Revista Bioética
Print version ISSN 1983-8042 | On-line version ISSN 1983-8034

Rev. Bioét. vol.30 no.4 Brasília Oct./Dec. 2022

Spirituality applied to medicine

Khemilly Bernardino do Carmo

Centro Universitário Presidente Tancredo de Almeida Neves, São João del-Rei/MG, Brasil.

Abstract

Spirituality is a uniting force between different constituents of the human being and, when exercised, provides a harmonious experience and promotes balance between physical, social, and mental well-being. As such, this narrative review proposes a secular approach to how spirituality is understood by medicine, its influence on health, and how it is perceived by professionals and patients. Bibliographic search was conducted on the PubMed database, using the following descriptors: "*medicine* and *spirituality* and *secularism*" and "*placebo effect* and *spirituality* and *medicine*." After reading the primary articles, the referenced sources were analyzed. Results show a confusion on how the term spirituality is used and a weak capacity and effectiveness with respect to the spiritual care provided by health personnel, thus ignoring the several benefits offered by such care, which is a tool for a more ethical and humane work.

Keywords: Medicine. Spirituality. Secularism. Placebo effect.

Resumo

Espiritualidade aplicada à medicina

Espiritualidade é a força que une os diferentes aspectos componentes do ser e, quando trabalhada, proporciona uma vivência harmônica e promove equilíbrio entre bem-estar físico, social e mental. Nesse sentido, objetivou-se abordar, secularmente, como a espiritualidade é vista na medicina, sua influência na saúde e a percepção de profissionais e pacientes acerca desse assunto. Para tanto, realizou-se revisão narrativa que priorizou buscas na plataforma PubMed por meio dos seguintes descritores: "*medicine* and *spirituality* and *secularismo*" e "*placebo effect* and *spirituality* and *medicine*". Em seguida foram analisadas fontes referenciadas pela leitura dos artigos primordiais. Percebeu-se que há confusão quanto ao uso do termo espiritualidade e que a capacidade e efetividade do cuidado espiritual prestado por profissionais da saúde são débeis, contrastando com inúmeros benefícios oferecidos por essa atenção, que é uma ferramenta para um trabalho mais ético e humano.

Palavras-chave: Medicina. Espiritualidade. Secularismo. Efeito placebo.

Resumen

Espiritualidad aplicada a la medicina

La espiritualidad es la fuerza que une los diferentes componentes del ser y al estimularse proporciona una experiencia armoniosa, además de promover el equilibrio de bienestar físico, social y mental. Ante lo anterior, este texto tuvo por objetivo abordar cómo se ve secularmente la espiritualidad en la medicina, su influencia en la salud y la percepción de profesionales y pacientes sobre este tema. Para ello, se realizó una revisión narrativa en la base de datos PubMed utilizando los siguientes descriptores: "*medicine* and *spirituality* and *secularismo*" y "*placebo effect* and *spirituality* and *medicine*". Después, se analizaron las fuentes mediante la lectura de los artículos principales. Se encontró una confusión con relación al uso del término espiritualidad, y es deficiente la habilidad y eficacia del cuidado espiritual que brindan los profesionales de la salud, contrastando con los numerosos beneficios de este cuidado, una herramienta para un trabajo más ético y humanizado.

Palabras clave: Medicina. Espiritualidad. Secularismo. Efecto placebo.

Research

The author declares no conflict of interest.

Spirituality is the search for meaning that provides individuals with harmony between body, mind, and spirit. The meaning and purpose of life are personal conceptions defined by one's experience in its entirety: body, significance, an experience [1]. In this regard, spirituality is a tool that allows people to feel and react according to their convictions.

Spirituality may be understood as the culture of the being, an identity constituted by various elements, such as religious beliefs, social and family life, geographical culture, meditative practices, yoga, and other activities. Spiritual exercise is, therefore, everything people practice that enable them to live in fullness, or at least help and influence them in difficult moments, decision making, and coping with any situation.

In the quality of life assessment proposed by the World Health Organization (WHO), spirituality is understood as people's perception of their position in their cultural context, and their values regarding their goals, expectations, standards, and concerns. In other words, spirituality is a broad concept applicable to the complex relationship between physical health, psychological state, level of independence, relationships, and personal beliefs.

Thus, spirituality, and consequently the meaning of life it provides, constitute the multifactorial dimension of quality of life [2]. Although a component of the self, spirituality is a unique domain and should be viewed as such [3].

Health and spirituality

From a comprehensive and complex understanding of the human being, we can place the discussion on spirituality within health care. When facing an illness, for example, pain is not only associated with physical stress, but also with the patient's perception. As such, spirituality can be understood as an inherent part of the disease experience [4].

Spiritual care is studied in the field of health as a tool to cope with difficult situations, and the WHO considers it as an influential factor in quality of life. Thus, spiritual needs do not arise only in moments of dissatisfaction with life or physical weakness; they are inherent to people, related to each person's behavior and point of view [3,5]. Working on such care amid chaos, insecurity, and illness tends to improve quality of life and well-being, providing patients with more adequate means for physical recovery.

Spirituality is not a choice, but part of human nature. Hence, the individuals is understood as a whole that manifests itself in the interaction between spiritual resources and the needs of the physical body. Pain can be better tolerated, and well-being achieved in a symptomatic context when patients use these resources and establish a high level of meaning, optimism, and a sense of hope [3,5,6].

An inverse relationship between life purpose and mortality is inevitable, so a meaningful life has been cited in several studies as benefiting the immune system and healthy behaviors. Besides, it would result in lower risks of cardiovascular disease, reduced depression rates, and better quality of life—conditions that promote greater longevity [3,7].

Body and mind

Many studies have discussed body feedback related to brain functions involved with emotion and vice versa. William James [8] claim it is hard to imagine emotion without its bodily expression. LeDoux [6] demonstrated the use of this feedback by asking respondents to make facial expressions related to different emotional states, and then to answer a questionnaire regarding their feelings—which were shown to have been significantly influenced by facial expressions, reflecting positive and negative states of mind [6].

Emotional influences on the physical body are countless, and many are well known. Chronic anxiety, long periods of sadness, pessimism, and stress double the risk of people being affected by headaches, gastric ulcers, asthma, and—most strikingly—heart problems. Ironson and collaborators [9] evaluated patients who already suffered a heart attack and showed that as they described moments of anger,

heart pumping decreased by up to 5%, to 7% or more in some cases.

John Barefoot, cited by Goleman [10], found that, in the angiography process, the extent of coronary lesion correlated with the score on resentment test. Obviously, these bad feelings were not the exclusive cause of the heart damage, but were related to it. Powell, Thoresen, and Pattillo [11] found similar results in a ten-year study with 929 men who suffered a heart attack: those who easily felt anger were three times more likely to die from cardiac arrest compared to individuals of more stable temper.

Cohen, Tyrrell, and Smith [12] noted a direct relation between level of tension and the chance of catching a cold, so that on exposure to the virus, 27% of low tension people contracted the cold, against 47% among the more tense. This is, therefore, another factor capable of weakening the immune system.

There is also meditation, a simple, secular practice that basically works on attention and breathing, showing benefits to well-being and life purpose [13]. Puchalski [14] observed that an average of 15 minutes of meditation twice a day resulted in decreased heart and respiratory rates and in slower brain waves. Moreover, meditation improved quality of sleep, reduced anxiety, and functioned as a positive factor in cases of infertility and premenstrual syndrome.

Another mortality risk factor is the absence of relationships, since the subjective feeling of loneliness, of having no one to share intimacy with, doubles the chances of contracting diseases. As early as 1988, House, Landis, and Umberson [15] found that loneliness is as important in mortality as smoking, high blood pressure, sedentary lifestyle, obesity, and high cholesterol.

Goleman [10] highlighted the importance of emotional care preceding some anxiety-inducing health context, such as surgery, by showing that recovery from this procedure can be advanced by up to three days when patients are offered relaxation techniques, solving all doubts and questions. He also observed potential financial gain in humanistic medicine: when addressing older adults' depression in conjunction with orthopedic therapy for hip fractures, it was possible to advance their discharge by up to two days, generating, among the total number of patients, a savings of nearly $100,000.

Good feelings are not enough to cure diseases, but they do impact their trajectories. For example, smoking and consuming alcoholic beverages in excess, along with low frequency of physical exercises, are more present in pessimistic people [10]. As noted by Williams and Chesney [16], depression raises the chance of death after treatment for heart attack by five times. It is unethical therefore to ignore what emotional expression generates in the body, and thus it would be inhumane to disregard such risk factors.

Physician-patient relationship

According to Puchalski, Frankl wrote that *man is not destroyed by suffering; he is destroyed by suffering without meaning* [14]. Physical weakness at any level can make it difficult for patients to cope with profound life issues, such as the loss of purpose, due to the concern with the future [14].

In this regard, we realize the extent to which health professionals, especially physicians, should integrate spiritual care in their practice. Considering that care centered on physician-patient relations tends to increase confidence and the sense of hope, considering the totality of the individual would provide even greater wellness to the patient [4,7,10].

Spiritual essence exists. Research has shown the influence of people's inner resources and the physician-patient relations on health outcomes in studies about placebo effect. This does not mean that a pill without biological effects is capable of bringing benefits, but the belief and positive thinking of both the patient and the professional, together with integral medical care, can contribute to improving the patient's health condition [14,17-19].

To perform compassionate work, health professionals must be able to offer humanized care by listening to patients, understanding their fears, expectations, and pains, collecting spiritual stories, to ultimately analyze the dimensions of the individual and their family members.

Only by knowing the patients' beliefs, limitations, and needs can doctors take a multidisciplinary action to address the multifactorial causes of an illness. One such example are patients who feel no improvement with medication, presenting quality of life impaired by this circumstance and depressive feelings, with no purpose in life, who feel better when conventional treatment is proposed in conjunction with guidance and indication of meditation [14].

Associating conventional with non-conventional therapy is not enough; we must get to know the individual who will receive care. Cohen, Bavishi, and Rozanski [13], for example, reported that people who do volunteer work have a reduced mortality rate, but this positive effect is only achieved by those who do it altruistically, and not by following any specification.

According to Koening [7], however, most doctors ignore the reasons for addressing spiritual issues in their consultations. Hence, we need further studies on the topic and to disseminate information for health professionals aiming at spiritual care, that is, a comprehensive understanding of the individual.

Deficient spiritual care by professionals

Hormonal, autonomic, and behavioral responses are generated by the emotional system in response to various stimuli, and they are different for each person, since perceptions and feelings are individual constructs established by upbringing, culture, and experiences. Moreover, Leventhal and Scherer [20] state that emotion synchronizes brain activities that are then embodied.

Therefore, a doctor must always question the medical knowledge regarding their patients' emotions. Would understanding their feelings and advising them to seek support in some environment that provides tools to control emotion and remain in harmony provide better conditions to fight the illness? Apparently yes, as each person is unique in terms of their components—body, mind, and spirit—; thus, if care targets only the body, people are not treated in their totality, which can compromise their well-being or constitute an obstacle to disease involution.

Doctors must collect the patient's entire history, rather than focusing solely on the physical symptoms, inquiring about the patient's beliefs, limitations, fears, social and family relationships, everyday problems (work-related, for example), habits, lifestyle, and interests. This allow us to understand patients in their totality and make the necessary orientations and referrals to sectors that work on their spiritualities.

For this to happen, healthcare providers must adopt a compassionate and attentive attitude, being aware of the medical limits encompassing their perception of the patient's totality and a sensitive orientation of care that can help them. In other words, the in-depth spiritual work should be left to the religious leadership: the psychologist, the yoga instructor, and so forth, according to the analyzed needs [7,14]. *The essence of spiritual care is therefore about listening and being present to another in their time of need* [4].

A study involving end-of-life patients associated spiritual support with better quality of life and fewer invasive interventions; however, only 51% of the physicians showed interest in receiving spiritual care training, despite 80% of them finding this type of care interesting [21]. Perhaps this interest—which can be considered low given the benefits—is due to Descartes' ideal, as highlighted by Damasio [22], regarding the geometrization of man, which brought great advances to medicine. Currently, however, we note a neglect of the individual's non-material needs linked to visceral sensations, such as emotion.

What could then be the reasons why spiritual care is still not widely offered? Available time, doubts regarding the benefits, and discomfort when practicing spiritual care are the main complaints of professionals [7,21]. Koenig [7] claims, however, that a quick spiritual history taking adds a maximum of two minutes to medical care, and that it is unnecessary to inquire about it at every medical visit and from every patient. Thus, the low offer of this type of care may result from the lack of professional training—if professionals

were prepared, they would at least know when to offer it and its duration.

Hence, despite the deficient academic education on the topic, changing the perspective on the importance of spiritual care is the first step to spark the physician's interest, and constitutes one of the purposes of this paper. Moreover, its applicability requires a significant prerequisite: the healthcare provider needs to have spiritual experience. Through either previous religious practice, art, music, meditation, or yoga, among many other spiritual practices, physicians become compassionate to the spiritual needs of their patients [4].

Based on specialized literature, this article analyzes the influence of spirituality in clinical medicine, as well as its relationship with the patients' lives and professional performance. In this perspective, it discusses whether spiritual care constitutes an important element in patient care, and seeks to identify whether physicians have knowledge and training on the topic, to understand how patients are receptive to and need spiritual care, thus determining how spirituality influences their health. Importantly, although this work develops a secular approach to the subject, religion is admitted as a spiritual practice.

Method

By means of an analytical narrative review focused on studying the interaction between medicine and spirituality, this descriptive research sought, mainly, qualitative and quantitative results.

Bibliographic search was conducted on the PubMed database considering the following inclusion criteria: articles in English and Portuguese published between 1995 and 2018; studies that correlated spirituality with health and/or quality of life and/or medicine; and articles about the construction of the term "spirituality" and its applicability in clinical practice. One article from the George Washington University School of Medicine and Health Sciences was also used. The descriptors were selected from the Health Sciences Descriptors (DeCS) portal [23] and combined as follows: "medicine and spirituality and secularism" and "placebo effect and spirituality and medicine."

Exclusively religious articles were excluded to maintain a secular analysis. Publications discussing specific diseases and care were included to broaden the knowledge regarding spirituality in the medical field. Moreover, some bibliographic references cited by the selected articles and books on the topic were also studied.

All selected papers were first evaluated based on authorship, year of publication, objective, and method used, to build a sample in line with the inclusion criteria. Those that met the exclusion criteria or did not align with the inclusion criteria were excluded. In not so clear-cut cases, articles were read a second time.

Subsequently, we analyzed how each author uses the term "spirituality," as this concept still generates confusion among people, by carefully reading their production context, assessing whether or not healthcare providers were involved, and how prepared they were to provide spiritual care.

The need for spiritual care was then compared between patients and professionals, observing how much spiritual care was provided. Finally, we listed possible influences and benefits of spirituality on health, quality of life, and medical practice.

Results

The search strategy developed identified 140 articles. From an exploratory reading, we selected 15 studies correlating spirituality with health and/or clinical practice and/or quality of life, most of which emphasized how spirituality improved well-being and helped to cope with the illness.

As for the term "spirituality," some studies used "spirituality" as a synonym for "religiosity," or interchangeably with other religious criteria, while others used it consistently. However, many of the studies used in systematic reviews present an incorrect understanding of spirituality (Chart 1).

Chart 1. Use of the term "spirituality" in the analyzed articles

Authors	Use of the term spirituality
Bai and collaborators; 2015 [24]	Although secular, the study associates "spirituality" with other related terms as comparable, such as peace and faith
Kuyken, cited by The World Health Organization Quality of Life Assessment (WHOQOL); 1995 [2]	Consistent use of the term
Pesut and collaborators; 2008 [25]	Incorrect understanding of the term "spirituality"
Paley; 2009 [26]	Secular conceptualization of the term
Baldacchino, Draper; 2001 [19]	Consistent use of the term, emphasizing that non-religious patients also use spirituality
Büssing and collaborators; 2013 [5]	Uses "spirituality" highlighting its non-restriction to religion, which was widespread years ago and still causes confusion
Puchalski; 2017 [14]	Consistent use of the term
Brady and collaborators; 1999 [3]	Despite the secular approach, the authors associate related terms as comparable, such as faith, peace, and emotional well-being
Koenig; 2004 [7]	Uses "spirituality" and "religion" interchangeably
Puchalski; 2004 [4]	Consistent use of the term
Harrison and collaborators; 2009 [27]	Spirituality was assessed as a domain, but no defined
Cohen, Bavishi, Rozanski; 2016 [13]	Consistent use of the term
Balboni and collaborators; 2012 [21]	Secular use of the term "spirituality"; although familiar with the patients' religion, their beliefs did not bias the study
Bonnet; 2011 [17]	Consistent use of the term
Kohls and collaborators; 2011 [18]	Consistent use of the term

Such misunderstanding and misuse may have influenced the results, since research participants might ignore the meaning of spirituality unless correctly explained to them. Moreover, the small number of papers analyzed might have limited the effectiveness of this narrative review.

Regarding the research context, most studies focused on more severe clinical pictures. As for perceptions about spiritual care, our analysis showed that healthcare providers are unprepared to provide this care, resulting in little effectiveness; whereas patients see spirituality as an inherent need that lies unfulfilled in most cases (Chart 2). In contrast to this deficient practice, many of the studies observed a beneficial interaction between spirituality and comprehensive patient care (Chart 3).

Chart 2. Context of the analyzed studies, approach regarding health professionals and patients' perception of spiritual care

Authors	Analyzed context	Approach regarding the health professional	Patient perception
Baldacchino, Draper; 2001 [19]	Use of spiritual coping strategies in nursing	-	Study cites not only the importance, but also the need for spiritual care reported by patients
Büssing and collaborators; 2013 [5]	Identify unmet spiritual needs in chronic pain and cancer patients	-	Many feel the need for spiritual care, but most did not have this need met
Puchalski; 2017 [14]	Spiritual care in health care	Discusses only the responsibilities incumbent upon healthcare providers	Most patients agree that physicians should adopt a spiritual approach, at least in severe cases. However, few of those who considered spiritual care important received it
Koenig; 2004 [7]	Address how physicians can use the patient's spiritual history	According to the author, physicians give little importance to spiritual care.	62% of patients stated that their beliefs would influence their decisions in case of serious illness; 80% said they would be receptive to inquiries about their beliefs
Puchalski; 2004 [4]	Influence of spirituality on chronically ill patients and health care in general	Discusses only the responsibilities incumbent upon healthcare providers	They see spirituality as important to resignify the illness
Harrison and collaborators; 2009 [27]	Identify unmet support needs of cancer patients	-	Spirituality went unmet for 14% to 51% of patients, despite little investigation about the domain
Balboni and collaborators; 2012 [21]	Spiritual care for patients with advanced and incurable cancer diagnosis	More than 80% of professionals lacked training in spiritual care. Physicians considered spiritual care less relevant than nurses and patients, but no professional classified it as negative	Although 60% of professionals considered spiritual care relevant, its provision was deficient
Bonnet; 2011 [17]	Reflect on the relationship between spirituality and placebo effect	Author correlates physician-patient relationship and spirituality as placebo effect factors	-
Kohls and collaborators; 2011 [18]	Correlate spiritual practices to salutogenesis, associating them to the placebo effect	Physicians must evaluate the patients' spirituality, due to its effects on health, as well as to strengthen the physician-patient relationship, aiming at greater trust and motivation	-

Chart 3. Benefits of spirituality applied to health care

Authors	Benefits provided through spirituality
Bai and collaborators; 2015 [24]	Spiritual well-being was an important predictor in quality-of-life measurement
Kuyken, cited by The World Health Organization Quality of Life Assessment (WHOQOL); 1995 [2]	Use of spirituality is an important factor to assess quality of life.
Pesut and collaborators; 2008 [25]	The authors evaluated spirituality negatively, stating that this concept implies economic and political interests
Paley; 2009 [26]	Despite the secular conceptualization of spirituality, the author stated that spiritual care should not be performed by nurses, so as not to alter secular patient care
Baldacchino, Draper; 2001 [19]	Spirituality can reduce patient stress, assisting in the adaptation to illness. It can also improve well-being in the face of physical imbalance
Büssing and collaborators; 2013 [5]	It helps to cope with the illness, acting to improve well-being despite symptoms
Puchalski; 2017 [14]	Spirituality gives meaning to the illness, facilitating acceptance and coping with the disease. Meditation can improve vital signs and spirituality contributes to the placebo effect
Brady and collaborators; 1999 [3]	Coping mechanism that improves well-being and the ability to enjoy life when compared with less spiritual patients, besides providing an overall better quality of life
Koenig; 2004 [7]	Positive relationship between spirituality, mental health, healthier lifestyle, improved immune system, and several other health benefits
Puchalski; 2004 [4]	Spirituality can help to positively resignify the disease and cope with it, and gives meaning to the patient's life
Harrison and collaborators; 2009 [27]	Authors point out that unmet needs, including spirituality, tend to have a detrimental effect on the patient's well-being
Cohen, Bavishi, Rozanski; 2016 [13]	Religiosity and spirituality can generate life purpose benefits, but such causality requires further research
Balboni and collaborators; 2012 [21]	Improved quality of life, less aggressive interventions, and less hospice care
Bonnet; 2011 [17]	Spirituality relieves symptoms and is associated with the placebo effect. Patient spiritual history is important to analyze any negative outcomes
Kohls and collaborators; 2011 [18]	Placebo effects can be explained by the effects of spirituality, especially regarding healthy lifestyle, social support, and meaning of life

Discussion

Given the common confusion between religiosity and spirituality—since the former encompasses the latter—, a correct understanding of the concept of spirituality is paramount to ensure accurate analysis, research, and especially medical practice. By working only with religiosity, non-religious individuals are excluded from spirituality. In criticizing the current use of spirituality, Pesut and collaborators [25] showed how its detachment from theology and philosophy results in the simple repetition of vague and unbeneficial religious discourse.

According to the authors, spirituality stands in opposition to religion, and thus both concepts are usually understood as separate [25]. Other studies highlighted that many scholars tend to see spirituality positively and religion negatively [5], while others use these terms similarly. Koenig [7], for example, highlighted that spirituality and religiosity have been used interchangeably, with preference given to religiosity due to a better understanding of its meaning.

Spirituality should not be used to marginalize religion; rather, we should give importance, in technical and practical contexts, to a concept that favors all patients. Besides, religion could be a mechanism used by patients to find spiritual alignment. But if healthcare providers use exclusively the concept of religion, they will fail to approach non-religious individuals in their totality.

Hence the serious deficiency observed regarding the understanding of spirituality and its use in scientific studies [3]. Some results show that existential needs for inner peace and joyful giving were similar between skeptics and non-skeptics [5]. Thus, assigning the meaning of spirituality solely to religion and belief in God would exclude many from spiritual care [19].

Conversely, Paley [26] argues that the need to conceptualize religiosity and spirituality based solely on theology and philosophy—disregarding how other sciences such as anthropology, psychology, sociology, and neurology, also say something about human nature—is illogical.

However, theology is not a field recognized by all religions. Despite defending such position, Paley [26] considers that healthcare providers do not require spiritual care, given the separation between Church and State in secular states. A new confusion or misunderstanding about spiritual care is thus introduced: its provision is not an attack on secularism, but its absence can hinder the patient well-being and humanized care.

Historically, medicine has sought to resolve illness by often putting patients aside and forgetting how the body is influenced by the mind. Illness is a complex status that encompasses physical body, social, and spiritual factors, affecting individuals in their uniqueness. Consequently, patients become insecure, have their personality disrupted by a lack of self-recognition, and become aware of their vulnerability [4,10,19,24].

A study with patients in waiting rooms found that of the three or more questions they asked the doctor, only about one and a half were answered. Unfortunately, this reality caused by unmet emotional needs generates greater insecurity and fear, as well as difficulty in following a medical prescription [10].

Despite variations in their analyses with cancer patients, Harrison and collaborators [27] identified psychological (12-85%), spiritual (14-51%), and communication (2-57%) unmet needs, highlighting how its deprivation can negatively interfere with patient well-being.

According to Chart 3, healthcare providers lose many benefits by neglecting spiritual care, including improved quality of life, support in coping with the illness and its re-signification. These benefits would make patients more suitable for

treatment, either by adhering to better life habits, or by presenting a stabilized emotional state.

However, some healthcare providers do not believe in the connection between the emotional and physical body, sometimes considering it as trivial [10]. Thus, it is questionable whether patients with difficult treatment adherence or inefficient treatment response are asked questions such as: "How is your relationship with your family?," "Are you worried about anything?" and "What is troubling you?" Apparently this is not recurrent—let us recall that only half of the patients' questions are answered.

This shows the importance of effectively integrating spirituality into general practice [10], since it refers to one's essence, and is able to influence the mind, body, health, and behavior. Moreover, spirituality can unify the aspects of the individual and, when practiced, bring them into harmony.

One's state of balance is related to one's meaning and purpose of life, affecting the physical, psychological, and social well-being, helping to cope with problems [19]. Spirituality thus plays an important role in how patients understand disease and suffering [3,13].

For example: given the subjective nature of pain, the degree of suffering may vary in two people with the same degree of pain. Spirituality is then a mechanism to ensure the ability to enjoy life and to improve medical condition, even amidst symptoms [3].

Spiritual essence could be the solution to many incurable diseases, since it helps patients to feel more comfortable in accepting probable outcomes, thus improving their quality of life. In Puchalski's study [14], 93% of the 108 evaluated women stated that their spiritual beliefs helped them cope with cancer [14].

As such, a conduct focused on spiritual well-being in newly diagnosed patients with advanced cancer could result in greater satisfaction with life for these patients [24]. Spirituality is therefore paramount to health care, establishing life purposes that bring vitality and contentment to patients, providing them with behaviors, such as a healthy lifestyle and emotional habits, that facilitate conventional therapy [13].

Conversely, Balboni and collaborators [21] showed that 13% of nurses and 6% of physicians provided patients with spiritual care. When questioned, nurses claimed they provided this care to 31% of their patients, whereas physicians reported providing it to 24% [21]. These numbers would be questionable when imagining, for example, that some patients sought care because of a simple headache. However, this study was conducted with end-of-life patients, a very delicate moment that requires comprehensive care.

Regarding the degree of importance of spiritual care, 65% of interviewees in a survey considered positive the fact that physicians talked to them about spirituality, but only 10% said they had experienced these moments with such providers. An analysis of patients with pulmonary alterations found that 66% of them agreed that a spiritual approach would strengthen the physician-patient relations, and 94% of those who considered this element important would like to have this conversation with providers and for them to be sensitive to their beliefs [14].

Moreover, 50% of the interviewees stated that physicians should provide spiritual care in severe cases, even if they think it trivial [14]. Physicians and nurses agreed that spiritual care should be offered at least occasionally for patients with advanced cancer undergoing treatment [21]. We observe thus the non-alignment between physicians and patients highlighted in Chart 2, even knowing that their beliefs interfere in their behavior and in decision-making when coping with illness [14].

In this regard, Koenig [7] cites a study by Silvestri and collaborators conducted with 100 patients with advanced cancer, their caregivers,

and 257 oncologists. Participants were asked to rank, in order of importance, a series of factors capable of influencing adherence to or rejection of chemotherapy treatment. All groups considered the medical recommendation to be the most important element. Faith in God ranked second for patients and their families, but as the least relevant factor for physicians.

Although the present study has used the terms "religion" and "spirituality" interchangeably, the latter encompasses the former. This aspect confirms the lack of discussion regarding the topic among those involved [7] and the great set of issues surrounding the different understandings of spiritual care.

In a study about the lack of spiritual care for patients with terminal cancer, Balboni and collaborators [21] made it clear to participants that they did not need to consider themselves spiritual or religious to answer the survey. The results were as follows: 41% of nurses and 67% of patients classified the impact of spiritual care experiences as very positive; 20% of physicians and 72% of patients rated it similarly. As for spiritual care, 81% and 63% of patients said they had never received this type of care from physicians and nurses, respectively. This stems from the fact that more than 80% of these professionals lack training in spiritual care.

Spirituality acts as a great relief factor even in exhausting situations. A quality of life assessment in oncology showed that among patients with high spiritual well-being, 78.6% felt no fatigue and 66.2% of those who did, enjoyed living; conversely, only 26.8% and 10.7%, respectively, of those with low spiritual well-being mentioned such satisfaction [3].

For all these reasons, the practice of spirituality in clinical medicine is not only important, but a *sine qua non* condition for the ethical exercise of medicine, aiming at a more humanized care in which patients are understood in their totality.

Final considerations

This study allowed to understand spirituality from a health care perspective, showing that knowledge dissemination, even regarding the correct understanding of the concept, is paramount to increase its application in medical practice. This would provide patients with the benefits of spiritual care found by this research.

Finally, given the limited number of studies on the topic, the scope of this work is not ideal.

References

1. Teixeira EFB, Mueller MC, Silva JDT. Espiritualidade e qualidade de vida. Porto Alegre: EDIPUCRS; 2004. p. 8-9.
2. The World Health Organization Quality of Life Assessment (WHOQOL): position paper from the World Health Organization. Soc Sci Med [Internet]. 1995 [acesso 19 out 2022];41(10):1403-9. DOI: 10.1016/0277-9536(95)00112-k
3. Brady MJ, Peterman AH, Fitchett G, Mo M, Cella D. A case for including spirituality in quality of life measurement in oncology. Psychooncology [Internet]. 1999 [acesso 19 out 2022];8(5):417-28. DOI: 10/b8bxr6
4. Puchalski CM. The spiritual dimension: the healing force for body and mind. Cons-Ciências [Internet]. 2004 [acesso 19 out 2022];2:173-95. p. 183. Disponível: http://hdl.handle.net/10284/777
5. Büssing A, Janko A, Baumann K, Hvidt NC, Kopf A. Spiritual needs among patients with chronic pain diseases and cancer living in a secular society. Pain Med [Internet]. 2013 [acesso 19 out 2022];14(9):1362-73. DOI: 10.1111/pme.12198
6. LeDoux J. O cérebro emocional: os misteriosos alicerces da vida emocional. São Paulo: Objetiva; 1996.
7. Koenig HG. Religion, spirituality, and medicine: research findings and implications for clinical practice. South Med J [Internet]. 2004 [acesso 19 out 2022];97(12):1194-200. DOI: 10.1097/01.SMJ.0000146489.21837.CE

8. James W. What is an emotion? Mind [Internet]. 1884 [acesso 18 nov 2022];9(34):188-205. Disponível: https://bit.ly/3UTjXZB
9. Ironson G, Taylor CB, Boltwood M, Bartzokis T, Dennis C, Chesney M *et al*. Effects of anger on left ventricular ejection fraction in coronary artery disease. Am J Cardiol [Internet]. 1992 [acesso 19 out 2022];70(3):281-5. DOI: 10.1016/0002-9149(92)90605-x
10. Goleman D. Inteligência emocional: a teoria revolucionária que redefine o que é ser inteligente. 2ª ed. São Paulo: Objetiva; 1995.
11. Powell L, Thoresen C, Pattillo J, Simon SR. Emotional arousal as a predictor of long-term mortality and morbidity in post-MI men. Circulation [Internet]. 1990 [acesso 18 nov 2022];82(4 supl 3):III259. Disponível: https://bit.ly/3EiyarW
12. Cohen S, Tyrrell DAJ, MD, Smith AP. Psychological stress and susceptibiltiy to the common cold. N Engl J Med [Internet]. 1991 [acesso 19 out 2022];325(9):606-12. DOI: 10.1056/NEJM199108293250903
13. Cohen R, Bavishi C, Rozanski A. Purpose in life and its relationship to all-cause mortality and cardiovascular events: a meta-analysis. Psychosom Med [Internet]. 2016 [acesso 19 out 2022];78(2):122-33. DOI: 10.1097/PSY.0000000000000274
14. Puchalski CM. The role of spirituality in health care. Proc (Bayl Univ Med Cent) [Internet]. 2017 [acesso 19 out 2022];14(4):352-7. p. 352. DOI: 10.1080/08998280.2001.11927788
15. House JS, Landis KR, Umberson D. Social relationships and health. Science [Internet]. 1988 [acesso 19 out 2022];241(4865):540-5. DOI: 10.1126/science.3399889
16. Williams RB, Chesney MA. Psychosocial factors and prognosis in established coronary artery disease. JAMA [Internet]. 1993 [acesso 19 out 2022];270(15):1860-1. DOI:10.1001/jama.1993.03510150094038
17. Bonnet U. Ein kurzes Essay über die Spiritualität von Placebo aus (evolutionär) psychiatrischer Sicht. Fortschr Neurol Psychiatr [Internet]. 2018 [acesso 19 out 2022]; 87(7):347-54. DOI: 10.1055/a-0637-1940
18. Kohls N, Sauer S, Offenbächer M, Giordano J. Spirituality: an overlooked predictor of placebo effects? Philos Trans R Soc B Biol Sci [Internet]. 2011 [acesso 19 out 2022];366(1572):1838-48. DOI: 10.1098/rstb.2010.0389
19. Baldacchino D, Draper P. Spiritual coping strategies: a review of the nursing research literature. J Adv Nurs [Internet]. 2001 [acesso 19 out 2022];34(6):833-41. DOI: 10.1046/j.1365-2648.2001.01814.x
20. Leventhal H, Scherer K. The relationship of emotion to cognition: a functional approach to a semantic controversy. Cogn Emot [Internet]. 1987 [acesso 19 out 2022];1(1):3-28. DOI: 10.1080/02699938708408361
21. Balboni MJ, Sullivan A, Amobi A, Phelps AC, Gorman DP, Zollfrank A *et al*. Why is spiritual care infrequent at the end of life? Spiritual care perceptions among patients, nurses, and physicians and the role of training. J Clin Oncol [Internet]. 2012 [acesso 19 out 2022];31(4):461-7. DOI: 10.1200/JCO.2012.44.6443
22. Damásio A. O erro de Descartes: emoção, razão e o cérebro humano. São Paulo: Companhia das Letras; 2012.
23. Descritores em Ciências da Saúde [Internet]. [s.d.] [acesso 19 out 2022]. Disponível: https://bit.ly/3gfGOzo
24. Bai M, Lazenby M, Jeon S, Dixon J, McCorkle R. Exploring the relationship between spiritual well-being and quality of life among patients newly diagnosed with advanced cancer. Palliat Support Care [Internet]. 2015 [acesso 19 out 2022];13(4):927-35. DOI: 10.1017/S1478951514000820
25. Pesut B, Fowler M, Taylor EJ, Reimer-Kirkham S, Sawatzky R. Conceptualising spirituality and religion for healthcare. J Clin Nurs [Internet]. 2008 [acesso 19 out 2022];17(21):2803-10. DOI: 10.1111/j.1365-2702.2008.02344.x
26. Paley J. Religion and the secularisation of health care. J Clin Nurs [Internet]. 2009 [acesso 19 out 2022];18(14):1963-74. DOI: 10.1111/j.1365-2702.2009.02780.x
27. Harrison JD, Young JM, Price MA, Butow PN, Solomon MJ. What are the unmet supportive care needs of people with cancer? A systematic review. Support Care Cancer [Internet]. 2009 [acesso 19 out 2022];17(8):1117-28. DOI: 10.1007/s00520-009-0615-5

Research

Khemilly Bernardino do Carmo – Undergraduate – khemillybernardino@gmail.com
0000-0002-3415-5663

Correspondence
Khemilly Bernardino do Carmo – Trav. Mons. Silvestre de Castro, 20, Colônia do Marçal
CEP 36302-022. São João del-Rei/MG, Brasil.

Received: 7.20.2021
Revised: 10.26.2022
Approved: 10.27.2022