



SPIRITUALITY AND MEDICINE: A PROPOSAL

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Introduction

Dissatisfaction with medical care has increased among patients and providers, despite unprecedented medical successes.^{1,3} This paradox may be caused by a number of possible reasons, including a higher degree of patient education, improved access to information, criticism of the profession by the media, emergence of alternative forms of medicine that make unrealistic promises, increased cost of care, fragmentation of care into specialties and subspecialties, and divestment of primary care of its original role of patient advocacy.

We suggest a more basic cause for the growing dissatisfaction with medical care. We contend that underlying the discontentment of patients and providers is an enlarging cultural rift that manifests as distrust and closer scrutiny of each other, cavalier practice of the criticism at personal and societal levels, personal isolation, the dissolution of traditional social structures such as the family, and an inability to work together toward a common goal.⁴ Not surprisingly, the effects of these social changes are first experienced in critical situations such as disease, illness, and death. Thus, it is reasonable to consider the practice of medicine as a model to study both the causes and the solutions of social problems in evolution.

We identify the loss of a common scope — and with this the loss of a common language — as the basis of the present cultural rift. We believe this loss has been caused by

the failure to acknowledge the role of spirituality in human relationships. In this perspective, spirituality is the connective tissue that allows coordinated and meaningful activities by human beings.

Definition of Spirituality

A spiritual perspective in medical practice has been advocated with increasing urgency in mainstream medical journals during the last few years.⁵⁻⁸ Despite the urgency of these calls, the definition of spirituality remains elusive. Some studies bestow on the patient the burden to define himself or herself as spiritual. Other studies try to establish a distinction between religion and spirituality, as epitomized by the Fetzer religious spirituality questionnaire.⁹ Still other studies define spirituality as “a form of relationship to the transcendent” or “a comprehensive and coordinated way to relate to others and to interpret the reality.”^{5,10-12} These definitions fail to provide a “gold standard” necessary to validate individual claims to spirituality and to distinguish among different forms of spirituality. Such a “gold standard” would serve to identify a defined spiritual perspective of the patient and its importance to the patient’s self-understanding. It would not be a measure of religious authenticity.

The first step in exploring the role of spirituality in the practice of medicine is a review of constructs of spirituality and the tools available to study this human dimension.

Spirituality and Transcendent

We recognize the defining attribute of spirituality as a relationship with the transcendent, which is the experience or disposition that conveys a sense of belonging to something greater than oneself. The role of the transcendent in everyday life is witnessed by the histories of philosophy and religion throughout the centuries and in our time is epitomized by Octavio Paz in *The Labyrinth of Solitude*: “History bears the cruel hallmarks of a nightmare; the greatness of humankind consists in making beautiful and durable work of art with the material of this nightmare.”¹³ This statement, based on the review of the history and culture of Mexico and its relationship with other histories and cultures, implies that the creativeness of humankind, founded on a vision and sense of purpose, can transform a hostile environment into one that allows the fulfillment of humankind’s whole potential. This statement is particularly germane to the world of medicine where physical pain, emotional anguish, and the quest of meaning provide the everyday material of the physician’s intervention. In a later text, *The Double Fire*, which explores the interactions of sex, eroticism, and love, Paz adds a new consideration of spirituality that is congruent with many modern views of the world.¹⁴ Rather than establishing a distinction or an opposition between the material and spiritual world, the author sees spirituality as a deeper awareness of the

meaning of the spiritual world, something the material world needs if it is to be interpreted and affected. This view offers spirituality as the fundamental personal experience to a culture that values personal experience as the only legitimate source of learning. In this way, a centuries-old gap between worldly and otherworldly is finally bridged, and spirituality is the foundation of the bridge.

Transcendent and Sacrifice

The recognition of that which is transcendent implies that every human experience, whether involving another person or an object, may have a special and unique meaning requiring that it be “reserved” for a special use. This reservation of use of a person or object makes it sacred. In its simplest meaning, a sacrifice is the act of setting oneself or something dear to oneself apart from its ordinary use for self-gratification and reserving it for something special in order to experience some greater purpose or insight into life.

An easily accessible and almost universal example of sacrifice is sex in marriage, where the spouses vow to sacrifice (ie, to reserve) their sexes to each other. In this situation sex ceases from being a self-fulfilling activity and becomes a means for the unique goals of procreating with and communicating love to a chosen person. The choice to sacrifice sex within the marriage transcends the act of sex itself as it inscribes this act into a

purpose that is accomplished only through the sacrifice.

Sacrifice requires freedom and gratuitousness. The quintessential sacrifice is the kosher observance, where certain forms of food and food preparation in and of themselves are accepted or rejected as pleasing to the deity, even though they may also have secondary rationales (eg, hygiene or cultural affiliation). Believers accept the restriction of certain foods because by doing so, they accept the identity that the deity provides to them, and the deity gives no other reasons for the restriction other than it serves as a mark of grace and favor for establishing the identity of the believer.

While both the language of sacrifice and these examples are drawn from Western religions, it would be a mistake to imply that we are concerned only with Western concepts. The concept of the sacred is universally found in human culture. Usually, the religious concept of sacrifice refers to a propitious act to win the favor of a deity. However, it has also come to mean metaphorically the price one is willing to pay to achieve a goal. We propose to use the concept of sacrifice in medical investigations as a marker of defined spiritual perspectives. From a practical standpoint, this form of sacrifice needs to be distinguished from certain new-age rituals where specific powers are attributed to certain objects and materials.

In the field of medicine, a spiritual perspective also entails the

sacredness of each human being, whether patient or provider, and denounces any action that denies this sacredness, from patient abandonment for lack of resources to frivolous malpractice lawsuits for the pursuit of easy gain. A poignant direction for the preservation of this sacredness during the late stages of life is provided by Byock, who felt the need to connect his medical expertise to an organized philosophical thought. He suggests that even when cure is not possible, healing is always possible.¹⁵ While cure refers to the disease, healing refers to illness and the personal experience of the disease. Healing is the ability to make a “sacrifice” of the illness by accepting it and by recognizing the unique perspectives illness and death bring to life, such as forgiveness, reconciliation, and insights.¹⁶

Spirituality and Religion

Throughout human history, religion has represented a major source of spirituality, and often the two terms have been used synonymously.

Religion refers to a body of beliefs and practices shared by a community of people as necessary either to establish a relation with the deity or to be in harmony with ultimate reality (as may be the case with non-theistic Eastern religions). By definition, religion implies a relation to the transcendent as a defined form of spirituality. Personal or communal prayer is the spiritual practice most com-

mon to almost all religions. This understanding of religion elicits at least two questions: (1) Can prayer represent an alternative landmark of spirituality to sacrifice? (2) While there cannot be religion without spirituality, can there be spirituality without religion?

Prayer is an obvious manifestation of spiritual belief. Studies have not always distinguished among the many forms of prayer or critically evaluated their medical effectiveness. Is prayer an expression of “spiritual practice” in the same way that sacrifice is? Until this answer emerges from prospective studies, prayer and sacrifice should be studied independently.

One can conceive of spirituality outside the boundaries of an organized religion as long as the category of the transcendent is involved, at least implicitly. Useful references for this form of spirituality are represented by the two Kantian “imperatives” expressed in *The Critiques to Practical Reason*¹⁷: “I must because I must,” and “You shall never use humanity as a means, but always as an end.” Kant concluded that the final implication of his imperatives was the existence of a God. We are not interested, however, in the end of the spiritual process or in establishing whether the discovery of spirituality leads to God or the discovery of God leads to spirituality, or whether the two discoveries are inextricably linked. Can a person be spiritual without simultaneously embracing a specific religious belief? This possibility exists, and consequently spirituality and reli-

gion should be studied separately, albeit not independently.

Spirituality and Psychology

It should be determined whether spirituality should be inscribed among classical psychological categories, such as emotions or behavioral mechanisms, or if it represents a different class of human experience that may be influenced, but not wholly accounted for, by human psychology. From a practical standpoint, the distinction between spirituality and psychology is warranted for two reasons:

(1) The anatomical and physiological pathways of human activities related to spirituality, including self-awareness and moral consciousness, are only just now being explored (*Newsweek*. Religion and the brain. May 7, 2001. <http://stacks.msnbc.com/news/566079.asp>). It is possible then that these activities belong to a sphere that is different from emotions and behavioral mechanisms.

(2) Western culture enshrines self-determination as the supreme ruler of any course of action. Self-determination implies that a person feels free to choose a course of action that appears best for him or her. Each choice, by its own nature, implies a sacrifice that is the “reserved use” of some personal attributes, for specific goals. Thus, freedom of choice presupposes an idea of what is good and evil — that is, presupposes a relation with

the transcendent. The corollary of this association is that only a person who feels unconstrained in choosing can embrace a spiritual perspective.

Study of Spirituality

The four basic issues related to the interactions of spirituality and medicine are (1) relationship of spirituality and public health, (2) the efficacy of a spiritual perspective in overcoming additive disorders, (3) the influence of a patient's and practitioner's spirituality on disease outcomes, and (4) the influence of spirituality on patient-physician communication. These issues can be addressed using a variety of study techniques ranging from epidemiologic to interventional. A number of problems are common to all studies, including the following:

- Absence of a "gold standard" of spirituality.
- A number of unexplained confounding variables.¹⁸ For example, it is possible that religious ministers have longer and healthier lives because they are less likely than the lay public to adopt high-risk lifestyles (eg, tobacco and alcohol use, sexual promiscuity). The effect of spirituality on enabling a healthy lifestyle cannot be discarded as simply a confusing variable. The possibility needs to be considered that only thanks to spirituality can this difficult lifestyle be embraced and followed.
- Practical and ethical difficul-

ties in conducting randomized clinical studies.

Despite these difficulties, enormous strides have been made in the study of the medical effects of spirituality:

- Large population studies exploring the influence of religious affiliation on health and survival may provide reliable information as long as the study population is large enough to account for other variables.
- The 12 steps of Alcoholics Anonymous have provided a model for the treatment of a number of addictions.¹⁹
- A number of instruments have been validated to study spirituality and religiosity, including the Fetzer instrument²⁰ and the Expression of Spirituality Inventory (ESI).²¹ Even in the absence of "gold standards," these instruments have demonstrated internal consistency and content validity and are available for studies of spirituality.
- Prayer mirrors spirituality. The extent of this practice is easy to establish and correlate to outcome.
- The desires of patients and physicians in terms of spiritual discussions are also easily obtainable.
- Claims of miraculous cures have been reported in different religious settings for over a thousand years. Whereas old claims may be difficult to document, the medical profession has also

shunned recent claims, even though the diagnosis of the disease and the reality of cure may be documented according to the most current medical knowledge.²²⁻²⁴

- We have already noted the assertion that where cure is not possible, healing is always possible.^{15,16} Given the importance of healing both the personal experience of the present illness and the bitterness of unresolved conflict, a number of studies have explored spirituality at the end of life.

These approaches have provided an impressive body of information that can be used to shape current practices and to indicate the direction of future research.

Evidence of Spirituality in Medicine

Table 1 summarizes some of the most meaningful studies on the interactions of spirituality and medicine.²⁵⁻⁵⁰ With all of the limitations already outlined, these studies present the following points.

- A lifelong spiritual practice is associated with decreased mortality as well as improvement of intermediate end points, such as prevalence of comorbid conditions, function, and acceptance of a healthy lifestyle.²⁵ A potential problem with this study was that the main effect was seen among women. A possible explanation is the fact that a higher percentage of women (29%) than men (20%) attended religious services regularly.²⁵

• Spiritual awareness may cure substance addiction, especially alcoholism. The most compelling example is Alcoholics Anonymous (AA), whose 12 steps are a modern translation of a treatise on spirituality.

Although AA does not embrace a specific religion, it promotes surrender to the will of “a higher power” (God, if one desires to say so). At least 21 studies have shown that AA has been consistently able to keep

more than one third of its adherents sober for 1 year or longer.³⁶

• Other studies have shown that a spiritual perspective was associated with a more rapid and

Table 1. — Quality of Evidence on Interactions of Spirituality and Medicine

| Question | Type of Study (References) | Result | Quality of Evidence |
|---|---|---|---------------------|
| Spirituality and public health | Religious attendance and mortality over 28 years: cohort studies (25-27) | Decreased mortality Decreased use of alcohol and tobacco Decreased risk of divorce | Type II |
| | Mortality among ministers of catholic and Mormon denominations: cross-sectional study (28-31) | Decreased mortality Decreased morbidity Better function preservation | Type II |
| | Mortality and morbidity among Jewish orthodox: cross-sectional study (32) | Decreased mortality and morbidity | Type II and III |
| | Comparison of mortality between a religious and a secular Kibbutz in Israel: cross-sectional study (33) | Decreased mortality and morbidity in the religious kibbutz | Type II |
| | Epidemiology of certain diseases among particular religious groups (Seventh-day Adventist, Mormon): cross-sectional studies (34,35) | Decreased morbidity and mortality | Type II |
| Spiritual intervention in addiction | 21 cohort studies of Alcoholics Anonymous (36) Application of the 12 steps to other forms of addiction (37) | Overall 34% success rate at 1 year Inconclusive | Type II Type III |
| Spirituality and disease outcome | Recovery from serious illness: cohort study (38,39) | Improved | Type II |
| | Depression: cohort study (40) | Improved | Type II |
| | Substance abuse: cross-sectional study (37) | Improved | Type II |
| Prayer and recovery | Patient prayer in the intensive care unit: randomized, controlled study (41) | Positive effect | Type I |
| | Prayer by proxy: randomized, controlled studies (42-45) | Positive effect | Type I |
| Spirituality and physician-patient communications | Patient's desire: questionnaire (46-48) | More than 70% of patients wanted to address spiritual concerns with the physician, and approximately 50% wanted the physician to pray with them | Type I |
| | Communication studies at end of life: survey, narrative (49) | Positive | Type III |
| | Healing at end of life: observation, narrative (50) | Positive | Type III |

complete recovery from cardiac surgery³⁸ and rehabilitation from serious illnesses,³⁹ improvement of depressive symptoms⁴⁰ and ability to recover from substance abuse.³⁷ A conscious relation with the transcendent via meditation, prayer, or religious attendance favor recovery both from physical and emotional diseases.

- A systematic review of randomized trials of prayer²⁰ reported minor benefits in two of five studies, with no effect on length of hospital stays.

- In a number of reports, patients expressed the desire to address spiritual issues in the course of a visit and even to pray with their physician.⁴⁶⁻⁴⁸ These findings suggest that including religion and spirituality in a medical visit may lead to a better communication by making the physician discussion more congruent with the patient's need. Several reports indicate that discussing these issues facilitates end-of-life care.⁵⁰ However, these efforts have been largely circumscribed to end-of-life care, while spirituality informs all the aspects of a person's life and not only at the time of death.

In an exhaustive review of more than 1,100 published studies on the interactions of spirituality and health, Koenig⁵¹ observed that in most cases the practice of spirituality was associated with an improved outcome and, equally remarkable, in no case was the practice of spirituality associated with a negative health effect.

Spirituality and Medicine: Practical Applications

In the previous discussion we have established that:

- Every human decision involves a sacrifice, ie, it involves a spiritual activity. Awareness of this involvement gives a person a defined spiritual perspective.

- A defined spiritual perspective is associated with decreased mortality, better function, and increased social stability, and it may play an important role in recovery from physical and mental illness.

- A defined spiritual perspective may facilitate the patient-physician communication.

- A defined spiritual perspective may allow healing even when cure is not possible.

What are the consequences of these findings on the practice of medicine, on medical education, and on future research? While we can attempt some provisional answers, our principal purpose is to state the problems and open an informal forum on an important issue that pertains to all of us. Before analyzing each question separately, it should be recognized that a number of health care professionals and patients either ignore or do not accept a spiritual dimension of their profession and of their disease. We also reiterate that without freedom, there is neither sacrifice nor spirituality. Any activity trying to impose a spiritual perspective in medicine would

be counterproductive. A spiritual perspective cannot be coerced on physicians and patients. Both groups, however, could be alerted to the potential benefits of having a defined spiritual perspective. Such a perspective requires mutual respect and understanding. It would be inappropriate for a physician to promote any type of religious belief as a form of alternative or adjunctive therapy,⁵² but it would be equally inappropriate for a physician to ignore, criticize, or belittle the hope of a patient to obtain cure and healing through prayer.

Regardless of personal spiritual perspective, physicians should be able to accommodate the spirituality of their patients. This requires a modification of the current model of medical care, which considers the disease as the only variable on which health care professionals have control and is based on the following assumptions.

- A disease can be diagnosed with certainty.

- There is a "best treatment" for the disease.

- The disease is a purely physical entity that can — or cannot — be cured by physical means.

- The provider and the patients are emotionally neutral toward each other.

This model is inadequate for the current practice of medicine in Western countries for the following reasons:

- As our medical knowledge expands, so do the uncertainties about the nature of diseases.

- Likewise, for the majority of diseases, new emerging treatments offer several options to a patient. The best treatment option is that which is most congruent with the patient's desires and values rather than the option that assures the best survival. To propose the best treatment, the practitioner needs to know and better understand the patient.

- Patients and physicians are not emotionally neutral toward each other. Rather than ignoring these personal interactions, it may be productive to channel them toward more effective care.^{53,54}

A model of medical care that is more consistent with the current situation is presented, in which a physician's knowledge and experience and a patient's illness (ie, experience of the disease) meet on a common ground of multiple interactions from which the treatment plans arise. Under the best circum-

stances, this common ground is the encounter of provider's and patient's spiritual perspective.

A physician should not attempt to act as a minister, a role in which he or she has not been trained. While health care professionals can provide spiritual advice, they should do so only in a nonauthoritative way. They should be able instead to relate to their patients' spirituality and to comprehend their patients' spirituality in the treatment plan.

Teaching Spirituality

Spirituality as a way of life does not come from simply reading books or attending courses. In fact, spirituality is probably best absorbed within a family with spiritual perspectives. Lack of this family association should not lead to quiescence, however. Several provisions may enhance spiritual understanding in medical schools:

- Courses on religion and spirituality during the early years of training.

- Focus groups throughout the years for students who desire to get in touch with their own spirituality and that of their patients.

- Exposure to examples of spiritual interactions by the clinical faculty.

Many medical schools in the United States have adopted one or more of these programs,⁴ and the American Association of Medical Colleges holds a symposium every 2 years on spirituality to study new ways to link spirituality and medical education. An agenda for this research is summarized in Table 2. A "gold standard" of spirituality to validate current instruments is missing. Attending religious services or practicing prayer may fail to include deeply spiritual individuals who do not belong to a religious denomination. Future studies might use attitudes toward sacrifice to gauge individual spirituality rather than association with religious denominations. Given the success of spiritual intervention in AA, the effects of these interventions on the recovery of other forms of drug abuse should be studied. The influence of spirituality and prayer on the recovery from a number of diseases needs further clarification. The advent of new instruments such as the ESI may allow the collection of information related to specific diseases (eg, breast cancer, prostate cancer). Furthermore, the issue of miracles deserves renewed study by the medical profession.

Previous studies have examined spirituality as a whole, without distinction of different religious affilia-

Table 2. — Research Agenda on Spirituality and Medicine

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|---|
| Define "gold standard" of spirituality to validate current and new instruments |
| Perform dose/effect study of spirituality and health preservation |
| Evaluate spirituality and recovery from substance addition |
| Report cohort studies of spirituality and outcome of specific diseases |
| Compare the medical outcomes of persons belonging to different religious affiliations |
| Study effects of prayer on survival, cure, and healing |
| Monitor effects of a spiritual perspective in patient-physician communication |

tions or the absence of religious affiliations. These studies are necessary, as spirituality may involve the faith in a deity. We cannot assume *a priori* that this superior entity may not directly intervene and modify the course of diseases.

One area in which a spiritual perspective may have the most lasting impact is in patient-physician communication. We expect to find that sharing spiritual perspectives will make communication easier, more effective, and more satisfactory.

Finally, innovative types of research may be necessary to comprehend the spiritual dimension. Qualitative research provides a new and effective way to approach these issues.

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