



# Brazilian Physicians' Beliefs and Attitudes Toward Patients' Spirituality: Implications for Clinical Practice

Mary Rute Gomes Esperandio<sup>1</sup> · Geilson Antonio Silva Machado<sup>2</sup>

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## Abstract

A substantial amount of international research has demonstrated the impact of spirituality/religiosity (S/R) on health outcomes. However, we do not know much about physician's beliefs and attitudes toward patient's spirituality. The aim of this study was to evaluate the implications of physicians' beliefs toward patient's spirituality for clinical practice in the Brazilian context. Results of a literature review as well as an empirical research carried out on a sample of 48 Brazilian physicians, from two hospitals, regarding their beliefs and attitudes toward patient's spirituality are presented. There appears to be an ambiguous attitude of receptivity and silence on S/R issues in clinical practice. Ethical issues related to the integration of patient's spirituality/religiosity into health care practices are discussed.

**Keywords** Brazilian physicians' beliefs · Spirituality/religiosity · Clinical practice

## Introduction

Studies on spirituality and health are robust in demonstrating how much the patient's spirituality/religiosity guides and influences the course of the treatment. In Brazil, literature on spirituality and health has grown significantly, especially since 2010. Medicine and nursing are the leading research fields on this subject. However, if compared to USA and Europe, it may be alleged that research in Brazil is just beginning.

A subset of the emerging work in Brazil addresses the role of physician's beliefs. Do their understandings influence and/or determine their practices? This study reflects on clinical practice implications of physician's beliefs and attitudes toward patients' spirituality in the Brazilian context. We initially review the Brazilian literature on the subject. Then, we present survey data collected between 2014 and 2015 from 48 doctors who

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✉ Mary Rute Gomes Esperandio  
mary.esperandio@pucpr.br

Geilson Antonio Silva Machado  
geilson.teologia@gmail.com

<sup>1</sup> Post-Graduate Program in Bioethics, Pontifical Catholic University of Paraná (PUCPR), Rua Brigadeiro Franco, 4185, ap. 11, Curitiba, PR CEP 80.220.100, Brazil

<sup>2</sup> Department of Theology, Faculty of Theology, Pontifical Catholic University of Paraná (PUCPR), Curitiba, PR, Brazil

worked in two hospitals in the city of Curitiba (capital of the State of Paraná, in the South of Brazil). Finally, we point out some of the challenges and ethical issues that should be taken into account when it comes to the integration of spirituality into health care practices.

It is first necessary to define the words “religiosity” and “spirituality” as they are used here. Religiosity, derived from religion, is shaped by the individual’s involvement in specific religious activities, such as prayers, attendance at worship services, masses and the most varied types of encounters promoted by some form of established religion. As noted in the study of Esperandio (2014, p. 808), “in general, the religious subject assumes certain ethical-moral beliefs, practices and values linked to an established religion.”

Spirituality, on the other hand, is a term with a more complex meaning, and the dissent around its meaning is not of little importance. Studies do not always point out a distinction between religiosity and spirituality, and an interchangeable use of the two terms can be found. Taking the word spirituality as originating from spirit (source of the vital energy of the human being) one can assume that spirituality cannot be understood outside the parameters of seeking for ultimate purpose and meaning to existential questions. In this perspective, both terms, spirituality and religiosity, are linked to the spiritual dimension of subjectivity where the need to produce meaning arises. As stated by the European Association for Palliative Care,

Spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant, and/or the sacred. (Nolan et al. 2011, p. 88).

For the purpose of this study, we will use the binomial spirituality/religiosity (S/R).

## **Overview of Brazilian Studies on Physicians’ Beliefs and Attitudes Toward Patients’ Spirituality/Religiosity**

A search in three databases was undertaken: SciELO—Scientific Electronic Library Online;<sup>1</sup> VHL—Virtual Health Library<sup>2</sup> and CAPES (Coordination for the Improvement of Higher Education Personnel)—Database. The following search terms were used: “physicians and beliefs”; “physicians and religion”; “physicians and spirituality”; “spirituality and medical practices.” The search was carried out in Portuguese and English in 2016 and again in 2018. We found 69 articles on SciELO database; 248 studies on VHL database (245 articles and three Masters Dissertations); and 262 studies on CAPES database.

After the elimination of irrelevant works and/or duplicate studies and letters to the editor, 13 studies remained for analysis, of which 10 were in the medicine field, 2 in psychology and 1 in bioethics. The studies were categorized into 3 areas: (1) absence of content on spirituality and health in the Medical Education curriculum; (2) practice of S/R integration from the perspective of professionals and patients; (3) dominant trend in the current medical practice on the integration of S/R in patient care.

<sup>1</sup> SciELO is an electronic library that covers 344 Brazilian scientific journals.

<sup>2</sup> The information sources of VHL Brazil derive from National Thematic VHL instances, obeying their quality criteria and methodology. The coordination of the VHL Brazil portal is maintained by the Ministry of Health in Brazil and BIREME/PAHO/WHO.

## Absence of Content on Spirituality and Health in the Medical Education Curriculum

Four studies investigated how spirituality and health issues appear in the medical education process and in the curriculum of Medicine Courses in Brazilian Universities (Lucchetti et al. 2012; Banin et al. 2013; Lucchetti et al. 2013; Reginato et al. 2016). Lucchetti et al. (2012) investigated the issue of teaching spirituality and health (S/H) in 180 Brazilian universities among 86 survey respondents. The authors pointed out that “only two medical schools have S/H courses that involve hands-on training and three schools have S/H courses that teach how to conduct a spiritual history” (Lucchetti et al. 2012, p. 1). Two studies (Banin et al. 2013; Lucchetti et al. 2013) show the perception of medical students about the relation between spirituality and medical practice.

Lucchetti et al. (2013) carried out a multicenter research trial in 12 Brazilian universities which collected data from 3630 medical students. The results showed that 68.2% of the medical students believed that spirituality has a positive impact on the patients’ health. During the course, however, 81.0% claimed they had never participated in any activity on the theme “spirituality and health,” a subject rarely addressed by their tutors/professors. Furthermore, 48.7% of students felt unprepared to address the issue of spirituality with patients. The majority of students believed they should be prepared on how to deal with such issues in clinical practice (61.6%) and that this content should be included in the curriculum (62.6%).

The study of Banin et al. (2013) makes a comparison between the perception of students and professors about the training received. A total of 475 medical students and 44 professors participated in the study. Results indicated that students addressed the subject with patients less often than did professors. Noteworthy is the fact that not only did the students feel unprepared to approach S/R issues with patients, but professors also feel unprepared to discuss these topics with their students.

The experience of offering the course “spirituality and medicine” for medicine and nursing students at the Federal University of Sao Paulo (UNIFESP) and *Escola Paulista de Enfermagem* (Sao Paulo’s Nursing School) was described and analyzed by Reginato et al. (2016). The course was offered for four years (2007–2010), with the participation of 114 undergraduate medicine and nursing students (between the 3rd and 8th semesters). Based on student evaluations, the authors concluded that “for an adequate preparation of the student entering the health area, the field of spirituality cannot be evaluated as a curiosity or a possibility, but a necessary requirement, as declared by the students themselves” (Reginato et al. 2016, p. 252).

## Practice of S/R Integration from the Perspective of Professionals and Patients

Four studies (Oliveira et al. 2013; Junqueira 2008; Albuquerque 2006; Souza Júnior et al. 2015) analyze the practice of physicians in relation to the integration of S/R in patient care and highlight the divergence that exists between the physician’s and the patient’s perception on this topic.

Oliveira et al. (2013) conducted a cross-sectional study with 101 patients in a general hospital setting regarding their perceptions of how doctors and other health professionals approach S/R issues. Participants reported high levels of religiosity and great belief in the potential influence of religiosity on health. According to researchers, 84.2% of participants believed that “to take care of health also means to be assisted in spiritual/religious needs”;

81.1% felt that health professionals should recognize the religious/spiritual beliefs as part of the treatment plan; 76.7% felt entitled to have their spiritual/religious needs met during a medical care or hospitalization; and 81.3% believed that their religious beliefs helped them to understand and deal with the process of health and disease. Despite this, 86% of patients had never been asked about their beliefs on medical care. The researchers conclude that there is a gap between the desire of patients on this subject and medical conduct.

Souza Júnior et al. (2015) compared the perception of physicians with the perception of patients they treated. The researchers collected data from 10 patients and 10 clinicians on the personal conception of religion and the importance of the same for the treatment. Both groups said they considered it very important in the evolution and prognosis of the disease, because it provides strength and comfort, and this perception was reported by 60% of physicians and 90% of patients.

The research projects of Junqueira (2008; conducted in Brasília), and Albuquerque (2006; in São Paulo), have similarities in design and results. Both studies are in the area of psychology and the researchers conducted in-depth interviews with 8 physicians, to identify their R/S conceptions and behaviors toward patients. The studies highlight the difficulty of these professionals in integrating spirituality/religiosity in the practice of care. Those who address the topic, however, report that their intuition is that it changes the bond between them and the patients.

### **Dominant Trend in Current Medical Practice on the Integration of S/R in Patient Care: Between Recognition and Unpreparedness**

Five studies address the dominant trend in current medical practice (Aguilar et al. 2017; Lucchetti et al. 2015; Azambuja and Garrafa 2010; Pinto and Falcão 2014; Spinelli et al. 2014). In the area of bioethics, Azambuja and Garrafa (2010) “studied the extent of knowledge and acceptance of hemocomponents and hemoderivatives, fresh and stored, by Jehovah’s Witnesses and proposed bioethical tools for any ethical and moral conflicts identified in their relation with physicians and dentists.” The authors found that 83% of the 150 subjects in the sample were never asked for their religious choice by their dentists, and 71% were not asked by their physician. Azambuja and Garrafa concluded that data showed little concern of medical professionals on this issue.

Although based on a small sample, the research of Pinto and Falcão (2014) is very significant and represents some Brazilian physicians’ perceptions on this topic. The researchers investigated what medical doctors think about patients’ religiosity regarding the disease and treatment; how they deal with their own religion in the work context; and how they approach patient’s religiosity. The study was conducted in the context of treatment of chronic kidney disease patients (CKD), in Rio de Janeiro (Pinto and Falcão 2014). The researchers used the Theory of Social Representations (discourse of the collective subject) for collecting and analyzing data. The researchers concluded that almost all the investigated medical group understood religious belief as a powerful psychological resource for situations in which human suffering is involved, as in the case of CKD patients on hemodialysis. Nevertheless, in clinical practice, religion is frequently relegated to the background and its approach is “seen as problematic,” especially because of the lack of preparation for such conversations. The study also reveals that S/R “seen as problematic” is not based on studies of the subject, on academic preparation or on the exchange of experiences between peers. For the researchers, the difficulties could be linked to the biomedical model and has prevailed in medical training. The authors’ conclusions align

with quantitative surveys regarding how medical education in Brazil deals with this human dimension in relation with health.

The study of Spinelli et al. (2014) highlights implications of medical beliefs in clinical practice. Describing the use of emergency contraception in Family Health Centers (USF) in Recife (northeastern Brazil), the authors note that 65.8% of physicians and nurses who participated in the study agreed that religion interferes with their decision for prescription/orientation of emergency contraception.

Lucchetti et al. (2015) carried out a cross-sectional, cross-cultural, multicenter study from 2010 to 2012 in three economically emerging countries from two continents. A total of 611 physicians (194 from Brazil, 295 from India and 122 from Indonesia) participated in the study. The Brazilian physicians enrolled in the study were from Marília University Hospital, Marília Faculty of Medicine and Marília Medical School in Brazil. The majority of Brazilian physicians are Christians (94.9%), and 5.1% reported no religious tradition. According to the authors, 55.2% of the participating Brazilian physicians believed that S/R influenced patient's health and that this influence is positive (70.7%). However, when asked how frequently they inquire about patient's S/R issues, only 11.1% said they do it often. Additionally, 95.9% reported not having received any formal training regarding S/R.

The most recent study conducted by Aguiar et al. (2017) among 73 family medicine physicians shows that 89% consider spiritual care in health practices as “important” or “very important,” and 94.6% consider that spirituality contributes to physical health. However, only 13.7% reported having encountered this content during formal training. The study points out that “doctors seem to recognize the importance of spirituality for patients and health, but are less strongly inclined to consider their role as caregivers of this dimension” (Aguiar et al. 2017, p. 310).

Brazilian studies reveal the biomedical perspective as the dominate posture governing this subject. The literature points out that the practice of “lay medicine” or the search for “neutrality” in the Brazilian medical context (Albuquerque 2006; Junqueira 2008; Oliveira et al. 2013; Pinto and Falcão 2014) causes a gap between the patients' desire to integrate spirituality in the health treatment and the silence of the professionals regarding these issues.

The studies also point out that medical students are receptive to the S/R theme, although teachers still have difficulties approaching the topics with the students. The demand for specific education for students and professionals regarding the integration of spirituality into clinical practice is therefore evident. As the various studies show, R/S values and beliefs of professionals have some role to play in the care relation of the patient.

## The Empirical Research: Method

This is a descriptive and exploratory cross-sectional study using a questionnaire submitted to health professionals, physicians and chaplains of two general hospitals in the city of Curitiba-PR, Brazil: Cajuru University Hospital and Santa Casa of Curitiba. Both hospitals serve the population of the Unified Health System (public service), and have an enormous patient flow, keeping physicians very occupied and making recruitment of participants difficult. At the time of the research, both hospitals were directed by the Marist Group.

The National Registry of Health Establishments of Curitiba (CNES—Curitiba) showed that, at the time of the research, in one of the hospitals there were about 150 registered doctors and in the other, about 170. Around 600 health professionals (physicians, nurses, pastoral care staff) of these two hospitals were informed about the research project by

means of an electronic mail sent by the coordinator of the Department of Hospital Humanization. All of them were invited to participate in the study. The Department of Humanization, responsible for the coordination of the Pastoral Service of the two hospitals, provided support for data collection in both places, pointing out potential participants, who were personally approached and invited.

Two modes of participation in the study were offered. The instrument was self-administered. Some people filled out an electronic (Qualtrics) version. Others completed a printed version and then returned it to the researcher who transferred the information to Qualtrics. The data analyses were carried out using SPSS 20 (Statistical Package for the Social Science).

In one of the hospitals, data were collected from 105 health professionals (nurses, pharmacists, psychologists, social workers, chaplains, etc.), including 21 physicians. At the other hospital, data were collected from 27 physicians (without the participation of other health professionals). This study presents results only from the combined sample of the 48 physicians. The Department of Humanization estimated that this number represented just over 10% of the physicians working in these two hospitals.

Data were collected by the second author, between 2014 and 2015. The study was approved by the Research Ethics Committee of the Pontifical Catholic University of Paraná (Process 48582). Informed consent was obtained from all participants. The instrument used for collecting data was constructed by the first author. It was comprised of 32 closed-ended questions and one open-ended question organized in 5 sections: 1. Sociodemographic data, 2. Concepts of religiosity and spirituality, 3. Beliefs and attitudes about the relation between spirituality/religiosity and health, 4. Spiritual/religious coping, 5. Expertise and experience in integrating spiritual/religious issues in healthcare settings. Possible answers to the closed questions ranged from 1 to 5 (Likert scale): “I totally disagree (1)—I totally agree (5)” and from “very untrue” (1) to very true (5).

## Results

### Sociodemographic Data and Religious Profile

From the 48 physicians, 26 were hired doctors and 22 were residents. They represented a variety of specialties: infectologist physician; general practitioner; cardiologist; nephrologist; anesthesiologist; general surgeon; vascular surgeon; psychiatrist; otorhinolaryngologist; administrative physician; and oncologist. The average time-in-profession was 14 years. The gender distribution, age, marital status and professional work time are presented in Table 1.

Spirituality/religiosity has an important place in the research sample. This is evidenced by the self-reported religiosity, the frequency of attending religious services and the frequency in which respondents engage in private religious activities (See Fig. 1 and Table 2).

Most of the doctors considered it important to have a private time for prayer and/or meditation; this was more valued than group practices. Most of the physicians (79.2%) strive to live a life according to their religious beliefs, while 54.2% say that their whole life is based on their spirituality and 83.3% of them said they felt God’s divine presence in their lives.

**Table 1** Sociodemographic data.  
*Source:* The authors

	Frequency	Valid percentage
<b>Gender</b>		
Male	20	41.7
Female	28	58.3
Total	48	100.0
<b>Age</b>		
21–25 years	1	2.1
26–30 years	12	25.0
31–35 years	13	27.1
36–40 years	12	25.0
+ 40 years	10	20.8
Total	48	100.0
<b>Marital status</b>		
Single	19	39.6
Married (or living as married)	20	41.7
Divorced	6	12.5
Widowed	3	6.3
Total	48	100.0
<b>Professional working time</b>		
0–5 years	12	25.0
6–10 years	14	29.2
11–15 years	13	27.1
16–20 years	5	10.4
+ 20 years	4	8.3
Total	48	100.0
<b>Internship/employed physician</b>		
Employed physician	26	54.2
Internship	22	45.8
Total	48	100.0

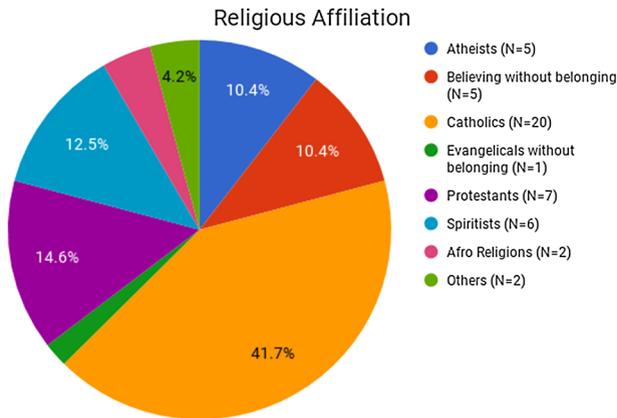
### Physicians' Beliefs Concerning the Relation of Spirituality/Religiosity and Health

As to the beliefs and attitudes regarding the relation between spirituality and health, data show that the majority of medical doctors perceive a positive impact of spirituality into the treatment, especially the influence of religious activities during the treatment process (Table 3).

What is the relation of these beliefs and values to the medical practice? Most of the physicians agree that they should better understand the potential relation between S/R and health and not only know the religious beliefs of the patient, but also their spiritual needs.

### Physicians' Beliefs and Medical Practices

How do doctors feel about addressing S/R matters with their patients? Do they feel comfortable? When asked if patients would like to bring S/R issues into the treatment,



**Fig. 1** Religious affiliation. *Source:* The authors

41.7% chose the option “not true/nor false,” indicating that they have doubts about it, perhaps due to unawareness about the expectations of the patient regarding these issues.

A high percentage of physicians agree on the need for a hospital chaplaincy service. However, the majority of the Brazilian hospitals do not offer this service, which is usually performed by volunteers without professional training in spiritual care.

It is important to notice the gap between the perceived positive influence of spirituality on the treatment (85.4%), the importance of recognizing the patient’s spiritual needs (77.1%) and the (self-reported) frequency with which such issues are addressed with patients. When asked to reflect on the statement: “I frequently ask my patients about S/R matters,” 25% of them reported “somewhat true” and only 8.3% responded “very true” suggesting that few of them actually do it frequently (Table 4).

### **Open-Ended Question: Self-reported Experience of Integration of S/R in Patient Health Care**

The open-ended question asked the physicians to report an integration experience of spirituality/religiosity in the treatment. The processing of such data was based on the content analysis methodology. Eighteen participants (37.5%) did not answer the question. The 30 valid answers (62.5%) were categorized as follows:

#### **Recognition of the Positive Influence of Spirituality/Religiosity Into the Treatment of Patients ( $n = 11$ )**

Physicians maintain a respectful attitude, but are passive and/or distant in relation to this issue. This can be demonstrated by comments such as:

“I note that the patient with a greater religiosity and spirituality has a better recovery or treatment adherence” (female; employed physician; Catholic; +40 years old; +20 years professional work time)

“We must respect the beliefs and convictions of others even if they do not make sense to me.” (male; employed physician; Atheist; 30–35 years old; 6–10 years professional work time)

**Table 2** Spiritual/religious practices. *Source:* The authors

	Frequency	Valid percentage
“Frequency of church attendance”		
Once a week	13	27.1
2 or 3 times per month	8	16.7
Some times per year	11	22.9
Once a year (or less)	9	18.8
Never	7	14.6
Total	48	100.0
“Frequency of private religious activities (prayer, meditation etc.)”		
More than once per day	7	14.6
Daily	15	31.3
2 or 3 times per week	10	20.8
Once a week	2	4.2
Some times per month	5	10.4
Rarely or never	9	18.8
Total	48	100.0
“I frequently use my religious beliefs to cope with difficult situations”		
Very untrue	4	8.3
Somewhat untrue	3	6.3
Neither true nor untrue	6	12.5
Somewhat true	20	40.0
Very true	15	31.3
Total	48	100.0

### Reasons Presented for not Integrating These Issues into the Treatment ( $n = 16$ )

Physicians do not address spirituality/religiosity issues in the treatment because of:

(a) Lack of time ( $n = 3$  out of 16)

“In the rush of our everyday life, I have little time to treat the patient and even less time to know him beyond his illness” (female; employed physician; Evangelical; 26–30 years old; 0–5 years professional work time)

(b) Lack of knowledge and training ( $n = 4$  out of 16):

“I confess not to think too much about the relation between spirituality and my daily work” (male employed physician; Catholic; + 40 years old; 16–20 years professional work time).

“I do not feel comfortable or prepared to deal with religious issues, so I consider the work of psychologists and pastors, that have training and sufficient information to deal with this important aspect of patients” (male; resident physician; Atheist; 36–40 years old; 6–10 years professional work time).

“I never thought there was any proximity of both issues, but thinking calmly about it, I realize that religiosity and patient care are inseparable” (male; employed physician; No-Religion; + 40yo; 6–10 years professional work time).

**Table 3** Physicians' beliefs concerning the relation between S/R and health. *Source:* The authors

	Frequency	Valid percentage
“People turn to religion when facing health problems”		
Strongly disagree	1	2.1
Neither agree nor disagree	4	8.3
Agree	27	56.3
Strongly agree	16	33.3
Total	48	100.0
“Religious issues impact health outcomes”		
Strongly disagree	4	8.3
Disagree	1	2.1
Neither agree nor disagree	12	25.0
Agree	23	47.9
Strongly agree	8	16.7
Total	48	100.0
“Some religious beliefs and practices have negative impact on health treatment”		
Strongly disagree	2	4.2
Neither agree nor disagree	7	14.6
Agree	29	60.4
Strongly agree	10	20.8
Total	48	100.0
“Patient’s religious activities (such as prayer, meditation and church attendance) positively contribute to the treatment”		
Disagree	1	2.1
Neither agree nor disagree	7	14.6
Agree	23	47.9
Strongly agree	17	35.4
Total	48	100.0
“Patient’s spirituality has a positive influence on the treatment”		
Disagree	1	2.1
Neither agree nor disagree	6	12.5
Agree	28	58.3
Strongly agree	13	27.1
Total	48	100.0

These same difficulties are reported not only by physicians but by several other health professionals as well (Esperandio 2014; Marques et al. 2015).

(c) Ethical concerns ( $n = 4$  out of 16):

Some of them consider that S/R is a private matter:

“I consider the religious experience to be personal and not transferable, so I consider it difficult to ponder over the need of my patients in addressing such issues.” (male; resident physician; Afro-Bras-Relig.; 31–35 years old; 6–10 years professional work time)

**Table 4** Clinical practice and S/R: physicians' beliefs and perceptions. *Source:* The authors

	Frequency	Valid percentage
<b>“It’s important for healthcare professionals to better understand the relationship between S/R and health”</b>		
Strongly disagree	1	2.1
Neither agree nor disagree	7	14.6
Agree	26	54.2
Strongly agree	14	29.2
Total	48	100.0
<b>“It is important to recognize the patient’s spiritual needs”</b>		
Strongly disagree	1	2.1
Neither agree nor disagree	10	20.8
Agree	25	52.1
Strongly agree	12	25.0
Total	48	100.0
<b>“Physicians need to know their patients’ religious beliefs”</b>		
Strongly disagree	2	4.2
Disagree	1	2.1
Neither agree nor disagree	10	20.8
Agree	26	54.2
Strongly agree	9	18.8
Total	48	100.0
<b>“Patients would like to bring S/R issues into treatment”</b>		
Somewhat untrue	2	4.2
Neither true nor untrue	20	41.7
Somewhat true	24	50.0
Very true	2	4.2
Total	48	100.0
<b>“I frequently ask my patients about S/R issues”</b>		
Very untrue	7	14.6
Somewhat untrue	14	29.2
Neither true nor untrue	11	22.9
Somewhat true	12	25.0
Very true	4	8.3
Total	48	100.0
<b>“I feel comfortable in raising and exploring S/R issues during treatment”</b>		
Very untrue	14	29.2
Somewhat untrue	11	22.9
Neither true nor untrue	14	29.2
Somewhat true	13	27.1
Very true	7	14.6
Total	48	100.0
<b>“It’s important to have chaplaincy services to assist patients’ spiritual needs”</b>		
Disagree	1	2.1
Neither agree nor disagree	3	6.3
Agree	24	50.0

**Table 4** continued

	Frequency	Valid percentage
Strongly agree	20	41.7
Total	48	100.0
“I would refer a patient to a chaplain if I knew he/she is competent to assist the patients’ S/R needs”		
Very untrue	1	2.1
Somewhat untrue	2	4.2
Neither true nor untrue	6	12.5
Somewhat true	20	41.7
Very true	19	39.6
Total	48	100.0

- (d) Some other physicians stated that they had no experience of integrating S/R into the treatment to report ( $n = 5$  out of 16).

### Self-reported Experiences of Integration

Self-reported experiences of integrating S/R into the clinical practice were described only by three female physicians. Such integration is carried out as follows:

- (a) By suggesting S/R practices: comfortable or prepared to deal with

“Whenever possible, I suggest my patients to pray, and when entering a surgery, I always say to the family that God is operating with us.” (male; employed physician; No-Religion; 36–40yo, 11–15ypwt).

- (b) Through an empathic listening:

“I learned that for a proper diagnosis it is essential to listen to the patient, and often this listening process brings up the religious issue. I remember a case in which a patient was diagnosed with breast cancer and immediately associated the disease to a divine punishment because of an abortion experienced years before, on this occasion I had the opportunity to embrace her and help her face the shock of the diagnosis with a little more calm.” (female; employed physician; 36–40yo; Evangelical; 11–15ypwt).

- (c) Based on doctors’ own beliefs/values:

“...to make the patient understand the importance of faith.” (female; employed physician; 36–40yo; Spiritism; 16–20ypwt)

### Discussion

As other studies in Brazil show and the present study agrees, there appears to be an ambiguous attitude of receptivity and silence on S/R issues in clinical practice. The “receptivity” is evidenced by the belief that “patients’ faith is very important to their healing process [and because of that], it is important to respect it” (female; resident physician; 36–40yo; atheist; 6–10ypwt). This indicates that the professionals seem sensitive to the subject, albeit with a “passive recognition,” characterized by silence in front of these

issues. Although the majority of Brazilian physicians in this study are Christians, use religious beliefs to cope with difficulty and believe that patients use R/S for coping, few of them ask about S/R issues (8.3%). This strongly evidences the suppression of the S/R dimension from their care practices. This attitude may be signaling an attempt to search for “scientific neutrality” in front of this dimension, leaving the S/R processes for individual patients to navigate.

### Patients will Integrate the Spiritual Dimension Anyway

Although most professionals do not integrate this dimension in the treatment process, it is done by the patient. In this case, patients will do it their own way, with their own resources, since S/R is a cultural trait in the subjectivity of Brazilians. So, this integration will be made with or without the knowledge of the professional, as indicated by studies of Ferreira and Espírito Santo (2012) when investigating the “pathways of healing” among slum dwellers of Rio de Janeiro. The authors point out the risk of negative consequences in the treatment; for example, physicians may not notice that their patients have not adhered to the treatment for religious reasons.

There is a clear perception of the positive influence of S/R in health outcomes. But as Curlin et al. (2005) notes, medical doctors are not susceptible to address these issues simply because S/R may in some situations be related to the general welfare and to better coping with the disease. Behind this approach lies the old conflict about what is or is not scientific. Studies highlight that some aspects of religious or cultural tradition may affect health care choices and coping skills (Lucchetti et al. 2015). However, the recognition of the spiritual/religious dimension of the patient may be a benefit (one of the principles of bioethics) for the treatment, in most cases, once it:

- (a) Strengthens the doctor–patient bond. When the patients feel validated in their S/R beliefs, they will feel entirely welcomed. To know they are respected and valued places them in a more collaborative role in the treatment; it strengthens their trust in the health professional (Junqueira 2008; Albuquerque 2006).
- (b) Opens space for dialogue and enhances patients’ autonomy in medical decisions, dismantling the professionals’ paternalism. Wheatley (2002, p. 22) observes that “real change begins with the simple act of people talking about what they care about.” She argues that there is both power and empowerment in people giving voice to the things that really matter to them. It is not possible to deliver good health care apart from an appropriate listening that empowers patient’s autonomy. The present study shows that physicians are listening to what their patients are saying about this theme. However, some doubts about the quality of such listening remain, since only few of them often ask their patients about S/R issues.
- (c) Enables appropriate intervention. It is noteworthy that there is a positive attitude of physicians in relation to the role of the hospital chaplain, although this is still a rare position in Brazilian hospitals. When addressing S/R issues, the professional can identify potential spiritual conflicts (as in the case of the patient who linked cancer to a divine punishment for an abortion performed years earlier). But beyond the role of chaplains, the consideration of S/R issues demands an interdisciplinary intervention, with the participation of additional professionals such as physicians, nurses, psychologists and social workers. Thus, in order to identify patient’s spiritual needs/conflicts, the professionals can provide a proper referral to the chaplaincy service, and in situations of antagonistic postures between doctor and patient based

on S/R elements, assistance can be given by the Hospital Ethics Committee. Physicians do not have to be “super (wo)men,” responsible for every aspect of their patients’ needs. On the contrary, sharing responsibilities with other professionals by referring patients to be assisted in their needs is an exercise of humility, compassion and self-compassion, and this attitude also prevents burn-out and empathy fatigue.

### **Bioethical Issues—Some Challenges to the Brazilian Context**

This study suggests that beliefs and medical values have implications for health care practices in Brazil. Sometimes such influences can be visible and convincing, other times, they are unseen and subtle.

Despite the evidence suggesting the potential importance of integrating spirituality into patient care, it is important to note that this integration has nothing to do with prescribing religious practices. No religion can be prescribed. Moreover, integration does not depend on the belief or disbelief of professionals. The focus of care should be placed on patient’s needs (patient-centered-care). In this sense, it is possible to describe spirituality as an invisible resource, without cost, that may contribute to positive health outcomes; it should be properly considered by health care professionals. The integration of spirituality into the treatment characterizes a holistic care approach and embodies the bioethical principle of Beneficence and Dignity, for treating the patient holistically is treating the patient with dignity.

Coping with an illness characterizes a vulnerable situation (Schramm 2008). The search for meaning in the midst of suffering is one of the main strategies used by the patient to minimize the effects produced by the state of vulnerability in which they find themselves. It is in the dimension of spirituality that this sense will be found or constructed. For some, the meaning will be found in religious beliefs and practices, because religion is a way of expressing spirituality. Therefore, allowing the patients to bring their S/R beliefs into the treatment can be beneficial (Puchalski and Romer 2000; Koenig 2004). In the case of medical decisions, especially in the context of chronic diseases and palliative care, S/R beliefs may be both, a deterrent or a tool, and the physician needs to be aware of it (Nawawi et al. 2012; Koenig 2004).

Thus, the need for specific training is becoming more and more conclusive, so that health professionals know how to take a spiritual history. The spiritual history makes it possible to adequately support the patient’s beliefs and meet their spiritual needs, such as referring them to specialized care with a hospital chaplain (or a religious leader) of the multidisciplinary team (Puchalski and Romer 2000; Koenig 2004).

One of the challenges that the study reveals is the need of chaplaincy service, with qualified chaplains, with abilities for interdisciplinary dialogue, in order to meet the spiritual needs of patients. Investigations that will strengthen and contribute to a shift from the biomedical paradigm to a biopsychosocial and spiritual (holistic) paradigm are urgent in Brazil.

### **Final Considerations**

This empirical study is limited in size. It points out, however, that the beliefs and values of physicians about S/R influence their practices. As the goal in medical education is the biomedical perspective, the dimension of S/R is generally undervalued in clinical practice, yet professionals recognize it as a potential factor for health care. This study confirms that

one of the difficulties for the non-integration of S/R in clinical practice is related to the received education. It suggests a need for efforts toward specific brief courses on the subject. However, beyond the aspect linked to the issue of professional education, the challenge actually seems to be in the paradigm shift underlying medical postures in the practice of care. The benefits of the integration of spirituality in the care practice are beyond their potential role in patients' physical health, as pointed by Reginato et al. (2016). It can also enhance the physicians' quality of life, since it relates to their spirituality as well. The biopsychosocial model needs to be extended (Hefti 2013). It calls for revisiting the way of seeing the human being beyond the disease, diagnosis and merely physical welfare, and also beyond a "place or role," not mattering if this human being is a patient or a health professional.

To advance the studies on this topic, future research should focus, for instance, on how the integration of spirituality speaks to both patient's and physicians' quality of life; which strategies might be the best to be applied for a better health care; how non-religious patients could adequately be assisted in their spiritual (not religious) needs.

Considering the importance of religiosity in the Brazilian cultural context, the deepening of studies on this subject would be of great relevance for Public Health and for the various sciences that deal with ethical aspects in the health field. In this sense, it is suggested that research adopts an interdisciplinary perspective, especially the theoretical–practical considerations developed in bioethics, psychology and theology, that can contribute greatly to the future studies on the subject.

## Compliance with Ethical Standards

**Conflict of interest** The authors declare that they have no conflicts of interest.

**Ethical Approval** The study was approved by the Research Ethics Committee (Process 48582; CAAE: 04643412.1.0000.0020) of the Pontifícia Universidade Católica do Paraná – PUCPR - Brazil.

**Informed Consent** Informed consent was obtained from all individual participants included in the study.

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