Spirituality in medicine: what is to be done?

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'Nothing in life is more wonderful than faith—the one great moving force which we can neither weigh in the balance nor test in the crucible . . . Faith has always been an essential factor in the practice of medicine . . . Not a psychologist but an ordinary clinical physician concerned in making strong the weak in mind and body, the whole subject is of intense interest to me.'

William Osler[1]

WHAT IS SPIRITUALITY?

Spirituality is a concept globally acknowledged[2]. However, attempts to reach a consensus regarding its nature have met with noble failure[3]. Recourse to the *Oxford English Dictionary* reveals that spirituality is the 'quality or condition of being spiritual', and spiritual 'pertaining to . . . the spirit': spirit, in turn, is the 'vital principle in man', one's 'essential character, nature or qualities', 'a special attitude or bent of mind characterizing men'[4]. Therefore, in discussing spirituality, one is really discussing the ways in which people fulfil what they hold to be the purpose of their lives.

With this in mind, it becomes possible to see why so many different definitions of spirituality have been proposed. People's views of the purpose of their existence are influenced by their genes, at least insofar as their genes control their temperament, and by their environment: environmental influences will include the family and the wider society, and the religious and other values to be found therein. Many people say that, in addition, each human being has a non-material essence; this is a central teaching of all the major religions. However, each essence will be different in nature, as will each creation of heredity and environment: it is therefore evident that there are as many spiritualities as there are human beings.

Can any common trends be identified? Human beings can be regarded as having two realms of existence, which may conveniently be labelled *inner* and *outer*. The outer realm consists of a human being's interaction with the world; the inner realm is his or her interaction with the transcendental, whether this be a divine being or ideals hinted at through such experiences as beauty, awe and love.

Here, in practice, the ideas converge. Most people hold that correct action in the outer realm consists of justice and magnanimity, and that the inner realm can be dwelt in only through sincerity. These principles may arise from different contexts—for example, in the monotheistic faiths one acts justly to know God, whereas in Buddhism one acts justly to be released from suffering[5]—but people with various different beliefs have spiritualities that are fundamentally similar.

PATIENTS AND THEIR SPIRITUAL NEEDS

In answering the question of how medicine can help people to fulfil their spiritual needs, the first principle is to acknowledge the importance of the question. In their interactions with doctors, patients do not cease to be human beings with deep and wide-ranging needs. Indeed, in times of illness, questions of life and death may loom all the more strongly in a patient's consciousness. This is particularly true in obstetrics and gynaecology, which deals with bringing people into the world and with terminating pregnancies; in palliative care and intensive care, which are largely concerned with people's exits from the world; and in psychiatry, which seeks to help people who are no longer relating to the world in a way that is perceived as functional. In primary care, too, a doctor must be aware of the patient's spirituality, since the patient's perceived needs will often be very different from the presenting problem. Indeed, recognizing a patient's spiritual concerns may be viewed as an essential part of the 'patient-centred' medicine increasingly seen as crucial to high-quality patient care[6].

The second principle is to acknowledge the wide variety of ways in which people seek to fulfil the purpose of their lives. In Britain, there has historically been a dichotomy between an inner realm, in which faith may or may not be an important influence, and an outer realm which has been heavily secularized, with utilitarianism a major influence. However, this dichotomy does not reflect the needs and aspirations of all patients, especially in a multicultural and multifaith society. For some British Christians, spirituality, and therefore faith, must fully embrace the outer realm if it is to have integrity[7]. For Jews, spirituality is far from other-worldly, and orthodox Jews wish to live their lives in the

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outer world to accord with the laws of their faith[8]. The same can be said of followers of other faiths. In a hospital environment, this may consist of having an appropriate diet; of not having to be on a mixed-sex ward; of having prayer facilities; of being kept physically clean; of having a chaplain of an appropriate faith. But it can also affect the entire nature of hospital care. For instance, for a Muslim, it can be important to die with loved ones present, in a heightened state of awareness of God[9]; and dealing with illness may well be not only a matter of returning to physical or mental health, but of journeying towards enlightenment[10].

It is also important for the doctor to be non-judgmental. No matter how surprising someone's spiritual needs may be, they should be respected both for their intention and for the fact that they are borne by a fellow human being.

SPIRITUALITY AND DIFFERENT MEDICAL TRADITIONS

The above principles having been acknowledged, how can medicine allow people to fulfil their spiritual needs? Different schools of medicine have taken different approaches. Some have viewed medicine as an aspect of a wider spiritual picture. For example, the Sufi healers of Africa and Asia (now also found in the UK) are primarily mystics: they regard their medical work as a process assisting them and their patients on their spiritual journeys[11]. The same can be said of many faith healers working in North America and Europe—although, unlike the Sufis, these healers do not necessarily have to undergo rigorous systematic training. (Note that healing with spirits should not be confused with spiritual healing: some practitioners who claim to be in communication with non-visible beings may have little concern for their patient's spiritual welfare. Similarly, the term spiritual healing is often used to describe healers who have a sense of the paranormal, and treat on an emotional level, but cannot be said to operate within a primarily spiritual framework.)

Other medical traditions are considered to have spiritual origins but are not necessarily practised within that spiritual context. For example, the conceptual basis of Chinese medicine practised under Maoism lies in Taoism[12]. Ayurvedic medicine is traditionally said to have originated in the Vedas, Hindu holy texts[13].

Finally, there are schools of medicine in which a patient's spiritual needs are taken into account but spirituality is central to neither the origin nor the practice of the medicine. Biomedicine, with its mechanical view of the body as espoused by Descartes[14]—although, pragmatically enough, only taken up when physiology made it possible to analyse the body mechanically[15]—is one of these schools. In analysing how to accommodate patients' spiritual needs, it is our starting point.

ADDRESSING PATIENTS' SPIRITUAL NEEDS

Patients' spiritual needs can be addressed at the levels of academia, training and practice. In academia, relatively little attention has been paid to spirituality: a search of the Medline 1966 database, in February 2000, with the search terms *spirit**, *religio**, *faith** and *pray** yielded 19 301 out of 10 074 921 articles—less than 0.2%. Further examination of the first 200 abstracts revealed that only 68 dealt with spiritual issues (very generously defined). Given that spiritual considerations are absent from few consultations, this absence of overt recognition is remarkable.

As regards training, a perusal of the standard general medical textbooks reveals that spirituality is not considered central to medicine. Except in texts on palliative care[16] and in ethics courses and seminars, spirituality is not directly considered in medical teaching, even though spiritual considerations will be present whenever patients' rights and needs are discussed. Clinical practice varies appreciably between departments and between individual doctors, but it seems that most doctors do not regard spiritual issues as very important in their practice.

If this medical perception is wrong and patients' spiritual needs are of prime importance, how can medicine better address them? Doctors cannot claim special wisdom or insight into the human condition. All that can reasonably be expected is that they will recognize the likely spiritual needs of patients and develop ways to handle them sympathetically.

An awareness of spiritual needs is best achieved through education. Ethics courses should include not just discussions of situations which are contentious, such as consent in psychiatry or termination of pregnancy, but coverage of different spiritual perspectives and discussions regarding the needs and perspectives of doctors-to-be as well as of their patients. Doctors should be required to learn about the ways in which religion and culture can influence a patient's needs. In some fields, particularly psychiatry, they will have to think deeply about what they wish to achieve. A physician discussing termination of pregnancy successively with a married Hindu woman and a single Muslim girl, both Bengali-speaking Indians, will require insight into the patients' positions within very different worlds[17]. Perhaps the most sensitive scenario to handle is death: when doctors have learnt to allow people to die with dignity and spiritual awareness, they will be better equipped to help them in life.

Academically, investigations should be undertaken into the most effective and efficient ways to meet patients' needs. For hospitals there should be no great difficulty in providing appropriate diets and prayer facilities, in forming links with members of minority faiths who can act as chaplains or spiritual advisers, and in using translators who are able to convey a sense of context as well as a sense of

meaning. Facilities such as single-sex wards and prompt cleaning may sometimes be unattainable, but an awareness of the felt absence of a facility will be found to be valuable. Liaison with recognized heads of minority communities can be more complex, since to link with the right people under appropriate circumstances will require an understanding of the dynamics within and between communities; this does not mean that we should expect any less.

GAINING FROM OTHER MEDICAL TRADITIONS

Clearly, biomedicine could do better in catering for patients' spiritual needs; however, can it learn from more overtly spiritual medical traditions? The swift answer is yes: doctors are human beings, and sympathy and insight, which are crucial to such mundane affairs as history-taking and prescription concordance, may be learnt from other human beings, even healers from different traditions. Boundaries between medical traditions are far from immutable, and traditions have inspired and informed each other throughout history. In the Hippocratic corpus, where rationalistic medicine is said to have originated, prayer is advocated as a treatment for physical illness[18]; and Roger Bacon, widely regarded as the founder of the scientific method, stated that he had learnt it from Sufi alchemists[19]. Therapies originating in other medical traditions may be of use to a biomedical practitioner. Many a drug was first discovered in a herbalist's pharmacopoeia[20]. There is evidence from meta-analyses that acupuncture may be of value in postoperative nausea and vomiting[21], and that Chinese herbal treatment promotes recovery from malaria[22]; high-quality randomized controlled trials (RCTs) also point to benefits from Chinese herbal remedies in the treatment of irritable bowel syndrome[23] and impaired cognitive function[24]. Many more benefits may yet be uncovered, since biomedicine is only just beginning to explore other traditions systematically.

However, numerous pitfalls lie in wait for the doctor wishing to assess therapies from different traditions. A therapy may originate from an environment where the definitions of disease, health and treatment are different. Also, the categorization of therapies may be problematic: for example, as noted above, the term spiritual healing is used to describe a wide variety of treatments, not all of which are primarily spiritual. The term distant healing has been applied to many spiritual techniques, on the grounds that the healing process is held to be unencumbered by considerations of space or time: but practitioners of distant healing may consider themselves to be donating psychic energy, or utilizing a connection between healer and patient akin to the non-local interactions between subatomic particles in quantum physics[25,26].

RCTs of therapies from traditions other than biomedicine have often been on a small scale, and many have not been double-blinded. Much of the research is not readily accessible. It is also possible that negative trials will not be reported, for example in the Chinese literature[27], although publication bias also occurs with trials of biomedical therapies.

The limits of RCTs must also be acknowledged. For example, as noted in a recent review[28], a majority of investigators have found positive results with 'therapeutic touch', a form of healing in which the practitioner first focuses on the patient in a process known as centring, then assesses and 'unruffles' the patient's energy field[29]. However, most of the double-blind trials have found no therapeutic effect: in addition, these findings must be viewed in the light of a study by Rosa *et al.*, in which therapeutic-touch practitioners failed signally to detect human energy fields from behind a screen[30].

On the other hand, we should recognize that therapies may work in the apparent absence of a rationale grounded in modern science: for example, the *Yellow Emperor's Classic of Internal Medicine* (attributed to Huang Di, *c* 2600 BC, although it may have been written as late as 300–100 BC) offers advice on lifestyle and diet that many of today's physicians would wholeheartedly endorse[31]. It owes little to modern physiology.

Some therapies may be unsuitable for assessment by controlled trial. Intercessory prayer has been subjected to several RCTs: two well-designed large-scale trials found that prayer was associated with reduced mortality among coronary care patients[32,33]. However, for those who believe in God, the premise that an omnipotent, unfathomable deity produces predictable results may seem unsupportable; the prayers of the well-wishers of the patients in the control arms of the trials also seem to have been overlooked. Those who do not believe in God may have to consider the possibility that prayer to a non-existent deity may be a valuable therapeutic modality; they too may find RCTs of prayer to be inappropriate. Similarly, it is possible that a consciously spiritual outlook may be associated with good physical health, even if only because those following spiritual paths are likely to forego recreational drugs and sexual promiscuity: but any trial of the health impact of spiritual commitment would be philosophically and practically unfeasible.

RCTs are far from an ideal method for evaluating primarily spiritual therapies. Such therapies tend to envisage a unique and variable interaction between patient and healer, or patient and deity. Standardization of therapies is not necessarily the norm, and different healers are expected to achieve different results with different patients. In addition, for those using such therapies, improvement in pathological terms may not be as important as a subjective

improvement in health; indeed, physical health may be of secondary importance to happiness or inner peace, and the therapy may be viewed as simply a part of the patient's spiritual journey.

Doctors may therefore be sympathetic when their patients consult spiritual healers, particularly where patients perceive their needs as going beyond clinical endpoints[34]. This is especially likely to be the case with members of certain religious and cultural minorities, for whom it is the norm to approach spiritual healers under certain circumstances[35]. However, it is important for any doctor considering liaising with spiritual healers to gain some understanding of how to identify those who are all that they claim to be, within their sociocultural milieu.

FUTURE DIRECTIONS IN BIOMEDICINE

In addition to adopting, learning from and recognizing therapies from other medical traditions, doctors may find it beneficial to adapt existing therapies to patients' spiritual perspectives. For example, cognitive therapies may be more effective if they take a patient's religious beliefs into account[36]. Patient-centred approaches as a whole help to maintain the patient's dignity and to ensure that the interventions offered are appropriate: positive outcomes include increased compliance with medication and greater patient satisfaction[37]. In addition, respect for a patient's spiritual needs can be expected to improve the doctor–patient relationship, with consequent benefits for diagnosis and management[38]. Much of the healing process is due not to drugs or surgery *per se* but to the placebo effect[39], and this will be enhanced when the patient has trust in the doctor's methods and beliefs. A doctor's understanding and consideration of a patient's spirituality is therefore likely to increase the placebo effect; indeed, such relationships may account for the survival of medical practice in past centuries when few remedies were more effective than placebo[39].

The opportunity to maximize the placebo effect is noted at a time when commentators such as Le Fanu are recording a growing sense of the limitations of biomedicine[40]. There are complaints that most clinical trials are methodologically flawed[41], that benefits in trials do not necessarily translate into benefits on the wards[42] and that, while biomedicine has performed brilliantly in fields such as bacterial infection and surgical emergency, it has done poorly at handling chronic illness[43].

It is curious that such doubts should surface at a time when evidence-based medicine is considerably enhancing the rigour with which treatments are devised and selected; paradigm shifts are, as Kuhn notes, affected by wide social and cultural trends[44]. However, it may be that a direct approach to questions of spirituality will not only improve patient care and doctor–patient relationships but will come to be seen as the salvation of biomedicine.

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