For these reasons, we argue that this doctrine represents a limited understanding of human reality and undermines our ability to comprehend fundamental aspects of human suffering. Medicine requires a different approach if it is to move beyond the problems of Cartesianism. At the heart of this debate is the question of meaning.

Human beings exist in a meaningful world. When we use terms such as "mind" and "mental" we are referring to some aspect of this world. But this is not something internal, locked away inside a physical body. Think of a painting by Picasso: the famous "Guernica," perhaps. How do we understand and appreciate this? The type of pigment is important, as are the brushstrokes used. So too are the colours and the shapes of the figures. But to understand what the painting means and the genius of its creator we reach beyond the canvas itself to the context in which it was created. This entails historical, political, cultural, and personal dimensions. Without engaging with its context, we could never appreciate "Guernica" as a work of genius. Its meaning does not reside in the pigment or the canvas but in the relation between these and the world in which it was created and now exists. Similarly, we will never be able to understand the various elements of our mental life such as thoughts, beliefs, feelings, and values if we think of them as located inside the brain. Trying to grasp the meaningful reality of sadness, alienation, obsession, fear, and madness by looking at scans or analysing biochemistry is like trying to understand a painting by looking at the canvas without reference to its wider world. The philosopher Wittgenstein and his modern followers argue that "mind" is not inside but "out there" in the middle of a social world.[5] We agree.

We also agree with philosophers from the European continent who have warned against treating human experience as just another thing in the world. People who are influenced by Heidegger understand human reality as being in the world in a way that is fundamentally different from the way other things are in the world.[6] We bring meaning to the world that we inhabit: we construct our world as we live in it. Humans have a certain way of hearing, seeing, and smelling the world, a certain way of experiencing space and time. We bring colour and sound to it. It is difficult for us to imagine what sort of world "opens up" to a fruit fly, a fish, or a bat. We are simply not "in" a world that is separate from ourselves. Rather, we allow a world to be by our very presence and through our physical bodies. But these also depend on the sociocultural context in which this opening occurs. Heidegger used the composite term "being-in-the-world" and argued that human reality is not a "thing" at all but is better understood as a "clearing," a site in which a meaningful world is revealed. One of us has recently used this framework to explore the question of trauma and its sequelae.[7]

Conceptualising our mental life as some sort of enclosed world residing inside the skull does not do justice to the lived reality of human experience. It systematically neglects the importance of social context.[8] Signs are encouraging that psychiatrists are becoming interested in philosophy.[9] But the rest of medicine also needs to get beyond the legacy of Descartes. For this, medicine will require a deeper relation with philosophy.

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Spirituality and clinical care

Spiritual values and skills are increasingly recognised as necessary aspects of clinical care

Medicine, once fully bound up with religion, retains a sacred dimension for many. Differing religious beliefs and practices can be divisive. Spirituality, however, links the deeply personal with the universal and is essentially unifying. Without boundaries, it is difficult to define, but its impact can be measured.[1] This is important because, although attendance in churches is low and falling,[w1] people increasingly (76% in 2000) admit to spiritual and religious experiences.[2]

The World Health Organization reports: "Until recently the health professions have largely followed a medical model, which seeks to treat patients by focusing on medicines and surgery, and gives less importance to beliefs and to faith—in healing, in the physician and in the doctor-patient relationship. This reductionist or mechanistic view of patients is no longer satisfactory. Patients and physicians have begun to realise the value of elements such as faith, hope, and compassion in the healing process."[w2] In one study, 93% of patients with cancer said that religion helped sustain their hopes.[3] Such high figures deserve our attention.

A signal publication offers a critical, systematic, and comprehensive analysis of empirical research, examining relations between religion or spirituality and many

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physical and mental health conditions, covering more than 1200 studies and 400 reviews.[4] A 60-80% relation between better health and religion or spirituality is found in both correlational and longitudinal studies covering heart disease, hypertension, cerebrovascular disease, immunological dysfunction, cancer, mortality, pain and disability, and health behaviours and correlates such as taking exercise, smoking, substance misuse, burnout, and family and marital breakdown. Psychiatric topics covered include psychoses, depression, anxiety, suicide, and personality problems. The benefits are threefold: aiding prevention, speeding recovery, and fostering equanimity in the face of ill health.

Especially interesting are the excellent results obtained in intractable conditions through teaching people coping methods based on meditation.[5 w3] Qualitative research complements empirical studies, and "new paradigm" methods provide helpful detail about spirituality in clinical practice.[6 7] Examples include questionnaires,[8 w4] interviews, focus group studies,[9] and narrative based enquiries.[w5]

It is instructive to distinguish cure of symptoms from healing of people.[6 7] The words "heal" and "whole" have common roots. Healing entails restoration of psychobiological integrity, with the implication of personal growth and a sense of renewal.

Spiritual values and skills are increasingly recognised as necessary aspects of clinical care, to be more openly discussed[w6] and taught.[w7] A textbook of nursing, for example, states: "In every human being there seems to be a spiritual dimension, a quality that goes beyond religious affiliation, that strives for inspiration, reverence, awe, meaning, and purpose even in those who do not believe in God. The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite, and comes essentially into focus in times of emotional stress, physical illness, loss, bereavement, and death."[10] Mental illness should be added to this list.

Guidance is available for doctors to assess spiritual needs and provide for healing even when they are unable to cure.[7 w8] It may be especially cost effective if the hypothesis that to provide spiritual care affords reciprocal benefit proves true. If patients and their professional carers both gain, lower levels of conditions such as substance misuse and burnout can be forecast, with improvements in staff morale and hence recruitment and retention. Greasley et al's cohort, however, observed that spiritual needs are not a priority for medical staff, relative to more tangible issues.[9] This is important because, for Nathan's patients, spiritual care is an area perceived as necessarily involving all care providers.[11]

With much new research showing that prognosis is radically improved by spiritual care,[4] what are the hindrances to implementing it? Haines and Donald describe some general problems about getting evidence into practice.[12 w9] McSherry gives more details where spirituality is concerned.[8] The problem areas are interrelated: education (lack of training, resulting in lack of knowledge or insight or confidence) and economics (lack of staff or time or resources), environment (lack of space or privacy), and personal obstacles (sensitivity or own belief systems).[8] These need addressing under the two headings of clinical governance and continuing personal and professional development and can be remedied if given priority.

Compare spirituality with nutrition; neither is a subject that healthcare providers can take for granted. Inadequate nutrition is costly. If people are not fed properly, resistance weakens and wounds do not heal. Evidence is growing in volume and quality that this holds for spiritual sustenance too.[4]

The way forward is to give rein to natural inquiry, to rediscover and communicate openly about this vital area, and to foster the rhetoric of spirituality.[w6] Our managers, multidisciplinary colleagues, and—especially—our relatively few chaplains[w10] are natural coalition partners with whom to engage in this endeavour, together with our patients and their families.

According to Nathan, spiritual care promotes the healthy grieving of loss and the maximising of personal potential.[11] It provides a sense of meaning, resulting in renewed hope and peace of mind, enabling people to accept and live with otherwise insoluble problems. Physical and mental illnesses therefore provide all concerned with particular opportunities for healing, personal development, and spiritual growth. Improved outcomes naturally follow.

Many see religion and medicine as peripheral to each other, yet spirituality and clinical care belong together. The time is thus ripening for doctors to recall, reinterpret, and reclaim our profession's sacred dimension.

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