

Spirituality in Family Practice: an integrative review

A espiritualidade na prática da Medicina de Família e Comunidade: uma revisão integrativa

Espiritualidad en la práctica de la Medicina Familiar: una revisión integradora

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Abstract

Spirituality is another aspect of health care and its importance in clinical practice in primary health care is perceived every day. To explain spirituality; to analyze the perception of spirituality by users of the Basic Health Units and doctors; and to discuss how it can be learned and developed in the medical field and in residency in Family Practice. An integrative review carried out in the Bireme and PubMed databases with the descriptors “Spirituality” and “Primary Health Care” combined with the Boolean operator AND. From 9 selected articles, thematic cores were developed with the synthesis of quantitative and qualitative information: concept of health, spirituality, spirituality instrument, perception of doctors and patients, perception and attitude of doctors, perception of users, and teaching of spiritual care. Spirituality is understood as a motivating force that governs decisions and guides the individual as a component of health. It should be considered in the daily practice of primary care in contexts of health promotion, distinct comorbidities and community approach. Spiritual care is based on the basic principle of person-centered medicine, respecting individualities through active and respectful listening.

Keywords: Spirituality; Primary health care; Patient-centered care; Integrality in health.

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Resumo

A espiritualidade é outra vertente do cuidado em saúde, e a cada dia percebemos a importância dela na prática clínica da atenção primária à saúde. Definir a espiritualidade; analisar a percepção da espiritualidade pelos usuários da Unidade Básica de Saúde (UBS) e pelos médicos; e discutir como ela pode ser aprendida e desenvolvida no campo médico e na residência em Medicina de Família e Comunidade (MFC). Foi realizada uma revisão integrativa na base de dados da Bireme e do PubMed, utilizando os descritores “Spirituality” e “Primary Health Care” combinados com o operador booleano AND. A partir de 9 artigos selecionados, desenvolvemos núcleos temáticos com a síntese das informações quantitativas e qualitativas: conceito de saúde, espiritualidade, instrumento de espiritualidade, percepção de médicos e pacientes, percepção e atitude dos médicos, percepção dos usuários e ensino do cuidado espiritual. A espiritualidade é entendida como uma força motivadora que orienta as decisões e guia o indivíduo, sendo um componente da saúde. Ela deve ser considerada no dia a dia da prática da atenção primária em contextos de promoção da saúde, comorbidades distintas e abordagem comunitária. O cuidado espiritual baseia-se no princípio básico da medicina centrada na pessoa, respeitando as individualidades por meio de uma escuta ativa e respeitosa.

Palavras-chave: Espiritualidade; Atenção primária à saúde; Assistência Centrada na pessoa; Integralidade em saúde.

Resumen

La espiritualidad es otro aspecto de la asistencia sanitaria y cada día se percibe su importancia en la práctica clínica en la atención primaria de salud. Explicar la espiritualidad; cómo es la percepción de la espiritualidad por parte del usuario de la Unidad Básica de Salud, por el médico y cómo se puede aprender y desarrollar en el campo médico y en la residencia en Medicina Familiar y Comunitaria (FMC). Revisión integradora realizada en las bases de datos Bireme y PubMed con los descriptores “Espiritualidad” y “Atención Primaria de Salud” combinados con el operador booleano AND. A partir de 9 artículos seleccionados, se desarrollaron núcleos temáticos con la síntesis de información cuantitativa y cualitativa: concepto de salud, espiritualidad, instrumento de espiritualidad, percepción de médicos y pacientes, percepción y actitud de los médicos, percepción de los usuarios y enseñanza del cuidado espiritual. La espiritualidad es entendida como una fuerza motivadora que dirige las decisiones y orienta al individuo como componente de la salud. Debe ser considerada en la práctica diaria de la atención primaria en contextos de promoción de la salud, distintas comorbilidades y enfoque comunitario. El cuidado espiritual se fundamenta en el principio básico de la medicina centrada en la persona, respetando las individualidades a través de la escucha activa y respetuosa.

Palabras clave: Espiritualidad; Atención Primaria de Salud; Atención dirigida al paciente; Integralidad en salud.

INTRODUCTION

Over the centuries, the health-disease process and religion have been related in a synchronous, sometimes antagonistic way, oscillating between emotion and reason to justify or question adversities in the human body.¹

Religion can be understood as an organization based on doctrines, teachings, rites, and laws that guide and direct a way of living with the purpose of achieving salvation. Religion is one of the paths to an experience that transcends reality and has transformative potential in actions. Religiosity is the search for transcendence without being associated with a specific religion, but which can incorporate spiritual elements from different religions in a personal approach.¹

Spiritual experiences, although private, have a relevant meaning in the community, as they can modify the perception of life, allowing new meanings and behaviors.¹ The encounter of the “I” strengthens the sense of identification with the “other”, demonstrated by compassion and mercy.² Compassion, according to Aristotle, is a feeling of “suffering with” the person,³ and mercy is the willingness to transform this feeling into action, alleviating the suffering of others.²

By valuing people instead of diseases, by allowing suffering and the experience of illness to be approached through techniques developed by Family Practice, spirituality is intrinsically and intuitively a field of approach and implications for care. However, its approach in primary care can be precarious and undervalued, especially in clinical practice. Valuing spirituality not only during

medical consultations with the person seeking care, but also with health professionals, is believed to enable the development of resilience skills, self-knowledge, identification, and elaboration of purposes, in addition to promoting the improvement of compassion and self-care. Given this premise, the present integrative review aimed to define spirituality, to analyze the perception of spirituality by basic health care units' (*Unidade Básica de Saúde – UBS*) users and doctors, and to discuss how it can be learned and developed in the medical field and in residency in Family Practice (FP).

METHODS

This study is an integrative review of the scientific literature on spirituality in primary health care. The guiding research questions are: “What is spirituality?”; “How is the perception of spirituality by UBS users and family practice physicians?”; “And how can spirituality be learned and developed during medical graduation and residency in family practice?”

This research was carried out using Health Sciences Descriptors (Decs) and Medical Subject Headings (MeSH) to define the keywords “Spirituality” and “Primary Health Care”, combined with the Boolean operator “AND”. The following databases were searched: Virtual Health Library (VHL/ Bireme) and PubMed/Medline (National Library of Medicine — NIH). The research was carried out in May 2021.

Inclusion criteria were established for articles that evaluated the practice of spirituality by family practice physicians (FPP) and articles that addressed patients' views regarding the spiritual care offered by these professionals in primary health care, in Portuguese, English, and Spanish. There was no limitation regarding the years of research.

Exclusion criteria were titles and abstracts of articles that deviated from the proposed topic. Furthermore, articles that discussed the subject based on a specific pathology were excluded, as well as those that addressed spirituality being carried out by professionals other than FPP. It was also established that inaccessible articles, reviews, opinions, editorials, reports, letters, and research projects would not be included in this research.

During the search, a total of 748 publications were obtained based on the defined descriptors, 358 texts from VHL and 390 from PubMed. Analysis and selection of articles were conducted by two researchers independently, with subsequent critical confrontation and mutual consensus. Based on title analysis, 52 articles were selected from VHL and 52 articles from PubMed. Of this total of 104 articles, 18 were discarded due to duplications. The remaining 86 articles were analyzed based on the abstracts, and using the criteria mentioned above, resulting in 4 editorials, 1 letter to the editor, 4 research proposals, 6 reports, 3 opinion articles, and 5 literature review articles. Seven articles were not accessible. The 31 surpluses were excluded because they were not related to the central theme. This resulted in 25 articles to be read and critically analyzed regarding their quality and the information obtained by the two researchers independently.

The analysis identified 8 review articles, 4 articles that addressed spirituality not only by FPP, 2 with proposals for spiritual care for a specific morbidity, and 2 that were beyond the purpose of the research. Therefore, nine articles remained for the integrative review. This information was identified after in-depth reading and re-reading of the texts (Figure 1).

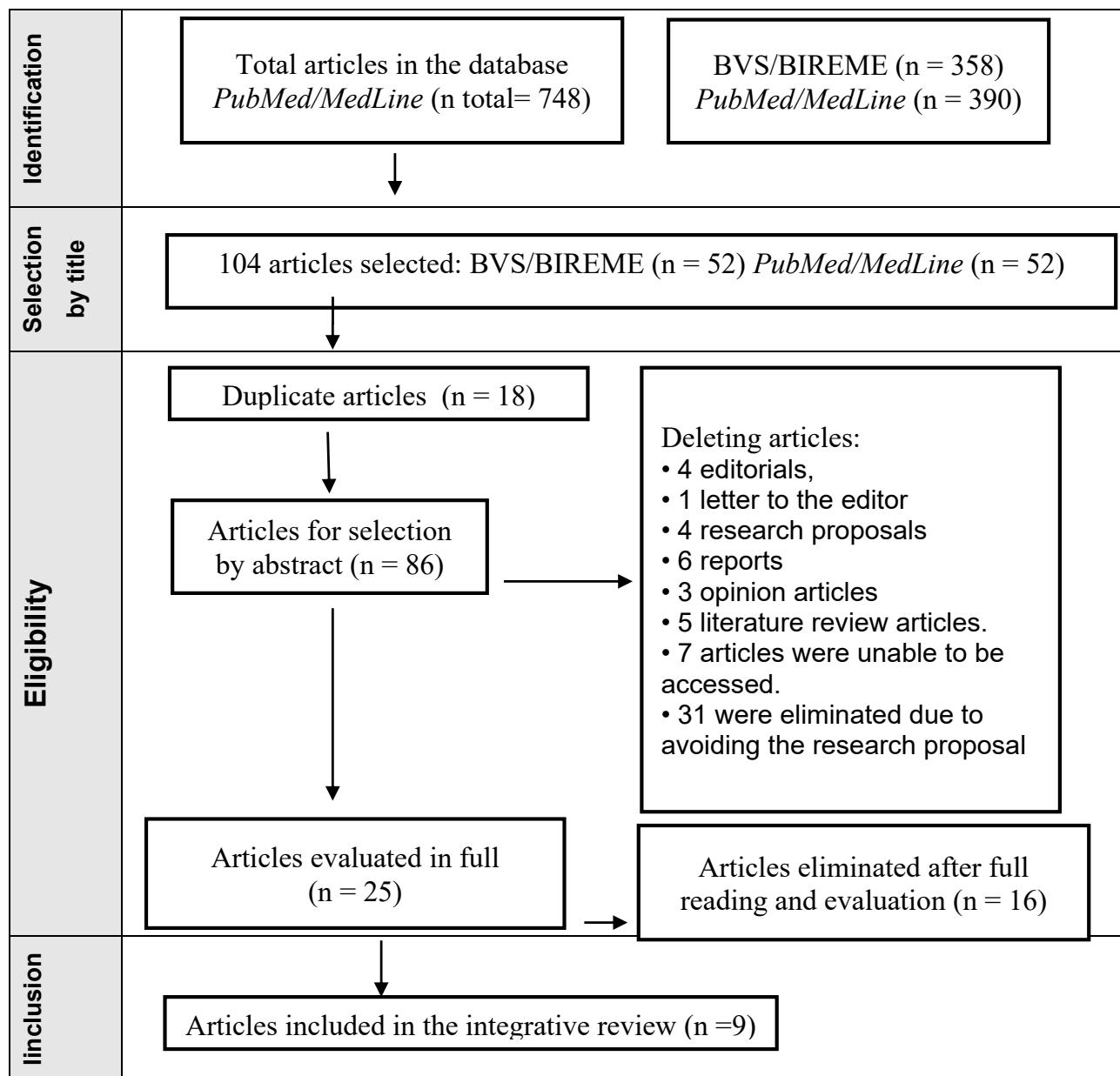


Figure 1. Flowchart of the article selection process.

RESULTS AND DISCUSSION

Reading the articles in full allowed the analysis and collection of data for the construction and synthesis of knowledge. The selection of articles was carried out through analysis and agreement between the two reviewers. In the end, information was analyzed and extracted from 9 articles, which are included in Table 1.

Of the 9 studies selected, 8 articles were published in the USA and 1 in Scotland; the research were published between 2004 and 2021, 5 in the 2000s. There were 3 qualitative research, 3 quantitative, and 3 mixed research (quantitative and qualitative). The topics covered ranged from the relevance of spirituality to health, from the perspective of doctors and patients, to current and suggested approach strategies.

Table 1. Publication Analysis.

Provenance/ Origin	Title	Authors	Journal (vol, No., page, year)	Objective	Considerations
VHL/PubMed USA	Impact of spiritual symptoms and their interactions on health services and life satisfaction/ Impacto dos sintomas espirituais e suas interações nos serviços de saúde e satisfação com a vida	Katerndahl	Annals of Family Medicine (6,5,412-420, 2008)	To assess independent effects of spiritual symptoms and interactions with biopsychosocial symptoms on health care utilization, extreme service use, and life satisfaction among primary care patients.	Panorama found from an analysis carried out using hierarchical logistic regression with data collection through adults filling out the Biopsychosocio-spiritual Inventory (BioPSSI) in the waiting room of two Basic Health Units, measures of satisfaction and use of health services.
PubMed USA	concordant spiritual orientations as a factor in physician–patient spiritual discussions: a qualitative study/ Orientações espirituais concordantes como fator nas discussões espirituais médico-paciente: um estudo qualitativo	Ellis and Campbell	Journal Religion Health (44, 1, 39-53, 2005)	To understand the impact of the religious/spiritual orientation of doctors and patients in the clinical encounter	Qualitative research. Data obtained through semi-structured interviews with ten family practice physicians and ten of their patients.
VHL Scotland	GPs and spiritual care: signed up or souled out? A quantitative analysis of GP trainers' understanding and application of the concept of spirituality/ Médicos de família e comunidade (MFC) e cuidados espirituais: inscritos ou finalizados? Uma análise quantitativa da compreensão e aplicação do conceito de espiritualidade pelos preceptores de médicos de família e comunidade	Appleby et al.	Journal Education for Primary Care (29, 6, 367-375, 2018)	To evaluate spirituality concepts and application in a sample of FPP preceptors; to statistically explore the relationship between personal spiritual affiliation, attitudes and reported practice of spiritual care; and to examine whether FPP preceptors consider training in spiritual care appropriate.	Research involving 87 FPP preceptors who submitted a questionnaire with the purpose of analyzing the relationship between the concept of spirituality and the clinical practice of this health dimension. Likert scale and multinomial trend tests were used in this analysis.

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Table 1. Continuation.

Provenance/ Origin	Title	Authors	Journal (vol, No., page, year)	Objective	Considerations
VHL USA	Exploring community health center and faith-based partnerships: community residents' perspectives/ Explorando o centro de saúde da comunidade e parcerias baseadas na fé: a perspectivas dos moradores da comunidade	Patel et al.	Journal of Health Care for the Poor and Underserved (24, 1, 262-274, 2013)	To examine the perspectives and experiences of low-income residents with the meaning of health and the role of spirituality; and to analyze the participation of religious congregations in community health.	Qualitative study that seeks to identify the impact of the participation of community religious congregations in primary health care units from the perspective of local residents. It is clear that spirituality is considered essential for health, but its influence is heterogeneous in the community linked to specific groups and ethnicities. It suggests that partnerships between religious groups and Basic Health Units can collaborate with access to health.
VHL USA	Are residents willing to discuss spirituality with patients?/Os residentes estão dispostos a discutir espiritualidade com os pacientes?	Saguil et al.	Journal of Religion and Health (50, 2, 279-288, 2011)	Assess whether family practice residents are willing to discuss spirituality with the patient.	National quantitative study (USA) achieved through a survey with a random sample of FP residents in which it was observed that the discussion about spirituality depends on the patient's will as well as on the resident's interest and mastery of this topic. It is indicated that training in the spiritual approach can prepare doctors to have more confidence and propensity to include this component in the clinical discussion.
VHL USA	Screening the soul: communication regarding spiritual concerns among primary care physicians and seriously ill patients approaching the end of life/Examinando a alma: comunicação sobre preocupações espirituais entre médicos de assistência primária e pacientes seriamente doentes chegando ao fim da vida	Holmes et al.	American Journal of Hospice & Palliative Medicine (23, 1, 25-33, 2006)	To explore the spiritual concerns of seriously ill patients and the spiritual care practices of primary care physicians (PCPs).	Research carried out using questionnaire analysis in primary care with terminally ill patients and with family practice physicians. It was observed that spirituality, despite being seen as important, is rarely addressed. It denotes insufficient understanding and confidence in how to approach the topic of spirituality during the clinical encounter.

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Table 1. Continuation.

Provenance/ Origin	Title	Authors	Journal (vol, No., page, year)	Objective	Considerations
VHL USA	The spirituality index of well-being: a new instrument for health-related quality-of-life research/Índice do bem-estar espiritual: um novo instrumento para pesquisa de qualidade de vida relacionada à saúde	Daaleman and Frey	Annals of Family Medicine (2,5, 499-503, 2004)	To test a valid and reliable measure of spirituality	Cross-sectional research conducted with primary care patients in Kansas who underwent the Spiritual Well Being Index (SWBI). It was determined that the SWBI is a valid and reliable instrument to assess the level of quality of life under the spiritual dimension. Multicenter study carried out through verbal questions in the waiting room of basic health units with adult patients, including information about spiritual well-being and their respective preferences for medical involvement or not with spirituality. It is noted that the minority of patients do not want a spiritual interaction in a routine consultation. Note that interest in this care increases proportionally to the severity of the clinical context and that the spiritual approach, if it occurs, should not be exacerbated, nor in the medical office.
VHL USA	Patient preference for physician discussion and practice of spirituality/ Preferência do paciente por discussão médica e prática de espiritualidade	MacLean et al.	Journal of General Internal Medicine (18, 1, 38-43, 2003)	To determine patient preferences for addressing religion and spirituality in medical encounters.	Cross-sectional study with adult primary care patients in rural and urban areas researching demographic information, measures of religiosity, patient desire for spiritual assessment and frequency of spiritual assessment in practice. Univariate logistic regression analyses were used to compare the two populations. It is concluded that the majority of interviewees have a religion or are spiritual; They have a desire for evaluation and a spiritual approach, but their belief is rarely or never discussed in medical consultations. The need for greater enthusiasm and interest in approaching spirituality in order to provide more holistic care is noteworthy.
VHL and PubMed USA	Patient desire for spiritual assessment is unmet in urban and rural primary care settings/O desejo do paciente por uma avaliação espiritual não é satisfeito em ambientes de cuidados primários urbanos e rurais	Fuchs et al.	BMC Health Services Research (21, 289, 2021)	To compare patient desire for spiritual assessment based on community type, particularly between urban and rural communities.	

Through the gathering of information, thematic nuclei were established that configure the review: Concept of health, Spirituality, Spirituality Instrument, Perception of doctors and patients, Perception and attitude of doctors, Perception of users and Teaching of Spiritual care. These thematic cores will be discussed below.

Health concept

The concept of health encompasses multiple dimensions, denoting a more holistic view. Health is a dynamic synchrony between psychic care, spiritual practices, physical and social well-being.⁴

There is a complex and individual synergy between these dimensions, and the results cannot be generalized.⁵ For example, low social interaction can contribute to better introspection in some individuals, promoting spiritual well-being, while for others it can be harmful, reducing quality in this same field.⁵ Understanding must be done with caution, as the relationships between the four fields (physical, mental, social, and spiritual) are not linear, which indicates that, as a rule, the results expressed are unpredictable. Therefore, the approach must be comprehensive and include a variety of strategies for providing care.⁵

Spirituality

Spirituality was defined by FP as an abstract, unclear, but relevant and useful concept. It focuses on a personal need that carries its own deep meaning for each person and may have a connection with the divine or have a more universal character. It represents the purpose of life, which brings motivation, strength and support to daily living.⁶ It is the result of the continuous search for self-knowledge and the construction of self-care.⁶

There has been a growing increase in people who identify as spiritual and non-religious and show interest in spiritual attention in healthcare.⁷ It has been observed that the desire to have a spiritual assessment is similar between the rural and urban populations.⁷

Ethnicity has a cultural impact, including in the spiritual field. Different ethnicities have different views on spirituality and/or religion.⁴ African Americans have demonstrated a stronger connection between health and spirituality compared to Latinos and Caucasians.⁴ Along with a lower economic status (income and education), African Americans are more likely to dedicate more time to spiritual issues and to give up, if necessary, physical demands during medical consultations.⁸

It was observed that more male patients were referred to spiritual leaders, aiming for more in-depth care of spiritual health.⁹ Spiritual assessment can be discussed in different situations and is not exclusive to serious and terminal illnesses.⁷ Common issues in Primary Health Care (PHC), such as hyperutilization, polypharmacy, and dissatisfaction with the health system and with one's own life, were often related to spiritual conflicts, in addition to social, chronic physical, and psychological issues.⁵

The lack of motivation and goals in life was linked to impaired functionality, symptoms originating from the spiritual and social fields and the interaction between them.⁵ On the other hand, it was observed that a sense of purpose in life is associated with a better quality of life and perceived health, fewer psychological symptoms and better rates of self-control, restraint, and moderation. The meaning of life is associated with religiosity and collective desire, consistent with the importance of spirituality and socio-spiritual interaction.⁵

It appears that spirituality has great potential in the treatment of people dependent on psychoactive substances, providing strength, resilience, and hope to users and their family.⁴ A catalytic action of

symptoms such as somatization, anxiety and sadness/mourning toward a placid and robust posture to move forward is also observed, even in the face of daily adversities.⁴

Spirituality has a community role when in religious environments, which can serve as a link between patients and the UBS.⁴ There are congregations that link preventive and screening programs, in addition to rehabilitation, such as physical activity practices and health education.⁴ Among other functions, religious centers can also distribute educational pamphlets, invite UBS professionals to speak and hold health fairs.⁴

Congregations have great influence, legitimacy and knowledge of the organizational structure of the community, especially in low-income environments, where residents have great trust, attendance and dependence on religious services. They can also contribute with physical space and employees to assist with health strategies.⁴ The guarantee of adherence and trust in these services is greater when health professionals are participating in the organization of partnerships.⁴

Spirituality Instrument

The term spirituality has multiple interpretations and meanings, which makes it difficult to structure an instrument that illustrates these different interpretations. The absence of purpose and a state of alienation from oneself, others and the world are considered low levels of spiritual well-being.¹⁰

The System of Belief Inventory (SBI) measures religious/spiritual beliefs and practices, as well as social support, as a criterion of quality of life.¹⁰

The Spiritual Well Being Scale (SWBS) leans toward a more religious content, associating levels of well-being through the relationship with God. This theological character limits this instrument in non-religious populations.¹⁰

The Spiritual Well Being Index (SWBI) is an instrument that quantifies spiritual well-being through 20 questions, using the Likert scale to assess respondents' agreement with positive and negative considerations. Each statement scores between 1 and 6, and the higher the total value, the greater the sense of well-being.¹¹ Although the proposal to construct this index is based on religious/spiritual tolerance, it tends to have a monotheistic character.¹¹ Still, it is a more sensitive questionnaire for a larger population.¹¹ It does not measure religious practices. It is suggested that SWBI is a valid and reliable tool for use in UBS.¹¹

It is considered that, given the range of spiritual manifestations, a scale with more ecumenical characteristics would have a greater reach among the population.¹¹

Perception of doctors and patients

Most users of the Family Health Strategy (FHS) and FP consider the spiritual approach important. Generally, in both groups, this issue is not raised or interest in this field is not shown during the clinical encounter.^{7,9}

Users and FP recognize that a person's beliefs and values go beyond religious concepts.¹² Both groups agree that cultural concordance is a facilitator for spiritual interactions. On the other hand, different beliefs can make it difficult for spiritual discussions to arise. It is observed that different spiritual views generate insecurity when dealing with the listener's reactions, which impacts the doctor-patient relationship.¹² As a solution, a mutual ecumenical perspective dispels likely barriers and provides quality spiritual care. Respectful active listening and a dialogue centered on the person who has the demand are

resources defended by both sides.¹² Furthermore, dialogue with spiritual leaders may help in familiarizing with spiritual matters and understanding the anxieties of patients in spiritual suffering.¹² Clinical emergencies are exceptions in which spiritual differences become less relevant.¹²

Perception and attitude of doctors

It is noted that FP physicians/residents who have greater personal interest and attribute greater importance to spirituality are those most involved in spiritual care.^{6,11} It is inferred that, although many are interested in addressing^{7,11} and valuing spirituality, few actually do it, demonstrating a gap in medical qualifications and training, whether during undergraduate or postgraduate/medical residency.⁶ It was found that more experienced doctors are more likely to explore spirituality in consultations, which suggests that the doctor's mastery of this approach is acquired over time, by desire or by the need to understand the patients' suffering.¹¹

Different attitudes were observed when faced with a spiritual demand: rejection, reserve, pragmatism, and acceptance. The attitude of rejection is demonstrated by discomfort and disregard for this subject, whether due to unpreparedness or invalidation of the importance of spirituality. Reservation consists of a more neutral, superficial, and convenient action. If the spiritual approach is guaranteed to be successful and good for the patient, the doctor with a pragmatic attitude will approach it with greater intensity and encourage the patient himself to strengthen resources related to spirituality. This welcoming behavior will not only encourage but also provide a spiritual care plan with enthusiasm and willingness.⁶

Familiarity with religious and/or spiritual experiences brings a wealth of strategies with greater mastery and security for medical performance in spiritual care.¹² Doctors who sparingly manage divergent opinions have greater potential to channel the impact of spiritual/religious perspectives contrary to their own.¹² It is considered that there is no ready-made tool to meet all spiritual demands and that the best strategy is empathetic listening, with attentive perception of those who also need referral to a spiritual leader.⁹

Spiritual management begins with questioning patients' beliefs and medical understanding of the influence of religion/spirituality on health over time. Spiritual anamnesis can contribute to the principle of comprehensiveness, enhancing attention and care and improving health rates.⁷

Spiritual first contact can be conducted not only by doctors, but also by nurses, social workers, and spiritual leaders. All members of the healthcare team must understand the importance of religion and/or spirituality for the patients' health and must be trained with appropriate strategies for a spiritual approach. Spiritual care should be another way of building bonds between users, doctors, and the health team.⁷

Users' perception

It was found that patients want their religious and spiritual practices to be known to the FPP.⁸ Lack of religious affiliation is not an obstacle to the desire for spiritual care, and everyone deserves spiritual attention, if they so desire, regardless religious or spiritual agreement with the professional.⁷

When doctors share their spiritual/religious attitudes with the users', they feel more comfortable expressing spiritual issues during the consultation, promoting therapeutic well-being during the clinical encounter itself.¹²

Users see the doctor's inflexibility in the face of divergent dogmas and proselytism as a barrier. It is clear that what constitutes a quality spiritual approach does not necessarily depend on the convergence of beliefs, but on respectful clinical communication, active listening, and effective doctor-patient interaction. It is observed that patients have greater adherence to spiritual care with more informal medical attitudes than those based on fixed spiritual screening questions.¹²

Interestingly, it was observed that the majority of patients, despite considering the doctor's interest in spirituality and the dilemmas involved in this field important, find it inappropriate to discuss spiritual anxieties with the FPP.⁹ It appears that the greater the severity of the disease, the greater the desire of patients to involve spirituality during the medical consultation.⁸ For example, in screening and follow-up consultations, patients rarely want to talk about spirituality, unlike situations with patients with chronic diseases and an unfavorable prognosis, when the spiritual demand is welcomed and requested by patients themselves.⁸

Another interesting fact is about the degree of spiritual interaction. This is better accepted the less intense this interaction is (investigation about belief, dialogue about belief, silent prayer by the doctor, and active prayer between doctor and patient).⁸ Patients consider that this would be going beyond the doctor's role. Users are covered by attentive listening by the FPP, which reflects the maxim of person-centered care.⁹

Patients consider that spiritual screening is important as a means of signaling, identifying whether or not it is possible to comment on matters in the spiritual sphere with the FPP, as long as they are demands coming from themselves, the patients.⁹

Teaching spiritual care

It is understood that spirituality is one of the pillars of health. The commitment to offering quality care involves a commitment to comprehensiveness, focusing care and attention on the person. The FPP needs to establish new paradigms, allowing spirituality to be discussed if the patient so desires.¹¹

Spiritual care should be included in medical graduation curriculum and explored with greater potential during residency in FP.¹¹

The first step is to teach students to be compliant, through active, welcoming and non-harmful listening to beliefs, regardless of whether they agree or not with spiritual guidance. An essential attribute to be built is commitment to care and compassion for the suffering of others, exploring the experience of illness.

It is necessary to value these demands to explore them and build a care plan in the light of person-centered medicine, as well as any other demand that a family and community doctor is capable of developing.¹¹

FINAL CONSIDERATIONS

It is clear that spirituality has developed a certain rationality in recent years. Reason and emotion are no longer antagonistic forces and, in synchrony, allow care to be achieved in a more holistic and organized way. Spiritual care is another dimension of health and, like the others, it also requires attention and coordination.

PHC, given the exclusive arsenal of longitudinality and greater interaction with the community, is a unique and potential space for spiritual care. The use of tools is most useful as a way of providing access and signaling that it is possible to discuss spiritual anxieties during the clinical encounter.

The person-centered approach, individualizing management, refers to common practice by FPPs. The community, the family health strategy team, as well as other health professionals, can collaborate in spiritual care. It is noteworthy that there is little research aimed at the particularities and actions that PHC can offer and develop regarding spirituality. There is a low content in prescriptions and teaching methods during graduation and during residency in FP. However, it is noted that it is a promising field with growing acceptance in the academic research and teaching space, in view of greater comprehensiveness in care and the recognition that belief is also a determinant of health.

CONFLICT OF INTEREST

Nothing to declare.

AUTHORS' CONTRIBUTIONS

OOZMA: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Writing – Original Draft. DCF: Conceptualization, Project Administration, Supervision, Validation, Writing – Review & Editing.

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