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Editorial

Spirituality, Religiosity, and Cardiology: a Challenge for Clinical Practice

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Holism is a medical doctrine that analyzes the phenomena of man as an indivisible whole, which cannot be explained by the sum of its parts. The human being's relationship with the Sacred was part of the culture of peoples. Sometimes it was direct, human and Sacred; in general, they were mediated by religions, organizations or systems which took this relationship as absolute, according to their concepts.

According to DEMCA (Cardiovascular Study Group on Spirituality and Medicine - Brazilian Society of Cardiology), spirituality is a set of moral, mental and emotional values that guide thoughts, behaviors and attitudes in intra- and interpersonal relationships.

According to the holism, when evaluating the trinomial Health, R/E, we are considering subtle energies, still poorly evaluated, understood and unknown that, for a more attentive observer, are present in the daily doctor-patient relationship.

The concept of holism (from the Greek, holos whole) has existed since ancient Greece. It is a medical doctrine that analyzes the phenomena that occur to man as an indivisible whole, which cannot be explained by the sum of its parts. It is a scientific approach that prioritizes global understanding, discarding isolated analysis of the components [1]. The human being's relationship with the Sacred was an integral part of the culture of peoples. In rare cases it was direct, human and Sacred; in general, they were mediated by religious organizations, which took this relationship as absolute, and unfortunately, at times, they used it for their own ethical and unethical ends. Indeed, "All religions are given by God and necessary for the peoples to whom they have been revealed. and if we could read the scriptures of these faiths, with the eyes of their followers, we would find that they were always helpful to one another" (Mahatma Gandhi).

Spirituality(E)isthebeliefsystemthatencompassesintangibles and conveys vitality and meaning to life events. These beliefs can mobilize positive energies and initiatives, with unlimited potential to improve the quality of life. "There is an association between spirituality and health that is probably valid, and possibly causal" [2]. According to the Cardiovascular Study Group on Spirituality and Medicine (GEMCA) of the Brazilian Society of Cardiology (today, DEMCA), spirituality is a set of moral, mental and emotional values that guide thoughts, behaviors and attitudes in intra- and interpersonal relationships [3]**.** Spirituality plays an adjuvant factor in the quality of life in apparently healthy populations with cardiovascular diseases.

Religion is the belief in the existence of a superior, supernatural principle, which determines the destiny of the human being and to which respect and obedience are owed; in religious practices (liturgy), and in the exercise of faith, motivation is sought to overcome obstacles and sufferings and to find happiness. Religiousness (R) is correlated with physical performance and is a strong predictor of emotional well-being [4]**.** In the USA, a Christian country, it was found that patients who seek spiritual assistance present a linear association between spiritual depression and reduced quality of life. Individuals whose spiritual needs were met had higher levels of mental and physical quality of life [4]**.** In Iran, an Islamic country, positive correlations were described between religious practices and quality of life in the mental and health dimensions [5]**.**

Religious people experience better mental health, adapt better to daily stress, are physically healthier, have healthier lifestyles, and require less health care [2].

Hummer et al. were the first authors to demonstrate a correlation between religious practice and a reduction in cardiovascular mortality [6]**.**

In Japan, parents are mostly Buddhist and Shinto. 13,846 people declared to be at least somewhat religious; 3685 people

denied having religious beliefs. Individuals with religious backgrounds were fewer smokers and more physically active and had a lower risk of obesity [**7].**

In the US, high degrees of depression in the elderly were predictors of stroke, an influence minimized by the practice of religious services [8].

Aspects of religiosity, such as weekly practice, could be protective factors for cardiovascular diseases, promoting better anxiety/stress control and healthy lifestyle habits; some publications did not confirm these findings [9].

There is a significant correlation between R/S and quality of life in patients with coronary heart disease and heart failure deserved numerous studies. 10 In countries linked to Western Christian Jewish culture, a systematic review registered 15 articles published between 2002 and 2017. In 10 studies, a positive and significant association was established between R/S and quality of life. Emotional and mental well-being was related to spiritual well-being, intrinsic religiosity and attendance at religious services. These findings were not confirmed in some publications. In general, the correlations between R/S and quality of life and related variables showed a reduced correlation coefficient [9]. The concept of Religion involves liturgy and theology, and in figurative terms, respectively, religious acts and faith, which must necessarily include certainty as to the credibility of these concepts and acts. It is possible that these results a related to a lower degree of credibility in relation to religious values.

In our experience, religious experiences can have different effects, depending on the positive or negative nature of the patients' personal and family backgrounds. Social, philosophical, cultural aspects can interfere with religious understanding and even cause anguish and hopelessness to the patient. Meta-analysis (n = 49) evaluated the relationship between religious experience and psychological adjustment to stress; in general, the positive and negative forms of religious experience were associated, respectively, with positive and negative psychological adjustment to stress. Positive correlations between religious conflict and anxiety, depression, negative mood, guilt and social dysfunctions were described [10,11]. Religious or spiritual pain can increase conflicts in many patients.

It comes from the concept of sin, cultivated and proclaimed by the God of Terror, who manifests and reigns through terror, duality, heaven and hell. It is the pain that is based on Guilt, which leads to punishment, fear and feelings of shame and inferiority [12]. In these cases, it is necessary to raise the patient's self-esteem and show the true God of absolute love, forgiveness and mercy. Religious or spiritual pain can increase conflicts in many patients. It comes from the concept, the cultivated and proclaimed sin of the God of Terror, who manifests and reigns through terror, duality, heaven and hell. This is pain that is based on Guilt, which leads to punishment, fear and feelings of shame and inferiority [12].

Patients with congestive heart failure often present high levels of religiosity, given the prolonged clinical condition, reducing stress with positive attitudes towards God. Religious conflict was a significant predictor of hospitalization; religious aid reduced personal and social costs.

There is a fundamental discrepancy in concepts between the Western Christian Jewish religions and the Kardecist movement and other cults, important for the patient-physician relationship. The first refers, in general, to the sin to be punished, implying the concept of heaven and hell; the other to the karmic situation to be repaired, implying the concept of reincarnation.

The "Hermetic doctrine teaches us that "All is Mind", "The Whole is mind; everything is mental" This is a basic concept to guide the doctor-patient relationship [13]. It is up to the physician not only to treat but also to know the patients' minds, anxieties and fears. Physicians and patients should keep in mind that "religion is not a servitude imposed on man, it is a help offered to him."

For us "Assessing R/S in patients in acute and unstable situations" is viable; for this, acumen and, of course, clinical experience is enough; a simple and unpretentious analysis can be of great value to the critically ill, as we have already done and witnessed in our times in the ICU. It is clear that the doctor is not able to "Prescribe prayers, religious practices or specific religious denomination". However, every physician endowed with reasonable Spirituality, can and should, if requested, explain to the patient that what matters is not the consecrated prayer, but the intention and faith, which do not depend on a specific religious liturgy, avoiding standardized formulas, sometimes used decoratively and repetitively. The value of repetitive prayer is not denied, but of prayers uttered mechanically "from the lip out".

DEMCA outlined a series of practical recommendations for physician-patient relationships, bearing in mind religious and spiritual issues. They are all unambiguous and should always be in the minds of healthcare professionals [10].

We believe, however, that the number of recommendations "12. Assess spirituality and religiosity in patients in acute and unstable situations" (III C) and the number "13. Prescribing prayers, religious practices or specific religious denomination"' (IIIC) could be used with discretion and caution and would not fit the IIIC. In our experience, "Assessing spirituality and religiosity in patients in acute and unstable situations" is an act that could be perfectly performed in these circumstances, without the need for a traumatizing intervention, and for this, clinical acumen and discernment, the professional's goodwill and, of course, clinical experience. A simple and unpretentious analysis could be of great

value to the critically ill, as we often witnessed in our past ICU tasks.

Among us, we live R/E within the precepts and traditions of Western Christian Jewish culture. and we forget the spiritual concepts of other cultures capable of bringing more elements to our experiences. In fact, as Pedro Brugada taught us "We use crude methods, however refined, and we may be seeing things wrong...".

When evaluating trinomial Health, R/E, we are considering subtle energies, still poorly evaluated, understood and unknown that, for a more attentive observer, are present in the daily doctor-patient relationship.

Conclusion

1. R/S are innate to human beings and must be experienced at all times in thoughts, feelings and actions.
2. R/E are immaterial realities, which do not have instruments capable of measuring.
3. The evaluation by Questionnaires, although validated, would be, at least, gross, incompatible with the immaterial reality of the daily experiences of the human search for the Sacred.
4. Health is the complete physical, mental, social, and spiritual well-being, not just the absence of affections and infirmities, determined by the interaction of physical, mental and social, religious factors. and spiritual.
5. Physicians should try to dialogue with patients in terms of R/S, respecting and tolerating beliefs and expectations.

References

1. Karademas EC (2010) Illness cognitions as a pathway between religiousness and subjective health in chronic cardiac patients. J Health Psychol 15: 239-247.
2. Saad M, Masiero D, Battistella LR (2001) Espiritualidade baseada em evidências. Acta Fisiátrica 8: 107-112.
3. Précoma DB, Oliveira GMM, Simão AF, Dutra OP, Coelho OR, et al. (2019) Atualização da Diretriz de Prevenção Cardiovascular da Sociedade Brasileira de Cardiologia - 2019. Arq Bras Cardiol.
4. Trevino KM, McConnell TR (2014) Religiosity and religious coping in patients with cardiovascular disease: change over time and associations with illness adjustment. J Relig Health 53: 1907-1917.
5. Abolghasem-Gorji H, Bathaei SA, Shakeri K, Heidari M, Asayesh H (2017) The effect of religiosity on quality of life in Muslim patients with heart failure: a study in Qom, the religious capital of Iran. Mental Health, Religion and Culture 20: 217-218.
6. Hummer RA, Rodgers RG, Nam CB, Ellison CG (1999) Religious involvement and U.S. adult mortality. Demography 36: 273-285.
7. Daiki Kobayashi, Takuro Shimbo, Osamu Takahashi, Roger B Davis, Christina C Wee (2015). The relationship between religiosity and cardiovascular risk factors in Japan: a large–scale cohort study J Am Soc Hypertens 9: 553-562.
8. Colantonio A, Kasi SV, Ostfeld AM (1992) Depressive symptoms and other psychosocial factors as predictors of stroke in the elderly. Am J Epidemiol 136: 884-894.
9. Abu HO, Ulbricht C, Ding E, Allison JJ, Salmoirago Blotcher E, et al. (2018) Association of religiosity and spirituality with quality of life in patients with cardiovascular disease: a systematic review. Qual Life Res 27: 2777-2797.
10. Bean MK, Gibson D, Flattery M, Duncan A, Hess M (2009) Psychosocial factors, quality of life, and psychological distress: ethnic differences in patients with heart failure. Prog Cardiovasc Nurs 24: 131-140.
11. Ano GG, Vasconcelles EB (2005) Religious coping and psychological adjustment to stress: a meta - analysis. J Clin Psychol 61: 461- 480.
12. Lamont S (2001) Guilt, Shame, and Religious and Spiritual Pain. Holist Nurs Pract 15: 30-39.
13. Três Iniciados (2011) O Caibalion: estudo da antiga filosofia do Egito e da Grécia. Editora Pensamento. São Paulo 2nd Edn 20-46.