JAOA

Editorial

Spirituality in medicine

The body of literature dealing primarily with spirituality in medicine is increasing. A number of articles appearing in the medical literature focus specifically on various aspects of spirituality and salutary effects of, for example, intercessory prayer, meditation, and faith communities on various health outcomes. This is not surprising. Indeed, throughout history, the practice of medicine has had a relationship with spirituality. More so in the past, but in some forms presently, this relationship can be very intimate, while at other times, quite casual. Consider, for example, modern American medical practice where, for the most part, physicians pay little attention to patient spirituality. In the October issue of *JAOA,* we encounter more evidence of an increasing awareness of the relationship between medicine and spirituality.

In that issue, Spaeth[1] provides readers with a rather direct, cogent, and compelling recommendation for the incorporation of an assessment of a patient's spirituality. He builds from the premise that spirituality is an important component to a person's well-being. He cites recent evidence supporting that most Americans, at least, believe in God, pray daily, and attend some place of worship. He reminds us, however, that despite patients wishing that their physicians would share in their spiritual experience by praying with them, very few patients are actually prayed for by their physician. Moreover, Spaeth suggests that a patient-physician relationship would be much greater if physicians paid attention to spirituality in the care of patients.

Spirituality, however, is not discussed generally with patients. It is seen as taboo, and many barriers contribute to the absence of spirituality in physicians' care of patients. Physicians often feel uneasy with the subject and are frequently ill equipped because of lack of training in this area. Further, a physician's spirituality may be quite different from a patient's spirituality, creating yet another barrier. Some physicians are concerned about proselytizing. There may be confusion regarding differences between religion and spirituality. Also, there may be a perceived conflict between spirituality and medical science. All these factors are potential barriers between medicine and spirituality and contribute to a divide between these two disciplines.

Spaeth goes on to suggest that perhaps the most significant barrier to the discussion of spirituality with patients, however, is the physician's uneasiness with this topic. But, apart from physicians being uneasy discussing matters of spirituality, the fragmentation of the human person into a physical, spiritual, and emotional or psychological being has further led to reluctance of physicians to discuss spiritual matters with their patients. To remedy this reluctance, Spaeth suggests five aptitudes that physicians should have in order to meet the spiritual needs of their patients. They are to (1) be trustworthy, (2) treat the patient as a person, (3) be kind, (4) maintain hope, and (5) assist in determining what it means to live. He then goes on to describe history-taking tools that may be used by physicians to assess their patients' spirituality.

This article, among many others appearing in the medical literature, seems to urge us as physicians to pay more attention to spirituality in our practice. Admonitions regarding proselytizing and overstepping lines of privacy are well taken. We agree that physicians would do well to focus some attention on spirituality and perhaps explore such matters with the appropriate patient. Evidence would suggest that doing such might actually be to the patient's benefit; however, the investment in time and attention paid to spirituality in the context of patient care must exist as an adjunct to conventional medical practice and should not be substituted for any aspect of this care.

We must be careful. Engaging in the area of spirituality in the context of a physician-patient relationship raises a number of potential ethical issues. In making inquiry into a patient's spiritual well-being, a physician may create some confusion with respect to his or her role as a healer. The patient might appropriately wonder why a person recognized as a spiritual leader is not involved with such inquiry, or at least part of the process in exploring such matters. Patients may become uneasy entering into discussion of spirituality with their physicians, even if they initially wished to have such conversation. Physicians entering into spiritual matters so explicitly with their patients may convey to the patients that they have some special power or authority over and above physicians who do not engage in such activity, and this may not be appropriate. Patient autonomy may be compromised if a patient feels coerced in any way. Patients' ability to make certain decisions might be influenced such that their autonomy is not preserved. Also, it is conceivable that a physician who is not sufficiently trained in such spiritual matters potentially may induce some harm to the patient's spirituality.

Physicians need to be careful in entering into spiritual matters with their patients in the context of the professional-patient relationship. The boundaries, though at times difficult to define, nonetheless must be preserved. Indeed, healthcare providers, especially physicians, are privileged to share in many experiences with their patients. The opportunity to contribute and participate in the healing process is very special. Even when there appears to be no chance for physical healing, or when a physician is caring for a patient through the dying process, these experiences can be most sacred. Physicians and their patients, when they share in these special moments, enter into something that above all else is spiritual. We would do well to acknowledge this as such. ◆

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Reference

Spaeth DG. Spirituality in history taking. *JAOA* 2000;100:641-644.