

Chapter 7

Doctor's Beliefs

GENERAL PRACTITIONERS' VIEWS ABOUT SPIRITUALITY

A qualitative study of General Practitioners' views By Naomi Beer

There exists, for many in our society, an area of patient care that is not adequately addressed by the bio-physiological model which is dominant in the practice of medicine in the west. There also exists a growing body of literature on 'spirituality' and its interface with medical practice. It is obvious from the literature that there is no universally employed definition for the concept of spirituality. Nevertheless its use as a term reflects the need for patients and physicians to have some language to represent an area of health care with which they are familiar, even if no agreed universal terminology exists.

I have been a general practitioner (GP) for 16 years. Early on in my dealings with patients I became increasingly aware of the importance of this 'other' dimension of family practice. It is implicit in good practice as taught to GPs in training but not defined. It best found its expression in the value placed on the doctor-patient relationship and in continuity of care. This research was an attempt to examine the views and attitudes of other GPs around this dimension and the language and concepts they use to describe it. GPs are in an almost unique position to address the whole field of human experience of illness and health in their encounter with patients but so far there has been limited detailed exploration of this interaction with an emphasis on 'spirituality'. This study sought to explore this dimension in practice and begin to develop a framework for further understanding, research and education.

BACKGROUND LITERATURE REVIEW

Many conceptual models have been proposed to help our understanding of the role of physicians in the care of patients. One of the most formative is the biomedical model which still drives much of medical education, research and practice and which reduces medicine to a process of identifying and treating disease in a body which is seen as essentially mechanical. Increasingly the limitations of this model have been highlighted both from within the profession (34), particularly in the field of palliative care (1,2), and from outside it by social scientists, anthropologists and other commentators (3) who recognise the important distinction between illness as a human experience and disease as a biological process (4). The bio-psychosocial model has been appropriated by family medicine (5) in an attempt to encompass those aspects of care which have been recognised and well documented, particularly with regard to the doctor-patient relationship and the consultation (6,7). However even this model has been criticised as inadequate in addressing the whole field of human experience of illness, and the roles of culture (8) and spirituality (9,10) have been emphasised as neglected but essential factors.

The term 'spirituality' has gained increasing recognition in the popular domain and in the medical literature. In 1997 The NHS Executive made it a requirement of NHS Trusts to address patients' spiritual needs (11). This, perhaps, mirrored a 1977 World Health Assembly Resolution which invited member states to consider including a 'spiritual dimension' in their health-for-all strategies;

a dimension which ‘belongs to the realm of ennobling ideas, beliefs, values and ethics that have arisen in the minds and conscience of human beings’. However, despite many reviews, editorials, quantitative research papers on aspects of spirituality and theoretically based attempts to define the term there is no universally accepted definition for the concept.

The aim of this study was to mutually construct knowledge about a less well researched but important aspect of general medical practice which is increasingly coming onto the public’s agenda. Without a better understanding of this dimension, it will remain difficult to teach on it, develop skills around it, research it and evaluate its benefits in health care.

METHOD

The value of qualitative research in family practice has been well described- For the purposes of this study, a qualitative research method was deemed the most appropriate as the aim of the study is to understand the processes and meanings inherent in a particular, ill-defined and subjective area of practice. In 1997 I undertook a piece of qualitative research, interviewing twenty two East London GPs using a detailed and developing interview schedule. The GPs were selected using local knowledge and according to a sampling frame in order to represent males and females of all main faith/ non-faith groups (Table 1). The interviews were recorded, transcribed and analysed thematically in stages according to the principles of grounded theory. As themes emerged through analysis, these were tested in further interviews so the development of the themes was a process of constant revision over time. (The detail of this method is not given here)

Table showing faith background of the doctors in the sample

All of the doctors were local GPs over 40 yrs of age. They are not a quantitative representative sample, but rather a qualitative one

Beliefs	Male	Female
Christian	5	2
Jewish	1	1
Moslem	2	2
Atheist/Agnostic	4	3
Other faiths	2	0
Totals	14	8

RESULTS

Three main areas emerged out of the data.

- 1 The first area was the development of a typology of GPs in relation to their approach to the ‘spiritual’ or ‘other’ dimension of care.
- 2 The second area included the concepts and language used by the GPs to describe and illustrate this ‘other’ dimension, this feature of general practice which most, but not all of the doctors interviewed felt could not be adequately incorporated into the usual bio-psychosocial model.
- 3 The third area is an examination of the apprenticeship of GPs. In exploring the nature of the spiritual dimension it was frequently linked to the development of the expertise or ‘art’ of a

general practitioner. This was particularly so when discussing the doctor-patient relationship.

Only the first theme will be discussed here.

TYPOLGY OF GPs

In conducting the research, it became evident, not surprisingly, that different GP's had different approaches to the question of spirituality. This variety of views reflects the lack of uniformity of definition in the literature which has caused difficulties for researchers (18) For example in my research, spirituality was described in terms of religious practice, relationships or encounters with people or with God, inner spiritual or soul journeys, emotions, moral values and the value of the individual.

Despite these variations, the analysis of the data did reveal a varied but identifiable grouping of approaches to the spiritual dimension among GPs. (Examples of how the data support these groupings are given below). It is important to emphasise that the purpose of the research was not primarily to define in detail the spirituality of each individual doctor interviewed. Rather, the categories now described emerged from analysis of comments made by the doctors in response to questions about the existence or definition of a dimension to practice which might lie outside the current model. The groupings are therefore summaries of different approaches to the idea of a 'spiritual' dimension. There was also overlap between the groupings as might be expected. From this analysis I have developed a broad typology of GPs which may help others to understand their own approaches to the question of spirituality as part of a spectrum. The groupings made sense when based upon 2 significant variables. Both variables could be considered as existing along a continuum and so they have been represented below as 2 axes.

The "Transcendent axis" describes the extent to which the individual acknowledges or recognises something outside the material world. At one extreme it might extend to include the acknowledgement of a spiritual life and existence which is as real as the material. At the other extreme it might represent the view that life has no meaning beyond itself and that humanity is the result of an accidental collation of circumstances in the physical world.

A doctor's approach could be described as 'transcendent' if they framed their responses and explanations in terms of either self transcendence (openness to powers or forces outside of self) and/or communion with a deity. In contrast, a doctor who had purely behaviour-based, physiological or psychological explanations for the 'spiritual' dimension might be described as 'Non-transcendent'. It does not mean that a non-transcendent person is unable to appreciate something aesthetically, to make relationships or to love. It means that they define this capacity in purely emotional or psychological terms.

The "Theistic axis" describes the extent to which the person acknowledges the existence of an individual being which they call 'God'. The continuum represents the extent to which their belief in 'God' impacts their existence and world view, (a necessarily subjective judgement).

There were 4 main groupings or types of approaches to the spiritual dimension in practice. The first group had a further subdivision into 2 groups.

1 Theistic Transcendent group: (Faith groups) this group would include all the major faith groups which worship a deity- Christians, Jews, Muslims and Hindus.

1a Observance-based theistic transcendent group (Orthodox)

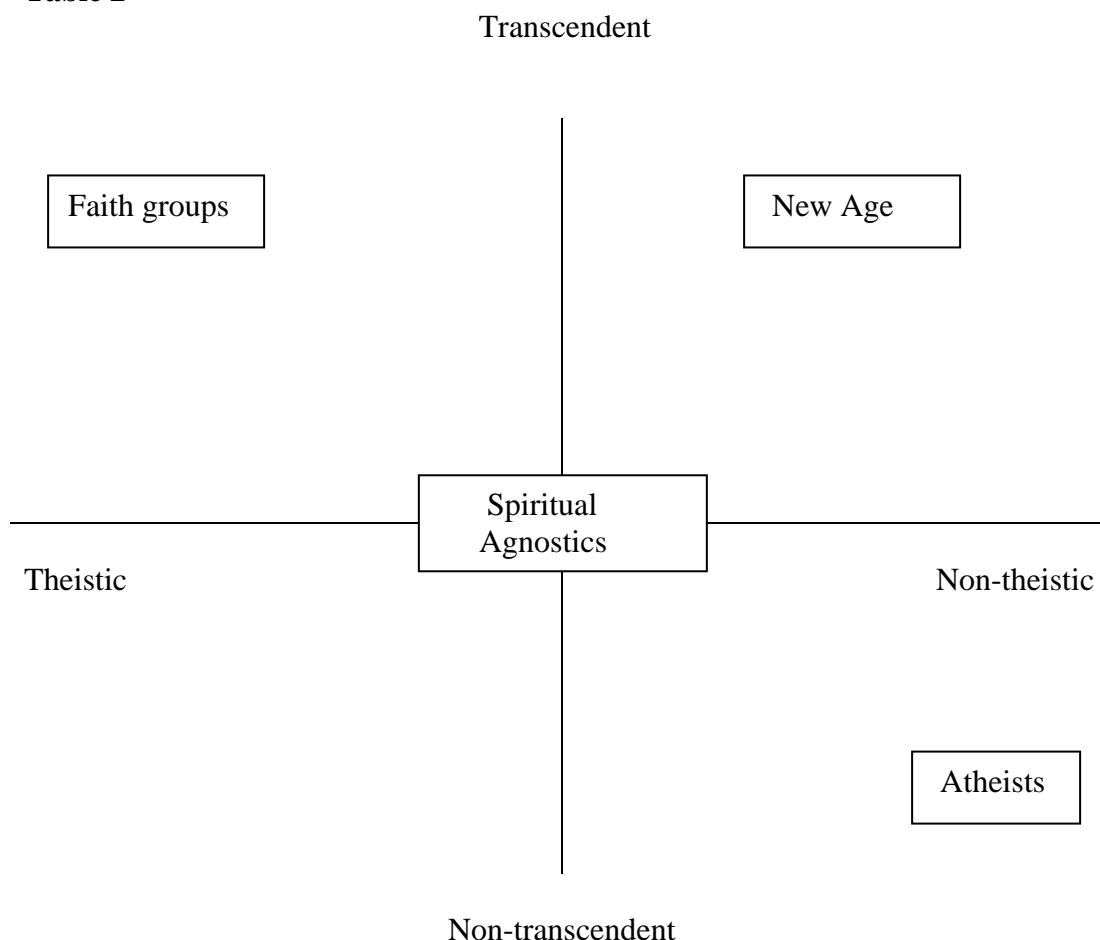
I have further divided group 1 according to religious practice because it became clear that in the experience of some General practitioners, religious observation and practice dominated everything about their lives and their patient's lives. Everything was defined and expressed primarily by religious law (rather than personal encounter), including their relationship to the deity. This was particularly the case for Orthodox Jews and Muslims and had significant implications for their health care. I felt that this created such a particular difference in approach that it warranted a grouping of its own (although of course there may still be overlap with other groups).

2. Non Theistic Transcendent: (New Age) including for example Buddhists and those with a New Age world view.

3. Non Theistic non Transcendent: (Atheists) including atheists and humanists

4. Spiritual Agnostics: needed a category of their own because they have not rejected either the transcendent nor the possibility of a God and are open-minded as to the effect of these on themselves and their patients. Analysis of the data suggested the need for a group which seemed to be bridging 2 camps and was important to distinguish from the other categories because it seemed to be in 'transition' or tension.

Table 2



The representation above shows a general placement of the groups described. It is to be understood that the borders of these groupings will inevitably overlap with others as individuals vary so widely in their beliefs and practice.

Features of these groupings and how they relate to the data:-

Non-theistic non-transcendent (atheists)

These doctors on the whole equated 'spiritual' with religious practice and framed other dimensions to the consultation in psychological or psycho-dynamic terms. Anything currently falling outside human knowledge may eventually be explained. The relationship between mind and body is acknowledged as is the influence of one person upon the other, but these are not considered to be of another order, merely an unpacked psychological or psycho-dynamic phenomena. There was some resistance to the use of the word 'spiritual' as it was deemed unnecessary in this framework.

Words such as 'pastoral', 'emotional' or 'unexplained' were used to convey their interpretation of what they thought others might refer to as 'spiritual'.

..People who are religious are linking that (spiritual) to their sorrow and expressing it in that way.. I mean it's not how I would express it. I think when people are talking about someone who's died and talking about 'God's taken them' I don't think that's an intellectual exercise, I think its emotional. In that kind of conversation you're relating to someone on quite an emotional level anyway and they're talking about their feelings'

..I don't have an alternative religious belief, I just feel a great deal of the world is.. because it's infinitely large, it's infinitely incomprehensible as well, and that's not a spiritual statement in the way I would see the word spiritual it is a factual existential, whatever, expression of failure to understand'.

When exploring more value-based ideas that might constitute the 'other' dimension, such as the quality of a relationship or encounter, doctors in this group gave responses that were framed more psycho-dynamically. So words such as 'friendship', 'rapport', 'people who speak your language', 'empathy' and 'emotional' were used to describe something about the quality of a particular doctor-patient encounter or relationship as well as just 'being there' for the patient.

Non-theistic transcendent ('New Age')

Only two doctors fell into this category of my research subjects. It includes those who expressed ideas of self-transcendence, involving some sense of spiritual quest or striving and even specific practices whilst at the same time acknowledging forces outside themselves which take no identifiable personal form. Their views are perhaps more post-modern, taking account of experiential factors rather than the modernist foundation of scientific rationalism which underpins the previous group.

*..forces outside of individual human rationalism... not limited to a particular belief system..
..sources of meaning that are outside of individual striving and straining to kind of make sense of the world.. for me it (spiritual) doesn't work well as a noun but it works well as an adjective- 'spiritual forces' or 'spiritual endeavours' or 'spiritual conflict'
..you are believing that there is a power beyond our human. There is looking after us or helping us..*

In essence, the defining quality of the 'spiritual' dimension in this category is expressed in the human to human encounter of the doctor and patient. It is to do with sharing something essential to our being and is most closely identified with the word 'spirit'.

This viewpoint is shared with the faith groups (theistic transcendent) and is also what makes the spiritual agnostics group different from the atheists (non-theistic non-transcendent group).

..You know you could go so far as to say that in every deep human relationship is a spiritual relationship as well because what is it that we're showing when we meet another human being? We're showing our background, our education, our likes and dislikes and we're also showing something else that is quite essential... Rudolf Steiner talks about the higher ego which is something only human beings have and it's where we meet, it's the ground on which we meet as human beings, and you know he would say that's spiritual, what else is it? Talk to a materialist and they would say, 'what do you mean that's just human?'

The difficulties of defining the uniquely spiritual elements of an encounter were acknowledged.

..Good psychological medicine and, you know, medicine influenced by spiritual concerns, I would defy anyone to draw a clear line between them..

The concept of value was considered to be a spiritual concept. This was taken up more expansively in the theistic transcendent group as being a core characteristic of the 'spiritual' dimension. (The concept might be re-framed or integrated in some other way in the non-transcendent groups.)

.. I think that when you take a personal interest, what you are doing is.. giving a bit of value to them (the patient) because again it's spiritual..

Spiritual Agnostics

This group works with a basic psychological/ psycho-dynamic model. However they were also were prepared to acknowledge the existence of an 'other' dimension which might lie outside a physical or psychological/psycho-dynamic explanation. One doctor referred to it as a term of exclusion, encompassing those things that other definitions and models don't cover.

..It's a very convenient cover word. It's everything to all people so I kind of, I suppose I view it as an exclusion term. It is to describe those things which can't be described by other terms. I would say it is the irritable bowel syndrome of psychological aspects of people's health.

The defining difference between this group and the previous group is its approach to the human encounter. Doctors struggled to find the language to express the difference in quality in the encounter but used words such as 'bonding', 'trust', something 'special' and 'feeling of humanity' and 'electricity'. Particular sorts of encounter might emphasise for them the existence of this 'other' dimension of experience, such as what is felt at the birth of a child.

There was acknowledgement that practicing medicine was not just about treating disease

..And I see it as a very important part of general practice, it's not just treating people's physical ailments and getting them better from that.. it's the whole cabouche of psychotherapy and getting involved in their lives to an extent that you need to in order to sort the person out rather than just their ailment.

One doctor recognised something in patients that was described as a ‘hunger’ for something in their life which was then linked to the ‘spiritual’ dimension. This parallels the language of doctors in the theistic transcendent group who identify the ‘hunger’ as that for the deity.

..I think I've seen patients who are you know very materialistic and who do not have much you know sort of religious but in terms of illness I do sometimes feel they look for something, there is also some sort of hunger for that sort of dimension.. they do show that sort of hunger of that part of their being which is absent in their life..

Doctors expressed an awareness of the contribution of their own state of mind and approach to the use or expression of the ‘spiritual’ dimension in the consultation.

..it's kind of difficult to express but I think one can facilitate that unknown dimension. I think you can make it easier to achieve but it does depend on how you are and what's in the background.

Theistic-transcendent (faith groups)

This group of doctors was the most represented in the research subjects. There is an acknowledgement of transcendence both in relationships with others and with the deity and included within this is a concept of ‘value’. It most closely resembles the non-theistic transcendent group but it is the relationship with the deity that gives definition to the value of the person and those with whom they have a relationship. This concept and its meaning in the doctor-patient relationship was not, however, unique to this group.

*..you can define it as that part of humanity which relates to God.. but also to other people in a non-sort of superficial way and probably also relates to the created world..
..well I suppose for myself as a Christian it would really be an awareness that there is more to life than just the purely physical , the ‘flesh’, and that that awareness to me is an awareness of God and that because of that, each person, because each person's made by God, is loved by him, then there is that spiritual quality in all of us but many don't recognise it and don't have any, well, they don't have any awareness of it..*

The ‘special’ quality that may be identified in the human encounter is not unique to this group but it was given particular emphasis. It is hinted at in the use of words such as ‘value’, ‘hope’, ‘trust’, ‘love’, ‘commitment’ and ‘community’ which in this group were seen as being spiritual qualities. They are also qualities intrinsic to good doctor-patient relationships (and all good human relationships).

..And in that sense I suppose that's a sort of.. spiritual encounter because it's about one human being saying to another, ‘look you are still valuable and still precious and you know there's rotten bits of you like there is with everybody but that is OK. So it counts as a spiritual encounter but it has obvious therapeutic value in psychological terms and maybe in physical terms as well..

Perhaps not surprisingly, the spiritual dimension was referred to in the context of seeking explanations or meanings for patients’ problems.

.. that part of us that you would say would communicate with the higher power, God, if you believe in God. Something that helps in the understanding of things that aren't explained by either mental or physical feelings or events.

Some doctors wanted to emphasise that the relationship between the terms 'religious' and 'spiritual' were not always straightforward or synonymous thus emphasizing the distinction between the subdivisions in the theistic group.

..We're really now talking about formal religious experience as opposed to spiritual experience.

..Definitely.. spiritual side has got importance in well-being, although I'm not a religious person.

One doctor explained that he thought it was possible to work spiritually with people without using spiritual language. He did not see it as psychological because it involved the qualities of the human encounter

.. It's a type of working with somebody that doesn't depend on me being an expert, doesn't depend on my particular skills, it depends on me being, allowing myself to be me, to be human and sharing that humanity with somebody else.. ..And that's why it's not about psychology, it's about human encounter and I guess that's where I get back to this rather woolly and not very satisfactory definition of spirituality being something about encounter.. ..so not just a person encountering God but person encountering person in a similar way to person encountering God,... but equally a person encountering the created world..

.. I feel very comfortable with the Balint model but I think that that is psychology.. it's psychology because it's one side the doctor is being the expert in analysing what's going on. It becomes spiritual when the doctor is prepared to forget or put to one side the doctor part of that and just be themselves..

Doctors in this group gave many examples of things they did in practice that might lie outside 'normal' therapeutic activity. The use of prayer was one area that is almost unique to this group. It was expressed as the logical outworking of the belief that a God exists who can make a difference to the lives of patients. Not every doctor in this group was necessarily comfortable in praying with patients. When doctors did pray with patients or advise prayer, it was reported as being offered tentatively.

..Actually when I'm praying I can often express much more of the caring that I'm feeling than I can when I'm talking to people because I feel sort of embarrassed and I suppose when I pray I sort of...express more of what you're feeling deep down for the patient. And I think probably the patient sort of suddenly feels, 'Wow! Do you really see it like that?'

..A patient came in very worried about her child because the child was having recurrent nightmares and I uhmed and aahed and I oohed and I talked round it and all the rest of it and I said, 'I wonder if I can tell you what I would do?' I said I'd do this very hesitantly, I said, 'you can ignore what I'm gonna say', and I was very sort of self-deprecating, I said, 'I know what I would do.. I've done it with my grandchildren. Slip in there and just pray over them when they're asleep, if that's the sort of thing you do.'

There were other examples of what doctors in this group did for their patients. For example, one doctor was asked to baptise his patient

*..One day I went round to see her (patient dying of cancer) because she was in a lot of pain and she couldn't swallow and she needed to go on a syringe driver and she was barely conscious and all her family were there. She said to me, "Doctor, I want to be baptised.." I said, "Right, I'll see what I can do." And she said, "No doctor, **you** baptise me!" But it was an odd experience. So she'd known that I do some lay preaching and she thought I could just sort of do it, so it was an odd experience. I broke open a bottle of sterile water.. and baptised her with that and we said some prayers together and so did her family..."*

Guilt is a well recognised feature of some patient's problems, particularly mental health problems. Doctors in this group gave examples of how they specifically addressed this in the light of their understanding of forgiveness.

..She has a tremendous problem with not being able to forgive herself and I think guilt, you know, is overriding everything and she has very physical symptoms which have been extensively investigated, but she now comes to understand that it's a lot connected with this fact that she can't forgive herself... I just prayed that she would receive forgiveness because she felt so bad and that she would have God's peace . And you know she seemed to be appreciative of that, so I mean I do see a lot of people who need to be forgiven.

Observance-based theistic transcendent- (orthodox)

This group is broadly part of the theistic transcendent group but does have a different approach to the 'other dimension'. Doctors with this approach broadly saw no need for an 'other dimension' because it is assumed as already being part of everything they do. In this group, 'everything they do' is described in terms of what is allowed by religious law and practice in the daily routines and rituals of life. The theme of religious practice dominates their approach.

..Well you see the problem is it doesn't mean an awful lot (the word 'spiritual') because if everything you do.. has some connection with spirituality ..then we don't divide the spiritual and the non-spiritual because everything that you do has, or should have some spiritual basis..

.. The rules and regulations are there, and that is how we live... that is not there for discussion.

This approach is not restricted to any single faith and is not uniform amongst those holding a particular faith- for example it might be illustrated by the difference between orthodox and non-orthodox groups in a particular religion. Concepts to do with human encounter were not developed as with the rest of the Theistic transcendent group.

Doctors in this group did not seem to have a framework or language with which to examine or explore the spiritual dimension to their relationship with patients who did not share their faith. In patients who did share their particular faith, spiritual interactions were described either in terms of specific religious observances and their relationship to health, or in finding common explanations for happenings.

..It's in a very practical sense- sort of going back to the notion of patients who have different religious beliefs which may govern certain things like their behaviour..

..And when we talk about these things it's really to give them strength to get through it because we are all accepting the same thing.. it's not a questioning role it's more a reinforcing role.

The 'spiritual' dimension might be included in 'the unknown' as with the previous group but it is linked with the deity and explanations rest with him.

..Well you make the patient aware that there is no yes or no answer to everything. There are certain things you can't explain so you are not all-knowing. God is all-knowing so why can't you take the help of God?'

When talking to the whole spectrum of GPs about the possibility of actually discussing 'spiritual' issues with patients, some of the greatest barriers in establishing a dialogue were predictably the fear of crossing professional boundaries, the fear of cross-cultural misunderstanding and the apparent discomfort on the part of some patients (as well as the doctor) due to their uncertainty regarding their own beliefs.

...For me to live with what people believe and feel strongly about is in itself not a problem- it may be a problem to know what they do believe and establish a common ground but it's not a problem. Once I discovered – which I discovered in practice and not from books- that Bengali people tended to believe in sort of magical aspect of mental health and epilepsy, then to deal with that actually made it a lot easier...

...It ceased to be a big problem with those people who were feeling very convinced in their beliefs because then we could share a cross-patch because I could actually know what they were feeling, what they wanted to do and what was going to happen next but it's more difficult around areas where people themselves are feeling uncertain and perhaps embarrassed about what they do believe in

It can be seen from the above that the beliefs about human encounter or the human relationship became a discriminating factor in the definition of the different groupings. All but the atheist group and the observance based theistic group seemed to acknowledge this encounter to be of a different order (requiring explanations which were more than behavioural or psycho-dynamic), the latter group because they see everything in a spiritual light and the former because they see nothing as spiritual.

Most people acknowledge that it is important and helpful for doctors to understand how their beliefs relate (or do not relate) to the beliefs of the patients they see. The model outlined here gives them a way of assessing where they (and their patients) are on this spectrum of belief. It may therefore help them with their explanations and discussions with patients.

Discussion

One of the main problems inherent to any research on the subject of spirituality is the problem of definition or meaning. In his introduction to a journal devoted to the spiritual and pastoral dimensions of inter-professional care Dr John Horder says, "Few English words have such a wide range of meanings as 'spirit', 'spiritual' and 'spirituality'. Moreover they seem to inspire a reluctance

in those who use them to make clear which meaning they have in mind." (18) The aim of this research was to explore the concept of spirituality and its meanings for general practitioners in the doctor-patient encounter. This came out of the researcher's own observation in practice in which the relationships with patients seemed to have a dimension to them that wasn't adequately expressed in the currently agreed 'physical, psychological and social' framework for patients' problems nor the more psycho-dynamic models of Balint or Neighbour which are the foundations of teaching with respect to the doctor-patient relationships in general practice. The researcher would call this other dimension a 'spiritual' one but was aware that other GPs would not be happy with that label or language and so wanted to explore whether other GPs had observed a similar dimension and whether they would express it in a different way to 'spiritual'. The research interviews and analyses were conducted entirely by the researcher with input into the analysis of initial interviews by the supervisor and a GP research group. All final analysis was conducted by the researcher and not cross-checked so there will inevitably be the possibility of a large element of researcher bias in the analysis. Never-the-less the process of grounded theory works upwards directly from the data and all data is the recorded views of doctors. Detailed records were kept by the researcher on all aspects of the process of analysis and the data was constantly referred to in the original context in order to ensure that it was being used appropriately and relevantly.

This exploration took no account of the views of patients. It is still possible that some of the findings can be generalised to the population of patients- perhaps the typology in particular- but a further study would need to be done to explore this. The other question is whether it can be generalised to the population of UK general practitioners. The research did take account of a broad spectrum of GPs, both male and female, religious and non-religious and of different faith backgrounds. From the analysis, particularly of the typology, it would appear that there was an over-representation of views of faith-based doctors as opposed to non-faith-based. This would tend to support the researchers' own bias of assuming the need to express an 'other' existential dimension. However, the acknowledgement of its existence was by no means confined to the faith-based group and it was possible to explore the concept in other groups by using language that was not overtly spiritual. This tended to be the language of relationship. The 'other' or 'spiritual' dimension for many doctors came to embrace the indefinable quality in a relationship between doctor and patient as well as the whole process of dealing with the unknown or unknowable or situations where there was uncertainty. What was apparent was that doctors' views on the unknown would affect the explanations they use with patients.

It is perhaps not surprising that some doctors saw a need for the expression of something 'other' and some doctors did not. Those who did not simply included the 'other' into their existing framework of beliefs. This research only touched on the question of *how* a doctor with a psychological/ psycho-dynamic framework explains the aspect of 'human encounter' or 'spirituality' as perceived by others. However, there already exist examples of models that integrate the psycho-dynamic framework with a concept of the 'spiritual' (19-22).

In the literature, despite the many meanings that can be given to the word 'spirit' or 'spiritual', views can to some extent be summarised. For example, as Horder says, one common feature is that these ideas all describe what is immaterial, non-corporeal and intangible in contrast to tangible, observable matter or body(18). In his comment on spirituality in medicine, Yawar says that human beings can be regarded as having two realms of existence (14). The outer realm consists of a human being's interaction with the world, requiring justice and magnanimity; the inner realm consists of his or her interaction with the transcendental, either in the form of a deity or through experiences

such as beauty awe and love, and requires sincerity. In examining a 'spiritual' dimension of medical practice therefore, we are dealing with the intangible and with the outer realm of a doctor's interaction with the world. So one would expect a doctor's view of and approach to the outer realm to be dependent upon their own inner realm. One would also expect, particularly in the realm of inter-personal or doctor-patient relationships, that doctors will practice differently and that their approach will vary not only with personality and experience but with their fundamental beliefs and interaction with the transcendent. My research would tend to confirm this despite its dependence on doctors' reported beliefs and practices rather than analysis of actual practice. These differences are hardly surprising to general practitioners who regard the doctor-patient relationship and dealing with uncertainty as just as important a part of the essential elements of practice as diagnosis and treatment guidelines. The development of a typology of GPs should facilitate further examination of differences in approach. It would be interesting to find out more about how patients perceive these differences in practice and which patients, if any, and under what circumstances, if any, might consider them to be important to the quality of care they receive.

Whether or not one supports the idea of a 'spiritual' dimension, the large rise in the literature of references to the spiritual and its importance in medical practice cannot be ignored. There are a number of helpful summaries; (Dyson (17) and Tanyi (15) on meanings of spirituality, Balducci/ Meyer(22) on the interaction of spirituality and medicine, Waldfogel (23) on spirituality in medicine, Narayanasamy(24) on its historical perspectives, Mcgrath(25) on spirituality in Hospice care, Karasu(26) on spirituality in psychotherapy, Post (27) on professional ethics and Greenstreet(28) on teaching spirituality in nursing. This suggests that it is something that should be taken more seriously in medical practice, although, as Yawar points out, his medline search on the subject in Feb. 2000 yielded at most less than 0.2% of the total number of medline articles. He goes on to say that 'given that spiritual considerations are absent from few consultations, this absence of overt recognition is remarkable' My research suggests that many doctors would like to and do give it emphasis, given the time and this echoes other research findings. (31)

Culliford argued that 'Spiritual values and skills are increasingly recognised as necessary aspects of clinical care, to be more openly discussed and taught'(34). However, despite the growing emphasis on spirituality in some medical undergraduate training in the USA (32,33), it has yet to establish itself as part of the curriculum for medical undergraduates or even post-graduates in the UK. There are significant potential problems involved if this dimension is to gain recognition in medical curricula. Firstly there is the problem of definition as outlined above but there is substantial common ground to work with. Secondly, there is an understandable fear among non-theists that any debate about spirituality may serve to give undue value to theistic religious views (35) and a fear among theists that they may risk accusations of unethical behaviour if they seek to discuss spiritual matters with a patient of a different world view to their own. The problems are beginning to be addressed however. One helpful approach is to distinguish between spirituality and religion (15,36) a view reinforced by this study. To protect both patients and clinicians in the process of assessment, some argue for the development of a philosophical value theory, a broad enquiry into value and meaning (35). Others remain profoundly sceptical of any encroachment of the clinician into the field of 'spiritual assessment' arguing that such analyses should be left to specially trained people such as chaplains. (37) Never the less, this research demonstrates that the two aspects of clinical and spiritual do often intertwine. Patients' search for meaning must intersect and even arise from crises in their lives with which GPs are often involved. Thirdly, another reason for the lack of emphasis in medical curricula could be the tension in the continuing debate around defining the qualities of a good General Practitioner and even a good doctor. As Toon describes (38) various

models appear to compete with one another; the bio-mechanical doctor, the Balint doctor and the anticipatory care doctor, all with different moral and philosophical standpoints. Toon argues that we need a more integrated philosophy (39). He refers to Kuhn's view of scientific progress and applies it to these conflicting models, suggesting that "a new model would need to deal with the main difficulties which the old ones failed to cope with and include within it the satisfactory elements of the previous models". It remains to be seen whether a 'spiritual' dimension can or should be satisfactorily incorporated into any of the existing models. The heavy emphasis on outcome measures to drive the remuneration of GPs has elevated biomedical aspects of care far above relationship. Spirituality is danger of being either rejected completely or being consigned once again to one of the many possible 'pick and mix' elements of general practice.

As was seen from the results, the approach of the GP to the 'spiritual' dimension was largely defined by their views on the nature of the human encounter. Doctors in all groups seemed to emphasise the importance of relationship qualities to the function of the GP. This is not surprising given the prominence and centrality given to it since Balint. However, whereas some would describe this in terms of friendship, rapport, empathy, bonding, and the 'special' quality of particular relationships, having an entirely psychological psycho-dynamic explanation for this, others considered these qualities to be spiritual ones and included concepts such as trust, hope and value. Even though there are differences here in interpretation, the emphasis is on the 'non-corporeal' and non-quantifiable aspects of practice and the doctor-patient relationship. The fundamental problem of this kind of examination is that whatever descriptions and words are used, they will always be open to subjective interpretation. What means one thing to one may mean something different to another but what I have begun to examine here is a basis for common ground and a way of looking at the approaches of different doctors. The question is whether medical training can and should include some acknowledgement of these factors and how they can affect doctors' practice.

As mentioned above, the theme of value came out frequently from the data. This was in terms of the value of the patient, and the value of the interaction between doctor and patient. The assessment of what is valuable in general practice and how we value it is a pertinent question to the current malaise and low morale in general practice. It is not the remit of the research to comment on political developments in health care but if what many doctors value significantly about what they do is the non-quantifiable aspects of their work, then a system which only rewards the measurable will leave whole aspects of the skills and benefits of general practice unrecognised.

This research provides a framework for an approach to the spiritual in primary care as it arises directly out of the views of general practitioners. Large numbers of articles relate 'spiritual' health to physical health and we should not ignore this. I would argue that doctors are currently poorly equipped to deal with patients' spiritual needs yet a patient's 'spiritual' needs are often integral with their clinical ones. Whether we define these as spiritual or embraced within the psychological, they exist for patients and be recognised and integrated differently by different doctors depending on their philosophical view. British General Practice in its post 1948 form was marvellously placed to do this, whether or not practitioners accepted that what they were doing was spiritual (40) However, we now stand at a point where this form of practice which embraces continuity and places a high value on relationship may be significantly undermined and we might therefore loose a dimension of practice which is of great value to our patients and of particular value to the chronically sick or underprivileged. I would suggest also, that in devaluing relationship we are at risk of undermining much of the satisfaction that GPs derive from their work.

The contribution of this research is in the exploration of meaning of 'spirituality' to doctors in the context of their practice. It also provides a typology for the ways in which doctors look at the concept of the 'spiritual' dimension in their role as carers.

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