1. **Issues of Incorporating Faith Issues into Medical Practice**

Physicians are often hesitant to discuss spiritual matters or religion with patients for ethical and personal reasons (1). Some physicians may perceive questions about religion or spirituality as intrusive or a violation of physician-patient relationship; however, recent trends in medical education have caused 70% of medical schools to include course work on spirituality in clinical practice (2). Physicians are trained to treat patients regardless of the patient’s ethnic or religious background. The lack of quantitative methodologies to measure spiritual or religious activity limits the value of correlative studies that compare health outcomes to “spirituality”. This lack of clinical data reduces certainty among physicians about any demonstrated beneficial effect from personal faith as professed by the patient. Some physicians may doubt the existence of a higher power and some may harbor negative feelings towards religious or spiritual beliefs, as well as organized worship (3).

2. **Defining The Measurement of Spirituality and Religion**

Spirituality can be defined based on the HOPE paradigm. The HOPE spiritual assessment follows the acronym with “H” representing sources of hope or strength; “O” represents the role of organized religion; “P” represents personal spirituality and practices; and “E” depicts the effect on medical care and end of life decisions. Some longitudinal studies with specific diseases, such as HIV infection suggest that patient survival is related to frequency of prayer and inversely proportional to the patient’s judgmental attitudes (4). The intensity and quality of a patient’s spiritual life is difficult to measure (18).

The measurement of religion and spirituality may not provide equal prediction for outcomes. Several studies indicate that greater spirituality but not greater religiosity are more likely to predict good health in an older individual (5), (6).

3. **The Link Between Spiritual and Physical Vitality in Older Persons**

Spirituality appears correlated to health outcomes and quality of life in older individuals. For hospitalized older individuals, increased spirituality predicts fewer depressive episodes and better cognitive function (7), (8). Longitudinal
studies suggest that increased lifetime organized religious activity may predict decreased likelihood for prolonged, utilization of long-term care services by the older patient. Likewise, the magnitude of intrinsic, self-described spirituality appears correlated to outcomes of health and pain management (9).

Individuals with active, spiritual and religious lives demonstrate a diminished risk of developing depression in later life, as well as severe functional impairment produced by the psychiatric disability (10), (11), (19), (20). The relationship between spirituality, religion, and health outcomes may be related to stress coping and maintenance of mood. Individuals with active spiritual lives appear to enjoy diminished levels of stress and less evidence for depression producing better outcomes for chronic health problems or hospital care. The role of formalized religious activity is less clear; however, some studies do support the relationship between organized activity and reduced long-term medical morbidity (12), (13).

4. Conclusion About the Role of Spiritual Vitality in Maintaining Cognitive Vitality

Older individuals can become marginalized in spiritual communities. Pastors may not recognize the positive impact of spiritual activity on the quality of an elder’s life and longevity. No data exists to compare spiritual activity with risks for developing cognitive decline. Spirituality may enhance psychosocial function (22). Depression, chronic stress, and diminished activity are potential risk factors for cognitive decline in later life that may be mitigated by active, personal spirituality (CLICK HERE FOR MORE INFORMATION – 2513.31, 2513.51). A growing body of medical literature defines the role of spirituality in clinical practice (14), (15), (16). Physicians are encouraged to promote spiritual and religious activity in those patients who have selected to achieve these internal goals. Each physician must determine their level of comfort in discussing this matter with mid-aged and older individuals. Physicians should avoid proselytizing or attempts at convincing patients who hold contrary beliefs (13). Older persons often serve as caregivers and spirituality improves their overall outcome (20) (21).

Recommendations to Primary Care Physicians

1. Recognize that any active spiritual life may promote successful aging.
2. Consider the individual spiritual needs of each patient.
3. Encourage an active spiritual life in appropriate patients.
4. Respect those patients who do not maintain or value an internal spiritual life.
5. Empower patients to expect that their spiritual community will include them in all aspects of a faith life.
References:


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