliefs and practices?*
  - *Would you like to talk with someone about religious/spiritual matters?*
References