The Witches' Brew of Spirituality and Medicine

Raymond J. Lawrence, D.Min.
New York-Presbyterian Hospital
Columbia Presbyterian Center

ABSTRACT

Recent proposals to join spirituality and medicine are facile and ill defined. The notion that physicians have the time or training to make assessments and recommendations about spirituality is misguided. Whenever a physician demonstrates personal caring for a patient, the healing process is likely enhanced, and in that sense, physicians often promote the spirituality of the patient. However, recent proposals to extend the physician's task to that of assessing religion and directing the patient toward approved forms of spirituality are inappropriate. The languages of religion and science are radically different. The cultural body–mind split will not be solved by such simplistic solutions as having physicians endorse spirituality, which will result only in denigration of both medicine and religion. Physicians are encouraged to rely on clinically trained ministers for assistance in understanding the patient's state of mind or spirit and its possible effects on the course of illness and health.

(**Ann Behav Med** 2002, *24*(1):74–76)

The recent widespread and frenzied promotion of a marriage of spirituality and medicine is a juggernaut that needs a more critical analysis than one finds today in the literature. The facile manner in which even the most prestigious medical centers—Harvard and Duke, for example—are promoting a union of spirituality and medicine is simply astonishing.

Rather suddenly, in less than a decade, spirituality has become something of the darling of the medical world, and physicians, strangely enough, seem to be doing most of the talking. They are encouraging their fellow physicians to incorporate spirituality in their clinical practices, arguing that this will enhance their compassion and further a treatment of the patient as a whole person. They argue that spirituality benefits patients in terms of better health and longevity as well. They encourage physicians to endorse religious and spiritual practices for patients. They advocate that physicians take spiritual histories of their patients and update them annually, and they encourage physicians to pray with patients (1,2).

The first, tangential problem, and an intractable one, is that of definition. The task of grasping precisely what any one individual means by spirituality is a daunting one. Spirituality as a concept is pulled in two quite different directions. For some, it connotes the inner life force or vitality, in which case any living being can be said to possess some kind of spirituality. For others, spirituality connotes a connection with an imagined or real power source outside of the natural world. In their treatment of patients, physicians would do well to keep an arm's length from spirituality in both senses of the word (3).

Hardly anyone would dispute the contention that spirituality, problematic though the concept's definition is, probably has some bearing on health. Certainly a rare person would contend that the state of one's mind (or spirit or soul) has no effect on one's physical health. The simple matter of the will to live undoubtedly bears on one's physical health. However, the claim that physicians should involve themselves in their patients' spirituality is wrong-headed on several counts.

First, such an assignment would mean a stunning inflation of the physician's job description, and second, the notion that physicians are competent to assess their patients' religious and spiritual condition trivializes all forms of religion and spirituality (4,5).

The proposal that overworked physicians should expand their task into the arena of spiritual histories, updating them annually, is supremely unrealistic. The universal cry of physicians in this country at present concerns the negative impact of the clock on their patient care. This pressure put on them by managed care to cut to the chase with patients is not likely to go away anytime soon. It is pure fantasy to think that physicians will undertake the major new time-consuming task of examining patients' spirituality with no way to bill for the time involved. If they do undertake this task, what important aspects of clinical practice will they exclude to make time for it?

Furthermore, no one seems to have given much thought to problems and difficulties of taking spiritual histories and where a physician would learn to hone such a skill. Some suggest that a medical school elective would suffice (6,7). Others suggest that four simple questions that require *yes* or *no* answers will glean such a history, the ultimate trivialization. Even the best ministers and chaplains among us, after years of academic and clinical training, find the taking of spiritual histories a complex one. The world of spirituality, religion, and the imagination is often impenetrable, even by the most skilled and sensitive inquirer. Not every religious professional explores that world very well. It is shaped by a variety of traditions, some quite arcane, and it is a time-consuming undertaking. People who disclose the quality of their urine stream with reluctance and deception do not readily disclose their deeply held values and beliefs, many of which are ineffable, idiosyncratic, and often transparently irra-

Reprint Address: R. J. Lawrence, D.Min., New York-Presbyterian Hospital, Columbia Presbyterian Center, 622 West 168th Street, New York, NY 10032. E-mail: lawrenr@nyp.org.

tional. A clinically trained minister, chaplain, or pastoral psychotherapist would attempt to get a spiritual history of a patient only with the luxury of considerable time to invest and a clear willingness on the part of the patient to divulge very personal information, which by tradition is considered private. Physicians do not stand a chance.

What would a physician do, for example, with the patient with metastatic lung cancer who acknowledges that her decades of heavy smoking has brought her to this predicament and who believes that she is being punished and expects to die for her sins? This is, at least in part, a religious or spiritual problem, not lending itself to a quick fix or a formulaic response. Anyone who proposes to make him- or herself available to this patient, whether chaplain, physician, social worker, or whoever, should be well informed in counseling and theology and should have the luxury of time to give. A typical physician has neither the time nor the training to offer either pastoral counseling or psychotherapy. A good many illnesses would seem similarly related to such factors as patient choices, values, history, religion, and patterns of living and, therefore, invite serious personal reflection in the context of what we call pastoral counseling.

Few would dispute the contention that physicians generally would do well to become skillful in the art of interpersonal relations, or what used to be tritely called "bedside manner." Patients typically seek in a physician something more than simply a scientist. They want to believe that the physician actually cares about them as persons. They want to feel the compassion of the professional. Without a personal bond between the two, the healing process may be jeopardized. Physicians do not have a sterling reputation generally in the arena of interpersonal relations. For better or worse, science has taken over the territory.

Physicians could be more effective if they acted like they recognize that illness and health are overdetermined. Mental attitude, religious beliefs, family relationships, and other similar factors that impinge on health do not lend themselves readily to scientific scrutiny. Physicians would do well to be open to input from such nonmedical sources that might impact health. The patient treated for an ulcerated stomach, whose wife is continuing a sexual relationship with a family friend, is likely not to recover satisfactorily if his social life remains a source of trouble to him. Although this is a random and inflammatory illustration, probably the course of most illness is shaped in part by social, mental, and religious factors. Physicians would do well to enlist the aid of clinically trained chaplains and others similarly trained to assist in that arena.

Whenever a physician demonstrates compassion or understanding in relation to a patient, it could be said that spirituality is being added to medicine. After very successful spinal surgery, my primary care physician paid me a visit in my hospital room. He sat for 30 min and listened to my saga. I was greatly elevated in spirit because of his expression of care for me. However, he was making me a special case, and he does not have hours enough in a day to give all his patients such attention. Furthermore, I was not dying or otherwise in distress, as many of his patients are. He took no spiritual history. He barely touched the tip of the iceberg as regards my total "spiritual condition," but if he finds ways similarly to hearten all his patients by communicating a genuine personal concern for them, he undoubtedly furthers their good health. It could even be said that he contributes to their spiritual well-being. However, such a modest goal, valuable though it is, is far removed from the grandiose, inflated objectives of the new spirituality and medicine advocates.

The current literature promoting the union of spirituality and medicine is neither precise nor discriminating. Many writers take great comfort in the report that 70 medical schools are now teaching courses on spirituality and medicine, but the substance of such courses is subject to critical examination. To the extent to which such courses focus on the values, commitments, and vocation of medical students or on basic training in interpersonal skills, they might enhance medical practice. However, when such courses offer instant protocols for taking patients' spiritual histories, as some suggest, they are greatly oversimplifying a subtle and complex task.

Those who wish to mix religion and medicine do not understand that the language of science and the language of religion are radically different. Religion and spirituality exist in the realm of poetry and the imagination, not the realm of science where medicine dwells. The rules of discourse are different. To mix the languages can be highly misleading and disruptive. Physicians who are scientists cannot legitimately incorporate "relationships with transcendent beings" into their discourse as if it were another source of data like some laboratory result. To do so is schizophenogenic.

The widespread claim in much of the literature is that spiritual and religious activity should be promoted by physicians as beneficial to health. Implicit in most of the recent spirituality literature, on the one hand, is the assumption that anything spiritual is beneficial (5). Hence, the frequent injunction to physicians to encourage patients who are attendees of religious worship services to continue in such activities. On the other hand, many of the new spirituality advocates have no hesitancy about rejecting certain spiritual beliefs that they consider ill advised or harmful, as for example, the belief that illness is punishment from God. They recommend steering patients away from such beliefs. We have, therefore, a revolutionary new claim abroad in the land, that physicians have the task of screening out unhealthy from healthy religious beliefs and practices. Not only is this a full-time job, but it is one that even a well-trained religious professional would find odious. Much worse, it would place physicians in the new role of arbitrating between healthy and unhealthy religious and spiritual practices, a role no physician in his or her right mind would wish to assume.

Even more bizarre and irrational is the often-heard injunction that agnostic patients not be steered toward religious and spiritual practices, presumably out of respect for their agnosticism. Thus, the agnostics will be deprived of what in the spirituality literature is viewed as the best medicine, available only to the spiritually minded. Physicians caught up in this mess of contradiction and inflated job descriptions would ultimately envy even B'rer Rabbit. (For those physicians who actually do want to engage Tar Baby, I suggest as a random introductory exercise that they assess the differential therapeutic impact of the Evan-

gelical revival meeting, the Catholic mass, the sexual rites of Tantric Hinduism, Appalachian snake handling rites, and the whirling dervishes.)

One can read in a wide array of sources these days the hapless advice that physicians pray with patients, especially if requested to do so, or at least stand in silence while the patient prays. Physicians should do neither. The response of choice should be a referral of the patient to a chaplain or to an appropriate religious authority. Prayer is by no means the simple, innocuous, and invariably benign activity that it is typically assumed to be, but it is a complex value-laden undertaking rooted deeply in the imagination and tradition of particular persons. To suggest that a physician is competent to decode what well-trained ministers often find to be difficult and impenetrable semiotics is once again to trivialize religion and spirituality.

The problematic dichotomy between body and soul in modern medicine, as in the culture at large, is serious and debilitating. However, the notion that physicians will bridge that rift by assuming the role of religious and spiritual authorities is naive in the extreme.

It may be that in some future more advanced culture than our own, one recovering from Cartesian dualism of mind and body, that physicians will combine science with the content of religion, including imagination, symbols, myth, and poetry in their treatment. In such a world, the physician would become something like a physician–priest/pastor/guru. The current spirituality and medicine movement seems to be lobbying for such a world. Such a monumental change, if it ever does occur, will not come cheaply or quickly. Scientific education will then be supplemented by significant religious education. The current advocates of the union of spirituality and medicine are trying to create a new world on the cheap, without appropriate preparation, and seemingly oblivious to the radical nature of their vision and its implications.

Stirring spirituality and religion into the practice of clinical medicine in a facile manner, as promoted in much of the current discourse, will result only in a witches' brew that will embarrass medicine and trivialize religion. The best we can hope for in the spirituality–religion and medicine arena at present is for physicians to rely more on clinically trained ministers for input into the general state of mind or soul of a patient. Sometimes patients will disclose to a minister what they will not disclose to others. Sometimes nonmedical aspects of a person's life seem to have some bearing on the state of health, a thesis that should receive almost universal acceptance. In such conversation between physician and minister, we may bring some beneficial impact on the course of some person' s health. To think that we can accomplish much more than this in the present environment is unrealistic.

REFERENCES

(1) Koenig, H: Religion, spirituality, and medicine: Application to clinical practice. *Journal of the American Medical Association.* 2000, *284:*1708.

(2) Astrow AB, Puchalski CM, Sulmasy DP: Religion, spirituality, and health care: Social, ethical, and practical considerations. *Journal of American Medicine.* 2001, *110:*283–287.

(3) Lawrence RJ: The trouble with spirituality. *Contra Mundum.* 2001, *1:*91.

(4) Sloan RP, Bagiella E, VanderCreek L, et al.: Should physicians prescribe religious activities? *New England Journal of Medicine.* 2000, *432:*1913–1916.

(5) Sloan RP, Bagiella E, Powell T: Religion, spirituality, and medicine. *Lancet.* 1999, *353:*664–667.

(6) Puchalski CM: Spirituality and health: The art of compassionate medicine. *Hospital Physician.* 2001, *Mar:*30–36.

(7) Koenig, HG: *The Healing Power of Faith: Science Explores Medicine's Last Great Frontier.* New York: Simon & Schuster, 1999, 297–298.