Gordon Macdonald looks at how to address the spiritual needs of patients in general practice

PRIMARY CARE CHAPLAINCY

key points

- Most people we care for are aware of a spiritual/ existential aspect of their health problems, but do not always know how to articulate it.
- Likewise, Christians working in primary care know how spiritual issues affect health, but there are not always clear pathways to address these needs appropriately in the community setting.
- Primary care chaplaincy is one approach that is having an impact, facilitating a more whole person model of care, and with a growing evidence base to support its wider implementation.

Most patients accept they are more than their bodies, that they have an inner part of their life. They function as 'dualist interactionists', experiencing a fusion of body and soul, as opposed to the 'ghost in the machine' described by Ryle.[1] Many are directly aware of the bi-directional relationship between their physical health and their inner well-being. While they may not have articulated such thoughts, once highlighted they are often accepted as self-evident.

It is not uncommon in general practice to encounter patients who, through a complex interplay of physical disease, multimorbidity and functional decline, experience significant social isolation. Such patients know all too well the results that each of these physical 'losses' have on their inner life, with many living with loss of well-being or mental health issues. Conversely, doctors frequently see patients who, through traumas of their inner life or soul, present with physical manifestations such as hypertension, cutaneous reactions, headache or gastrointestinal symptoms to name but a few.

We should not be surprised by this, as Scripture has long since spoken of these truths. There are several examples of how the physical affects the spiritual. The story of Bartimaeus highlights how physical affliction can remove autonomy, diminish dignity and compromise an individual's deepest inner needs of security and purpose.[2] In Luke's Gospel, we see how a sense of identity and community was lost for the man with leprosy through his exclusion.[3] However, the greatest impact of the physical illness, in these stories was the individual's separation from public worship.

We instinctively agree with the psalmist as he describes the effect of unconfessed sin on his physical state.[4] We read with encouragement of our physical revival as we wait on the Lord.[5] Finally, as believers we acknowledge with Paul the inevitability of physical decline and the supremacy of Christ and his work of inner renewal.[6]

Primary care chaplaincy is one way to speak these truths to patients. 'Davie' is a case in point. A man in his 60s, he has served time for murder but now lives alone. His wife supported him and brought up their children. Sadly, she died ten years ago leaving Davie devastated with guilt – she was no longer there and no longer able to say she forgave him. He presented to me with anger, loss of well-being (as opposed to depression) and was increasingly nihilistic and isolated. His physical symptoms of pain were consequently magnified. We spoke of his deepest inner needs, his need for security and forgiveness and that these may not be met in the biomedical paradigm. He was referred to see our practice chaplain to talk about these spiritual needs and he continues to receive support.

Primary care chaplaincy (in a soundbite) is 'a talking therapy, provided by chaplains in general practice, with the aim of helping people find meaning for their deepest inner needs, in the midst

of suffering and to provide spiritual direction.'

We started offering a chaplaincy service in our surgery in 2008 and have provided over 1,600 appointments with nearly 10% of the practice list having attended at some point. Our model of chaplaincy is based on a fusion of Maslow's hierarchy of needs and Hanlon's 'modern maladies'.[7,8] We have summarised Maslow's peak needs as being those deepest inner needs of significance, security and self-esteem and ultimately transcendence. We have found these three 'S's (of significance, security and self-esteem) to be a helpful way of identifying 'cues' within a consultation and opening up a pre-chaplaincy conversation that facilitates a referral. We also find them a useful *aide memoire* and way of promoting understanding amongst colleagues, trainees and undergraduates. In practice, these three 'S's are frequently evidenced by one of Hanlon's modern maladies.

Hanlon describes how we have moved through several waves of public health – starting with the great public works (such as the clean water supply) through germ theory and its application, on through social reform and its impact on health, and then to the risk factor theory of disease and consequent control of such risk. Through each of these waves, Hanlon points out that the human condition has been increasingly dichotomised with body and soul being separated and the importance of the soul, of consciousness, of aesthetic and of individual value being eroded. He argues that the current prevailing philosophical societal values of reductionism, individualism, consumerism and economism have fuelled this dichotomy and created the 'crisis of modernity' with resulting modern maladies. These modern illnesses are defined as loss of well-being (as distinct from depression), obesity, addictive behaviours and depression or anxiety. If we pause to think, it is clear how such prevailing philosophies could result in such maladies; if for example I derive comfort from what I consume, it can be seen how obesity and addiction develop. If beauty, choice or community are no longer possibilities, it is evident how well-being could be affected. Such modern maladies can either function as an independent long-term condition or as a consequence of the other long-term conditions we so frequently face. As clinicians, we use each of these maladies as a marker highlighting the unmet needs of significance, security or self-esteem and of the potential benefit of a chaplaincy referral.

Chaplaincy appointments last up to one hour and provide patients with a rapidly accessible well-being / spiritual care service that meets the ideals of continuous, coordinated and comprehensive care, increasingly required in our primary care teams.[9] Patients, as we know, are complex and often require multiple appointments and multiple 'interventions'. Key interventions such as listening with generosity while being a 'compassionate presence'. Henri Nouwen, psychologist and Catholic priest, spoke of this 'compassionate presence', which emanates from a 'wounded healer'. Such a wounded healer is a self-aware practitioner, who is consequently non-judgemental and can provide not merely empathy, but rather overflows with the love they have received. Surely these are key attributes not only of our chaplains, but also of the resilient practitioners we are all encouraged to be.

Thankfulness is also helpful. What are the signs of life for which patients can be grateful? We have found that practical help can open up the way for deeper connections and input. So frequently the advice given is very practical, on problem-solving and helping patients understand the consequences of positive and negative actions. Fundamentally though, chaplaincy is a place where spiritual direction is available; a search for meaning, particularly in the midst of suffering; a search for the sacred and a pointing beyond one's self to a transcendent other. Prayer is frequently accepted as part of this journey.

As with any new service, confidence grows as evidence of efficacy accumulates. We have been able to publish some evidence that highlights the place of primary care chaplaincy. We have shown that patients who attend chaplaincy (as the sole therapy) have an improvement in well-being that is comparable to that of antidepressants.[10,11] A follow-up study has shown a reduction in GP appointment utilisation among those attending chaplaincy.[12] This study also highlighted that chaplaincy was responsive to a wide variety of presenting symptoms including 'loss of well-being'.[12] This 'loss of well-being' is related to the undifferentiated presentations we regularly need to respond to in general medicine. So it is helpful to see how chaplaincy is beneficial for this group of patients. Finally, chaplaincy was also seen to be a useful intervention for those with multimorbidity, a presentation now so common in primary care.[12]

Whilst these results are encouraging it is the narrative feedback that remains most important – what patients tell us. 'It gives me great comfort'; 'I can cope better with what's going on'; 'It re-affirmed I have not failed God.' These quotes point to so many wonderful stories of healing and restoration that confirm this model of whole person care.

Our experience is that like Bartimaeus or the person with leprosy; many patients' ultimate suffering is not their physical decline but rather their spiritual isolation from God. We see in 1 Kings 19 that Elijah's restoration was part physical provision and part spiritual encounter. Our hope is that chaplaincy, when embedded within primary care, allows physical and spiritual care to happen concurrently. Our desire is to see this service replicated in other surgeries, and ideally supported by the local church. It is recognised that chaplaincy must work within NHS spiritual care guidelines, but it seems clear that as we walk this line, we are well placed to share God's common grace which points to his goodness and restoring power.[13,14]

Gordon Macdonald *is a GP Principle at a Scottish General Practice*

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