Spiritual care

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Curriculum Vitae

Claire studied at Stellenbosch, and qualified with a MBChB in 1980. After some time at the Frere Hospital in East London, she moved to Venda. She is currently working in the Tshilidzini Hospital with emphasis on primary health care, training and community interaction in health. Claire is also busy with the M Fam Med at Medunsa. She is married to Wilhelm van Deventer and they have three children.

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Summary

Cultural understanding (which includes religions) is important if comprehensive or holistic health care is important. Especially in Africa. From practical experiences (patient reports given) the author illustrates how special spiritual skills are needed, and she pleads for specific training programmes in medical education, in undergraduate programmes and in continuing learning seminars. These skills will become more urgent and our competency more needed as we see more cancers, AIDS and infertility becoming epidemics.

Introduction

There seems to be a great emphasis placed on holistic care, in articles, policies[1,2] etc, since the international health conference in 1978 at Alma Ata. An interesting aspect of the definition of the Declaration of Alma Ata that I have is that health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[3]

This definition troubles me as it does not sound holistic. Where is the spiritual dimension in the definition? One could argue that it is incorporated in the mental part of the definition. However, "The spiritual dimension is different from the psychosocial dimension in that the former concerns a person's relationship to a higher being or God, as defined by the individual, and the latter concerns itself with the relationship of a person to himself or the environment. There is a distinct problem with teaching psychosocial intervention skills for meeting spiritual needs".[4]

In practice

A 26-year-old lady made an appointment with me because of headache and palpitations for the past year or so. She was

happily married, had a two-year-old son and was very active in the church. She was a teacher and said that there were no financial or other problems. Bit by bit, it transpired that the thing that sometimes frightened her was the thought of dying in a car accident. She was not scared of disease, neither of her husband or child's death/illness. I examined her well, found no physical abnormalities and gave her a low dose of propranolol asking her to see me again in one week.

At the follow-up visit, she was a little better but still having the symptoms – we seemed far from the root cause. I asked more about her feelings related to death. She said that she had "lost her joy" as a Christian. She didn't know the reason. As we spoke, I asked her how she would feel when facing God, after her death. She then told me that above all she feared that God would find her guilty and condemn her, even though she had felt that she had 'repented'. We spoke for a while about how this fear was related to her illness and I offered to pray with her and give her specific Bible verses to take home and think about. After praying, she left.

Our last consultation some time later was just a visit by her. She told me of an episode that had occurred the day after the second consultation. She had been sleeping and had suddenly woken up with a suffocating feeling and with severe palpitations. Her husband had taken the Bible verses and started reading them to her. After a short while, the palpitations subsided and they both fell asleep. She had not had an episode since then.

It is more than a year later and we see each other occasionally. She says she has not been ill since.

There was a spiritual need which, managed optimally or not, was addressed. It happened to be at the beginning of my studies at Medunsa and I experienced that the emphasis on patient-centred care helped me more than anything else to recognise that this patient had an agenda which was layers 'deep'.

A much unhappier outcome was one where I was requested to see a young girl of 14 with rheumatic valve disease. The ward doctor wanted a second opinion as this young girl was deteriorating and no cause could be found. She was awaiting a transfer to a thoracic unit for a valve replacement. There were no signs of cardiac failure, blood had not shown any infection – in spite of this she was started on intravenous antibiotics to rule out an underlying infective endocarditis. When I saw her, she was listless, with cardiomegally and heart murmurs but no cardiac failure and no signs of infective endocarditis. The chest X-ray showed a broadened mediastinum above the heart, possibly indicative of TB lymphadenopathy. I suggested more tests – ESR, Mantoux – although she was already in a borderline age for the real significance of a Mantoux, and possible bronchoscopy later.

The next I heard of the girl was when we discussed her postmortem at our weekly mortality meeting. As all the tests were being reported and the deterioration described, I realised how horribly we had failed her in the most important part – namely in recognising her as a person. No one had spoken to her about her fears or her thoughts on death; she had not been referred to our spiritual worker; we had done what is often done in the terminal sections of surgical wards – smiled brightly every day, greeting her and done more and more tests.

Spiritual caring should not be seen as a lukewarm kind of terminal counselling. There needs to be a constant sensitivity towards this need, as there should also be towards physical, social and psychological needs. In comprehensive care the balance is essential.

Research

Dr Thomas E Oxman[5] did a study to examine the impact of religion on cardiovascular mortality. He reported on 212

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Give the feelings of a patient back to him.

patients at least 55-years old who underwent elective coronary artery bypass graft surgery and/or aortic valve replacement. As part of this prospective study, they all underwent extensive psychiatric testing prior to their pre–surgical visit.

He undertook this effort because he recognised that for many people, religion increases in importance with age, while other social and coping resources diminish. Dr Oxman found a fourfold increased risk of death within six months, following cardiac surgery, in those having no religious support, even after there had been control of variables, eg, severity of cardiac disease.

How to address *our* and *our patient's* needs in this area?

Our dilemma is that there is such a low premium placed on spiritual health in terms of undergraduate training and that we subsequently all probably feel a bit lost when confronted with the 'how'. It has been convincingly stated at medical conferences by medical lecturers, that there is no spiritual dimension and therefore no need for sensitivity in this area and this point of view has remained unchallenged in a conspiracy of silence!

As part of the diploma in Clinical Nursing Science for nurses I am involved in as co-ordinator, there is an orientation period for the new students who are all experienced qualified nurses. Part of the time spent on discussing the concept of holistic health, is specifically delegated to spiritual care – as an introduction. It is hoped that the thoughts and interest stimulated in this period might be productively utilised throughout the year, laying a foundation for a further professional practice.

Students are given the article by Carole Piles[6] on the role of spiritual assessment and care and this is discussed the following day. There is a role play by students in which they attempt to recognise and cope with an expressed spiritual need. A number of counselling principles are usually also highlighted in this role play.

The main barrier to communication in general, often identified in the role play session, is the attempt of the health worker to always have the right answers for the patient – the giving-of-good-advice. In one session we spent some time around the comment made by the 'health worker' in the role play: "Mudzimu u a divha" ie "God knows". This was said in a reassuring way in response to a 'stroke patient' played by another student, who was reacting aggressively and angrily against her condition, the staff and God. When the 'patient' was asked how she had felt about this response "Mudzimu u a divha", she said she had felt frustrated and had felt that the person was not really listening. She had felt that she had a problem with God allowing this to happen to her and she really didn't need this sort of advice.

A very depressed person cannot handle a lot of input.

A previous year-group of students, after having read the article and having done a role play, were asked to discuss some ideas around the patient who says: "I don't want to die". They felt the following points might be helpful in such a situation:

- *Listening* is more important than giving answers.
- Try to give the feelings of the patient back to him – in order to help him to sort out his thoughts – that is, to be a facilitator. Even where the patient asks directly for help, throw the question back to him.
- If you don't have the information or skills – *refer*. Also refer for continuing care you might not be able to give.
- With a very depressed person, do not give too much input. A well-known psalm could just be read to such a person.
- For someone who is very absorbed and busy thinking about his suffering, *comfort* is what is most needed, eg, "I am here, I want to help you". Beware of saying you know how the patient feels.

Comfort is often what is needed most.

- The miracle lies in helping prepare a patient to have peace in life and death NOT a quick-prayer-cure. If the prayer is part of the process, this is acceptable.
- See the *patient's needs* first. Two comments made here concerned differing religious views, ie, it was asked: Should the patient, if a Moslem, be referred to his priest? (With the implication that often patients are proseletysed to another religion whilst at their most susceptible OR that the level of discomfort is so much more with a person of another religion that optimal spiritual caring might not be given.) It was felt that love and acceptance and listening unjudgementally would lead to greater patient openness than a discussion about the difference in our beliefs. The second comment was that the above would also apply when patients sometimes express the need to go to healing services – whether one agrees or not, the patient's needs (agenda) must be carefully weighed.
- Help patients to feel comfortable about God, not fearful.
- We need to know more about different religions and about spiritual care in general. The college (Nursing) should be approached to introduce something like this.
- If one wishes to use the Bible, the Gideon's version has specific verses at the back or front, which could be very helpful for different situations. One should, however, avoid Bible reading and prayer if you are very uncomfortable with it because the patient will perceive a falseness.
- Keep body language in mind.

These suggestions were made in a specific *context*. Another point made by a pastor who joined the 1994/1995 group for the discussion, was that there is a tradition of condemnation in the local churches which does not allow people to be free to speak of their spiritual needs. He mentioned examples like the following. Some people, before drinking tea, drive the demons out of the cup; before food is cooked, the demons have to be driven out, etc. This 'demonisation' has become a tradition in many churches in our context and leads to a difficulty for people to be able to share deeper things. There is a fear of condemnation which brings a barrier. He mentioned as well that the emphasis should be on the love and the power of God rather than on condemnation and the power of evil. A specific word he cautioned us not to use was the word 'why?' as this was often loaded with the implication of the sick person's *fault* or *sin*.

After the session with the pastor, we spent time on another question in the class: "Why do people here (in Venda) go to *all types* (eg faith healers, traditional healers and so-called Western healers) of healers for the *same complaint?*

No quick-prayer-cure!

A previous year-group had mentioned the following reasons:

- There is a Venda proverb "Muthu ndi ndou – hali muri muthihi fhedzi', ie "A man is an elephant. He does not eat from one tree only". This proverb is commonly applied to polygamous marriages but is also used to explain why people go to different healers. The students felt that it indicated a need to be treated holistically.
- *Healing* is the aim, not the *how*.
- Some people go to the traditional healer for one *part* and others then to another healer for another *part*.

Feel comfortable about God – not fearful.

The current group of students emphasised that bad attitudes of health workers often 'forced' people to try other options; when complications arose or a person did not get better from one sector, he or she would try another option; people want rapid results, eg, if antibiotics have not been perceived to have worked within one day, another method will be sought. Another reason was that 'western' medicine only partly helps in terms of healing the body but does not address the root cause, namely the *who* and the *why* of the illness.

A great deal of this discussion has to do with beliefs, values and norms. There is, in fact, not a great deal of discussion around the physical aspect.

Challenges

In medical undergraduate training there is little emphasis on sociology or on types of religions. One could argue that most doctors manage patients close to their own culture and therefore do not need this kind of undergraduate input. I believe that this is not the case. At all our universities, we are exposed to culture groups other than our own and a very central part of communicating and understanding is located in the understanding of patterns, ways of interpreting life events (eg illness). Spiritual understanding is inextricably linked with this cultural understanding especially in an African context.

This seems to be a serious vacuum, IF one is serious about so-called holistic care. Otherwise, is there not simply lip service being paid to the word and to the concept? I agree with Weston[7] that even in undergraduate programmes, the inclusion of the 'arts' is crucial to the curriculum.

Apart from the curriculum which needs to be more comprehensive in terms of cultural understanding (including religions), it is also important that before one can start working on strategies for coping with spiritual signals, one has to *recognise* such signals. This is different from knowing all about someone else's religious beliefs. I may know a great deal about the ZCC as a church but still miss the subtly expressed need of my ZCC patient! Piles mentions some clues which help in the recognition of this need: "Indicators of spiritual needs may be expressions of fear, doubt or despair whether verbal or non-verbal. The nurse's response to even simple clues may determine whether a patient is willing to share deeper concerns of a spiritual nature."[8] Other clues mentioned by her are fear of dying, anger at God, noting whether there are religious articles in the home or beside the bed, guilt feelings expressed by the patient and others.

In summary, the need seems to be for *skills training* also in the spiritual field. Many patients were found in Ms Piles' study to be more at ease with health workers than with pastors when it came to really expressing their doubts, fears and anger. This does not exclude *referral to the pastor or spiritual worker.* Part of holistic care is recognising one's limits and getting the best person to complement what one has already done. However, due to inexperience, embarrassment or fear, I might be referring patients far too soon and thereby limiting part of my role as family practitioner – continuity of care, understanding the context, being interested primarily in the person and not necessarily the cure and other facets that I should be fulfilling.[9]

Healing is the aim; not the how.

The above training should, I think, be available from undergraduate level and should also be available as seminars or as a continuing learning programme for postgraduate health workers. It is our responsibility as primary health care workers to be competent in an area which will be more and more necessary as we see cancer, AIDS and infertility becoming epidemics.

Spiritual understanding is inextricably linked with cultural understanding.

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