From:	Richard Wong
To:	medboardconsultation
Subject:	Public consultation on Good Medical Practice
Date:	Sunday, 5 August 2018 3:08:18 PM
Attachments:	Medical-Board---Consultation---Draft-revised-Good-medical-practice---A-code-of-conduct-for-doctors-in-Australia.DOCX CodeofEthics-2013 from Canada.pdf Good-medical-practice in the UK Policy_PS62-Statement-on-Cultural-Competency_20170715_V1-2 by ANZCA.pdf PS_Person-centered_Care_C2.pdf Spirituality_Staff_Resource.pdf RCN Spiritual Cre pocket guide.pdf

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---------- Forwarded message ----------
From: **Richard Wong** < >
Date: 5 August 2018 at 15:01
Subject: Faith is important in healthcare and should respectfully be included in the wording of the upcoming revised medical code of conduct
To: medboardconsultati[redacted]

Dear AHPRA,
thank you for the opportunity to send in a submission regarding the Medical Code of Conduct. Good medical practice being patient centred would benefit even more by taking into account our patients' beliefs and spiritual understanding. The Code of Conduct for Doctors in Australia 2009 states that "this includes cultural awareness : being aware of their own culture and beliefs and respectful of the beliefs and cultures of others, recognising that these cultural differences may impact on the doctor-- patient relationship and on the delivery of health services". Often in my twenty odd years of medical practice, the patient often benefits more when we treat the patient as a whole person rather than merely a scientific object devoid of feeling, belief or hope.

Faith therefore is important in health care, as shown by various articles and research papers correlating this with good health outcomes. Furthermore it has been shown that many patients are open and keen to discuss their religious beliefs in the context of their health. In addition to this, in a number of jurisdictions around the world, it is a desired element of best medical practice (some examples are attached below).

The Scottish patients' charter expresses this sentiment reasonably well "All patients can expect NHS staff to acknowledge their spiritual needs and aspirations and be sensitive to the wide variation in values and cultural backgrounds of their patients. In support of this, the NHS is expected to make every effort to provide for the spiritual needs of patients and staff".
Of course this is all the context of general good medical practice of treating the patient with sensitivity, permission and respect.

thank you for reading and considering my submission to the revised code of conduct. I am happy to correspond further.

Yours sincerely,

Dr Richard Wong
MB BS BSc(Med)
FRACGP DCH DRANZCOG
CTh DCH rural locum doctor
CMDFA /Healthserve

CODE OF ETHICS

With commentaries as adopted by the Council of the College of Physicians and Surgeons of New Brunswick

CODE DE DÉONTOLOGIE

Commentaires tels qu'approuvés par le Conseil du Collège des médecins et chirurgiens du Nouveau-Brunswick

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Fundamental Responsibilities

1. Consider first the well-being of the patient.

   The physician should consider the well-being of other patients, of society and of colleagues, as well as his/her own well-being, but that of the patient being treated at the time must be the physician's primary concern.

2. Practise the profession of medicine in a manner that treats the patient with dignity and as a person worthy of respect.

   Respect for persons is a fundamental principle of medical ethics; it excludes not only exploitation and discrimination but also discourteous and insensitive behaviour.

3. Provide for appropriate care for your patient, even when cure is no longer possible, including physical comfort and spiritual and psychosocial support.

   The physician should try to ensure that all the patient's needs will be met.

4. Consider the well-being of society in matters affecting health.

5. Practise the art and science of medicine competently, with integrity and without impairment.

Responsabilités fondamentales

1. Tenir compte d'adorb du mieux-être du patient.

   Le médecin doit prendre en considération le bien-être des autres patients, de la société et des collègues, ainsi que son propre bien-être, mais il doit avant tout se préoccuper de celui du patient en sa présence.

2. Exercer la médecine de façon à traiter le patient avec dignité et comme une personne digne de respect.

   Le respect pour la personne est un principe fondamental de la déontologie médicale; il exclut non seulement l'exploitation et la discrimination, mais aussi le manque de courtoisie et l'insensibilité.

3. Voir à ce que votre patient reçoive les soins nécessaires, même lorsqu'il est incurable, y compris le réconfort physique et l'appui spirituel et psychosocial.

   Le médecin doit chercher à s'assurer que l'on répond à tous les besoins du patient

4. Tenir compte du bien-être de la société en matière de santé.

5. Pratiquer l'art et la science de la médecine avec compétence et intégrité, et sans incapacité.

6. Engage in life-long learning to maintain and improve your professional knowledge, skills and attitudes.

   Continuous learning is necessary to maintain one's competence. Attitudes are central to the patient-physician relationship, as stated in article 2.

7. Resist any influence or interference that could undermine your professional integrity.

8. Contribute to the development of the medical profession, whether through clinical practice, research, teaching, administration or advocating on behalf of the profession or the public.

9. Refuse to participate in or support practices that violate basic human rights.

10. Promote and maintain your own health and well-being.

Responsibilities to the patient
General Responsibilities

11. Recognize and disclose conflicts of interest that arise in the course of your professional duties and activities, and resolve them in the best interest of patients.

12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants.

    If the denial or delay of treatment has the potential to cause harm, the physician is obligated to expedite access to another physician if possible. In any case, the physician cannot obstruct such access.

6. Chercher à approfondir toujours votre savoir afin de préserver et d'améliorer vos connaissances, compétences et attitudes professionnelles.

   La formation continue est indispensable pour garder ses compétences. Les attitudes sont au centre des rapports patient-médecin, comme l'indique l'article 2.

7. Combattre toute influence ou ingérence risquant de miner votre intégrité professionnelle.

8. Contribuer à l'avancement de la profession médicale, par la pratique clinique, la recherche, l'enseignement, l'administration ou la défense des intérêts de la profession ou du public.

9. Refuser de participer à des pratiques enfreignant les droits humains fondamentaux, ou d'appuyer de telles pratiques.

10. Promouvoir et préserver votre propre santé et votre propre mieux-être.

Responsabilités envers le patient
Responsabilités générales

11. Reconnaître de dévoiler les conflits d'intérêt survenant dans l'exercice de vos activités et devoirs professionnels, et les résoudre dans le meilleur intérêt des patients.

12. Prévenir votre patient lorsque vos valeurs personnelles auraient un effet sur la recommandation ou la prestation de toute intervention médicale que le patient souhaite ou dont il a besoin.

    Si le refus ou le report du traitement risque de causer du tort au patient, le médecin a l'obligation d'envoyer sans délai le patient à un autre médecin. De toute façon, le médecin ne peut l'empêcher de consulter un autre médecin.

13. Do not exploit patients for personal advantage.

14. Take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient.

15. Recognize your limitations and, when indicated, recommend or seek additional opinions and services.

    Others may include non-physicians as well as physician colleagues.

16 In determining professional fees to patients, consider both the nature of the service provided and the ability of the patient to pay, and be prepared to discuss the fee with the patient.

Initiating and Dissolving a Patient-Physician Relationship

17. In providing medical service, do not discriminate against any patient on such grounds as age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation or socioeconomic status. This does not abrogate the physician's right to refuse to accept a patient for legitimate reasons.

    The categories of discrimination are not closed. It is also improper to deny access to the other "classes" of patients. Examples might include current and former patients of a particular physician or physicians, or a class based on some other factor such as place of residence. Similarly, the right to deny access may be limited according to availability of alternate care.

13. S'abstenir d'exploiter les patients à des fins personnelles.

14. Prendre toutes les mesures raisonnables pour éviter de causer un préjudice aux patients; si le patient devait subir un préjudice, lui révéler.

15. Reconnaître vos limites et, au besoin, recommander ou solliciter des avis et des services supplémentaires.

    Les autres peuvent comprendre des personnes qui ne sont pas médecins de même que des collègues médecins.

16. Dans l'établissement des honoraires professionnels exigés des patients pour des services non assurés, tenir compte à la fois de la nature du service fourni et de la capacité de payer du patient, et être disposé à discuter des honoraires avec le patient.

Amorce et cessation des rapports patient-médecin

17. Dans la prestation des services médicaux, n'exercer de discrimination envers aucun patient en raison, notamment, de son âge, son sexe, son état civil, son état de santé, son origine nationale ou ethnique, son incapacité physique ou mentale, son affiliation politique, sa race, sa religion, son orientation sexuelle ou sa situation socioéconomique. Cette disposition ne prive pas le médecin du droit de refuser un patient pour des raisons légitimes.

    La discrimination n'est pas limitée aux catégories énumérées. Il serait également répréhensible de refuser de soigner d'autres classes de patients comme les patients actuels ou anciens d'un médecin ou de médecins en particulier ou une classe fondée sur un autre facteur tel que le lieu de résidence. De même, le droit de refuser un patient peut être limité selon la disponibilité des autres médecins.

18. Provide whatever appropriate assistance you can to any person with an urgent need for medical care.

19. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted, until another suitable physician has assumed responsibility for the patient, or until the patient has been given reasonable notice that you intend to terminate the relationship.

    Termination of care cannot occur for an improper purpose such as noted elsewhere in the Code.

    "Adequate notice" will depend on the circumstances, particularly where necessary alternative care is not readily available.

20. Limit treatment of yourself or members of your immediate family to minor or emergency services and only when another physician is not readily available; there should be no fee for such treatment.

    There is a potential conflict between the roles of physician and family member when the patient is another family member. The definition of 'immediate family' will depend on the circumstances. Besides spouses, it generally includes parents, siblings, and children, but may include others depending on the potential for conflict.

18. Fournir toute l'aide appropriée possible à quiconque a un besoin urgent de soins médicaux.

19. Après avoir assumé la responsabilité professionnelle d'un patient, continuer de fournir des services jusqu'à ce qu'ils ne soient plus nécessaires ou souhaités, jusqu'à ce qu'un autre médecin approprié ait pris le patient en charge, ou après avoir avisé ce dernier de votre intention de mettre fin à la relation, dans un délai raisonnable.

    Un médecin ne peut cesser de mauvaise grâce de soigner un patient comme il est indiqué ailleurs dans le Code.

    «Délai suffisant» dépend des circonstances, particulièrement quand un médecin n'est pas facilement disponible.

20. Limiter les traitements administrés aux membres de votre famille immédiate ou à vous-même aux services mineurs ou d'urgence, et uniquement lorsqu'un autre médecin n'est pas facilement disponible; ces traitements devraient être gratuits.

    Quand le patient est un proche parent, il peut y avoir un conflit de rôles entre celui de médecin et celui de proche parent. La définition de «proche parent» dépend des circonstances. En plus du conjoint, elle comprend généralement les parents, les frères, les soeurs et les enfants, mais peut également comprendre d'autres personnes selon la possibilité de conflit.

Communication, Decision-Making and Consent

21. Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.

    The physician is obligated, as part of the process of informed consent, to provide the patient with whatever information will, from the patient's perspective, have a bearing on his/her medical care decision-making.

22. Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood.
    Informed consent requires good communication.

23. Recommend only those diagnostic and therapeutic procedures that you consider to be beneficial to your patient or to others. If a procedure is recommended for the benefit of others, as for example in matters of public health, inform your patient of this fact and proceed only with explicit informed consent or where required by law.

    Physicians have a duty to promote public health and to protect society, even when the procedures in question may not be intended for the direct benefit of the individual patient (e.g. certain vaccinations or diagnostic procedures such as serologic typing of some viral infections for the purpose of public health surveillance). Such procedures still require informed consent, unless required by law.

Communication, prise de décision et consentement

21. Fournir à vos patients l'information dont ils ont besoin pour prendre des décisions éclairées au sujet de leurs soins de santé et répondre à leurs questions au meilleur de vos compétences.

    Pour que le patient puisse donner son consentement en connaissance de cause, le médecin a l'obligation de lui fournir tous les renseignements qui, du point de vue du patient, auront une incidence sur sa décision quant aux soins médicaux.

22. Faire tous les efforts raisonnables pour communiquer avec vos patients de façon à ce que l'information échangée soit comprise.
    Le consentement en connaissance de cause exige une bonne communication.

23. Ne recommander que les services de diagnostic et de traitement que vous jugez bénéfiques pour votre patient ou d'autres personnes. Si un service est recommandé pour le bénéfice d'autres personnes, lorsqu'il est question de santé publique par exemple, il faut en informer le patient et obtenir préalablement son consentement éclairé explicite, à moins que la loi ne l'exige autrement.
    Les médecins doivent promouvoir la santé publique et protéger la société, même si les interventions en question ne sont pas destinées à profiter directement au patient (ex.: certaines vaccinations ou démarches diagnostiques comme le typage sérologique de certaines infections virales à des fins de contrôle de la santé publique). De telles interventions exigent toujours le consentement en connaissance de cause du patient, à moins qu'elles ne soient exigées par la loi.

24. Respect the right of a competent patient to accept or reject any medical care recommended.

25. Recognize the need to balance the developing competency of minors and the role of families in medical decision-making. Respect the autonomy of those minors who are authorized to consent to treatment.

    Physicians should be mindful of the Medical Consent of Minors Act. Patients aged sixteen and older have the full rights of adults for all aspects of their medical care, including consent and refusal of treatment and confidentiality. Those under sixteen have similar rights if they are considered competent to consent by a physician and the treatment is in their best interest.

26. Respect your patient's reasonable request for a second opinion from a physician of the patient's choice.
    "Reasonable" will be determined on the basis of whether the requested opinion has the likelihood of contributing to the patient's well-being.

27. Ascertain wherever possible and recognize your patient's wishes about the initiation, continuation or cessation of life-sustaining treatment.

    Good patient-physician communication is especially important with regard to life-sustaining treatment such as CPR, which some patients may want to forego under certain circumstances.

24. Respecter le droit d'un patient apte d'accepter ou de refuser tout soin médical recommandé.

25. Reconnaître la nécessité d'établir un équilibre entre l'aptitude grandissante des personnes mineures et le rôle des membres de leur famille dans la prise de décisions médicales. Respecter l'autonomie des personnes mineures qui sont autorisées à donner leur consentement au traitement.
    Les médecins ne devraient pas oublier les dispositions de la Loi sur le consentement des mineurs aux traitements médicaux. Un patient âgé de seize ans ou plus a les mêmes droits qu'un adulte pour tous les aspects des soins médicaux, y comprix le consentement à un traitement, le refus de traitement et la confidentialité. Un enfant de moins de seize ans a les mêmes droits si un médecin le croit capable de consentir au traitement et que le traitement est dans son intérêt.

26. Accéder à la demande raisonnable de votre patient qui veut obtenir un deuxième avis de la part d'un médecin de son choix.
    La demande est «raisonnable» s'il y a des chances que la consultation d'un autre médecin contribue au bien-être du patient

27. Déterminer, dans la mesure du possible, et reconnaître les désirs de votre patient au sujet de la mise en oeuvre, du maintien ou de l'interruption des traitements essentiels au maintien de la vie.
    Une bonne communication patient-médecin est particulièrement importante en ce qui concerne les traitements qui entretiennent la vie comme la RCR, auxquels certains patients peuvent vouloir renoncer dans certaines circonstances.

28. Respect the intentions of an incompetent patient as they were expressed (e.g., through a valid advance directive or proxy designation) before the patient became incompetent.

    'Respect' does not necessarily mean 'fulfill to the letter', but physicians should be mindful of the effect of a prestated refusal of any particular form of treatment. Where possible, physicians should also confirm the legal status of any consent provided by an individual other than the patient.

29. When the intentions of an incompetent patient are unknown and when no formal mechanism for making treatment decisions is in place, render such treatment as you believe to be in accordance with the patient's values or, if these are unknown, the patient's best interests.

    The patient's own values take priority over the physician's opinion of what is the patient's best interests.

30. Be considerate of the patient's family and significant others and cooperate with them in the patient's interest.

Privacy and Confidentiality

31. Protect the personal health information of your patients.

32. Inform your patients about the reasons for the collection, use and disclosure of their personal health information.

28. Respecter les intentions qu'un patient inapte a exprimées avant de devenir inapte (p. ex., en donnant des directives préalables valides ou en désignant un mandataire).

    «Respecter» ne veut pas nécessairement dire «exécuter à la lettre», mais le médecin ne devrait pas oublier l'incidence d'un refus d'une forme quelconque de traitement, qui a été exprimé à l'avance. Dans la mesure du possible, le médecin devrait vérifier le statut légal d'un consentement donné par une autre personne que le patient.

29. Lorsqu'on ne connaît pas les intentions d'un patient inapte et en l'absence de tout mécanisme officiel de prise de décision face au traitement, pratiquer les interventions jugées conformes aux valeurs du patient ou, si on ne connaît pas ses valeurs, à son meilleur intérêt.

    Les valeurs personnelles du patient ont la priorité sur ce que le médecin estime être l'intérêt du patient.

30. Faire preuve de prévenance envers les membres de la famille du patient et envers ses proches et collaborer avec eux dans l'intérêt du patient.

Respect de la vie privée et confidentialité

31. Protéger les renseignements personnels sur la santé de vos patients.

32. Fournir aux patients des renseignements raisonnables, compte tenu des circonstances, sur les raisons de la collecte, de l'utilisation et de la divulgation des renseignements personnels sur leur santé.

33. Be aware of your patient's rights with respect to the collection, use, disclosure and access to their personal health information; ensure that such information is recorded accurately.

34. Avoid public discussions or comments about patients that could reasonably be seen as revealing confidential or identifying information.

35. Disclose your patients' personal health information to third parties only with their consent, or as provided for by law, such as when the maintenance of confidentiality would result in a significant risk of substantial harm to others or, in the case of incompetent patients, to the patients themselves. In such cases take all reasonable steps to inform the patients that the usual requirements for confidentiality will be breached.

36. When acting on behalf of a third party, take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to the third party.

    This responsibility will include the right of a third party to a report of the assessment. The patient also has a right to such information.

37. Upon a patient's request, provide the patient or a third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.

33. Connaître les droits de vos patients en ce qui a trait à la collecte, à l'utilisation, à la divulgation et à l'accessibilité des renseignements personnels sur leur santé; veiller à ce que ces renseignements soient correctement enregistrés

34. En public, éviter de discuter des patients ou de faire à leur sujet des commentaires qui pourraient raisonnablement être jugés comme révélant des renseignements confidentiels ou permettant d'identifier la personne

35. Divulguer à des tiers les renseignements personnels sur la santé de vos patients uniquement avec le consentement de ces derniers, ou lorsque la loi l'exige, par exemple lorsque le maintien de la confidentialité risquerait de causer un préjudice grave à des tiers ou, dans le cas de patients inaptes, aux patients eux-mêmes. Il faut alors prendre toutes les mesures raisonnables pour prévenir le patient de la dérogation aux exigences habituelles de confidentialité.

36. Dans tout acte posé pour le compte d'un tiers, prendre des dispositions raisonnables pour s'assurer que le patient comprend la nature et l'étendue de votre responsabilité à l'égard du tiers.

    Cette responsabilité comprend le droit d'un tiers à un compte rendu de l'examen. Le patient a également droit à ces renseignements.

37. Sur demande du patient, fournir au patient ou à un tiers une copie de son dossier médical, à moins qu'il y ait une raison probante de croire que l'information contenue dans le dossier causera un préjudice grave au patient ou à quelqu'un d'autre.

Patients have an ethical, as well as a legal, right to this information, and physicians have both an ethical and legal responsibility to provide it. "Medical record" also includes reports prepared at the request of third parties, notwithstanding any objections by the third party to the release of information to the patient. Physicians are also obligated to provide information, whether in the form of a report or completed form, if the patient requires same in order to obtain a benefit. These obligations may continue after the physician-patient relationship has ended.

Le patient a un droit moral de même qu'un droit reconnu par la loi à ces renseignements et le médecin a une responsabilité à la fois morale et légale de les fournir. «Dossier médical» désigne également les rapports rédigés à la demande d'un tiers, nonobstant toute objection de la part du tiers à la divulgation des renseignements au patient. Le médecin a également l'obligation de fournir les renseignements, sous forme de rapport ou de formulaire, si le patient en a besoin pour obtenir une indemnité. Ces obligations peuvent durer après que les rapports patient-médecin ont pris fin.

Research

38. Ensure that any research in which you participate is evaluated both scientifically and ethically and is approved by a research ethics board that meets current standards of practice.

    This applies to community-based physicians considering participation in drug marketing studies no less than primary investigators in basic clinical research projects.

39. Inform the potential research subject, or proxy, about the purpose of the study, its source of funding, the nature and relative probability of harms and benefits, and the nature of your participation including any compensation.

40. Before proceeding with the study, obtain the informed consent of the subject, or proxy, and advise prospective subjects that they have the right to decline or withdraw from the study at any time, without prejudice to their ongoing care.

Recherche

38. Veiller à ce que toute recherche à laquelle vous participez soit évaluée sur les plans éthique et scientifique et approuvée par un conseil d'éthique en recherche répondant aux normes actuelles de pratique.

    Cela s'adresse aux médecins communautaires qui envisagent de participer à des études de marché de médicaments, aussi bien qu'aux principaux chercheurs qui participent à des projets de base de recherche clinique.

39. Informer un participant éventuel ou son mandataire de l'objet de l'étude, de la source du financement, de la nature et de la probabilité relative de préjudices et d'avantages, et de la nature de votre participation y compris de toute rémunération.

40. Avant de procéder à l'étude, obtenir le consentement éclairé du participant ou de son mandataire et informer les participants éventuels qu'ils ont le droit de refuser de participer à l'étude ou de s'en retirer en tout temps sans nuire aux soins qu'ils reçoivent.

Responsibilities to Society

41. Recognize that community, society and the environment are important factors in the health of individual patients.

    Because the health of patients is influenced by their life setting, physicians have a general responsibility to work towards the improvement of social and environmental factors in health.

42. Recognize the profession's responsibility to society in matters relating to public health, health education, environmental protection, legislation affecting the health or well being of the community and the need for testimony at judicial proceedings.

43. Recognize the responsibility of physicians to promote equitable access to health care resources.

44. Use health care resources prudently.

    Physicians have a responsibility to use resources efficiently and effectively subject to other legal and ethical obligations.

45. Recognize a responsibility to give the generally held opinions of the profession when interpreting scientific knowledge to the public; when presenting an opinion that is contrary to the generally held opinion of the profession, so indicate.

    The public needs to be protected against medically irresponsible opinions.

Responsabilités envers la société

41. Reconnaître que la communauté, la société et l'environnement sont des facteurs importants dans la santé de chaque patient.

    Parce qu'il y a une influence du milieu sur la santé du patient, le médecin doit s'efforcer d'améliorer les facteurs sociaux et environnementaux qui influent sur la santé.

42. Reconnaître la responsabilité de la profession envers la société à l'égard des questions qui ont trait à la santé publique, à l'éducation sur la santé, à la protection de l'environnement, à la législation touchant la santé ou le mieux-être de la communauté et à l'obligation de témoigner au cours de procédures judiciaires.

43. Reconnaître que les médecins doivent favoriser l'accès équitable aux ressources en soins de santé.

44. Utiliser judicieusement les ressources en soins de santé.

    Les médecins doivent avoir recours efficacement aux ressources à leur disposition sous réserve d'autres obligations juridiques et morales

45. Assumer la responsabilité de présenter les positions générales de la profession dans l'interprétation de connaissances scientifiques pour la population; lorsqu'un avis contraire à l'opinion générale de la profession est présenté, il faut le spécifier.

    Il faut protéger le public contre les opinions irréfléchies en médecine

Responsibilities to the Profession

46. Recognize that the self-regulation of the profession is a privilege and that each physician has a continuing responsibility to merit this privilege and to support its institutions.

    Physicians support self-regulation when they acknowledge its role in public protection and fully assist in that process. "Support" also includes respecting the authority and guidance of the College.

47. Be willing to teach and learn from medical students, residents, other colleagues and other health professionals.

    This is a general responsibility of the profession. The extent of such teaching by any individual will depend on the physician's judgement of his/her availability and suitability for the task. All physicians should be prepared to teach informally, by example, other health care workers involved in the care of their patients, but not all physicians are expected to be involved with formal teaching programs.

48. Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.

49. Be willing to participate in peer review of other physicians and to undergo review by your peers. Enter into associations, contract and agreements only if you can maintain your professional integrity and safeguard the interests of your patients.

    Peer review is an essential element of self-regulation as well as a learning

Responsabilités envers la profession

46. Reconnaître que l'autoréglementation de la profession est un privilège et que chaque médecin a la responsabilité de constamment mériter ce privilège et d'appuyer ses institutions.

    Un médecin appuie le concept d'auto-réglementation quand il reconnaît son rôle dans la protection du public et participe pleinement à son processus. «Appui» comprend également le respect de l'autorité et des directives du Collège.

47. Être disposé à enseigner aux étudiants en médecine, aux résidents, aux autres collègues et aux autres professionnels de la santé, et à apprendre d'eux. .

    Il s'agit d'une responsabilité générale de la profession. L'importance de cet enseignement dépend de la disponibilité du médecin et de son aptitude à la tâche. Tous les médecins devraient être disposés à enseigner à titre non-officiel, par exemple, d'autres professionnels de la santé qui s'occupent de leurs patients, mais on ne s'attend pas à ce que tous les médecins participent à des programmes spécifiques d'enseignement.

48. Éviter d'entacher la réputation de collègues pour des raisons personnelles, mais signaler aux autorités compétentes toute conduite non professionnelle de collègues.

49. Être disposé à participer à des examens critiques par des pairs et à s'y soumettre soimême. Établir des liens, des contrats et des ententes uniquement lorsqu'il est possible de maintenir votre intégrité professionnelle et de protéger les intérêts de vos patients.

    L'évaluation collégiale est un élément essentiel de l'auto-réglementation ainsi

opportunity for both reviewers and those being reviewed.

50. Avoid promoting, as a member of the medical profession, any service (except your own) or product for personal gain.

51. Do not keep secret from colleagues the diagnostic or therapeutic agents and procedures which you employ.

52. Collaborate with other physicians and health professionals in the care of patients and the functioning and improvement of health services. Treat your colleagues with dignity and as persons worthy of respect.

Responsibilities to Oneself

53. Seek help from colleagues and appropriately qualified professionals for personal problems that adversely affect your service to patients, society or the profession.

    Physicians are reminded that they may need help with their own personal problems if they are to serve their patients adequately.

54. Protect and enhance your own health and well-being by identifying those stress factors in your professional and personal lives that can be managed by developing and practising appropriate coping strategies.

qu'une occasion d'apprentissage pour l'inspecteur et celui qui fait l'objet de l'évaluation.

50. Éviter de promouvoir, comme membre de la profession médicale, tout service (autre que le vôtre) ou produit dans le but d'en retirer des gains personnels.

51. Ne pas cacher à ses collègues les agents et procédures diagnostiques ou thérapeutiques utilisés.

52. Collaborer avec d'autres médecins et professionnels de la santé aux soins des patients, au fonctionnement et à l'amélioration des services de santé. Traiter vos collègues avec dignité et comme des personnes dignes de respect.

Responsabilités envers soi-même

53. Solliciter l'aide de collègues et de professionnels dûment qualifiés lors de problèmes personnels qui pourraient nuire aux services que vous offrez aux patients, à la société ou à la profession.

    On rappelle aux médecins qu'ils peuvent avoir besoin d'aide pour régler leurs problèmes personnels s'ils veulent bien servir leurs patients.

54. Protéger et améliorer votre propre santé et votre propre mieux-être. À cette fin, cerner les facteurs de stress de votre vie professionnelle et personnelle susceptibles d'être gérés, en mettant au point et en adoptant des stratégies adéquates de gestion du stress

Good medical practice

Working with doctors Working for patients

General Medical Council

The duties of a doctor registered with the GMC

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make sure your practice meets the standards expected of you in four domains.

Knowledge, skills and performance

- Make the care of your patient your first concern.
- Provide a good standard of practice and care.
  - Keep your professional knowledge and skills up to date.
  - Recognise and work within the limits of your competence.

Safety and quality

- Take prompt action if you think that patient safety, dignity or comfort is being compromised.
- Protect and promote the health of patients and the public.

Communication, partnership and teamwork

- Treat patients as individuals and respect their dignity.
  - Treat patients politely and considerately.
  - Respect patients' right to confidentiality.
- Work in partnership with patients.
  - Listen to, and respond to, their concerns and preferences.
  - Give patients the information they want or need in a way they can understand.
  - Respect patients' right to reach decisions with you about their treatment and care.
  - Support patients in caring for themselves to improve and maintain their health.
- Work with colleagues in the ways that best serve patients' interests.

Maintaining trust

- Be honest and open and act with integrity.
- Never discriminate unfairly against patients or colleagues.
- Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Good medical practice

This guidance has been edited for plain English.

Published 25 March 2013
Comes into effect 22 April 2013.

This guidance was updated on 29 April 2014 to include paragraph 14.1 on doctors' knowledge of the English language.

You can find the latest version of this guidance on our website at **www.gmc-uk.org/guidance**.

For the full website addresses of references in this guidance, please see the online version on our website.

General Medical Council

Contents

About this guidance

Good medical practice includes references to explanatory guidance. A complete list of explanatory guidance is at the end of the booklet.

All our guidance is available on our website, along with:

- learning materials, including interactive case studies which bring to life the principles in the guidance and show how they might apply in practice
- cases heard by medical practitioners tribunals, which provide examples of where a failure to follow the guidance has put a doctor's registration at risk.

Professionalism in action

1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues,[1] are honest and trustworthy, and act with integrity and within the law.

2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.

3 *Good medical practice* describes what is expected of all doctors registered with the General Medical Council (GMC). It is your responsibility to be familiar with *Good medical practice* and the explanatory guidance[2] which supports it, and to follow the guidance they contain.

4 You must use your judgement in applying the principles to the various situations you will face as a doctor, whether or not you hold a licence to practise, whatever field of medicine you work in, and whether or not you routinely see patients. You must be prepared to explain and justify your decisions and actions.

5 In *Good medical practice*, we use the terms 'you must' and 'you should' in the following ways.

- 'You must' is used for an overriding duty or principle.
- 'You should' is used when we are providing an explanation of how you will meet the overriding duty.
- 'You should' is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can follow the guidance.

6 To maintain your licence to practise, you must demonstrate, through the revalidation process, that you work in line with the principles and values set out in this guidance. Serious or persistent failure to follow this guidance will put your registration at risk.

Domain 1: Knowledge, skills and performance

Develop and maintain your professional performance

7 You must be competent in all aspects of your work, including management, research and teaching.[3, 4, 5]

8 You must keep your professional knowledge and skills up to date.

9 You must regularly take part in activities that maintain and develop your competence and performance.[6]

10 You should be willing to find and take part in structured support opportunities offered by your employer or contracting body (for example, mentoring). You should do this when you join an organisation and whenever your role changes significantly throughout your career.

11 You must be familiar with guidelines and developments that affect your work.

12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.

13 You must take steps to monitor and improve the quality of your work.

Apply knowledge and experience to practice

14 You must recognise and work within the limits of your competence.

14.1 You must have the necessary knowledge of the English language to provide a good standard of practice and care in the UK.[7]

15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient

b promptly provide or arrange suitable advice, investigations or treatment where necessary

c refer a patient to another practitioner when this serves the patient's needs.[8]

16 In providing clinical care you must:

- **a** prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs[9]
- **b** provide effective treatments based on the best available evidence
- **c** take all possible steps to alleviate pain and distress whether or not a cure may be possible[10]
- **d** consult colleagues where appropriate
- **e** respect the patient's right to seek a second opinion
- **f** check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications
- **g** wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.[9]

17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.[4, 11, 12]

18 You must make good use of the resources available to you.[3]

Record your work clearly, accurately and legibly

19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

20 You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection law requirements.[14]

21 Clinical records should include:

- **a** relevant clinical findings
- **b** the decisions made and actions agreed, and who is making the decisions and agreeing the actions
- **c** the information given to patients
- **d** any drugs prescribed or other investigation or treatment
- **e** who is making the record and when.

Domain 2: Safety and quality

Contribute to and comply with systems to protect patients

22 You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:

- **a** taking part in regular reviews and audits of your work and that of your team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary
- **b** regularly reflecting on your standards of practice and the care you provide
- **c** reviewing patient feedback where it is available.

23 To help keep patients safe you must:

- **a** contribute to confidential inquiries
- **b** contribute to adverse event recognition
- **c** report adverse incidents involving medical devices that put or have the potential to put the safety of a patient, or another person, at risk
- **d** report suspected adverse drug reactions
- **e** respond to requests from organisations monitoring public health.

When providing information for these purposes you should still respect patients' confidentiality.[14]

Respond to risks to safety

24 You must promote and encourage a culture that allows all staff to raise concerns openly and safely.[3, 15]

25 You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.

a If a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away.

b If patients are at risk because of inadequate premises, equipment[13] or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance[14] and your workplace policy. You should also make a record of the steps you have taken.

c If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken.[14, 16]

26 You must offer help if emergencies arise in clinical settings or in the community, taking account of your own safety, your competence and the availability of other options for care.

27 Whether or not you have vulnerable[17] adults or children and young people as patients, you should consider their needs and welfare and offer them help if you think their rights have been abused or denied.[18, 19]

Risks posed by your health

28 If you know or suspect that you have a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must follow their advice about any changes to your practice they consider necessary. You must not rely on your own assessment of the risk to patients.

29 You should be immunised against common serious communicable diseases (unless otherwise contraindicated).

30 You should be registered with a general practitioner outside your family.

Domain 3: Communication, partnership and teamwork

Communicate effectively

31 You must listen to patients, take account of their views, and respond honestly to their questions.

32 You must give patients[20] the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.[21]

33 You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.

34 When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support.

Working collaboratively with colleagues

35 You must work collaboratively with colleagues, respecting their skills and contributions.[3]

36 You must treat colleagues fairly and with respect.

37 You must be aware of how your behaviour may influence others within and outside the team.

38 Patient safety may be affected if there is not enough medical cover. So you must take up any post you have formally accepted, and work your contractual notice period before leaving a job, unless the employer has reasonable time to make other arrangements.

Teaching, training, supporting and assessing

39 You should be prepared to contribute to teaching and training doctors and students.

40 You must make sure that all staff you manage have appropriate supervision.

41 You must be honest and objective when writing references, and when appraising or assessing the performance of colleagues, including locums and students. References must include all information relevant to your colleagues' competence, performance and conduct.[22]

42 You should be willing to take on a mentoring role for more junior doctors and other healthcare professionals.[3]

43 You must support colleagues who have problems with their performance or health. But you must put patient safety first at all times.[3]

Continuity and coordination of care

44 You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:

a share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers[8, 14]

b check, where practical, that a named clinician or team has taken over responsibility when your role in providing a patient's care has ended. This may be particularly important for patients with impaired capacity or who are vulnerable for other reasons.

45 When you do not provide your patients' care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient.[8]

Establish and maintain partnerships with patients

46 You must be polite and considerate.

47 You must treat patients as individuals and respect their dignity and privacy.[16]

48 You must treat patients fairly and with respect whatever their life choices and beliefs.

49 You must work in partnership with patients, sharing with them the information they will need to make decisions about their care,[21] including:

- **a** their condition, its likely progression and the options for treatment, including associated risks and uncertainties
- **b** the progress of their care, and your role and responsibilities in the team
- **c** who is responsible for each aspect of patient care, and how information is shared within teams and among those who will be providing their care

d any other information patients need if they are asked to agree to be involved in teaching or research.[12]

50 You must treat information about patients as confidential. This includes after a patient has died.[14]

51 You must support patients in caring for themselves to empower them to improve and maintain their health. This may, for example, include:

a advising patients on the effects of their life choices and lifestyle on their health and well-being

b supporting patients to make lifestyle changes where appropriate.

52 You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role.[23]

Domain 4: Maintaining trust

Show respect for patients

53 You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.[16]

54 You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.[23]

55 You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:

- **a** put matters right (if that is possible)
- **b** offer an apology
- **c** explain fully and promptly what has happened and the likely short-term and long-term effects.

Treat patients and colleagues fairly and without discrimination

56 You must give priority to patients on the basis of their clinical need if these decisions are within your power. If inadequate resources, policies or systems prevent you from doing this, and patient safety, dignity or comfort may be seriously compromised, you must follow the guidance in paragraph 25b (see section *Domain 2: Safety and quality*).

57 The investigations or treatment you provide or arrange must be based on the assessment you and your patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient's actions or lifestyle have contributed to their condition.

58 You must not deny treatment to patients because their medical condition may put you at risk. If a patient poses a risk to your health or safety, you should take all available steps to minimise the risk before providing treatment or making other suitable alternative arrangements for providing treatment.

59 You must not unfairly discriminate against patients or colleagues by allowing your personal views[24] to affect your professional relationships or the treatment you provide or arrange. You should challenge colleagues if their behaviour does not comply with this guidance, and follow the guidance in paragraph 25c (see section *Domain 2: Safety and quality*) if the behaviour amounts to abuse or denial of a patient's or colleague's rights.

60 You must consider and respond to the needs of disabled patients and should make reasonable adjustments[25] to your practice so they can receive care to meet their needs.

61 You must respond promptly, fully and honestly to complaints and apologise when appropriate. You must not allow a patient's complaint to adversely affect the care or treatment you provide or arrange.

62 You should end a professional relationship with a patient only when the breakdown of trust between you and the patient means you cannot provide good clinical care to the patient.[26]

63 You must make sure you have adequate insurance or indemnity cover so that your patients will not be disadvantaged if they make a claim about the clinical care you have provided in the UK.

64 If someone you have contact with in your professional role asks for your registered name and/or GMC reference number, you must give this information to them.

Act with honesty and integrity

Honesty

65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

66 You must always be honest about your experience, qualifications and current role.

67 You must act with honesty and integrity when designing, organising or carrying out research, and follow national research governance guidelines and our guidance.[4]

Communicating information

68 You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.

69 When communicating publicly, including speaking to or writing in the media, you must maintain patient confidentiality. You should remember when using social media that communications intended for friends or family may become more widely available.[14, 27]

70 When advertising your services, you must make sure the information you publish is factual and can be checked, and does not exploit patients' vulnerability or lack of medical knowledge.

71 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.[22] You must make sure that any documents you write or sign are not false or misleading.

a You must take reasonable steps to check the information is correct.

b You must not deliberately leave out relevant information.

Openness and legal or disciplinary proceedings

72 You must be honest and trustworthy when giving evidence to courts or tribunals.[28] You must make sure that any evidence you give or documents you write or sign are not false or misleading.

a You must take reasonable steps to check the information is correct.

b You must not deliberately leave out relevant information.

73 You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in *Confidentiality*.

74 You must make clear the limits of your competence and knowledge when giving evidence or acting as a witness.[28]

75 You must tell us without delay if, anywhere in the world:

a you have accepted a caution from the police or been criticised by an official inquiry

b you have been charged with or found guilty of a criminal offence

c another professional body has made a finding against your registration as a result of fitness to practise procedures.[29]

76 If you are suspended by an organisation from a medical post, or have restrictions placed on your practice, you must, without delay, inform any other organisations you carry out medical work for and any patients you see independently.

Honesty in financial dealings

77 You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals.[30]

78 You must not allow any interests you have to affect the way you prescribe for, treat, refer or commission services for patients.

79 If you are faced with a conflict of interest, you must be open about the conflict, declaring your interest formally, and you should be prepared to exclude yourself from decision making.

80 You must not ask for or accept – from patients, colleagues or others – any inducement, gift or hospitality that may affect or be seen to affect the way you prescribe for, treat or refer patients or commission services for patients. You must not offer these inducements.

Endnotes

1 Colleagues include anyone a doctor works with, whether or not they are also doctors.

2 You can find all the explanatory guidance on our website.

3 *Leadership and management for all doctors* (2012) GMC, London

4 *Good practice in research* (2010) GMC, London

5 *Developing teachers and trainers in undergraduate medical education* (2011) GMC, London

6 *Continuing professional development: guidance for all doctors* (2012) GMC, London

7 This paragraph was added on 29 April 2014. Section 35C(2)(da) of the *Medical Act 1983*, inserted by the *Medical Act 1983 (Amendment) (Knowledge of English) Order 2014*.

8 *Delegation and referral* (2013) GMC, London

9 *Good practice in prescribing and managing medicines and devices* (2013) GMC, London

10 *Treatment and care towards the end of life: good practice in decision-making* (2010), GMC, London

11 *Making and using visual and audio recordings of patients* (2011) GMC, London

12 *Consent to research* (2013) GMC, London

13 Follow the guidance in paragraph 23c if the risk arises from an adverse incident involving a medical device.

14 *Confidentiality: good practice in handling patient information* (2017) GMC, London

15 *Raising and acting on concerns about patient safety* (2012) GMC, London

16 Maintaining boundaries (2013) GMC, London

- *Intimate examinations and chaperones* (paragraphs 47, 25c)
- *Maintaining a professional boundary between you and your patient* (paragraph 53)
- *Sexual behaviour and your duty to report* (paragraphs 53, 25c)

17 Some patients are likely to be more vulnerable than others because of their illness, disability or frailty or because of their current circumstances, such as bereavement or redundancy. You should treat children and young people under 18 years as vulnerable. Vulnerability can be temporary or permanent.

18 *0–18 years: guidance for all doctors* (2007) GMC, London

19 *Protecting children and young people: the responsibilities of all doctors* (2012) GMC, London

20 Patients here includes those people with the legal authority to make healthcare decisions on a patient's behalf.

21 *Consent: patients and doctors making decisions together* (2008) GMC, London

22 *Writing references* (2012) GMC, London

23 *Personal beliefs and medical practice* (2013) GMC, London

24 This includes your views about a patient's or colleague's lifestyle, culture or their social or economic status, as well as the characteristics protected by legislation: age, disability, gender reassignment, race, marriage and civil partnership, pregnancy and maternity, religion or belief, sex and sexual orientation.

25 'Reasonable adjustments' does not only mean changes to the physical environment. It can include, for example. Being flexible about appointment time or length, and making arrangements for those with communication difficulties such as impaired hearing. For more information see the EHRC website.

26 *Ending your professional relationship with a patient* (2013) GMC, London

27 *Doctors' use of social media* (2013) GMC, London

28 *Acting as a witness in legal proceedings* (2013) GMC, London

29 *Reporting criminal and regulatory proceedings within and outside the UK* (2013) GMC, London

30 *Financial and commercial arrangements and conflicts of interest* (2013) GMC, London

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General Medical Council

Australian and New Zealand College of Anaesthetists (ANZCA)

Faculty of Pain Medicine

Statement on Cultural Competence

1. PURPOSE

The purpose of this statement is as follows:

1.1 To identify ANZCA's commitment to the role and importance of cultural competence in effective clinical practice and patient care.

1.2 To identify and communicate the expected standards of cultural competence.

1.3 To serve as a resource to assist clinicians deliver culturally competent care to patients, and their family/support network.

2. SCOPE

This document is intended to apply to all trainees and Fellows of the Australian and New Zealand College of Anaesthetists (ANZCA), which includes the Faculty of Pain Medicine.

3. BACKGROUND

ANZCA's mission statement is "to serve the community by fostering safety and quality patient care in anaesthesia, pain medicine, and perioperative medicine". The statement is inclusive of all cultures – service to the community in its widest sense.

It is apparent that health inequities exist between different cultures, and the role of cultural competence is about challenging how as clinicians we practice - and what is it about our practice that maintains health inequities.

A person's culture is complex and can include participation in a number of cultural communities shaped by gender, religious or spiritual beliefs, age, employment and socio-economic status, sexual orientation and disability. People may identify with more than one cultural group, and it is also acknowledged that diversity exists within individual cultural groups.

Cultural competence involves ensuring the clinical environment is inclusive of the cultural needs of the patient, and their family/support network. Cultural competence

also involves doctors navigating the health system for patients to ensure they receive the best clinical care.

ANZCA recognises that the culture of the health system and a clinician's own culture and belief systems influence their interactions with patients, highlighting the need to be aware of the potential impact of this.

Cultural competence finds legitimacy in the positive experience of the patient and their support networks, and contributes to improved health outcomes.[1]

4. CULTURE AND CULTURAL COMPETENCE

4.1 In 1982 the United Nations Educational, Scientific and Cultural Oganisation (UNESCO) produced this definition of culture:

"Culture may now be said to be the whole complex of distinctive spiritual, material, intellectual and emotional features that characterise a society or social group. It includes not only the arts and letters, but also modes of life, the fundamental rights of the human being, value systems, traditions and beliefs."[2]

4.2 Flowing on from the concept of "cultural awareness" is the concept of "cultural competence". The Australian Medical Council, the Medical Board of Australia and the Medical Council of New Zealand have each expressed the expectation that medical specialists will demonstrate cultural competence in their practice of medicine.

The Medical Council of New Zealand defines cultural competence as:

"…an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this."

4.3 Culture defines our identities, thoughts, communications and values. In Australia and New Zealand the College acknowledges the specific impacts of colonisation and racism on the Indigenous peoples, the Aboriginal and Torres Strait Islander cultures (in Australia) and New Zealand Māori (in New Zealand).

5. PRINCIPLES FOR CULTURALLY COMPETENT PRACTICE

5.1 Respect and understanding

5.1.1 Good medical practice requires an understanding of the roles of both privilege and disadvantage within our communities, and the impact these have on health outcomes.

5.1.2 Respect extends to acknowledging patients' beliefs and values, and how these perspectives might impact on health. There will be times when these beliefs and values do not align with the medical model. It is the role of the healthcare system, including the doctor, to navigate a respectful and open approach to ensure the patient and their family are clearly informed of the likely diagnosis, available treatments and outcome expectations.

5.1.3 Doctors are encouraged to identify cultural biases and assumptions that are often reinforced by societal norms, which impact on health care. Doctors should strive to ensure they come into a clinical relationship with an open mind.

5.1.4 Doctors are encouraged to seek out appropriate professional development opportunities that address the impact of cultural bias on health outcomes.

5.2 Culturally appropriate communication

5.2.1 Safety and quality patient care relies on effective communication. The doctor needs to be sensitive to the patient's needs and wishes, and to seek clarification if unsure of how best to proceed. Communication can often be assisted by a third party, such as a professional interpreter, a health advocate, or a family or community member. It should be recognised that friends and relatives acting as interpreters may not be told private or personal information by the patient, and they modify and interpret information they communicate to the doctor.

5.2.2 Patients may not disclose important information if they do not feel the method of communication chosen is right or their values and beliefs are not respected.

5.2.3 It should not be assumed that silence means the patient understands and consents.

5.3 Patient-centred practice

5.3.1 Clinicians are encouraged to tailor care to the patient's specific communicated needs. It is important not to generalise or make assumptions about a person's needs or preferences based on a person's stated or assumed cultural group. For example, not all women may prefer a female doctor, and not all Māori patients may want whānau (family) present during consultations with a doctor.

5.3.2 Cultural safety aims to enhance the delivery of health services by identifying the power relationship between the medical practitioner and the patient, and through establishing a relationship founded on trust, empowering the patient to take full advantage of the health care service offered.[4] It is perceived that this will contribute to improved communication strategies which allow the sharing of clinically relevant information.

5.3.3 Patient-centred practice identifies that a relationship founded on trust is, in turn, established through the demonstration of respect, compassion, and clinical competence. These are of-course the hallmarks professionals should strive to establish in their dealings with all patients. In that sense cultural competence aligns with the universal expectations of patient care.

5.3.4 The cultural needs of the patient can only be defined by individual patients themselves, and the patient's support network. Patient-centred practice encourages the doctor to explore the patient's expectations of the consultation, and to demonstrate the high level of health literacy necessary to ensure patients are able to make informed health decisions.

5.3.5 There may be rare occasions when the clinician senses that tailoring clinical practice to achieve culturally appropriate care could potentially

compromise clinical safety. In this situation the practitioner should effectively discuss this with the patient to ensure that both parties are comfortable with the suggested diagnostic and therapeutic approach. That is, clinical care should ensure that both cultural safety and clinical safety are achieved, without one taking priority over the other. Such effective communication is likely to include the involvement of third parties.

5.4 Partnership

5.4.1 The role of partnership can only develop on a basis of a good working relationship, an appropriate communication strategy and an understanding of the patient's needs and wishes.

5.4.2 Partnership may take on different definitions within different cultural groups/realities. It is normal in some communities to revere doctors and not to challenge or disagree with an authority figure. In these circumstances, doctors need to be sensitive to situations that may arise, in which a person seems uncomfortable with advice but does not say so; or fails to comply with guidelines when they have expressed understanding of the information provided. Positive approaches might include politely asking the patient to share their thoughts with you, or asking them to explain the treatment plan in their own words. Shyness and fear can often be overcome by respect, and the willingness to work with a patient.

5.4.3 Anaesthetists work as part of a team providing care to a patient. The importance of cultural competence extends to their working relationships with medical colleagues, with nursing, midwifery and allied health staff, and with trainees.

5.5 Issues specific to anaesthesia

5.5.1 Anaesthesia and sedation frequently involve patients being placed in a vulnerable situation amongst strangers. In many situations it will not be possible for support people to accompany the patient. For patients this can increase feelings of vulnerability, and heighten common concerns that include dignity, the preservation of modesty, and observance of any specific rituals or processes. These issues can be discussed with the patient and family at the pre-anaesthesia assessment and consultation.

5.5.2 Pain management can be particularly challenging in a cross-cultural environment. Communication of pain can be affected by verbal and non-verbal indicators of pain, where 'expected' pain behaviours are misunderstood because of different underlying beliefs or concerns. This can also affect treatment. A more detailed discussion is found in the ANZCA publication *Acute Pain Management: Scientific Evidence 4th Edition, Section 10.3*.

RELATED ANZCA DOCUMENTS

The ANZCA publication Supporting Anaesthetists' Professionalism and Performance – A guide for clinicians is another resource that provides examples of good and poor behaviour within all ANZCA Roles including matters of cultural competence. Accessible at www.anzca.edu.au/resources/professional-documents

REFERENCES

1. Royal Australasian College of Physicians. An introduction to cultural competence. . 2004. http://www.racp.edu.au/docs/default-source/advocacy-library/an-introduction-to-cultural-competency.pdf Accessed on October 28, 2015.

2. United Nations Educational Scientific and Cultural Organization. Mexico City Declaration on Cultural Policies. 1982. http://portal.unesco.org/culture/en/files/12762/11295421661mexico_en.pdf/mexico_en.pdf Accessed on October 28, 2015.

3. Medical Council of New Zealand. Statement on cultural competence. August 2006. https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Statement-on-cultural-competence.pdf Accessed on October 28, 2015.

4. Richardson, Ivor and Cook, Len and Durie, Mason and Ballin, Ann and Bruce, Marlon and Noonan, Rosslyn, Preface: The April Report: Report of the Royal Commission on Social Policy (1988). Royal Commission on Social Policy, Wellington, 1988; Victoria University of Wellington Legal Research Paper Series Richardson Paper No. 25.

5. Secretariat of National Aboriginal and Islander Child Care Working and Walking Together: Supporting Family Relationship Services to Work with Aboriginal and Torres Strait Islander Families and Organisations. March 2010**.** http://www.snaicc.org.au/_uploads/rsfil/02497.pdf Accessed on October 28, 2015.

6. Acute Pain Management: Scientific Evidence 4th Edition, Section 10.3.

FURTHER READING

1. Australian Medical Council (2010) Good Medical Practice: a code of conduct for doctors in Australia. Accessible at: http://www.amc.org.au/index.php/about/good-medical-practice

2. Australian Charter of Healthcare Rights (2008). Accessible at: http://www.health.gov.au/internet/safety/publishing.nsf/content/PriorityProgram-01

3. The Code of Health and Disability Services Consumers' Rights 1996 (New Zealand). Accessible at: http://www.hdc.org.nz/the-act--code/the-code-of-rights

4. National Health and Medical Research Council (Australia): Cultural Competency in Health: A guide for policy, partnerships and participation (2005). Accessible at: http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/hp19.pdf

5. Australian Health Ministers' Advisory Council (2005). The Cultural Respect Framework for Aboriginal and Torres Strait Islander Health. Accessible at: http://www.health.vic.gov.au/__data/assets/pdf_file/0019/270154/cultural-respect-framework.pdf

6. Medical Council of New Zealand: Statement on Cultural Competence (2006). Accessible at: http://www.mcnz.org.nz/portals/0/guidance/cultural%20competence.pdf

7. Medical Council of New Zealand: Best Health Outcomes for Māori: Practice implications. Accessible at: http://www.mcnz.org.nz/Default.aspx?tabid=269

8. Medical Council of New Zealand: Best Health Outcomes for Pacific Peoples: Practice implications. Accessible at: http://www.mcnz.org.nz/portals/0/publications/Best%20health%20outcomes%20for%20Pacific%20Peoples.pdf

Professional documents of the Australian and New Zealand College of Anaesthetists (ANZCA) are intended to apply wherever anaesthesia is administered and perioperative medicine practised within Australia and New Zealand. It is the responsibility of each practitioner to have express regard to the particular circumstances of each case, and the application of these ANZCA documents in each case. It is recognised that there may be exceptional situations (for example, some emergencies) in which the interests of patients override the requirement for compliance with some or all of these ANZCA documents. Each document is prepared in the context of the entire body of the College's professional documents, and should be interpreted in this way.

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Person-centred Care

Position Statement

November 2014

Key Statement

The Australian College of Nursing (ACN) believes that the principle of person-centred care is a central tenet underpinning the delivery of nursing care and health care generally. Person-centred care means:

- treating each person as an individual;
- protecting a person's dignity;
- respecting a person's rights and preferences; and
- developing a therapeutic relationship between the care provider and care recipient which is built on mutual trust and understanding.

A nurse's ability to deliver person-centred care is determined by the attributes of the nurse; their nursing practice; and the care environment.

- Attributes of a nurse that enable her/him to deliver person-centred care include professional competence (the knowledge, skill, attitudes, values and judgments required); well-developed interpersonal skills; self-awareness; commitment to patient care; and strong professional values.
- Nursing practices that contribute to person-centred care include those that: acknowledge peoples' cultural and spiritual beliefs, preferences and rights; empower people to make informed decisions about their care; provide a sympathetic presence; and provide holistic care.
- Elements in a care environment that support person-centred care include; an appropriate staff skill mix; the presence of transformational leadership enabling the development of effective nursing teams, shared power, potential for innovation, supportive workplace culture and effective organizational systems); and the functionality and aesthetics of the built environment.[1]

In Australia, nurses' ambitions for person-centred care are often challenged by health care policies that drive patient throughput in a resource constrained environment. ACN believes that health care organisations need to design and implement policies which support person-centred care to achieve a better balance between economic and quality of care imperatives.

Policy makers, nurses and consumers of care must collaborate in the development and implementation of such policies and systems.

Background and Rationale

Person-centred care (also referred to as patient centred care, client centred care and patient centred approach/practice) has been an important principle underpinning the provision of quality health care.[2 3 4] The principle of a person's individual needs and preferences being a central consideration in the provision of nursing care constitutes a philosophical foundation for nurses across all nursing specialties and settings[5] and is articulated in the Nursing and Midwifery Board of Australia's professional practice framework.[6] When the principles of person-centred care are embedded in all considerations of a health care organisation then individuals' needs and preferences remain at the centre of their care delivery.

Evidence demonstrates that person-centred care positively affects health outcomes and nurses' job satisfaction but losing sight of this principle can have a disastrous effect on the quality of care provided. Examples of evidence of the positive effect on health outcomes include reduced mortality following myocardial infarction;[7] and positive impacts on the patient and family/carer experience;[8] decreased rates of hospital acquired infections;[9] and decreased admission rates to hospital from aged care facilities when following advance care directives.[10] Evidence also associates the provision of person-centred care is associated with nursing staff's increased job satisfaction.[11 12]

The Francis Report into care at the Mid Staffordshire Foundation Trust (UK) illustrates the disastrous ramifications for quality of care if organisations and nurses fail to place patients' needs and interests at the core of their work. The report describes failures in care provision which include many examples of patient neglect.[13]

Embedding person-centred care into health systems remains a challenge for nurses. Environmental attributes such as an inappropriate staff skill mix; a focus on disease based models of care; and funding incentives that encourage patient throughput present barriers to operationalising person-centred care.[14] Further, the delivery of person-centred care is often challenged by the competing care demands the person, carer and/or family, best practice, and organisational imperatives place on the nurse.

The development and maintenance of a person-centred culture of care requires individual, team and organisational commitment.[15]

Nurses as individuals and in teams must be committed to incorporating the principles of person-centred care in every aspect of nursing care, including assessment, treatment, and advocacy. They also need to manage issues in the care environment such as organisational policies and care routines which constitute barriers to person-centred care. Health care organisations need to support person-centred care by educating staff on this care philosophy; developing staff communication skills; providing the transformational leadership required for practice change and collaborative work relationships; and promoting individual accountability for person-centred care.[16 17]

At the level of the health care system a person-centred approach is supported in a range of national and state initiatives, including the Australian Charter of Healthcare Rights,[18] National Safety and Quality Health Service Standards, and the Australian Safety and Quality Framework for Healthcare.[19 20] National health reforms also propose to link evidence of person-centred care with performance and funding incentives.[21] Nurses can build on these initiatives in their effort to firmly embed the principles of person-centred care in their practice.

Nurses, their health professional colleagues, consumers and policy makers need to collaborate in the implementation of person-centred models of care to better balance the contradictory demands placed on health care organisations.[22]

References

1 McCormack, B & McCance, T 2010, *Person-Centred Nursing: Theory and Practice,* Wiley Blackwell, Chichester.

2 Institute of Medicine, Committee on Quality of Health Care in America 2001, *Crossing the Quality Chasm: A New Health System for the 21st century,* National Academy Press, Washington.

3 Bradley, S & Mott, S 2013, 'Adopting a patient-centred approach: an investigation into the introduction of bedside handover to three rural hospitals', *Journal of Clinical Nursing,* vol. 23, no. 13-14, pp. 1927-1936.

4 Consumers Health Forum of Australia 2012, *Submission to the International Alliance of Patients' Organizations* Patient-Centred Healthcare Indicators Review, https://www.chf.org.au/pdfs/sub/sub-876-IAPO-patient-centred-care.pdf, accessed 26 June 2014.

5 McCormack, B, Karlsson, B, Dewing, J & Lerdal, A 2010, 'Exploring person-centredness: a qualitative meta-synthesis of four studies', *Scandinavian Journal of Caring Sciences,* vol. 24, no. 3, pp. 620-643.

6 Nursing and Midwifery Board of Australia 2008, *Code of Ethics for Nurses in Australia,* http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements.aspx, accessed 29 October 2014.

7 Meterko, M, Wright, S, Lin, H, Lowy, E & Cleary, PD 2010, 'Mortality amongst patients with acute myocardial infarction: the influences of patient centred care and evidence based medicine', *Health Services Research,* vol. 45, no. 5 (part1), pp. 1188-1204.

8 Ewart, L, Moore, J, Gibbs, C & Crozier, K 2014, 'Patient and family centred care on an acute adult cardiac ward', *British Journal of Nursing,* vol. 23, no. 4, pp. 213-218.

9 Isaac, T, Zaslavsky, A, Cleary, P & Landon, B 2010, 'The relationship between patients' perceptions of care and measures of hospital quality and safety', *Health Services Research,* vol. 45, no. 4, pp. 1024-1040.

10 Graverholt, B, Forsetlund, L & Jamtvedt, G 2014, 'Reducing hospital admissions from nursing homes: a systematic review', *BMC Health Services Research,* vol. 14, article no. 36.

11 Manley, K, Hills, V & Marriot, S 2011, 'Person-centred care: principles of nursing practice D', *Nursing Standard,* vol. 25, no. 31, pp. 35-37.

12 Latour, J & Albarran J 2012 'Privacy, dignity and confidentiality: a time to reflect on practice', *Nursing in Critical Care* vol. 17, no. 3, pp. 109–111.

13 The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary,* http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf, accessed 29 October 2014

14 Rattray, J & McKenna, E 2012, 'Person-centred care in intensive care: a myth or reality?', *Nursing in Critical Care,* vol. 17, no. 5, pp. 225-226.

15 McCormack & McCance 2010.

16 International Alliance of Patient Organisations 2007, *What is patient centred health care? A review of Definitions and Principles,* 2nd edn, IAPO, London.

17 Luxford, K, Safran, D & Delbanco T 2011, 'Promoting patient centred care: a qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving patient experience', *International Journal for Quality in Health Care,* vol. 23, no. 5, pp. 510-515.

18 Australian Commission on Safety and Quality in Healthcare 2008, *Australian Charter of Health Care Rights,* http://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights, accessed 5 June 2014.

19 Australian Commission on Safety and Quality in Healthcare 2010, *Australian Safety and Quality Framework for Healthcare,* http://www.safetyandquality.gov.au/national-priorities/australian-safety-and-quality-framework-for-health-care, accessed 5 June 2014.

20 Australian Commission on Safety and Quality in Health Care 2011, *Patient-centred care: improving quality and safety through partnerships with patients and consumers,* http://www.safetyandquality.gov.au/wp-content/uploads/2012/03/PCC_Paper_August.pdf, accessed 28 May 2014.

21 National Health Performance Authority 2012, *Performance and accountability framework,* http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/PAF, accessed 28 May 2014.

22 Clinical Excellence Commission 2012, *Your guide to the patient based care challenge,* http://www.cec.health.nsw.gov.au/pbcc, accessed 28 May 2014.

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Royal College of Nursing

Spirituality in nursing care:

a pocket guide

Introduction

This is a guide to enable nursing staff to address questions about the spiritual part of care. Media headlines have brought attention to the potential conflict that can exist between personal spiritual values/beliefs of nursing staff and their practice.

The Nursing and Midwifery Council expects newly qualified graduate nurses to be able to:

“ In partnership with the person, their carers and their families, makes a holistic, person centred and systematic assessment of physical, emotional, psychological, social, cultural and spiritual needs, including risk, and together, develops a comprehensive personalised plan of nursing care.”

In 2010, the RCN commissioned a survey on spirituality. It revealed that members wanted:

- more education and guidance about spiritual care
- clarification about personal and professional boundaries
- support in dealing with spiritual issues.

Spiritual care definition

That care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires'
(NHS Education for Scotland, 2009).

Spirituality during a time of crisis

It has been said that 'Often it is not until crisis, illness...or suffering occurs that the illusion (of security) is shattered...illness, suffering...and ultimately death...become spiritual encounters as well as physical and emotional experiences'
(Ganstrom in Hitchins, 1988).

Spirituality is about:

- hope and strength
- trust
- meaning and purpose
- forgiveness
- belief and faith in self, others, and for some this includes a belief in a deity/higher power
- peoples' values
- love and relationships
- morality
- creativity and self expression.

Spiritual care is not:

- just about religious beliefs and practices
- about imposing your own beliefs and values on another
- using your position to convert
- a specialist activity
- the sole responsibility of the chaplain.

Practising spiritual care

In our survey a member said *"Spiritual care is a fundamental part of nursing currently much neglected through ignorance and misunderstanding"*.

- The practice of spiritual care is about meeting people at the point of deepest need.
- It is about not just 'doing to' but 'being with' them.
- It is about our attitudes, behaviours and our personal qualities i.e. how we are with people.
- It is about treating spiritual needs with the same level of attention as physical needs.

What is needed from me?

- Adopting a caring attitude and disposition.
- Recognising and responding appropriately to people's needs.
- Using observation to identify clues that may be indicative of underlying spiritual need e.g. peoples' disposition (sad/withdrawn), personal artefacts (photographs, religious/ meditational books and symbols).
- Giving time to listen and attend to individual need.
- Being aware of when it is appropriate to refer to another source of support e.g. chaplain, counsellor, another staff member, family or friend.

Preparing to give spiritual care

Just as you would assess your patients' physical needs, an initial assessment of their spiritual concerns is also important. You may find questions such as these helpful:

- do you have a way of making sense of the things that happen to you?
- what sources of support/help do you look to when life is difficult?
- would you like to see someone who can help you?
- would you like to see someone who can help you talk or think through the impact of this illness/life event? (You don't have to be religious to talk to them).

Integrating personal beliefs and professional practice

It may become apparent that the client requires some intervention to support them with their spiritual or religious beliefs. Before taking any action you should consider the following:

- has the intervention been initiated by the patient/client?
- has clear consent been given?
- does it comply with your professional codes of practice?
- does it comply with your employer's codes of practice?
- is it safe and appropriate?
- is it likely to cause offence?
- do you feel comfortable?
- do you have sufficient knowledge and skills?
- is there adequate support and supervision for you and your patient/client?

Where do I go when I feel out of my depth?

It is about knowing your strengths, limitations and when to seek help. You may consider the following:

- another colleague, someone you trust (mentor or preceptor)
- the Chaplaincy team (who are there for staff and patients of all faiths and none)
- local contacts specific to your workplace
- psychosocial team (e.g. social worker, counsellor, psychologist)
- your own faith groups and/or other support networks.

Some helpful resources

Association for Children's Spirituality
www.childrenspirituality.org

Department of Health (2009) *Religion or belief: a practical guide for the NHS*, London: Crown.

Mental Health Foundation
www.mentalhealth.org.uk

Spirituality and Psychiatry Special Interest Group
www.rcpsych.ac.uk

Centre for Spirituality, Health and Disability
www.abdn.ac.uk

References

Hitchens E W (1988) *Stages of faith and values development and their implications for dealing with spiritual care in the student nurse-patient relationship*. Unpublished Ed.D Thesis, Seattle: University of Seattle.

Nursing and midwifery Council (2010) *Standards for preregistration education Nursing and Midwifery Council*, London: NMC.

NHS Education for Scotland (2009) *Spiritual care matters: an introductory resource for all NHS Scotland staff*, Edinburgh: NES.

Royal College of Nursing (2011) *RCN spirituality survey 2010*, London: RCN.

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

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Spirituality and Religion in Health Care Practice

A person-centred resource for staff at the Prince of Wales Hospital

DIVERSITY
health

THE PRINCE OF WALES HOSPITAL

SOUTH EASTERN SYDNEY
ILLAWARRA
NSW HEALTH
Multicultural Health Unit

Spirituality and Religion in Health Care Practice: a person-centred resource for staff at the Prince of Wales Hospital was prepared by the Spirituality and Health Project team:

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October 2007

Table of Contents

The purpose of this resource

Staff at POWH recognise the importance of spirituality/religion in person-centred health care, and are willing to incorporate patients' beliefs and practices into their treatment planning and care. However, staff acknowledge that they seldom ask patients about spirituality/religion, they lack confidence in responding to patients' comments on the subject, and they do not currently have strategies for integrating spirituality/religion into their practice.

This resource has been developed in response to these needs. It is based on an extensive literature review and two phases of research at POWH.

Key findings from POWH research

- Spirituality/religion is important to the majority of POWH patients
- Rituals and practices associated with beliefs are important to POWH patients
- Beliefs and practices are not easily categorised – they are eclectic, individualised and evolving
- Respecting the diversity of beliefs and practices is extremely important to POWH patients and staff
- Patient-centred care requires health care professionals to acknowledge and accommodate patients' beliefs, practices and wishes
- A patient-centred assessment of needs requires patient/staff engagement, attention to patient cues and, when appropriate, sensitive strategic questioning

Spirituality in health care: why is its important?

There is increasing recognition within contemporary western medicine of the significant links between spirituality/religion and health, and the need for health professionals to understanding their patients' spiritual/religious beliefs and practices because they can affect:

- the way people understand health, illness, diagnoses, recovery and loss[1,2,3,4,5]
- the strategies they use to cope with illness[3, 6]
- their resilience, resources and sense of support[3, 7, 8]
- decision-making about treatment, medicine and self-care[9,10]
- people's expectations of and relationship with health service providers[11]
- day-to-day health practices and lifestyle choices[12,13]
- overall health outcomes[2,11,14,15]

Spirituality/religiosity per se is not necessarily an indicator for better health outcomes because the relationship between beliefs, practices and health can be negative or neutral as well as positive.[2,16,17,18] The critical factor is not *if* someone is spiritual/religious, but *how* they are spiritual/religious. This may be influenced by a myriad of factors including culture,[8] family ties and social networks,[19] and life events such as health crises, trauma and loss of a loved one. [20, 21]

Understanding religion and spirituality

Religion

Religion is usually seen as the institutionalisation of shared beliefs and customary practices.[22] It is often integrated into a community's cultural life and can be a framework for understanding and decision-making.[23] Most religions have traditional beliefs and practices relating to healthy living, illness and death.

Spirituality

Spirituality means something different for everybody and consequently there can be no single all-encompassing definition.[24] It relates to how we find meaning and connection, and the resources we use to replenish ourselves and cope with adversity. Spirituality may be part of religious beliefs or another shared belief system, or something entirely personal and self-developed.

Based on these definitions religion is considered to be more structured, formal and rooted in tradition; while spirituality is perceived as more fluid, eclectic and individual.

Spiritual Worldview

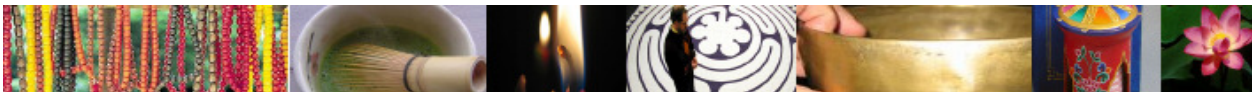
The concept of a 'spiritual worldview' incorporates religion and spirituality, as well as many other philosophical or popular beliefs and reference points that make assumptions about the larger context of human existence.[25] It may include fatalism ("It wasn't meant to be"); an unspecified universal design ("Everything happens for a reason"); 'New Age' concepts which encompass a diverse range of beliefs; advocacy of holistic approaches to health and ecology; astrology; non-theist spiritual practices such as Buddhism, Taoism and Paganism; ethical philosophies such as Humanism and Utilitarianism; and Agnostic and Atheist positions.

For many people, their worldview is the most important thing in their lives with a deciding role in directing behaviour; guiding attitudes to health, work and relationships; and strongly influencing how they regard themselves and others.

Why should we try to understand a patient's spiritual worldview?

Thinking about religion and spirituality as dimensions of a person's 'spiritual worldview' helps us to be responsive to the complex and diverse ways in which people personalise their beliefs. This means we are less likely to make assumptions about their needs, wishes and practices based on a generalised term on their admission sheet. It also:

- helps us to develop a better understanding of the patient and their context
- assists in the development of informed and comprehensive treatment plans
- contributes to the collaborative dialogue that encourages patients to commit to treatment regimens and healthy-living practices
- lets patients know that we are concerned with the whole person
- helps us to support spiritual patients to tap into resources that may contribute to improved coping and wellbeing



Customs, Rituals and Practices

> *"Ritual is a marking of an ordinary person's journey which tells them their experience is significant and that it is connected with the wider community of universal life and existence."* [26]

Customs and rituals may be religious, cultural or personally defined. People use them to connect with each other, with their faith, and their traditions: with whatever framework they have for meaning in their lives. Rituals and rites provide comfort and assistance when dealing with illness, anxiety, pain, confusion, misfortune, death, and the fear of these events. They can enhance quality of life, provide critical reassurance, offer a vehicle for therapeutic communication, enable a sense of purpose and control, and facilitate mutual support and solidarity with family, friends and community members.

Peer-reviewed studies have shown ritual practices such as meditation, prayer and social religiosity to have a positive impact on specific physical and mental health indicators.[6,27,28,29] It is widely accepted that rituals can directly affect patient wellbeing and quality of life by impacting upon stress/relaxation, hope, coping, and perceived recovery,[30] which in turn affect overall health outcomes.[31] Therefore, it is important that health professionals recognise the importance that rituals have for many patients and families, respect their practice, and support them whenever possible.

> *"A patient on my ward was dying. Apparently the family requested a chaplain but, for some reason, staff delayed making the call and the patient died before the chaplain could attend. The family was very upset because certain rituals hadn't been administered. They felt guilty and concerned that their relative's spirit would not be able to rest. It had a huge impact on their ability to grieve and move on."* POWH Nurse

Spirituality and religion in Australia

Spirituality is an important aspect of life for many Australians, with two thirds of people stating that spirituality is significant in their lives,[32] and nearly three quarters of the population (74%) professing some form of religious affiliation.[33] These figures are higher in rural (86%) and elderly (83%) populations,[34] and tend to increase when people experience illness or injury.[35, 36]

Trends suggest that traditional religiosity is in decline, but that spirituality may be growing, as Australians increasingly turn to a range of eclectic beliefs and self-developed practices.[35,37,38,39] For example, a feeling of deep connection to the land/nature, which may in part have been inspired by indigenous Australians, is becoming an increasingly significant dimension of spirituality across Australian society.[39]

Spirituality and religion at the Prince of Wales Hospital

In-depth interviews with patients and clinical staff, followed by a hospital wide survey of 228 Prince of Wales patients and visitors[a] found that:

- **Most of our patients are spiritual/religious**
  Three quarters of people surveyed (74%) said they had spiritual or religious beliefs of some kind.

- **Patients feel there is a relationship between spirituality/religion and health**
  Over 80% of respondents stated that health is affected by religious or spiritual beliefs, and that these beliefs become more important when a person is ill. Whether it is *"God's healing"*, *"providing comfort"*, *"inner strength"*, *"living right"* or *"a placebo effect"*, nearly 74% agreed that spirituality and religion has an impact on the way that people view health and illness.

- **Patients want staff to know about their beliefs and practices**
  Over 70% of those surveyed felt it was helpful for hospital staff to know their patients' beliefs, and confirmed it was all right for staff to ask them. Respondents indicated they want staff to understand their beliefs and practices so appropriate support can be offered. This accords with international research which finds the majority of patients want clinicians to consider their beliefs[11, 40, 41] and would trust them more if they made this enquiry.[42] These findings contradict the misconception that patients tend to find religious/spiritual questions intrusive[43].

- **Spirituality and Religiosity are not synonymous**
  Of those who identified as spiritual/religious, one third (24% of all respondents) saw themselves as spiritual but not religious; while another 21% said they were religious but not spiritual.

- **People's beliefs are fluid and eclectic**
  When asked to select a religious/spiritual category that best described them, 22% of participants selected multiple categories. In many cases, this eclecticism overlapped significantly with traditional religious affiliations.

- **People's beliefs change**
  Over half those surveyed said their beliefs had changed over time. Changes included a 'deepening' faith or spirituality based on personal development or life experience; or rejected faith due to disillusionment. Life events were a strong influence, both positively and negatively: loss of health, lifestyle, or a loved one either enhanced or confirmed beliefs or caused people to question them.

- **Spirituality/religiousness does not necessarily mean church attendance**
  Although 74% of those surveyed said they were spiritual/religious, only 43% indicated they attended a place of worship or spiritual group.

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[a] See Hilbers, J., Haynes, A., Kivikko, J. & Ratnavyuha 2007, *Spirituality and Health at the Prince of Wales Hospital (phase two)*, Prince of Wales Hospital, SESIAHS, Sydney. Available at: http://sesiweb/powh/diversityhealth/PDFs/spirituality_report_2007

- **Religious/spiritual rituals and traditional practices are important**
  81% of POWH surveyed patients and visitors said that rituals and customs can help people when they are ill or suffering. Half (54%) the respondents observed rituals on a daily or weekly basis. 74% felt their rituals were of moderate or strong importance and, of this group, 68% said they wished to continue their practices while in hospital.

- **Spiritual/religious beliefs and practices can provide crucial support**
  In-depth interviews (n13) revealed that spiritual/religious beliefs and practices help people to cope during health crises, treatment and care, end-of-life and the bereavement process, offering comfort, guidance, meaning and connection.[43]

- **Chaplains are important**
  Nearly 40% of respondents said they would like to speak to a chaplain. A further 17% thought they might like to depending on their situation or on the attributes of the chaplain.

- **Respect is paramount**
  Patients and their families consistently told us that staff should acknowledge and respect their beliefs and practices, and those of other patients - whatever they are.

Incorporating spirituality in the hospital context

> *"The degree to which religious/spiritual beliefs and practices are important in health care depends on each individual patient. The safest starting point for discussion is to expect it might be important."*
> POWH doctor

The predominant biomedical position has been to leave spirituality out of medicine. However, the research, together with the increasing emphasis on a biopsychosocial model, strongly suggests that this is no longer acceptable in contemporary patient-centred health care. Indeed, the findings in the section above clearly show that the majority of our patients:

- are spiritual/religious
- feel that spiritualty/religion is more important during illness
- believe that rituals can help
- feel it is helpful for health professionals to know about a patient's beliefs
- are willing to be asked about their beliefs.

These findings are supported by national studies which indicate that patients want clinicians to incorporate spirituality into their treatment and care.[6] Therefore, we can conclude that patients and their families are likely to have some spirituality/religiosity that is significant to them in the health context, and that we should ask them about it so that we can respond appropriately.

The core spiritual issues that are likely to affect patients relate to **meaning** (how we make sense of what is happening to us, eg. how we tackle questions like "Why?") and **coping** (spirituality is a resource that transcends personal, social and material circumstances and so can offer sustenance in the face of all mortal adversity). Understanding and supporting these needs is not an addition to clinical care but an integral part of it.

Identifying needs

> *"One of my patients was gong to pass away. Neither she nor her family had mentioned spiritual needs. I happened to say to the daughter that one of the chaplains was on the ward. She burst into tears and said "Oh, please get him". It seemed that neither she nor her mother were able to vocalise their needs, perhaps they weren't even aware of the service, but it made a real difference to them. So now I make a point of asking people rather than assuming they will tell us what they want. Even when people say 'No', they often say they appreciated being asked. I think it shows them we care."* POWH nurse

What are we trying to identify?

In identifying 'spiritual/religious needs' in the hospital context we are attempting to gain an understanding of two broad issues:

1. Beliefs or practices which are significant to the patient's health in that they affect decision-making, coping, support networks, commitment to treatment regimens, complementary health practices and general wellbeing.
2. Patients' wishes about the way their beliefs and practices are acknowledged and supported while they are in hospital. This may include referrals to chaplains or other services.

Limitations of our current methods

In most cases at POWH the matter religion/spirituality is addressed only at admission in response to a question on the admission form[b] which asks patients to state their "Religion/denomination". This is followed by an option, "If you want your religion withheld from the chaplaincy service, please tick this box".

How do we identify spirituality?

The phraseology of the admission form fails to identify patients who see themselves as spiritual but not religious - nearly a quarter (24.1%) of those surveyed. The significant and increasing numbers of Australians in this group are well documented,[40,41] yet they are excluded by our data collection instruments.

How do we identify religion?

The question on the admissions form will generally capture patients who associate with a traditional religion/denomination providing (a) they are asked / able to read the question, (b) they understand the question, and (c) they feel able to answer honestly. However, an answer does not necessarily denote religiosity.[38,44] Research indicates a proportion of patients regard religion as a way to identify their cultural heritage or family background rather than as an expression of beliefs and practices, eg. "I was baptised in a Catholic Church so I guess that makes me Catholic". Furthermore, some people who do not see themselves as religious, and therefore leave this question blank on the admission form, return to the cultural /religious practices of their upbringing when facing a serious illness or death.

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[b] *Prince of Wales Hospital & Community Health Services Recommendation for Admission Form Perioperative Health Questionnaire S1258* (March 2005). Still in use at the time of writing.

Consequently, the information on the admission form does not tell us:

- To what extent patients' beliefs are important and are likely to play a part in health-related decision-making. For example, do they have deep religious convictions, or do they view their religion primarily as an inherited label?
- What their practices are and how these might affect medical treatment, rehabilitation and their overall health and wellbeing.
- How diagnosis may affect their spiritual worldview.
- What their needs and wishes are while in hospital, including if they would actively like to see a chaplain.

Therefore, we may be able to use admission form information as a potential starting point for talking with in-patients about spirituality/religion, but we need to engage in conversation to understand their worldview and its implications for health care.

'Spiritual assessment' versus patient engagement

> *"One size does not fit all. We need to talk to people as individuals. There are cases where deeply spiritual patients are neglected because they don't identify as religious so nothing is recorded on their record. I also know of a case where staff were trying to be non-prescriptive and asked an elderly Italian man "do you have any particular spirituality?". Although the patient had good English he didn't understand the question and said 'No', despite being a devout Catholic. Sadly, this wasn't discovered until after he died."* Hospital Chaplain

Some of the literature, particularly in the American context, advocates using a standardised spiritual assessment tool or inventory.[45,46] However, the quantifiable instruments that medical science favours employ a theoretical framework that sits uncomfortably with spirituality/religion[c]. People's spiritual worldviews and practices are eclectic, fluid and individualised; they cross paradigms and have different emphases and meanings; they are evolutionary – shifting in response to life changes and events; and the words, concepts and imagery used to express them vary from person to person. It is highly unlikely that any instrument using prescribed questions could capture this diversity and present it to staff practically.[10,47] Furthermore, this topic has profound meaning (even *ultimate* meaning) for many patients and families, and raises concerns for some of them. We know that formal administrative processes are not the best option for sensitive questioning because people respond more openly when they feel they have a connection with the person asking the questions.[47]

If we want meaningful answers we have to ask meaningful, appropriate questions. This requires an emphasis on engagement rather than the employment of routine screening tools. Therefore, instead of viewing spiritual assessment as a discrete activity using instruments that may be experienced as presumptuous, impersonal and invasive,[10] staff are encouraged to integrate the consideration of spiritual matters into their everyday practice, using the same person-centred communication skills they employ when talking with patients and families about other issues.[42] In this way, identifying and responding to needs becomes individualised, allowing staff to approach and respond sensitively to each patient in their context.

[c] This presents challenges for research in the field, an issue addressed in: Hilbers et al 2007, *Spirituality and Health at the Prince of Wales Hospital (phase two)*, Prince of Wales Hospital, SESIAHS, Sydney. Available at: http://sesiweb/powh/diversityhealth/PDFs/spirituality_report_2007

The patient and their context

As busy professionals working in an often rushed health care system, we do not have the luxury of engaging with every patient we meet. However, we are usually aware of a patient's medical context: issues such as pain, trauma, loss, increased dependency, the seriousness of diagnoses and prognoses and their associated psycho-social impacts are part of the clinical assessment and record. This knowledge can inform the degree to which we judge spirituality may be significant. In cases of serious illness and aged decline, major medical or surgical interventions, catastrophic injury, palliative care, and illness with significant implications (eg. affecting mobility, fertility, cognitive capacity, life style), spirituality is likely to be highly relevant to the patient and their family and should be addressed as part of holistic treatment and care.[32,48]

This does not mean there is a simple equation - greater health needs equate to greater religious/spiritual needs - but our professional understanding of the circumstances provides a context for considering how to deal with each patient as a whole person. When it comes to spirituality, this may mean the difference between asking patients about their spiritual worldview, or simply being attentive to the cues they give and being prepared to respond sensitively. This is the same for other dimensions of health and wellbeing such as social or psychological factors – some contexts indicate an increased likelihood of need, and some patient/staff relationships are more appropriate than others for raising the issues. However, regardless of the circumstances we must maintain our 'spiritual radar' so we are open to identifying and addressing the topic if the patient or their family give us reason to.

The next section offers some practical ideas about how to identify and respond to patients' and families' spiritual worldviews.

Responding to cues

> *"The skill is to be attuned to what a person's spiritual needs* might *be. Recognising cues and clues, the signs that spirituality/religion is an issue. It's about being attentive and having a 'spiritual radar'."* Hospital Chaplain

Patients and families often tell us about their beliefs and practices without being asked. Some cues are implicit, such as statements which suggest that a person's worldview is significant to their health situation, eg:

- *I keep wondering why this is happening to me*
- *What has she done to deserve this?*
- *Perhaps it was meant to be*
- *He knows his time has come*

Other cues are more explicit, especially overtly religious signs such as crossing oneself; holding rosary beads; praying; wearing faith-specific insignia or dress such as the Muslim hijab, Seikh turban, Christian crucifix, the Hindu tilaka (forehead dot) or Jewish kippah; and making statements which suggest a religious connection, eg:

- *I pray that I won't have to make that decision*
- *My friends from church will take me home*
- *It's in the hands of God*

Such cues give us an easy opening to ask further questions so that we can understand the person's spiritual worldview and give them the opportunity to express their feelings and tell us of any way in which we can support them.

Depending on the context, in cases where no cues are proffered we still have a responsibility to ask strategic questions in order to invite patients to explore this issue with the professionals who will be treating and caring for them.

Asking Questions

> *"Don't be afraid to ask. Don't assume you understand what people mean by the words they use, unless you have already discussed it. Eg. people may use words like meditation, God, prayer or fate in a way that might differ greatly from how you use them. This is not an invitation to 'probe' because any exploration should be gentle and voluntary, but it's OK to ask them to tell you more."* POWH Doctor

The questions provided in this resource are not a checklist, they are examples which may or may not be appropriate to particular patients in particular contexts. Use your professional judgement and communication skills to develop suitable questions for your treatment context, and to select one or two which gently facilitate discussion and avoid a feeling of 'interrogation'. Questions should be used sensitively and supportively, and prefaced with a rationale which puts them in context, eg. *It can help us to provide better treatment and care if we understand your point of view*, or *Religion or spirituality is important for many people when they are in hospital, so I would like to ask you a question about it if I may*.

Indirect questions

There are many questions which invite patients to express significant beliefs which may be philosophically, culturally and/or spiritually based. The examples below are cross-culturally sensitive and do not assume a spiritual dimension so they can be used in any conversation, particularly in cases of serious illness where some of the questions could be considered as part of an holistic assessment and treatment plan.

The core 'open' question used by many staff to gently explore a patient's coping and meaning-making context is:

- *Where do you get your strength from?*

or

- *Who or what supports you in life?*

Other questions are:

- *What do you think might have caused your illness?*
- *How would you describe what is happening to you?*
- *Why do you think it started when it did?*
- *What kind of treatment do you think you should receive?*
- *What are the most important results you hope to achieve from his treatment?*
- *What are the main problems your illness has caused for you and your family?*
- *What are your main worries about your illness?*[d]

[d] Adapted from Misra-Herbert, A. 2003 Physician cultural competence: Cross-cultural communication improves care. *Cleveland Clinic Journal of Medicine*, 70(4), 289-303.

Direct questions

Direct questions may be used in any context, but become particularly pertinent when the clinician considers that spirituality or religious belief is likely to play a significant role in their patient's health.

- *Are you a religious or spiritual person?*[e]
- *Is faith/religion/spirituality important to you?*
- *Do you have any religious or spiritual beliefs that you would like staff caring for you to be aware of?*
- *Spiritual or religious belief sustains many people in times of distress. What is important for us to know about your spiritual needs or faith?*
- *How can we support your beliefs and practices?*
- *Do you have anyone to talk to about religious/spiritual matters?*
- *Would you like to talk with someone about religious/spiritual matters?*[f]
- *How can we best support you?*

These questions facilitate improved understanding by staff and thereby enable more accurate assessment, better treatment planning and more responsive service provision; all of which are crucial to positive outcomes.

Responding to Needs

> *"Nurses, doctors, allied health and ward clerks are there to support. Spirituality is part of that. It isn't medical treatment, but it is something that nourishes and helps to heal a person's spirit"* POWH Nurse

Having engaged with and listened to patients in order to understand their spiritual worldview and associated needs, the task for staff is to:

- acknowledge their beliefs and consider how they relate to their health
- take account of beliefs and practices in treatment planning and care
- support rituals and other valued practices
- coordinate a team response to needs, eg. ensure they are documented and that colleagues understand them
- work with chaplains or representatives from the patient's faith community where appropriate

POWH Case Study: Rebecca

At her request, Rebecca had her family, friends and priests in the room praying with her. There was incense burning, rose petals and rosary beads. Rebecca had a very strong connection to her Maronite faith; this was a spiritual connection, but also important culturally. Rebecca has always been comfortable with an Australian way of life, but she seemed to identify more with her Lebanese heritage as she realised she was seriously ill. Staff consulted with her about how they could support her faith and practices, and how they could most appropriately continue to administer care while prayer and rituals were in progress.

[e] Note: the reply "not really" may be a way of telling you that there is an aspect of religiosity/spirituality that might usefully be explored. Mirroring back "not really?" is a non-invasive starting point.

[f] Responding to needs will often include asking patients and/or their families if they would like to talk with a hospital chaplain or social worker, or if they would like a religious/spiritual representative from their community to visit them (chaplains can arrange this).

Using resources and making referrals

> *"There are many misconceptions about chaplains: that we prey on the sick to convert them, or that we're only there for death/dying. In fact, we negotiate with patients and families about what they want, we have connections across all aspects of their lives, we adapt rituals and traditions to meet people's needs, we facilitate connections with family and friends, and we listen and support. We not only accompany people on spiritual journeys but across their life journeys due to our long associations with people from hospital, back to their home, and often through other major life events."* Hospital Chaplain

Chaplains are a valuable resource for POWH staff. Indeed, as Post et al note, "Referrals to chaplains can be critical to good health care for many patients, and can be as appropriate as referrals to other specialists." [43]

Chaplains can be used by health professionals to:

- provide a caring, listening ear for patients, their families and carers
- offer support across whole-of-life, not just end-of-life
- facilitate rituals and services
- participate in team meetings and case conferences
- arrange visits from religious representatives from the patient's faith community
- support staff and provide religious/spiritual services for them
- provide consultation on a breadth of spiritual/religiocultural beliefs and practices

When staff introduce the idea of using the Chaplaincy service it may be useful to provide some reassurance about the pastoral care model used by SESIAHS chaplains. This model emphasises an holistic, non-judgemental, non-directive and supportive approach that is open to the diversity of lifestyles, practices and beliefs. This is important because POWH research found that some patients were interested in speaking with a chaplain but had concerns such as being preached to, being judged due to their sexuality or lifestyle, being regarded as undeserving because they had 'lapsed', or the worry that chaplains would administer according to doctrine rather than exploring on the patient's own terms.[42] Others believed chaplains only tend to patients when they are dying. Therefore, it is good practice to let patients and family members know that chaplains are available for a range of services, including their main work which is simply to be with patients, listen to them and provide support.

POWH Case Study: Shen

After Shen's death his family wanted to know what would happen to his body. How would staff care for him after they left? Where would he be taken? Would his body go stiff or smell? Would he look the same? Would the hospital make them take his body before the funeral was arranged? Shen's wife, Amy, explained, "We don't know what's meant to happen". Like many people, Amy had never arranged a funeral before, let alone her husband's. Furthermore, having grown up in Australia without a particular connection to the Chinese community, she didn't know what a Chinese funeral entailed; however, she was clear that the funeral should be respectful of Chinese traditions. The social worker listened and offered reassurance and discussed options with her. They supported Amy to find a Chinese funeral director who could offer advice about cultural traditions as well as make practical arrangements. Having met with the funeral director Amy passed information on to staff so they could treat Shen's body appropriately before it left hospital.

What skills do health professionals need?

Incorporating spirituality into health care requires the same skills that competent practitioners already use in their delivery of person-centred care:

- Basic communication skills that allow you to engage with people and establish an accepting, empathic relationship
- The ability to ask appropriate, encouraging, open-ended questions
- Good listening skills and attention to non-verbal communication
- A appreciation for the importance that people's beliefs and practices play in their lives and the impact they may have on their health, their quality of life, their decision-making and their coping abilities
- Some familiarity with culturally related values, beliefs, and practices that are common among our patient populations[g]
- Comfort in talking about worldview issues with patients and their families
- A willingness to seek information from appropriate professionals and coordinate any spiritual/religious support
- A commitment to teamwork which includes colleagues from a range of disciplines (including chaplains) as part of the care team[h]

These skills are underpinned by the principle of respect. In practice, this does not mean we always have to *feel* respect for all patients and their beliefs and practices, but that we should always *act respectfully* towards them.

Professional roles and boundaries

Hospital staff, other than chaplains, should not feel a need to answer spiritual/religious questions, nor to resolve a patient's spiritual/philosophical crises or concern. Our task is to enquire, acknowledge, take account of and support where possible. We are **not** here to:

- proselytise or direct spiritual/religious discussion down a particular theological path
- suggest to patients or families that their beliefs are incorrect or misinformed
- assert our own beliefs in a way that contradicts or causes discomfort to others
- infringe privacy by asking interrogative questions

Good practice means that staff should clearly document patient needs, response to needs and outcomes; and should work collaboratively with the multidisciplinary team (and link with other agencies when required) to ensure needs are met. If in doubt, consult with the Chaplaincy Service.

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[g] While this information can be useful, it is important to remember that it is a general overview of religious/cultural traditions which may or may not be relevant to the individual patient. You can use it as a starting point, but it is essential to ask the patient what their personal wishes are rather than make assumptions, eg. "I believe that at this time (certain practices) often occur, is this the case for you?",

[h] adapted from Miller & Thoresen (1999). Spirituality and Health. In W.R. Miller (Ed.), *Integrating spirituality into treatment* (pp. 3-18). Washington, D.C: American Psychological Association.

This practice is responsive and consistent with what staff report they feel most comfortable doing – letting patients lead the way in any spiritual/religious discussion, and offering support where they can.

Beliefs and practices which may be detrimental to patients' health

POWH Case Study:
A Jehovah's Witness patient was admitted to POWH for surgery. He was anxious about how his blood product requirements would be managed, and how staff would view his religious beliefs. He was pleasantly surprised to find that staff consulted with him as a real partner in his care. They asked him questions to clarify his wishes and ensured they understood exactly what was permitted, and they advised him of their plans and gave him time to ask further questions. He felt that his hospitalisation had been a positive experience not only for himself, but also for staff who learnt from him.

Most of the time patients' beliefs are congruent with medical intervention, particularly when staff have engaged the patient in collaborative discussion which takes account of their wishes and beliefs. However, sometimes patients and their families hold beliefs or employ cultural or religious practices which clinicians judge to be obstructive or damaging. For example, patients may refuse certain treatments or resist making decisions because they believe outcomes will be determined by a higher power. Similarly, families may refuse to accept a patient will die because they anticipate a divine intervention, or they may reject clinician guidance due to perceived incompatibility with religious or cultural practices[i].

The valued beliefs of patients and families should not be refuted; this will only widen the chasm between clinician and patient, leading to greater tensions and increased likelihood of entrenched, polarised positions. The goal is to engage in exploratory conversation which elicits better understanding of the beliefs, and encourages expression of the ambiguity and dilemmas that many people experience when trying to reconcile their beliefs with the demands of secular contexts.
In these cases clinicians may find it helpful to move away from absolute or factual statements such as *She has a 50/50% chance of recovery*, or *He will suffer without X…,* or *The recommended course of treatment is…* Instead, use phrases which patients and families can relate to from their position such as *I hope…*, *I'm worried about…*, *We don't know if…*, *We think it's likely that…*, *Perhaps we could consider….*

Try to explore the belief and its relationship to the situation, *How will you know when God would like us to intervene?* or *You talked before about 'unnecessary suffering', do you think we may be approaching that point?* Questions like these recognise the expertise of patients and families to determine what is right for them within their belief system; and they help the parties to explore options collaboratively.

[i] Note that patient autonomy can be compromised in these cases when relatives are asked to interpret for non-English speaking patients and may change or omit information according to their beliefs. Always use professional health care interpreters when possible.

Barriers to integrating spirituality into health care

The literature, and research at POWH, addresses the obstacles that staff experience in incorporating spirituality into health care. These are some of the most prevalent:

"Spirituality and religion isn't relevant to my work with patients and families"

Research at POWH shows that over 80% of patients and families believe that spirituality/religion has an impact on health, and that it is useful for health professionals to know about their patients' beliefs (74%). Broader Australian and International literature supports these findings.[34]

"Spirituality and religion is personal, I'd feel I was intruding if I asked about it"

The overwhelming majority of patients tell us they are willing for staff to ask them about their beliefs and practices.[43] Furthermore, we routinely make other sensitive enquiries, eg. about sexual functioning and practices, drug and alcohol use, bowel movements and psychological health. Some patients would prefer not to answer such questions, but we ask them because it is important. It follows that if we feel patients' beliefs and practices are important, we will ask about them too. In the event that a patient says they are unwilling to disclose the information, we simply accept their wishes respectfully and move on.

"It's not my role to ask questions or respond to cues about religion/spirituality"

Spiritual/religious/philosophical beliefs and practices are an integral part of what it is to be human. These beliefs and practices influence our patients' understanding of their condition, their acceptance, decision-making, commitment to treatment regimens, coping strategies and their selection of complementary health practices. If you have more than a passing role in admitting, treating or caring for patients, or communicating with family members, and you believe in patient-centred care, it is definitely your role to take account of this dimension. [eg 9, 10, 12, 16, 22, 43]

"I don't have enough knowledge to talk with someone about their beliefs"

You don't need any knowledge, just an ability to engage with people and show a respectful interest in their experience and point of view. You are not facilitating a religious debate, you are simply acknowledging an issue that may be important to them and their health. It may be helpful to think about your response as 'interested' rather than 'knowing'. In fact, asking naïve questions can sometimes be the best way of supporting someone to explore an issue and talk freely.

"I don't know what words to use; do I say 'religion' or 'spirituality'?"

Australian research suggests that the term spirituality has more resonance with the majority of our community (a) because it embraces people who are unaffiliated with or alienated from organised religion,[34] and (b) because it "is vague enough to allow patients themselves to define the playing field".[15] However, there are many people, particularly those who are older or from non-English speaking backgrounds, who will not understand this term and need to hear the word 'religion' (see the quote on page 7 for an example of this). Therefore, it is safest to

use both terms, eg. *Is religion or spirituality important to you?*, *Do you have any religious or spiritual needs that we should be aware of while you are in hospital?*

"What if I don't share their beliefs, or interpret things differently to them?"

You don't have to agree with someone's spiritual beliefs anymore than you have to agree with their political views or taste in music. Simply show an interest in their perspective. If you are asked about your views it is up to you whether you share them or not. It is OK to say that you'd rather not disclose them, or to say that you have a different way of seeing things - as long as you return the focus of the conversation to the patient and don't dwell on your perspective.

"I'm uncomfortable talking about religion/spirituality in case I impose my beliefs on patients"

It is important for all staff to appreciate that our role is to listen, not to preach; but you can ask someone about their views and show an interest without imposing yours. Even if you are asked about your beliefs you can give general or vague answers, or simply state that you hold different views. By maintaining a respectful focus on the patient's perspective you will avoid imposing your views.

"I'm worried that if a patient and I talk about religion/spirituality we might get into some really deep or sticky issues"

Patients and their families are often already dealing with deep and sticky issues such as pain, fear, anger, confusion, loss and death. Spirituality/religion may offer meaning and comfort, or may be part of the issue they are struggling with. It is not your job to resolve spiritual/religious questions, but you can help by listening, or gently asking if they would like to explore the question further with a hospital chaplain or social worker, or someone from their religious/spiritual community.

"What if they try to convert me?"

Some patients may wish to talk about their beliefs in the hope that you will come to share them. If so, try to gently return the focus of the conversation to the patient - what do *they* value about their beliefs? If necessary you can let the patient know you see things differently, or thank them for their thoughts but remind them that work is not the place for you to be exploring your personal beliefs.

"How can I differentiate between cultural and religious/spiritual needs?"

You don't have to. We are not trying to label patients or tick off items on a checklist; we are trying to engage with each person as an individual so we can respond to their unique perspective and needs. All we need to know is what is important to the patient, and how they would like us to support them.

"I haven't got time to address this issue"

It is hard to make time for all the tasks we need to complete, but the way you prioritise your time depends on what you regard as important. Patients and their families tell us that spirituality/religion is important to them and they want it to be included as part of their health care. Since patient-centred practice demands that we try to be as inclusive of patients' wishes as possible, it is part of our job to consider their spiritual worldview when appropriate.[26, 44]

Resources and further Information

General information on major religions and their customary practices

www.abc.net.au/religion

www.dhcs.act.gov.au/__data/assets/pdf_file/0017/5282/Cultural_Dictionary.pdf

www.health.qld.gov.au/multicultural/health_workers/cultdiver_guide.asp

Hospital chaplains

Any member of staff, patient or family member may contact the chaplains at any time, day or night, via the POWH switchboard: 938 2222

Spirituality/religion at End-of-Life

http://sesiweb/powh/diversityhealth/PDFs/End_of_Life.pdf

www.pallcare.asn.au/mc/mccontents.html

Leaflets about palliative care and what to do when a relative dies in hospital are available in multiple community languages from www.mhcs.health.nsw.gov.au/mhcs/topics/Death_and_Dying.html

Jehovah's Witnesses: medical and legal advice relating to blood transfusion

www.publicadvocate.vic.gov.au/media/docs/C07-Jehovahs-Witnesses-and-Blood-Transfusions-fa6b29e7-02c6-4ff1-8d4a-994f45636f2f.rtf

Organ Donation

www.healthinsite.gov.au/topics/organ_donation

www.australiansdonate.org.au

www.organdonor.com.au

Spirituality and Religion at Prince of Wales Hospital
An action summary

The majority of patients at POWH:

- Have some religious affiliation or spiritual connection (74.1%)
- Feel that spiritualty/religion becomes more important when a person is ill (81.6%)
- Believe that rituals can help people when they are ill or suffering (81.1%)
- Say it is helpful for health professionals to know about a patient's beliefs (73.7%)
- Agree it is all right for health professionals to ask them about their beliefs (72.8%)

Staff at POWH:

- Respect the significance of people's beliefs and practices and want to support them
- Believe staff should not impose their own beliefs
- Are uncertain about how to integrate spiritual/religious issues into their practice

What health staff need to know

- Any beliefs or practices which affect decision-making, coping, commitment to treatment, use of complementary health practices and general wellbeing
- The patients' wishes about the way their beliefs and practices are acknowledged and supported while they are in hospital.

Incorporating spirituality/religion into health practice

- Engage with and listen to patients (and their families)
- Acknowledge their beliefs and consider how they relate to their health
- Take account of beliefs and practices in treatment planning and care
- Support rituals, customs and other valued practices
- Ensure needs are documented and that colleagues understand them
- Refer to and work with chaplains or representatives from the patient's community (chaplains can arrange this). Contact chaplains day or night via the switch x 22222.

How to engage with patients in relation to spirituality/religion

- Be attentive to clues about spiritual/religious beliefs and practices. Clues may be comments, actions, possessions or clothing with a spiritual/religious significance.
- As part of patient engagement you can ask: *Where do you get your strength from?* or *Who or what supports you in life?* These are non-intrusive 'open' questions.
- Gently ask patients specific questions:
  - *Do you have any spiritual or religious beliefs that we should know about in order to care for you properly?*
  - *Is faith/religion/spirituality important to you?*
  - *How can we support your beliefs and practices?*
  - *Would you like to talk with someone about religious/spiritual matters?*

References

[1] Kaldor, P., Hughes, P., Castle, K., & Bellamy, J. (2004). Spirituality and Wellbeing in Australia. National Church Life Survey (NCLS) Occasional Paper, 6.

[2] D'Souza, R. (2007). The Importance of Spirituality in Medicine and its application to Clinical Practice. *Medical Journal of Australia*, 186(10), S57-S59.

[3] George, L., D, L., Koenig, H. & McCullough, M. 2000, 'Spirituality and health: What we know, What we need to know', *Journal of Social and Clinical Psychology*, vol. 19, no. 1, pp. 102 - 116.

[4] Larson, J. 1999, 'The Conceptualization of Health', *Medical Care Research and Review*, vol. 56, no. 2, pp. 123-136.

[5] Johnson, M. 2004, 'Faith, Prayer and Religious Observances: Diversity in Medicine', *Clinical Cornerstone*, vol. 6, no. 1, pp. 17-24.

[6] Williams, D. & Sternthal, M. 2007, 'Spirituality, Religion and Health: evidence and research directions', *Medical Journal of Australia*, vol. 186, no. 10, pp. S47-S50.

[7] Hebert, R., Jenckes, M., Ford, D., O'Connor, D. & Cooper, L. 2001, 'Patient Perspectives on Spirituality and the Patient-physician Relationship', *Journal of General Internal Medicine*, vol. 16, no. 10, p. 685–692.

[8] Eckersley, R. 2007, 'Culture, Religion, Spirituality and Health: looking at the big picture', *Medical Journal of Australia*, vol. 186, no. 10, pp. S54-S56.

[9] Higginbotham, A. & Marcy, T. 2006, 'Spiritual assessment: A new outlook on the pharmacist's role', *American Journal of Health-System Pharmacy*, vol. 63, pp. 169-173.

[10] Rumbold, B. (2007). A Review of Spiritual Assessment in health care practice. *Medical Journal of Australia*, 186(10), S60-S62.

[11] Koslander, T. & Arvidsson, B. 2007, 'Patients' conceptions of how the spiritual dimension is addressed in mental health care: a qualitative study', *Journal of Advanced Nursing*, vol. 57, no. 6, p. 597–604.

[12] Koenig, H., McCullough, M. & Larson, D. 2001, *Handbook of Religion and Health*, Oxford University Press, New York.

[13] Larson, D. & Larson, S. 2003, 'Spirituality's Potential Relevance to Physical and Emotional Health: A Brief Review of Quantitative Research', *Journal of Psychology and Theology*, vol. 31.

[14] Mueller, P., Plevak, D. & Rummans, T. 2001, 'Religious Involvement, Spirituality and Medicine: implications for practice', *Mayo Clinic Proceedings*, vol. 76, pp. 1225-1235.

[15] Koenig, H. (2007). Religion, spirituality and medicine in Australia: research and clinical practice. *Medical Journal of Australia*, 186(10), S45-S50.

[16] Astrow, A., Puchalski, C. & Sulmasy, D. 2001, 'Religion, spirituality and health care: Social, ethical, and practical considerations', *The American Journal of Medicine*, vol. 110, no. 4, pp. 283-287.

[17] Pargament, K. & Mahoney, A. 2002, 'Spirituality: discovering and conserving the sacred', in C. Snyder & S. Lopez (eds), *Handbook of Positive Psychology*, Oxford Uni Press, Oxford.

[18] Beers, M. & Berkow, M. 2000, 'Social Issues: Religion and Spirituality', in M. Beers & M. Berkow (eds), *The Merck manual of geriatrics*, vol. 3rd Edition, Merck Research Laboratories, Whitehouse Station, NJ.

[19] Sherkat, D.E. & Wilson, J. 1995, 'Preferences, Constraints, and Choices in Religious Markets: An Examination of Religious Switching and Apostasy.' *Social Forces*, vol. 73, no. 3, pp. 993-1026.

[20] Pargament, K.I., Smith, B.W., Koenig, H.G. & Perez, L. 1998, 'Patterns of Positive and Negative Religious Coping with Major Life Stressors', *Journal for the Scientific Study of Religion*, vol. 37, no. 4, pp. 710-724.

[21] Hilbers, J., Haynes, A., Kivikko, J. & Ratnavyuha 2007, *Spirituality and Health at the Prince of Wales Hospital (phase two)*, Prince of Wales Hospital, SESIAHS, Sydney. Available at: http://sesiweb/powh/diversityhealth/PDFs/spirituality_report_2007

[22] Miller, W.R., & Thoresen, C. E (1999). Spirituality and Health. In W.R. Miller (Ed.), *In Integrating spirituality into treatment* (pp. 3-18). Washington, D.C: American Psychological Association.

[23] Schneiders, S.M. (2000). Religion and Spirituality: Strangers, Rivals, or Partners?, *Santa Clara Lectures Feb 2000.* Santa Clara University.

[24] Tanyi, R.A. (2002). Towards clarification of the meaning of spirituality. *Journal of Advanced Nursing*, 39(5), 500–509.

[25] Josephson, A., & Peteet, J. (2004). *Handbook of spirituality and worldview in clinical practice* Washington DC: American Psychiatric Publishing

[26] Mcrae-McMahon, D. (2005). Creating Simple Rituals in Health Care. Workshop at Prince of Wales Hospital, 19 Oct 05.

[27] Seeman, T.E., Dubin, L.F. & Seeman, M. 2003, 'Religiosity/spirituality and health: a critical review of the evidence for biological pathways', *American Psychologist*, vol. 58, no. 1, pp. 53-63.

[28] Jantos, M. & Kiat, H. 2007, 'Prayer as medicine: how much have we learned?' *Medical Journal of Australia*, vol. 186, no. 10, pp. S51-S53.

[29] Kendler, K., Liu, X., Gardner, C., McCullough, E., Larson, D. & Prescott, C. 2003, 'Dimensions of Religiosity and Their Relationship to Lifetime Psychiatric and Substance Use Disorders', *American Journal of Psychiatry*, no. 160, pp. 496-503.

[30] McRae-McMahon, D. 2004, *Rituals for Life, Love and Loss*, Jane Curry Publishing, Sydney.

[31] Clark, P., Drain, M. & Malone, M. 2003, 'Addressing Patients' Emotional and Spiritual Needs', *Joint Commission Journal on Quality and Safety*, vol. 29, no. 12, pp. 659-667.

[32] MacKinlay, E., & Trevitt, C. (2007). Spiritual Care and Aging in a Secular Society. *Medical Journal of Australia*, 186(10), S74-S76.

[33] Australian Bureau of Statistics (ABS) (2004). Australian Social Trends: Religious affiliation and activity: Australian Government.

[34] Peach, H. (2003). Religion, spirituality and health: how should Australia's medical professionals respond? *Medical Journal of Australia*, 178, 86–88.

[35] Wink, P., & Dillon, M. (2002). Spiritual Development Across the Adult Life Course: findings from a longitudinal study. *Journal of Adult Development*, 9, 79-94.

[36] Australian Institute of Health and Welfare (AIHW) (2002). *Australia's health 2002* Canberra: AIHW

[37] Bouma, G. (2003). Globalization, Social Capital and the Challenge to Harmony of recent Changes in Australia's Spiritual and Religious Demography: 1947 to 2001. *Australian Religious Studies Review*, 16(2), 55-68.

[38] Bouma, G. (2002). Globalization and recent changes in the demography of Australian religious groups:1947 to 2001. *People and Places*, 10(4), 17-23.

[39] Tacey, D. (2003). *The Spirituality Revolution: the Emergence of Contemporary Spirituality* Sydney: HarperCollins

[40] Post, S., Puchalski, C. & Larson, D. (2000), 'Physicians and Patient Spirituality: Professional Boundaries, Competency, and Ethics', *Annals of Internal Medicine*, vol. 132, no. 7, pp. 578-583.

[41] Speck, P. 1998, 'The Meaning of Spirituality in Illness', in M. Cobb & V. Robshaw (eds), *The Spiritual Challenge of Health Care*, Harcourt Brace, London.

[42] Ehman J.W., Ott B.B., Short T.H. et al. in Higginbotham, A. & Marcy, T. (2006), 'Spiritual assessment: A new outlook on the pharmacist's role', *American Journal of Health-System Pharmacy*, vol. 63, pp. 169-173.

[43] Hilbers, J., Haynes, A., Kivikko, J., & Ratnavyuha (2005). Spirituality and Health at the Prince of Wales Hospital: summary report (phase one). Sydney: Prince of Wales Hospital, SESIAHS.

[44] Cobb, M. (1998). Assessing spiritual needs: an examination of practice. In M. Cobb, & V. Robshaw (Eds.), *The Spiritual Challenge of Health Care.* London: Churchill Livingstone.

[45] Anandarajah, G., & Hight, E. (2001). Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment. *American Family Physician*, 63(1), 81-88.

[46] Galek, K., Flannelly, K., Vane, A. & R, G. 2005, 'Assessing a patient's spiritual needs: a comprehensive instrument', *Holistic Nursing Practice*, vol. 19, no. 2, pp. 62-69.

[47] Holt, P. 1995, 'Role of questioning skills in patient assessment', *British Journal of Nursing*, vol. 4, no. 19, pp. 145-146.

[48] McCord, G., Gilchrist, V., Grossman, S., King, B., McCormick, K., Oprandi, A., Labuda Schrop, S., Selius, B., Smucker, W., Weldy, D., Amorn, M., Carter, M., Deak, A., Hefzy, H. & Srivastava, M. 2004, 'Discussing Spirituality with Patients: a rational and ethical approach', *Annals of Family Medicine*, vol. 2, no. 4, pp. 356-361.