

TRADITION, HERITAGE AND SPIRITUALITY

Religion, Medicine and Spirituality: What We Know, What We Don't Know and What We Do

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Abstract

Religion and spirituality have been linked to medicine and to healing for centuries. However, in the early 1900's the Flexner report noted that there was no place for religion in medicine; that medicine was strictly a scientific field, not a theological or philosophical one. In the mid to the latter 1900's there were several lay movements that started emphasized the importance of religion, spirituality and medicine. Lay religious movements found spiritual practices and beliefs to be important in how people cope with suffering and find inner healing even in the midst of incurable illness. The rise of Complementary and Alternative Medicine as well as the Hospice movements also influenced attention on the spiritual aspect of medicine. The Hospice movement, founded by Dr. Cecily Saunders, described the concept of "total pain"--- i.e. the biopsychosocial and spiritual aspects of pain and suffering. Since the 1960's there has been increased research done in the area of religion and health and spirituality and health. Most of the studies are association studies which demonstrate an association of religious or spiritual beliefs and practices and some healthcare outcomes. More recently, studies on meditation have demonstrated significant improvement in health care outcomes and suggest meditation as a therapeutic modality. There are also numerous surveys that demonstrate patient need for having spirituality integrated into their care. Finally, a recent study demonstrated that patients with advanced illness who have spiritual care have better quality of life, increased utilization of hospice and less aggressive care at the end of life. In spite of all these studies, we still do not have a biological evidence base for mechanisms of beliefs and practices. There is considerable controversy over whether spirituality and religion can or even should be measured as criteria for integration into clinical care. Many believe that healthcare professionals have an ethical obligation to attend to all dimensions of a person's suffering, including the psychosocial as well as the spiritual and that ethical obligation is sufficient to require integration of spirituality into clinical care. Over the last twenty years, there has been an increase in the number of required courses in spirituality and medicine in US medical schools giving rise to a new field of medicine. In February of 2009, a national consensus conference developed spiritual care guidelines for interprofessional clinical spiritual care. These guidelines as well as the educational advances, research and ethical principles have supported the newly developing field of spirituality and health.

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Introduction

Religion and spirituality have been linked to medicine and to healing for centuries. Healing was in the realm of shamans, witch doctors, as well as religious figures such as Christ and many saints. Healing was and is considered a gift. Healing has played a significant role in the development of humankind. In the neo-Paganism tradition there were a variety of healing methods via herbal, or folk remedies. Eastern traditions have focused on the changing of the body's energy fields; Native American and shamanic techniques were present in Western traditions. Within all major religions, people believed in the power of prayer as healing. The understanding of the body and spirit also impacted how healing was viewed. In ancient times there

was no division between body, mind and spirit. Thus, healing was focused on all these domains as one.

Historically, spirituality was an integral part of the mission and practice of healthcare institutions and providers. The medical model of practice in healing prior to the 1900's was service-oriented compassionate care. Medical care was primarily supportive and palliative, with limited options for curing disease. Healers utilized a holistic approach of physical, psychological, social, and spiritual care.

The first hospitals in the United States were started by religious and service organizations whose service and calling were manifest in a focus of care on the whole person. Men and women choose careers in the health professions out of a calling to care for others, a desire to

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serve, and a commitment to make a difference in the well being of their patients (C. Puchalski & Lunsford, 2008). In the 1900's, with the development of science and technology, a biomedical model developed that focused on "cure" as the leading practice in the view of the western world. There was a shift away from spirituality with a resultant separation of body and spirit and a focus on the more physical body as the target of healing practices. The philosophy of present medicine began with Rene Descartes, in the 17th century, who alleged that the world operated according to mechanical laws without mention to meaning and purpose. As a result of this, discussion of spirituality and religion has long been considered inappropriate in the study and practice of medicine (C. M. Puchalski, 2001). In the early 1900's the Flexner report noted that there was no place for religion in medicine; that medicine was strictly a scientific field, not a theological or philosophical one. The Flexner Report, written by Abraham Flexner and published by the Carnegie Foundation in 1910, was a study of medical education in the United States and Canada. The Report called on American medical schools to use higher admission and graduation standards, and to adhere strictly to the protocols of mainstream science in their teaching and research (Flexner, 1910). This report reinforced the separation of body and spirit, focusing on scientific evidence of physical health, disease and treatment. Suffering was largely looked upon as physical pain.

In the late 1900's there was resurgence in the interest in spirituality and holistic care with the advent of the religious healing practices, as well as mind-body and integrative practices. In the mid to the latter 1900's there were several lay movements that started emphasized the importance of religion, spirituality and medicine. Lay religious movements found spiritual practices and beliefs to be important in how people cope with suffering and find inner healing even in the midst of incurable illness. The rise of Complementary and Alternative Medicine as well as the Hospice movements also influenced attention on the spiritual aspect of medicine. The Hospice movement, founded by Dr. Cecily Saunders, described the concept of "total pain"--- i.e. the biopsychosocial and spiritual aspects of pain and suffering (Puchalski et al., 2009).

Definitions

In addressing the area of spirituality and health, it is important to note that one of the difficulties with studies and discussion in this area is the lack of a uniform definition. Are religion and spirituality synonymous? Does spirituality only refer to transcendence? Can an atheist be spiritual? The challenge in defining spirituality is that any definition does not give justice to the full complexity of the human spirit and of the transcendent, however people understand that. Consequently, it becomes difficult to study spirituality and to find reductionist methods for integrating spirituality into healthcare and for studying it. In two consensus conferences, one in 1999 and one in 2009, definitions were developed for the purposes of having a common unified definition for study and clinical

work. In the first conference sponsored by the Association of American Medical Colleges, academic educators in medicine and clinicians developed a definition suitable for clinical care. The focus of this definition was on spirituality as the way people understand meaning and purpose in their life and that this understanding can be expressed in many ways, religious as well as non-religious. This definition also related spirituality to the way patients and clinicians understand health and illness and how they relate to one another in the clinical context. This definition is:

"Spirituality is recognized as a factor that contributes to health in many persons. The concept of spirituality is found in all cultures and societies. It is expressed in an individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All of these factors can influence how patients and health care professionals perceive health and illness and how they interact with one another" (Association of American Medical Colleges, 1999).

In 2009, over forty US leaders in palliative care, as well as spirituality and theology convened to develop models and guidelines for interprofessional spiritual care (Puchalski et al., 2009). In this conference, the definition developed is:

"Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred."

Again, meaning and purpose was considered an important element of spirituality but also how people experience their connectedness to others, to nature, the moment or how they define the significant or sacred. What both definitions emphasize is the necessity of an inclusive definition--- that all people are spiritual and the expression and understanding of that is broad.

Research in Spirituality and Health

Since the 1960's there has been increased research done in the area of religion and health and spirituality and health. Most of the studies are association studies which demonstrate an association of religious or spiritual beliefs and practices and some healthcare outcomes. In addition, there have been numerous theoretical papers written on the importance of spirituality in understanding and coping with suffering. Spirituality is often a central issue for patients at the end of life or those dealing with chronic illness (King & Bushwick, 1994, Ehman et al., 1999; Astrow et al, 2001; Puchalski et al., 2004). Every individual has to make a decision as to whether one's life has meaning and value that extends beyond self, life and death. Dealing with these existential questions focuses on a relationship with a transcendent being or concept (Sulmasy, 1999). Numerous surveys have indicated that people turn to spiritual and/or religious beliefs in times of stress and difficulty. Particularly when people are faced with a life-defining illness, such as cancer and AIDS, questions about meaning and purpose in the midst of

suffering arise. It is not uncommon for people to question God, fairness, and life choices. People often undergo a life review where issues related to their life, relationships and self-worth might arise. Spiritual issues that people face include hopelessness, despair, guilt, shame, anger and abandonment by God or others.

Spiritual and religious beliefs have been shown to have an impact on how people cope with serious illness and life stresses. Spiritual practices can foster coping resources (Halstead & Fernsler, 1994; Baider et al., 1999; Roberts et al., 1997; Koenig et al., 2001), promote health-related behavior (Koenig et al., 2001; Powell et al., 2003), enhance a sense of well being and improve quality of life (Cohen et al., 1996), provide social support (Levin et al., 1997; Burgener, 1999; Koenig et al., 2001) and generate feelings of love and forgiveness (Worthington, 2001; Puchalski, 2002). Spiritual beliefs can also impact healthcare decision-making (Roberts et al., 1997; Silvestri et al., 2003). Finally, a recent study demonstrated that patients with advanced illness who have spiritual care have better quality of life, increased utilization of hospice and less aggressive care at the end of life (Phelps et al., 2009).

Spiritual/religious beliefs however can also be harmful (Pargament, 2007). Pargament and colleagues (Pargament, 2007) have studied both positive and negative coping, and have found that religious experiences and practices, such as seeking God's help or having a vision of God, extends the individual's coping resources and is associated with improvement in health care outcomes. Patients showed less psychological distress if they sought control through a partnership with God or a higher power in a problem-solving way, if they asked God's forgiveness or were able to forgive others, if they reported finding strength and comfort from their spiritual beliefs, and if they found support in a spiritual community. Patients had more depression, poorer quality of life and callousness towards others if they saw the crisis as a punishment from God, if they had excessive guilt, or if they had an absolute belief in prayer and cure and an inability to resolve their anger if cure did not occur. Pargament, et. al. has also noted that sometimes patients refuse medical treatment based on religious beliefs.

There are many stories and anecdotal evidence that some patients are able to understand their illness as an opportunity for growth and for seeing their life and their relationships in a new way which enables them to find a meaning in their life that is more profound and gratifying than what it was prior to their illness (Puchalski, 2006). Tsevat and his colleagues found from doing focus groups with patients with HIV/AIDS that many found their lives were better than before their diagnosis (Tsevat et al., 1999). The same authors also found in a previous, small study, that most patients with HIV/AIDS were at peace with God and the universe. Finally, in a recent study we have shown that spirituality and non-organized religious activity were associated with HIV/AIDS patients saying their lives were better after their diagnosis than before their diagnosis (Tsevat, 2006). These results raise the question of whether attention to spiritual and/or religious issues might be beneficial to patients with HIV/AIDS as well as others with chronic illness.

More recently, studies on meditation have demonstrated significant improvement in health care outcomes and suggest meditation as a therapeutic modality. The mind has tremendous potential to impact how a person perceives life, stress, illness, dying and the world around. There are a number of studies on meditation, as well as other spiritual and religious practices that demonstrate a positive physical response, especially in relation to levels of stress hormones and modulation of the stress response (Benson & Stuart, 1993). The data demonstrates an association between meditation and some spiritual or religious practices and certain physiological processes, including cardiovascular, neuroendocrine, and immune function. These studies show a significant role for mind body interventions in stress management but also as an adjunct to treatment of chronic illness as well as end of life symptoms. For example, pain and dyspnea may effectively be managed by meditation or the relaxation response.

Spiritual beliefs and mindfulness help people tap into their own inherent abilities to heal and cope, find meaning and purpose, hope, and do well with whatever life offers them. By focusing only on the physical aspects of care, healthcare professionals, and as a result, the systems in which they operate, often neglect the very areas that research is now beginning to find critical to care. Such approaches allow for the recognition of people's ability to transcend suffering and offer opportunities for healthcare professionals to treat the whole person—body and mind. It has been generally accepted that spiritual practices such as prayer, meditation, yoga, tai chi, and many others counteract chronic stress effects on the body rebalance autonomic nervous system and HPA axis (Schneider et al, 2004; Puchalski et al., 2006).

While the data on meditation and other mind body intervention are beginning to show a biological effect, we still do not have a biological evidence base for mechanisms of spiritual beliefs and practices. How is it that prayer helps patients heal, or belief in the sacred of significant results in increased coping? There is considerable controversy over whether spirituality and religion can or even should be measured as criteria for integration into clinical care.

Ethical Obligation

Many believe that healthcare professionals have an ethical obligation to attend to all dimensions of a person's suffering, including the psychosocial as well as the spiritual and that ethical obligation is sufficient to require integration of spirituality into clinical care. In a recent ACP consensus conference on end of life, it was concluded that physicians have the obligation to address all dimensions of suffering including the spiritual, religious and existential suffering and further developed guidelines for how to communicate with patients about spiritual and religious (Lo et al., 1999). JAHCO requires that spiritual care be available to patients in hospital settings.

Physicians, nurses, and other health care professionals commit themselves to caring for patients as whole persons. That is the basis of what is currently called patient-centered

care. Illness and injury disrupt a patient's life in ways that extend beyond the physical, thus caring for whole persons must involve care of the spirit as well as the body. Physicians, nurses, and other health care professionals commit themselves, often by oath, to caring for patients as whole persons. Because illness and injury disrupt a patient's life in ways that extend beyond the body, encompassing families, communities, and a patient's religious commitments, a commitment to caring for whole persons must entail going beyond the care of the body. Human being is spiritual being. When injured or ill, human beings naturally ask transcendent questions about meaning, value, and relationship. Because health care professionals take an oath to provide compassionate holistic care, attending to the spiritual as well as the physical constitute a moral imperative. Attending to the spiritual needs of patients is justified because spirituality is intrinsic to nature of being sick and caring for the sick. This imperative is based on ethical precepts not dependent on evidence-based for improved health outcomes.

Patient-centered care enhances healing and the quality of care, as well as improves satisfaction of care (Epstein, 1999). The reason for this may be the attention to the spiritual aspects of people as well as the physical. But it also underscores the importance of the healing relationship between clinicians and patients. Building a relationship and the interaction inherent in the relationship are critical factors in spirituality in healthcare. Spirituality is seen as a basis for how healthcare professionals and patients interact (Association of American Medical Colleges, 1999). This interaction is intimate and transformational. It stems from the relational aspect of spirituality, where the physician or other healthcare professionals see the divine/sacred in their patients through the compassionate interactions with their patients. As noted by Kathe, "Our loving is a participation in the immensity of the love of the divine." This framework allows for the ultimate expression of compassion to patients, honoring their dignity as human and spiritual beings (Puchalski et al., 2009).

Medical Education

Based on this ethical mandate to attend to the whole person, there has been, over the last twenty years, an increase in the number of required courses in spirituality and medicine in US medical schools giving rise to a new field of medicine. The interest in spirituality in medicine among medical educators has been growing exponentially. Only one school had a formal course in spirituality and medicine in 1992. Now, over 100 medical schools are teaching such courses (Puchalski & Larson, 1998; Puchalski, 2006). A key element of these courses addresses listening to what is important to patients, respecting their spiritual beliefs, and being able to communicate effectively with them about these spiritual beliefs, as well about their preferences at the end of life.

In 1998, the Association of American Medical Colleges (AAMC), responding to concerns by the medical professional community that young doctors lacked these humanitarian skills, undertook a major initiative—The

Medical School Objectives Project (MSOP)—to assist medical schools in their efforts to respond to these concerns. The report notes that "Physicians must be compassionate and empathetic in caring for patients . . . they must act with integrity, honesty, respect for patients' privacy and respect for the dignity of patients as persons. In all of their interactions with patients they must seek to understand the meaning of the patients' stories in the context of the patients', and family and cultural values"(Association of American Medical Colleges, 1999). In recognition of the importance of teaching students how to respect patients' beliefs, AAMC has supported the development of courses in spirituality and medicine.

In 1999, a consensus conference with AAMC was convened to determine learning objectives and methods of teaching courses on spirituality, cultural issues, and end-of-life care. The findings of the conference were published as Report III of the MSOP. The outcome goals stated in MSOP III are that students will:

- Σ Be aware that spirituality, as well as cultural beliefs and practices, are important elements of the health and well-being of many patients

- Σ Be aware of the need to incorporate awareness of spirituality, and cultural beliefs and practices, into the care of patients in a variety of clinical contexts

- Σ Recognize that their own spirituality, and cultural beliefs and practices, might affect the ways they relate to, and provide care to, patients

- Σ Be aware of the range of end-of-life care issues and when such issues have or should become a focus for the patient, the patient's family, and members of the health care team involved in the care of the patient

- Σ Be aware of the need to respond not only to the physical needs that occur at the end of life, but also to the emotional, sociocultural, and spiritual needs that occur (Association of American Medical Colleges, 1999)

In 2009, The George Washington Institute for Spirituality and Health convened a group of medical educators to develop national competencies and standards in spirituality and health education. The report of this work will be forthcoming in 2011.

Clinical Model

In February of 2009, a national consensus conference developed spiritual care guidelines for interprofessional clinical spiritual care. These guidelines as well as the educational advances, research and ethical principles have supported the newly developing field of spirituality and health (Puchalski et al., 2009). A practical model of implementation of interprofessional spiritual care was developed by consensus. This model advocates that all clinicians address patient spirituality and integrate spirituality into the care of patients. The model is based on a generalist-specialist model, in which the board-certified chaplain is the expert in spiritual care. Thus, non-chaplain clinicians address spirituality as part of whole person care; they refer to the chaplains for treatment of spiritual distress and other spiritual issues that cannot be addressed by the clinician. This model addresses spiritual

distress as equally important to any other type of distress, physical or psychological, that the patient presents with and in fact calls on spiritual distress to be a vital sign in patient assessment.

Conclusion

Spirituality is an essential element of the care of patients, grounded in the whole person and patient-centered model of care. There are ethical mandates for including spirituality in the care of patients. There is also research that indicated the role spirituality might have in healthcare outcomes. Standards for spiritual care have been developed through medical education as well as a recent National Consensus Conference, which developed a model for implementation of interprofessional spiritual care. This work has formed the basis for the field of Spirituality and Health.

What is not yet known are the exact mechanisms of how spiritual and religious beliefs and practices affect healthcare outcomes and why spiritual care increases patient satisfaction and quality of life and affects healthcare decision making such as increased hospice use for patients with advanced cancer. While a national model of spiritual care implementation has been developed we do not have specific outcomes of spiritual care, nor data on outcomes of this model. These are areas for future research and work.

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