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3 **GP and Spiritual Care, Signed up or Souled out?**
4 **A quantitative analysis of GPs how GP trainers understand and apply the concept of spirituality**

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6

7 **Abstract**
8

9 Background: GPs have a wide range of attitudes to spirituality which contribute to variations in the spiritual
10 care they report to practice.

11
12 Aim/Objective: To assess concepts of spirituality and their application in a sample of GPs trainers. To explore
13 statistically the relationship between personal spiritual affiliation, attitudes to, and reported practice of,
14 spiritual care. To examine whether GP trainers consider training in spiritual care to be adequate.

15
16 Methods: Questionnaire: 87 GP trainers at a GP trainer's workshop using Likert scale responses. Multinomial
17 trend tests to analyse the relationships between "concept of spirituality" and attitude to, or practice of, spiritual
18 care. Cluster and latent class analysis to investigate whether groups of GPs are categorically different from each
19 other.
20

21 Results: GPs considered spirituality to be a meaningful, useful but unclear concept. 7/87 stated they did not
22 wish involvement in spiritual care, 24 had reservations, 40 were pragmatically willing and 11 expressed
23 keenness. 31/87 report they tend not to discuss spiritual matters. Only 9/87 reported receiving adequate
24 training in spiritual care. Latent class analysis suggests two thirds are *pragmatic supporters* of spiritual care and
25 one third are *tentative sceptics*.
26

27 Conclusion: GPs vary widely in their attitude to and practice of spiritual care. Two distinct groups were
28 identified – *tentative sceptics* and *pragmatic supporters*. Training for spiritual care is perceived to be
29 inadequate.
30

31 Keywords: Primary Health Care, General Practice, Spirituality, Education (medical)
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33

34 **Background**
35

36 General Practitioners are advised of the importance of spiritual factors in the assessment and treatment of
37 patients (1–3) and taking these into account is now considered essential by the General Medical Council – UK
38 (4) and affirmed by international GP bodies. (5) Although small exploratory studies exist for referral to
39 chaplaincy services(6,7) little evidence exists to show how the concept of spirituality is incorporated into GP
40 consulting and whether GPs can effect patient outcomes by offering spiritual care.
41

42 The current medical paradigm and cultural context may provide a challenging environment for discussions of
43 spirituality and may receive mixed responses from patients. (8) Questions remain about the degree to which
44 doctors offer any standardised concept of spirituality or spiritual care. (9) Studies repeatedly show that although
45 GPs may feel they have a role in spiritual care (10) they can be uncomfortable with spiritual, religious and
46 existential concerns of patients and may both fear crossing boundaries and struggle to find a connecting
47 language. (11,12) GPs who do address spiritual needs, rely partly on personal attributes or religious

48 affiliation(13), applying intuitive and unsystematic approaches(14) rather than those based on professional
49 training or evidence.

50
51 Progress has been made towards consensus definitions for spirituality in health care, for example that
52 published by Puchalski: *"Spirituality is the aspect of humanity that refers to the way individuals seek and express*
53 *meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to*
54 *nature, and to the significant or sacred,"* (15) However, our previous qualitative work suggests that despite this
55 there are large variations in how this concept is understood and applied clinically, including in primary care.
56 (16,17) Little is known about GP training adequacy apart from one study which investigated and reported very
57 low levels of training in spiritual care among GPs in the UK. (18)

58
59 Prior to this study we conducted detailed interviews with 19 Scottish GPs, sampled to maximize diversity of
60 spiritual affiliation, using an approach informed by grounded theory. The aim of this was to create a deep
61 description of the concept of spirituality which GPs hold, their attitudes to spiritual care and patterns of its
62 provision. Thematic analysis of these interviews discovered seven related and overlapping concepts of
63 spirituality, four attitudes to spiritual care and four reported patterns of spiritual care. These are summarised
64 below.

65
66 Table 1 – summary of concepts, attitudes and reported practice of spiritual care from interview study

67
68
69 This provides, to our knowledge, the first typology of concepts of spirituality, attitudes to and reported practice
70 in relation to spiritual care.

71 72 **Aims of the study**

- 73
74 1. To determine to what extent our previous descriptions of GPs' concepts, attitudes and practice in
75 relation to spiritual care are valid in a more generalisable group.
- 76 2. To examine statistical associations between these concepts, attitudes and modes of practice, and to
77 determine to what extent there may be distinct GP groups of attitudes and practice.
- 78 3. To examine the perceived adequacy of training.

79
80
81 **Ethical Approval.** The study was registered with the University of Aberdeen College Ethics Review Board, and a
82 certificate of compliance with standards obtained. The data was fully anonymized.

83 84 **Method**

85 Recruitment was by an invitation from the course organiser to GP trainers present at the regional trainers'
86 conference in the North of Scotland. GPs completed the questionnaire in free time. Formal written consent
87 was obtained and all attending GP trainers who were willing to take part were considered eligible. GPs were not
88 made aware of this survey or a detailed programme prior to attendance and it is unlikely that any attended out
89 of a specific interest in spirituality. The structured written questionnaire was prepared using concepts and
90 themes developed from our previous qualitative study(16) and used Likert scales of agreement and free text as
91 per Bryman. (19) Face and construct validity were judged to be high because of the derivation of concepts from
92 previous studies, the use of standard methodologies, triangulation of the data to other studies using different
93 methodologies, and the fact that respondents did not offer alternative themes or categories as free text. IBM

SPPS 24 and the R Software package (20) were used to analyse statistical associations between variables. For the full questionnaire, see appendix.

We first assessed whether attitude or practice appeared to be related to spirituality concept, represented in any of the Likert scale questions, in a univariate manner by tabulation and multinomial trend tests(21) We then sought to establish whether respondents could be classified into a number of groups based on their concept of spirituality using k-medoid clustering. (22)) Secondly we performed latent class analysis (23), collapsing the five point scales to three level scales by merging the first two levels (as 'Agree') and the final two levels (as 'Disagree') to avoid over-parameterisation.

Results

A total of 87 GPs responded out of a possible 93, 47 stating female gender, 38 male and 2 preferring not to say. Fifty one respondents indicated they were not affiliated to a religion, 32 that they were affiliated, and four preferred not to say. Of those who were affiliated, 29 stated Christian or Catholic with two Hindu and one Muslim respondents. Among those who stated an affiliation, 15 indicated that this was *somewhat important*, 6 indicated *important* and 18 stated this as *very important* to them – six participants circling “no religious affiliation” but then stating that this was important to them.

Concept of spirituality

Participants’ agreement with statements – derived from our previous study- about the concept of spirituality are represented below.

Table 2 Agreement about concept of spirituality

Attitude to providing spiritual care

The bar graphs represent the numbers of respondents reporting each of four attitudes to spiritual care.

Fig 1 – Attitude to providing spiritual care

Reported practice of Spiritual Care

The bar graph below represents the frequencies of participants reporting each of four patterns of practice: (1) *Invalidating* – tending not to discuss spiritual/religious matters, (2) *cultural-instrumental* – acquiring information about a patient’s religion or culture which could be of practical importance, (3) *referring-* additionally suggesting that some patients see a spiritual advisor, faith leader or chaplain and (4) *embracing* – in addition actively engaging with patients through spiritual discussion, exploration or reflection .

Fig 2 – Practice of spiritual care

Adequacy of training received

Only 9 respondents (10%) felt they had received appropriate training in spiritual care and 54 respondents (62%) disagreed or strongly disagreed that they had received appropriate training.

Table 3 – Answers to “the training I received is adequate for spiritual care”

Adequacy of training delivered. In answer to whether GPs trainers felt they deliver adequate training in spiritual care to trainees, one strongly agreed, 10 agreed, 28 neither agreed or disagreed, 37 disagreed and 10 strongly disagreed. One failed to answer.

Analysis

Do GPs’ concepts of spirituality predict attitude to spiritual care? Multinomial analysis shows significant relationships between *spirituality is a useful concept* and attitude to practice ($p = 0.004$), GPs believing spirituality to be useful were more likely to wish to provide spiritual care. There was also a statistical relationship between *spirituality is an unclear concept* and attitude to providing spiritual care ($p = 0.004$). Interpretation is problematic as both *guarded* and *embracing* patterns seem more likely in those who felt the concept was unclear. Belief that *spirituality is a fundamental aspect of humanity* was associated with more positive attitudes to involvement in spiritual care, with *pragmatic* and *embracing* patterns of spiritual care being more prevalent in those who agreed with this statement ($p = 0.01$).

GPs for whom spirituality was personally important had significantly more positive attitudes to offering spiritual care ($p = 0.03$). However, a pragmatic approach, being willing to be involved regardless of personal stance, if it would help a patient, was still the most common attitude expressed overall. No other statistically meaningful relationships could be demonstrated between a GP’s concept of spirituality and his or her attitude to care.

Does concept of spirituality affect reported pattern of care? Multinomial trend tests showed a relationship between the personal importance of spirituality to the GP and the reported pattern of spiritual care ($p = 0.03$) i.e. GPs for whom spirituality was more important were more likely to report more active patterns of care, but no other statistically significant relationships could be identified.

Are there distinct clusters of attitude or practice? - Cluster and Latent class analysis

We examined the possibility that distinct clusters of attitude and practice exist based on the concept of spirituality which GPs hold and/or its importance to them. Both latent class and cluster analysis, statistical methods which look to identify distinct underlying groups with common opinions or behaviour, support a two-group solution, this having the highest ratio of “between to within group” spread.

Fig 3 - Cluster analysis of preferred number of groupings

The larger group (55/86 – 64%), which we have termed *pragmatic supporters* are more agreed that spirituality is useful and important for general practice, that spirituality is about a personal sense of meaning, and is a fundamental aspect of humanity. They are also more likely to hold spirituality to be personally important or to be affiliated to a religion.

The second smaller (31/86 – 36%) group we have termed *tentative sceptics* are somewhat less likely to agree that spirituality is fundamental to humanity and is less important to them personally. Those who stated they had no religion were found in both groups, but more frequently in this group.

Do the two groups have different attitudes, and report differences in practice?

185
186 *Pragmatism* was the commonest attitude in both groups, however the *pragmatic supporters* group were more
187 likely to include *embracing* attitudes to spiritual care and almost all the GPs who held *rejecting* attitudes fell in
188 the *tentative sceptics*.

189
190 An *Invalidating* pattern, not discussing spiritual issues with patients, is the commonest practice in both groups.
191 While *cultural – instrumental* and *referring* practices occurred in both groups, all GPs who reported *active*
192 patterns were in the *pragmatic supporters* group.

194 Discussion

195
196 The study population represents similar levels of ethnic minorities to the Scottish population (3 - 4%) but lower
197 levels of Christian affiliation (33% vs 47%) and higher levels of religious non affiliation (59 % vs 48%)(24)

198
199 Although there are many prior descriptive studies, this study and its precursor are to our knowledge the first to
200 investigate the concept which GPs hold about spirituality, without either assuming or providing a concept or
201 definition, to offer a typology of these concepts, and attempt to measure their frequency. Where respondents
202 stated they had an alternate view consisted either a description of *practice* under the section about *attitude* or
203 was not expanded on in freetext. The categorisations of attitude and reported practice of spiritual care
204 discovered in our previous study are therefore probably a complete or very nearly complete description of this
205 population

206
207 **Concept of spirituality.** Very few GPs feel that spirituality is a *meaningless* concept, however many feel
208 spirituality to be an *unclear* term. There is broad agreement that the term refers to a *fundamental* aspect of
209 humanity, relating to a sense of personal *meaning/purpose* and is a *psychological need*. Most respondents feel
210 the concept is *useful* and *important* to general practice. There were mixed views about whether spirituality
211 implies a *divine connection*. This study helps us understand the variations that exist among GPs, and their
212 prevalence. We do not however analyse which of these might be philosophically robust leaving the possibility
213 that we report a culturally normative concept which is in common use by GPs, but, may be open to
214 philosophical dispute or problems of application.(25)

215
216 **Attitudes to care.** The conceptual understanding and personal importance of spirituality affect attitudes to
217 providing spiritual care, with the majority happy to provide care if it is helpful to the patient and some
218 welcoming this involvement. However, an appreciable minority have reservations and a small number wish not
219 to provide spiritual care.

220
221 **Practice of spiritual care.** Most GPs offer some sort of spiritual care. Around a third confine this to collecting
222 relevant cultural and religious information which may be of practical use. A quarter of GPs report that
223 additionally they may refer a patient for spiritual care. A substantial number report that they do not enquire
224 about spiritual or religious aspects. Although GPs who agreed that spirituality was personally important to
225 them are keener to be involved in spiritual care we could not show this effected the actual practice of spiritual
226 care, perhaps because of limited numbers of participants, or due to constraints on putting these attitudes into
227 practice.

228
229 This study suggests that there is an intention – action gap in spiritual care: 7(8%) stating they wish not to be
230 involved in spiritual care, but 31 (35.6%) reporting that they do not enquire about spiritual or religious aspects
231 with patients. There is evidence that socialisation during medical training conceptually limits medical trainees

in a way which may render engagement with patient's existential needs problematic. (26) An alternative explanation is that GPs feel they are providing implicit spiritual care without actually asking about it.

Clusters

Two distinct groups of GPs are identified, one more supportive and the other more sceptical. GPs who actively dialogue with patients about spirituality are found almost exclusively in the former group, and GPs who prefer not to be involved in the latter.

Training for spiritual care

Participants largely report inadequate training in spiritual care and this has implications for postgraduate and undergraduate training. The fact that GP trainers report that they fail to deliver adequate training to trainees suggests that, without change, this will continue.

Strengths and weaknesses of this study

This is an interdisciplinary approach that uses, in a novel way, statistical approaches to discover underlying groups of respondents and describe their characteristics. The North of Scotland is likely to have less cultural/religious diversity than other areas and different results might prevail in other populations. Formal reliability testing of questions was not carried out and would be helpful in establishing the cross-cultural applicability of this questionnaire. There may be differences in what GPs report they do, and what actually happens, or is experienced by patients, however the behavioural pattern described in our earlier interview study were drawn largely from descriptions of actual patient -doctor examples.

Relation to other studies

This is the only study known to contain a substantial majority of GPs who are not religiously affiliated.

A number of well conducted qualitative studies have outlined doctors' in general (17) and more specifically GPs' attitudes to spirituality and the barriers and facilitators to spiritual care (9,11). These sometimes lack interdisciplinary input or robust sampling approaches, but show consistently that GPs differ in their sense that that have a role in spiritual care, and in practice and they find this difficult to deliver. (27).

One previous study conducted among GP trainers in Holland reported statistical associations between denominational religious affiliations and the likelihood that GP trainers enquire about patients own religious affiliations (28), and US based studies support an association between personal importance in relation to religion and the likelihood of initiating discussions with patients (29).

This study is unique in both investigating GP concepts of spirituality itself, creating a typology based on previous empirical data, and relating this to practice using statistical methods. Additional to using statistical methods to examine associations between beliefs about spirituality and reported practice, we use cluster and latent class analysis to find distinct groups of belief and practice about spiritual care. Our findings both accord with, and extend with statistical methods, previous descriptive studies showing that personal stances and affiliations define and limit spiritual care.

Conclusions

This study describes, in the most systematic form currently available, the prevalence of concepts, attitudes and reported practice in a population of GPs with no expressed interest in spirituality. Although GPs report that they are unclear about the concept of spirituality, most, but not all, believe it to be important and to concern a potentially fundamental human and psychological need for meaning and purpose. We outline two groups of GPs who can be described as *tentative sceptics* and *pragmatic supporters* and their attitudes to spiritual care are influenced by personal stances. GPs feel inadequately trained for spiritual care and report that they fail to deliver appropriate training to future GPs. This study raises debates about the current capability of GPs for the task of spiritual care and highlights factors which may affect competency.

Acknowledgements: With thanks to Pam Sheriff and Rod Sampson for support and guidance

Conflicts of interest: The Authors declare that they have no professional or financial conflicts of interest. AA and JS are involved in medical humanities education in Scotland including spirituality training.

Appendices.

Table 1 - Agreement about concept of spirituality

Fig 1 – Attitude to providing spiritual care

Fig 2 – Practice of Spiritual Care

Table 2 – Answers to “the training I received is adequate for spiritual care”

Fig 3 - Cluster analysis of preferred number of groupings

Appendix 1 – see below - GPPS questionnaire

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- 369
370 Appendix 1 – Study Questionnaire – GPPS2

GPPS2 study. Please tick the relevant box – one for each statement.

In relation to General Practice:

	strongly agree	agree	neither agree or disagree	disagree	strongly disagree
Spirituality is a meaningless concept					
Spirituality is an unclear concept					
Spirituality is a useful concept					
Spirituality is about fulfilling a psychological need					
Spirituality is about a personal sense of meaning or purpose					
Spirituality is a fundamental aspect of humanity					
Spirituality is about connection to God or the divine					
Spirituality is important to General Practice					
Spirituality is important to me personally					
The training I received in General Practice is adequate for spiritual care					
I deliver appropriate training in spiritual care to my trainees					

With regard to spiritual care please tick the ONE response which is closest to your view.

- 1. I would rather not be involved in providing spiritual care
- 2. I have some reservations about providing spiritual care
- 3. On balance, If it helps patients, I am happy to be involved in the provision of spiritual care
- 4. I welcome the opportunity to provide spiritual care
- 5. My view is not close to any of the above

If you ticked 5 please state briefly your position if possible.....

Please indicate with a tick which ONE of the following is closest to your practice.

- 1. I acquire information about a patient's religion or culture which could be of practical importance
- 2. Additionally, I may also suggest that some patients see a spiritual advisor, faith leader or chaplain
- 3. Additionally, I may also actively engage with patients through spiritual discussion, exploration or reflection
- 4. I tend not to enquire about or discuss spiritual or religious issues with patients
- 5. My view is not close to any of the above

If you ticked 5 please state briefly your position if possible.....

How many years have you been in General Practice not including training?

Please circle your gender: Male Female Other Prefer not to say

Are you personally affiliated to a religion Yes/No. If so, please state which one

Please circle the importance of this affiliation to you: Very important / Important/ Somewhat important/ Of minor importance/ Of little importance.