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Qualitative Research

Experiences of German health care professionals with spiritual history taking in primary care: a mixed-methods process evaluation of the HoPES3 intervention

Carolin Huperz[1,2], Noemi Sturm[2], Eckhard Frick[3], Ruth Mächler[3], Regina Stolz[4], Friederike Schalhorn[4], Jan Valentini[4], Stefanie Joos[4], Cornelia Straßner[2,*]

[1]Institute for General Practice and Palliative Care, Hannover Medical School, Hannover, Germany
[2]Department of General Practice and Health Services Research, University Hospital Heidelberg, Heidelberg, Germany
[3]Department of Psychosomatic Medicine and Psychotherapy, Professorship of Spiritual Care and Psychosomatic Health, Technical University of Munich, München, Germany
[4]Institute of General Practice and Interprofessional Care, University Hospital Tübingen, Tübingen, Germany

*Corresponding author: Department of General Practice and Health Services Research, University Hospital Heidelberg, Im Neuenheimer Feld 130.3, 69120 Heidelberg, Germany. E-mail: Cornelia.strassner@med.uni-heidelberg.de

Background: Spiritual needs gain importance in old age but are often ignored in health care. Within the 'Holistic care program for elderly patients to integrate spiritual needs, social activity and self-care into disease management in primary care (HoPES3)' a complex intervention was evaluated in a cluster-randomized trial. The aim of this study was to explore the acceptability, feasibility, benefits, and harms of a spiritual history taken by general practitioners (GPs) as part of the complex intervention.

Methods: In this mixed-methods study telephone interviews with 11 German GPs and 12 medical assistants (MAs) of the HoPES3 intervention group were conducted and analysed using a content-analytical approach. Furthermore, GPs were asked to complete a questionnaire after each spiritual history. One hundred and forty-one questionnaires from 14 GPs were analysed descriptively.

Results: GPs considered the spiritual history very/quite helpful for the patient in 27% (n= 38) and very/quite stressful in 2% (n = 3) of the cases. Interviews indicated that GPs found discussing spiritual history easier than anticipated. GPs and MAs saw a difficulty in that many patients associated spirituality with religion or church and reacted with surprise or rejection. Benefits for patients were seen in the opportunity to talk about non-medical topics, and increased awareness of their own resources. Benefits for GPs mainly related to information gain and an intensified patient–physician relationship.

Conclusions: A spiritual history in general practice has the potential to reveal important information about patients' lives and to improve the patient–physician relationship. Implementation barriers identified in this study have to be considered and addressed.

Key words: aged, general practice, holistic health, multimorbidity, spirituality

Introduction

About one-third of patients seen by general practitioners (GPs) are 60 years old or older and 40% of these patients take 8 or more medications.[1] This patient group experiences a significantly lower quality of life.[2,3] Besides the burden of symptoms, the economic and social burden of disease also contributes to this. For instance, many studies show that multimorbidity is frequently associated with loneliness, hopelessness, and a feeling of powerlessness.[4–6]

Attempts to improve the care for this patient group usually focus on standardizing medical processes. In Germany for example, disease management programmes (DMPs) for patients with diabetes, coronary heart disease, and asthma/chronic obstructive pulmonary disease are offered by GPs. The core concept of DMPs are structured assessments every 3–6 months. The importance of such measures is undeniable. Yet there is a risk of neglecting other dimensions of care, such as patients' spirituality.[7–9]

The definition of spirituality is widely discussed and heterogenous. Often 4 attributes are assigned to spirituality and spiritual needs: *Connectedness* refers the feeling of being close to self, others, a higher power, and/or nature. *Transcendence* ('going beyond') describes a state of altered consciousness and a sense that there is more to reality than is evident within the usual everyday boundaries. Such experiences are for example made when plunging into nature or praying. *Inner peace* may for example be experienced when resting in a peaceful place. *Meaning in life* refers to the need to share life experience and to be certain that one's own life is meaningful.[10,11] In the context of health care it is assumed that all humans have spiritual needs which differ in substance and intensity. The definition of spirituality used in this study ('everything which gives meaning to a person's life thus serving as a personal resource') focussed on meaning in life to emphasize that spirituality may be a resource which encompasses more than religion.[12]

Spiritual needs increase with age[13] and may be a resource in boundary situations such as suffering, death, struggle, and absurd life experiences.[14,15] According to international literature many patients want their spiritual dimension to be recognized in medical encounters.[16] Studies proved that a spiritual history

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Key messages

- Previously known:• Multimorbidity often goes along with feelings of hopelessness and powerlessness.
- Spiritual needs and resources might be important to deal with this burden.
- Yet patients' spirituality is frequently ignored in primary care.
- This study adds:• Taking a spiritual history can improve the patient–physician relationship.
- It also may reveal important information about patients' lives and resources.
- Tools, such as the conversational model SPIR, can facilitate discussions about spirituality.

provides relevant information for the treatment of chronic diseases, such as heart failure, diabetes mellitus, schizophrenia, or chronic kidney disease[17–20] and contributes to improved treatment adherence,[10] well-being, and resilience.[13] A recent study found that spirituality in the sense of environmental, interpersonal, and transcendental connectedness was of high relevance to very old people and positively connected to quality of life outcomes.[21] Nevertheless, it is unclear how and to what extent GPs address spiritual issues during consultations. A recently published article concluded that 'although literature has reflected an aspiration for spiritual care in general medicine, it has not outlined concrete ways to operationalize it' and 'failed to address key issues for GPs' daily practice'.[14] An 'embedded model' to integrate spiritual care into general practice was strongly recommended. This is particularly relevant for Germany where the term 'spirituality' is often associated with esotericism, religion, and church and spiritual care is not as established as in other, mainly English-speaking countries.[22]

The aim of this study was to examine the acceptability and feasibility as well as the potential benefits and harms of a spiritual history offered by German GPs within the scope of the *Holistic care Program for Elderly Patients to Integrate Spiritual Needs, Social Activity and Self-Care into Disease Management in Primary Care (HoPES3)*.[12] Details of the programme are described below in the section *Context and Theoretical Framework*.

Methods

Methods and findings are reported following the Consolidated Criteria for Reporting Qualitative Research (COREQ).[23]

Study design

This mixed-method study consisting of a written survey with GPs and personal interviews with GPs and medical assistants (MAs) is part of the process evaluation of the HoPES3 trial.[12] The effectiveness of the HoPES3 intervention (described below in *Context and Theoretical Framework*) was evaluated in an exploratory cluster-randomized trial with 297 patients.[24] The study presented here focussed on the experiences of the participating GPs and MAs. Patients' views are reported in a separate paper.[25] The HoPES3 intervention consisted of several components (see below). In this paper only findings concerning the spiritual history are reported.

Research team and reflexivity

The telephone interviews with the GPs and MAs were conducted, transcribed, and analysed by the first author CH, who was a Masters student in health services research and implementation science and research assistant during the study period. All steps of the study were conducted in consultation with the principal investigator and GP CS (M.D.) and critically discussed with the research team. The conversation model SPIR (see Fig. 1) examined in this study is an adaptation of the FICA model[26] developed by EF who is a Jesuit priest and holds a professorship for Spiritual Care.

Context and theoretical framework

A theoretical model specifying the assumed effect mechanisms of the complex HoPES3 intervention was elaborated before the intervention started and published in the

S: Would you describe yourself – in the broadest sense of the term – as a believing/spiritual/religious person?
From what do you draw strength?

P: Was is the place of spirituality in your life? How important is it in the context of your illness?
How do these convictions influence the degree to which you care for yourself and for your health?

I: Are you integrated in a spiritual community?
Is there a person or a group of people who really mean a lot to you and who are important to you? Would you like to have more companionship?

R: What role would you like to assign to your doctor in the domain of spirituality?
What role should these beliefs play in your medical treatment?

Fig. 1. Key questions of the conversational model SPIR.[28] Key and exemplary subquestions of the conversational model SPIR.

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study protocol.[12] Patients of the intervention group were to receive a prolonged consultation within the scope of their regular DMP appointment. GPs were asked to take a spiritual history, i.e. to explore patients' spiritual needs and their desire for more social contacts and/or self-care. MAs were asked to give information about regional social activities for seniors and about self-care activities, which included things patients can do on their own, besides taking medications, to increase their well-being (e.g. home remedies, exercises). In Germany, MAs undergo a 3-year non-university education and perform mainly administrative tasks.[27] Although the MAs were not involved in the spiritual history as such, they may have indirectly received feedback and comments about it from patients and GPs. GPs and MAs were prepared for these tasks in a 5-h workshop which is described in detail in a separate publication.[12] GPs' training focussed on the previously evaluated conversational model SPIR comprising 4 key questions which can be exchanged or supplemented by subquestions (see Fig. 1 and Supplementary Fig. 1).[28,29]

Participant selection and data collection

All GP practices in defined areas around Heidelberg and Tübingen offering DMPs were invited by mail to participate in the HoPES3 trial (details are described in the study protocol).[12] For this mixed-methods study all GPs from the intervention group were asked to complete a one-page questionnaire within 2 weeks after each spiritual history with each patient. The questionnaire consisted of non-validated questions focussing on the required time, perceived helpfulness, and strain of the spiritual history. All GPs and MAs within the intervention group were invited to participate in a telephone interview. A semistructured interview guide covering all intervention components was used (see Supplementary Fig. 2). The first interview in each group served as a pilot. Audio recordings were pseudonymized and transcribed verbatim.

Data analysis

Questionnaires were analysed descriptively using IBM SPSS Statistics 25. The MAXQDA Analytics Pro 2020 (Release 20.0.8) software was used for data management and coding of the interview material. A content analysis according to Mayring[30] was conducted: Main categories were derived deductively from the interview guide and subcategories were extracted from the interview material inductively. Two researchers (CH and CS) developed the category system in a consensual process.

Table 1. Characteristics of the participants of the HoPES3 study (Germany, 2018–2020).

	Survey	Interviews
GPs		
Number	14[a]	11
Age in years	53 [36–64]	53 [36–64]
		—
Female gender, % (*n*)	50.0 (7)	54.5 (6)
Work experience in years, mean [range]	23.23 [4–40]	23.91 [4–40]
Working in group practice (more than 1 GP), % (*n*)	64.3 (9)	72.7 (8)
Additional qualification in complementary medicine, % (*n*)	57.1 (8)	63.6 (7)
Additional qualification in psychosomatics/psychotherapy, % (*n*)	7.14 (1)	9.09 (1)
Religious affiliation, % (*n*)		
Catholic	14.3 (2)	18.2 (2)
Protestant	35.7 (5)	36.4 (4)
None	42.9 (6)	45.5 (5)
In general, how important are spiritual or religious beliefs in your life? % (*n*)		
Not at all	7.14 (1)	9.1 (1)
Somewhat	28.6 (4)	27.3 (3)
Quite	35.7 (5)	45.5 (5)
Very much	21.4 (3)	18.2 (2)
		—
MAs		
Number	n.a.	12
Age in years	n.a.	44 [20–55]
Female gender, % (*n*)	n.a.	100 (12)
Work experience in years, mean [range]	n.a.	19.25 [1–35]
Working in group practice (more than 1 GP), % (*n*)	n.a.	58.3 (7)
Religious affiliation, % (*n*)	n.a.	
Catholic		50.0 (6)
Protestant		41.7 (5)
None		8.3 (1)
Missing		—
In general, how important are spiritual or religious beliefs in your life? % (*n*)		
Not at all		25.0 (3)
Somewhat		41.7 (5)
Quite		25.0 (3)
Very much		8.3 (1)

[a]One female GP did not provide information on her sociodemographic characteristics.

Results

Sample

Table 1 shows the sociodemographic characteristics of the participating GPs and MAs. Almost two-thirds of GPs had an additional qualification in complementary medicine. Furthermore, around 60% of the GPs stated that spirituality was of particular importance to their lives.

Survey data

Between July 2019 and March 2020 we received 148 questionnaires from all 14 GPs of the intervention group of which 141 could be analysed (Table 2). The response rate was 90% of the 164 patients who completed the baseline assessment and were therefore eligible for a spiritual history. In the vast majority of cases (87%, n = 122) the spiritual history did not last longer than 20 min and was considered at least a little helpful for the patients (86%, n = 121). GPs also did not perceive the spiritual history as stressful neither for themselves nor for their patients. Only in 3 cases (2%) did GPs describe that their patient had experienced significant distress.

Interview data

In total 11 out of 14 GPs and 12 out of 18 MAs agreed to participate in an interview. The interviews were conducted

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Table 2. GPs evaluation of the spiritual history—results of the written survey.

		Number	Percentage
Total number of questionnaires analysed		141[a]	100%
How long did the spiritual history last?	1–10 min	62	43.9
	11–20 min	60	42.5
	21–30 min	17	12.1
	<30 min	2	1.4
	Missing	0	0.0
How helpful was the spiritual history for the patient?	Not at all	19	13.5
	A little	83	58.9
	Quite	30	21.3
	Very	8	5.7
	Missing	1	0.7
How stressful was the spiritual history for the patient?	Not at all	113	80.1
	A little	25	17.7
	Quite	2	1.4
	Very	1	0.7
	Missing	0	0.0
How helpful was the history for the primary care of the patient?	Not at all	9	6.4
	A little	70	49.6
	Quite	49	34.8
	Very	11	7.8
	Missing	2	1.4
How stressful was the spiritual history for yourself?	Not at all	108	76.5
	A little	25	17.7
	Quite	6	4.3
	Very	0	0.0
	Missing	2	1.4

[a]We received 148 questionnaires from 14 GPs. Seven questionnaires were excluded from the analysis because it was specified that no spiritual needs assessment had been conducted.

between April and June 2020 and lasted on average 35 min (range 25–50 min). In the following, key themes are presented and illustrated by selected quotations translated from German into English as literally as possible. The complete system of categorization with additional quotations is provided in Supplementary Table 1.

Acceptability of the spiritual history *Motivation to participate in the study*

Interest in spiritual topics was frequently given as a reason to participate in the study. Having the impression that patients' spirituality had been neglected by society and medicine, the intervention was considered innovative. Therefore, GPs and MAs were eager to support this research field. GPs felt that paying attention to patients' spiritual needs was in line with their profession. Some stated that spirituality was important for their own lives.

> I have a very strong interest in healthcare, otherwise I wouldn't have done this job for 36 years. For me, it's a service that I provide to patients. I think it is great that this is now a topic of conversation and that it's becoming more integrated. (MA08)

> I think that spirituality is really undervalued and lived out in our world today and it's very marginalized, both in our society and in our medical model. (GP26)

Patients' reactions to the spiritual history

According to the GPs, many patients were surprised about the questions but quickly engaged in the conversation. They were grateful for the offer to talk about non-medical topics. Other patients declined to answer the questions. They felt that these questions were too intimate, too closely related to faith and religion or, as 1 GP assumed, they were afraid of showing weakness and losing control of their emotions. A few patients burst into tears. Others reacted with humour or irony. On the other hand, some seemed overwhelmed by the complexity or intellectual level of the questions.

> Generally the proactive offer of a different kind of conversation was gratefully accepted. (GP07)
>
> 'Spirituality' is really tricky—here in our practice we are aware that people don't really want to talk about it—definitely not on their own initiative and only unwillingly if they are asked to. They'd rather keep it private. (MA11)

Feasibility of the spiritual history

Most GPs reported that—after getting used to it—the spiritual history was 'easier to carry out than they imagined' (GP27).

> In the beginning it was definitely unusual because we'd never done it like this before. But I have to say, after two or three patients it was no problem. (GP08)
>
> Yes, it was relatively uncomplicated (…). It was pretty simple to put it into practice. It usually just took about 10–20 minutes. (GP33)

There were varying perceptions about the feasibility of the conversational model SPIR. On the one hand, SPIR was seen as a guide and as a helpful tool to check if all relevant topics had been raised. On the other hand, many GPs expressed difficulties concerning the opening question ('Would you say that you are—in the broadest sense—a religious/spiritual/believing person?'). This question frequently provoked resistance because patients thought that they were asked about their attitude towards church or religion. Some GPs explained that they had difficulties making the purpose of the conversation clear and suggested to open the conversation with a question about sources of strength instead.

> Our experience was that many understood it to mean that I wanted to question their connection or affiliation to a church group. And then you had to try and explain more to say what you really meant. So it worked okay but not quite right. You could tell that they weren't keen to answer the question and give you information. (GP08)

Furthermore, several GPs reported having had difficulties to follow the structure of the SPIR, which meant having to ask one question after the other. Instead they preferred a more open, natural discussion.

> It was like—right—there's a list of questions and we'll now work through them. In future I'd do it much more

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> smoothly and would probably try to introduce it a bit differently so it didn't come across just like a long list of questions. (GP07)

Other difficulties derived from the context in which the spiritual history was taken. Within the HoPES3 study the spiritual history was offered proactively during the regular DMP appointments without a specific reason. This was perceived as an artificial situation. Many GPs suggested offering a spiritual history in special situations, e.g. in palliative situations, if symptoms worsened, or if patients were about to move to a nursing home, lost someone close to them, experienced any kind of life crisis or were seen for the first time.

> It's a really hot topic, bringing up spirituality, especially religious topics within the practice. It's definitely not something we would do regularly. It really has to come up naturally. (GP11)

One GP and one MA mentioned difficulties in approaching patients whose religious affiliation was different from their own, either because of their lack of knowledge about other religions or because they struggled to find the right words.

> I can't talk with a Muslim easily about his religion. I can just ask: How important is this for you? Do you draw strength from it? Then I know, okay, that's how it is, but I do not have to go into it further. I also can't understand how he performs his rituals. But that's fine for me and then I know, okay, he got something there that means something to him. (GP03)
>
> For me it is so much easier if someone has Christian faith, rather than if theyre an atheist, because I'm a believer myself. If someone doesn't believe in prayer or in (…) mediation it's much harder to give comfort if someone's totally set against it. Yes for me it is definitely easier with believers than with non-believers. (MA08)

Some barriers and facilitators for successful implementation of the spiritual history were related to the study concept: GPs and MAs mentioned repeatedly that those patients who agreed to participate in the study were very well educated, intellectual, quite healthy, and active. This was considered helpful because taking a spiritual history with patients with 'a lower intellectual level (GP12)' was described as difficult.

> I doubt very much that the way this study has been set up can be representative because it was actually tailored to more active and intelligent patients. So someone who is stupid or let's say, has a lower intellectual level, didn't understand this at all. For me that really wasn't so good. (GP12)

Benefits and harms of the spiritual history *Benefits and harms for patients*

The greatest benefit was seen in the fact that GPs were interested in their patients as actual people and that spiritual, religious, and other non-medical issues could be raised during the medical appointment. Topics that were raised included abuse by priests in childhood and the consequences of a Catholic education but also positive life events and someone's sources of strength. Several GPs and MAs felt that the spiritual history provided relief for many patients, helped to raise awareness of their own internal resources, and may have also contributed to the prevention of somatization. Most interviewees did not see any harm for their patients except 1 MA who expressed concerns about the emotional distress patients might have experienced upon self-reflection which was triggered by the spiritual history.

> We should have a look at these three aspects again and again to ease the tension, allowing (us) to intervene as early as possible at a point where patients' worries, feelings of loneliness, distress and dissatisfaction have not yet led to physical illness. (GP22)
>
> I think the most important thing was that we showed patients that they are allowed to talk about such topics, that they are meaningful, that they're also important for us as physicians and that it's not something that they have to handle alone but that they can share, even in the field of medicine. (GP33)
>
> They really did feel comfortable talking about things in their lives that moved them, or that they found positive and you could probably also say made them feel more positive. We talked as well about many positive things—like how well patients were settled in and I think that really helped them to think—wow I do actually have a lot of good things in my life. (GP27)

Benefits and harms for GP care

Many GPs and MAs reported that their participation in the study increased their awareness of their patients' spirituality. Many GPs stated that as a result they now feel less inhibited to ask patients proactively about their spiritual needs and their own sources of strength.

> So people's thresholds in talking about something like this have definitely decreased, and its become more normal that you can even discuss things like this. Yes, that's it. (GP27)

A significant benefit from the spiritual history was seen in a more trusting patient–physician relationship and having gained insight into patients' lives. This allowed for a deeper understanding of patients' behaviour and may serve as a resource in times of crisis. Some thought that the improved relationship may have even contributed to better treatment adherence. One GP described the spiritual history as a philosophical discussion and an 'exchange on eye level' which blurred the lines between the lecturing doctor and the listening patient.

> Those people who had the spiritual history with me, I got to know them even better. And it helped me understand why they sometimes react the way they do. This was a real benefit for me and I think it was also a benefit for the patients. (GP12)
>
> I think we've found another way, a more intensive insight beyond the purely medical. I think this is very good and actually can be a real source of strength, for example if a patient slips into a crisis one day or even is just having a difficult time. Then you can reflect back on what they said back then, what's important to them, what's helped them and then I can draw upon it. (GP26).

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> It was more like an exchange, rather than just one-sided instructing—which is what it's frequently like in medicine, no it was more like an exchange. Yep, I liked this very much, I felt very comfortable with this. (GP33).

Several GPs expressed that their participation in the study made them scrutinize their working routine because they became aware of how little they often know about their patients' lives.

> GP: Sometimes you don't really think about the patients and you don't really understand how they live. It makes you question once again what you do here every day […]. Interviewer: In what way did you talk to patients about spiritual issues before the study? GP: In this particular form actually very rarely, I have to say… So I have to ask myself critically, why actually not? (GP19)

In contrast to this, some GPs and MAs stated that their participation in the study had little or no benefit for their care. They were either already used to exploring their patients' spirituality in terms of sources of strengths, or the content of the spiritual history was not relevant for their medical decisions and did not influence their patient–physician relationship.

> It was interesting to do it once, but it hasn't changed my way of working […]. Because, as I said, coming from psychosomatics, I think in a resource-oriented way, I ask, not about how religious you are but where do you draw strength from, I do this anyway […]. But now I'm looking back on three quarters of a year with the same patients, without any helpful consequences for me or the patient or myself behaving differently or having different kinds of conversations. No, for me, nothing has changed. (GP03).

Discussion

This study delivers interesting insights about the acceptability and feasibility as well as benefits and harms of a spiritual history in German GP practices. While the statistical analysis of the HoPES3 trial showed a noteable effect of the complex intervention on mental well-being in patients who stated that their spiritual or religious beliefs were very important to them,[24] this study focussed on the experiences of the trial participants with the spiritual history. Many GPs and MAs considered it a helpful tool to build better rapport with older patients and to make them aware of their own resources. This is partly in line with the patients' perspective which is reported in a separate publication.[25] Interviews with participating patients revealed that many patients did not really open up or rejected the spiritual history. If they engaged in the discussion, they would much rather talk about their biography and decisive life events than about their spirituality. However, these patients reported that the conversation had significantly improved the relationship with their GP.[25]

In this study, GPs and MAs mentioned several challenges for the implementation of a spiritual history which are discussed in the following considering the international literature.

Proactive versus reactive spiritual history

In the HoPES3 study the spiritual history was offered proactively to patients. Many GPs reported that this resulted in an 'artificial' situation and suggested offering a spiritual history only under certain circumstances, such as severe incidents, including life crises or end-of-life situations, or if patients themselves took the initiative. The advantage of a proactive approach is that the benefits of a spiritual history described above are offered to a broad spectrum of patients. One could argue that assessing chronically ill patients' beliefs and resources should always be part of their medical history because these factors could help or hinder them in coping with their disease or could even cause certain illnesses.[31–34] Furthermore, a reactive approach implies the risk of ignoring patients whose desire for a spiritual history is/seems to be less obvious. Another argument in favour of a proactive approach is the fact that the spiritual history was overall not perceived as harmful or stressful for patients, neither by the participating health care professionals nor by the participating patients—although patients did sometimes react with surprise, rejection or emotional outbursts.[21–25] From this point of view GPs can be encouraged to initiate discussions about spiritual issues with older patients, although this has to be balanced against their limited time resources.

Structured tools for a spiritual history

In this study GPs expressed difficulties in following the structure of the conversational model SPIR. The advantages and disadvantages of such structured tools are discussed in the literature: Assessment tools can support physicians in initiating, structuring, and concluding a conversation about patients' spirituality and can facilitate documentation and follow-up.[35,36] On the contrary, 1 criticism is that rigid assessment tools do not address all of a patient's spiritual needs and are not always coherent with a patient's subjective associations concerning spirituality.[35,37]

The idea of the conversational model SPIR is to combine the advantages of structured and open approaches by using a semistructured conversation guide. Key questions are used to structure an open and flexible discussion. It should not be used like a 'list of questions' as some GPs assumed in this study. Furthermore, it must be explained that terms like spirituality or faith should be understood in a broader sense and not necessarily related to religion or church. Moreover, the conversational model entails the possibility to replace key questions by subquestions. For example, it is possible to initiate the discussion with a question about 'sources of strength' if it is anticipated that the patient will dislike or misunderstand the term 'spirituality'. Adaptation of the wording to individual patient preferences should be enhanced in training concepts.

Adapting the spiritual history to patients' educational and intellectual level

Some GPs mentioned that a spiritual history was not suitable for patients with a lower educational or intellectual level. This statement reflects a rather paternalistic attitude and could be indicative for deficiencies in the education and communication skills of German GPs. Even though literature indicates that many patients who are interested in the topic of spirituality indeed have a higher level of education,[8] this should not lead to the conclusion that spiritual needs should be ignored in less intellectual or eloquent patients. A study with patients with dementia showed that even cognitively impaired patients may benefit from the interest shown in their spiritual needs and resources provided that the interviewer is able to enhance the use of body language and to reduce the complexity

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and number of sentences.[38] Such skills should be a focus of training concepts for spiritual care.

Strengths and limitations

A strength of this study is its linkage to a cluster-randomized trial and the combination of qualitative and quantitative methods. The content analytic approach chosen for the interview analysis focussed mainly on the categorization of the emerging themes and not on latent structures of meaning. Another limitation of this study is the limited comparability of the sample. It is likely that mainly GPs who had a positive attitude towards spiritual care and patients with higher educational levels participated. Furthermore, the vast majority of the participants were of Christian faith or unaffiliated with any religion. In this study, only the perspectives of GPs and MAs on the spiritual history were examined. Separate publications focus on the patients' perspective and the other intervention components and should be considered when interpreting the results of this study.[24,25]

Conclusions

The proactive offer of a spiritual history in primary care has the potential to enhance the quality of care in older multimorbid patients. Potential positive effects on health are likely to be mediated by a more trustful patient–physician relationship, better knowledge about patients' biography and increased awareness for patients' resources. Training of GPs is essential and should focus on adaptions of the conversation techniques to various patient types.

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Supplementary material

Supplementary material is available at *Family Practice* online.

Supplementary Fig. 1. Conversational model SPIR—full version in German and English.[27]

Supplementary Fig. 2. Interview guideline.

Ethical approval

This study was approved by the Ethics Committee of the University of Heidelberg (reference number S-730/2018).

Conflict of interest

None declared.

Data availability

The data underlying this article will be shared on reasonable request to the corresponding author.

References

1. Sap AC, Wurm S, Ziese T. Inanspruchnahmeverhalten. In: Böhm K, Tesch-Römer C, Ziese T, editors. *Beiträge zur Gesundheitsberichterstattung des Bundes: Gesundheit und Krankheit im Alter*. Berlin, Germany: Oberdruck AG; 2009. S. 134–160.
2. Vyas A, Kang F, Barbour M. Association between polypharmacy and health-related quality of life among US adults with cardiometabolic risk factors. *Qual Life Res*. 2020;29(4):977–986.
3. Makovski TT, Schmitz S, Zeegers MP, Stranges S, van den Akker M. Multimorbidity and quality of life: systematic literature review and meta-analysis. *Ageing Res Rev*. 2019;53:100903.
4. Hajek A, Kretzler B, König H-H. Multimorbidity, loneliness, and social isolation. A systematic review. *Int J Environ Res Public Health*. 2020;17(22):1–12.
5. Coyle L-A, Atkinson S. Imagined futures in living with multiple conditions: positivity, relationality and hopelessness. *Soc Sci Med*. 2018;198:53–60.
6. Duguay C, Gallagher F, Fortin M. The experience of adults with multimorbidity: a qualitative study. *J Comorb*. 2014;4(1):11–21.
7. Selman LE, Brighton LJ, Sinclair S, Karvinen I, Egan R, Speck P, Powell RA, Deskur-Smielecka E, Glajchen M, Adler S, et al. Patients' and caregivers' needs, experiences, preferences and research priorities in spiritual care: a focus group study across nine countries. *Palliat Med*. 2018;32(1):216–230.
8. Astrow AB, Wexler A, Texeira K, He MK, Sulmasy DP. Is failure to meet spiritual needs associated with cancer patients' perceptions of quality of care and their satisfaction with care? *JCO*. 2007;25(36):5753–5757.
9. Taverna M, Berberat PO, Sattel H, Frick E. A survey on the integration of spiritual care in medical schools from the German-speaking faculties. *Adv Med Educ Pract*. 2019;10:1009–1019.
10. Weathers E, McCarthy G, Coffey A. Concept analysis of spirituality: an evolutionary approach. *Nurs Forum*. 2016;51(2):79–96.
11. Büssing A. Application and implementation of the spiritual needs questionnaire in spiritual care processes. In: Büssing A, editor. *Spiritual needs in research and practice*. Cham: Springer International Publishing; 2021. p. 79–85.
12. Straßner C, Frick E, Stotz-Ingenlath G, Buhlinger-Göpfarth N, Szecsenyi J, Krisam J, Schalhorn F, Valentini J, Stolz R, Joos S. Holistic care program for elderly patients to integrate spiritual needs, social activity, and self-care into disease management in primary care (HoPES3): study protocol for a cluster-randomized trial. *Trials*. 2019;20(364):1–11.
13. Fegg MJ, Kramer M, Bausewein C, Borasio GD. Meaning in life in the Federal Republic of Germany: results of a representative survey with the Schedule for Meaning in Life Evaluation (SMiLE). *Health Qual Life Outcomes*. 2007;5:59.
14. Becker G, Xander CJ, Blum HE, Lutterbach J, Momm F, Gysels M, Higginson IJ. Do religious or spiritual beliefs influence bereavement? A systematic review. *Palliat Med*. 2007;21(3):207–217.
15. Thuné-Boyle IC, Stygall JA, Keshtgar MR, Newman SP. Do religious/spiritual coping strategies affect illness adjustment in patients with cancer? A systematic review of the literature. *Soc Sci Med*. 2006;63(1):151–164.
16. Best M, Butow P, Olver I. Why do we find it so hard to discuss spirituality? A qualitative exploration of attitudinal barriers. *J Clin Med*. 2016;5(9):1–10.
17. Alvarez JS, Goldraich LA, Nunes AH, Zandavalli MCB, Zandavalli RB, Belli KC, Rocha NS, Fleck MPA, Clausell N. Association between spirituality and adherence to management in outpatients with heart failure. *Arq Bras Cardiol*. 2016;106(6):491–501.
18. Watkins YJ, Quinn LT, Ruggiero L, Quinn MT, Choi Y-K. Spiritual and religious beliefs and practices and social support's relationship to diabetes self-care activities in African Americans. *Diabetes Educ*. 2013;39(2):231–239.
19. Huguelet P, Mohr S, Betrsey C, Borras L, Gillieron C, Marie AM, Rieben I, Perroud N, Brandt PY. A randomized trial of spiritual

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assessment of outpatients with schizophrenia: patients' and clinicians' experience. *Psychiatr Serv*. 2011;62(1):79–86.
20. Fradelos EC, Tzavella F, Koukia E, Papathanasiou IV, Alikari V, Stathoulis J, Panoutsopoulos G, Zyga S. Integrating chronic kidney disease patient's spirituality in their care: health benefits and research perspectives. *Mater Sociomed*. 2015;27(5):354–358.
21. Reissmann M, Storms A, Woopen C. Individuelle werte und spiritualität und ihre bedeutung für affektives wohlbefinden und aktive verbundenheit mit dem leben in der hochaltrigkeit. *Z Gerontol Geriatr*. 2021;54(Suppl 2):85–92.
22. Gijsberts M-JHE, Liefbroer AI, Otten R, Olsman E. Spiritual care in palliative care: a systematic review of the recent European literature. *Med Sci (Basel)*. 2019;7(2):1–21.
23. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6):349–357.
24. Sturm N, Krisam J, Szecsenyi J, Bentner M, Frick E, Mächler R, Schalhorn F, Stolz R, Valentini J, Joos S, et al. Spirituality, self-care, and social activity in the primary medical care of elderly patients. *Dtsch Arztebl Int*. 2022;119(8):124–131.
25. Mächler R, Sturm N, Frick E, Schalhorn F, Stolz R, Valentini J, Krisam J, Straßner C. Evaluation of a spiritual history with elderly multi-morbid patients in general practice—a mixed-methods study within the project HoPES3. *Int J Environ Res Public Health*. 2022;19(1):538.
26. Puchalski C, Romer AL. Taking a spiritual history allows clinicians to understand patients more fully. *J Palliat Med*. 2000;3(1):129–137.
27. Freund T, Peters-Klimm F, Boyd CM, Mahler C, Gensichen J, Erler A, Beyer M, Gondan M, Rochon J, Gerlach FM, et al. Medical assistant-based care management for high-risk patients in small primary care practices: a cluster randomized clinical trial. *Ann Intern Med*. 2016;164(5):323–330.
28. Frick E, Riedner C, Fegg MJ, Hauf S, Borasio GD. A clinical interview assessing cancer patients' spiritual needs and preferences. *Eur J Cancer Care (Engl)*. 2006;15(3):238–243.
29. Kunsmann-Leutiger E, Straßner C, Schalhorn F, Stolz R, Stotz-Ingenlath G, Buhlinger-Göpfarth N, Bentner M, Joos S, Valentini J, Frick E. Training general practitioners and medical assistants within the framework of HoPES3, a holistic care program for elderly patients to integrate spiritual needs, social activity, and self-care into disease management in primary care. *J Multidiscip Healthc*. 2021;14:1853–1861.
30. Mayring P, Fenzl T. Qualitative Inhaltsanalyse. In: Baur N, Blasius J, editors. *Handbuch Methoden der empirischen Sozialforschung. 2. Aufl. 2019*. Wiesbaden: Springer Fachmedien Wiesbaden; Springer VS; 2019, p. 633–648.
31. Curlin FA, Chin MH, Sellergren SA, Roach CJ, Lantos JD. The association of physicians' religious characteristics with their attitudes and self-reported behaviors regarding religion and spirituality in the clinical encounter. *Med Care*. 2006;44(5):446–453.
32. Fitch MI, Bartlett R. Patient perspectives about spirituality and spiritual care. *Asia Pac J Oncol Nurs*. 2019;6(2):111–121.
33. Hvidt N, Kappel Kørup A, Curlin F, Baumann K, Frick E, Søndergaard J, Nielsen JB, DePont Christensen R, Lawrence R, Lucchetti G, et al. The NERSH international collaboration on values, spirituality and religion in medicine: development of questionnaire, description of data pool, and overview of pool publications. *Religions*. 2016;7(8):1071–1023.
34. Utsch M. Spiritualität-Wert der Beziehung. *Nervenarzt*. 2016;87(11):1152–1162.
35. Hamilton IJ, Morrison J, Macdonald S. Should GPs provide spiritual care? *Br J Gen Pract*. 2017;67(665):573–574.
36. Borneman T, Ferrell B, Puchalski CM. Evaluation of the FICA tool for spiritual assessment. *J Pain Symptom Manage*. 2010;40(2):163–173.
37. Assing Hvidt E, Søndergaard J, Ammentorp J, Bjerrum L, Gilså Hansen D, Olesen F, Pedersen SS, Timm H, Timmermann C, Hvidt NC. The existential dimension in general practice: identifying understandings and experiences of general practitioners in Denmark. *Scand J Prim Health Care*. 2016;34(4):385–393.
38. Ødbehr LS, Kvigne K, Hauge S, Danbolt LJ. Spiritual care to persons with dementia in nursing homes; a qualitative study of nurses and care workers experiences. *BMC Nurs*. 2015;14(1): 70.

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