The spiritual dimension: the healing force for body and mind

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Resumo

A espiritualidade é muitas vezes essencial para as pessoas que enfrentam problemas de doença crónica e de saúde débil. Trata-se de um primeiro recurso através do qual os pacientes encontram ajuda e significao para os seus padecimentos. Um largo espectro de estudos vêm mostrando que a espiritualidade pode desempenhar um papel significativo na melhoria da qualidade de vida dos pacientes afectados por problemas cardíacos, cancro, em situações de convalescença, depressão e cuidados de saúde em geral. O respeito pelas crenças individuais e os valores envolvidos é condição essencial na relação clínica, podendo revelar-se um aspecto essencial da cura.

Intoduction

Suffering is intrinsic to our human condition. We suffer in our mind; we suffer in our bodies. Helping to bring healing to both mind and body is a therapeutic endeavor that will bring healing to our being. Many people suffer from a wide variety of causes — illness, poverty, loss of loved ones, disability, and war. Eric Cassell defines suffering as a state of severe distress associated with events that threaten the intactness of personhood—the interconnected physical, social, spiritual and psychological aspects of self.[1] At the root of this suffering is a sense that "what ought to be whole is being split apart."[2] Suffering results from the perception of brokenness. People

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with serious illness, such as cancer, depression, heart disease or disability and many other chronic illnesses suffer not only physical pain but also a separation from self, from others and from God or the transcendent. Thus the individual's sense of personhood is disrupted leading to suffering. It is not until there is integration of self that a person can be healed.

In the healthcare system, physicians and other healthcare providers encounter people who suffer deeply on many levels. Illness or trauma can result in suffering in many dimensions – physical, emotional, social and spiritual. Cancer, for example, results in physical pain from the tumor(s) as well as from the therapy. People experience associated symptoms such as nausea, vomiting, constipation or diarrhea, all of which greatly disrupt one's life. People need to miss days of work due to illness. Some people need to take short or even long-term disability leading to financial stress and burden. One's social life is disrupted. Many people with cancer talk of the stress the illness puts on relationships with family and friends as well as colleagues. Fatigue from chronic illness can prevent one from doing the activities that previously gave meaning to a person's life. One of my patients who eventually died of metastatic breast cancer told me that the cancer had ravaged not only her body but also her life and her soul. She struggled daily with the severe fatigue that made lifting a cup of tea too difficult. When her daughter jumped on her lap, my patient bit her lip to avoid crying out in pain and frightening her young daughter. Her relationship with her husband was distant. He was frustrated because he could not take her pain away leading him to feel impotent in his ability to care for her. She perceived his frustration as not understanding her pain and isolation. Her own sense of worth was challenged. She had been a successful public health nurse with an active career. She published numerous academic articles. Now, in the midst of her illness she could no longer concentrate on a magazine article let alone write a paper. She once told me "I am no longer a member of society, no longer a good wife and mother—so who am I, doctor?"

Aging, while not an illness, also has its challenges. Many elderly people suffer deeply due to a number of factors. First, as people age, the likelihood of chronic illness increases. Thus, all of the above conditions exist and may even increase as the number of illnesses increase with age. Many people have multiple conditions such as diabetes, hypertension, congestive heart failure and severe arthritis. This can result in physical debilitation and the inability to continue with previous activities including work and hobbies.

There is also an increased dependence on care from others, which can affect both the senior person's sense of independence and dignity as well as result in financial strain. Medical expenses increase particularly for prescription medications, which are not covered by Medicare and some other insurance plans. One of my patients once asked me what was more important – taking their medicine or eating three meals a day. Other aging friends and family die which often leads to isolation and loneliness. Because most aging people deal with chronic illness and disability, there are fears of recurring physical or psychological pain that cause even more suffering and a sense of unrelenting hopelessness.[3] In the United States, seniors (people over 65) have the highest suicide rate of all age groups.[4] While people 65 and over comprise only 13 percent of the US population, they account for 19 percent of all suicides. The suicide rate in 1999 was 10.3 per 100,000 while among the aged it was 15.9 per 100,000 (almost 50 percent above the national average). This fact has received little publicity, which may reflect the US society's obsession with youth and its fear of aging and death. But because of the denial of the predicament of our elderly, and the lack of adequate support programs for the elderly, there is increased suffering and distress that aging people face and unfortunately face in isolation.

1. Technological Advances

While suffering has existed throughout all the ages of human existence it may be more prevalent due to illness, since the last century. The technological advances of the last century have help find more effective treatments for disease even offering cure for many conditions that were previously fatal. These advances also led to an increased life expectancy. People did not live as long as they do now. At the turn of the century, an average American's life expectancy was 50 years. Now, 73% of deaths are among people at least 65 years old and 24% of deaths are among those at least 85 years old. The causes of deaths in 1900 were influenza, tuberculosis, diphtheria, heart disease, cancer and stroke. Today, heart disease is the number one cause of death, followed by cancer and stroke.[5] Infection usually was not treatable in the early 1900's and people frequently died quickly from these causes. The time frame of dying from heart disease, cancer and stroke is much longer. In effect, modern medicine has increased

the period of time over which a chronically ill patient dies. The end of life can now last several years. So people face the challenges, pain and suffering of chronic illness over longer periods of time in their lives.

While these technological advances have benefited people in many ways, they have failed to eliminate suffering. People still face tremendous pain and suffering in their lives and some face even more because of the challenges of chronic illness. And unfortunately, while the medical system in the United States is advanced technologically, it is devoid of compassion. Consequently, while people are given the opportunity to live longer with chronic illness they are not given the support to address their spiritual suffering. The scientific and technological advances have shaped the medical system in the western world. While this is very positive in some ways, it has tended to focus care on the technological and curative aspects, diminishing the importance of the humanitarian and compassionate aspects of care. As Doka wrote, "Efforts to humanize patient care are essential if the integrity of the human being is not to be obscured by the system."[6] Thus many people, while having their physical pain attended to, fail to have their spiritual distress and suffering addressed.

2. Spiritual Suffering

As mentioned above illness can result in physical, emotional, and social suffering. It can also give rise to a less evident but perhaps more intense suffering—spiritual suffering. Many physicians use the words pain and suffering interchangeably, even when referring only to physical pain. But physical and spiritual suffering are not the same.[7] Most suffering in chronic illness and in dying is not related to the physical pain but to one's inability to answer some of the most fundamental questions of being:

- Who am I?
- What gives value to my life?
- What gives me meaning and purpose?
- What is my worth in this world today?
- What is my ultimate destiny?
- What is my relationship to others and to God/the transcendent?

These are existential questions which, if left unanswered can cause distress and a sense of unconnected to self, God and others. This disconnectedness then leads to the sense of fragmentation and brokenness. Suffering is not a condition that can be cured by modern medicine. It is the state of being characterized by shattered dreams, destroyed meaning, and lost hope. Any assumptions one had about the world and about one self can be obliterated.

My patients who face the diagnosis of a serious illness or the real prospect of dying want answers to major questions about life.

- Why is this happening to me?
- Will I have time to finish my life's work and achieve my goals?
- Will I see my children grow up?
- Is God there for me? Why is he letting me suffer?
- Will I be remembered when I die?

There are no answers for questions such as these. Patients grapple with these questions daily. Western medicine trains physicians to diagnose, treat and provide answers. For treatment of the disease there may be answers; for the existential questions that arise for our patients, there are none. On teaching rounds when my patients ask the "Why is this happening to me" question of my students or residents, most young physicians either freeze in discomfort or attempt to answer in a biological way – you have a genetic predisposition to breast cancer which is why this is happening. But this question is not about answers. It is a plea for an opportunity to be heard about the deep pain and suffering that the patient is experiencing. Our model of western medicine is based in a "fix-it" model. In this model there is no room for uncertainty. Yet, spiritual suffering is all about uncertainty. Acceptance of the uncertainty or the mystery is what may lead to healing.

3. Mystery

Life presents us with mystery all the time. Rabbi Lawrence Kushner writes, "The first mystery is simply that there is a mystery. A mystery that can never be explained or understood. Only encountered from time to time…"[8] The mystery that confronts us in situations of death and illness has

to do with the lack of control we ultimately have in our lives. Not all illnesses and life conditions are curable and fixable. One reason may be that we need more research; that eventually answers will be found. But, if history has any lessons for us, even with technological advances, death and suffering cannot be avoided.

There simply are no answers to existential questions. Part of compassionate care is recognizing when to simply sit in silence as the person grapples with his or her own quest for meaning. Honoring the mystery is sitting in silence, being present to another's grief as well as our own grief and sadness while surrounded by unanswerable questions. Life and death become more precious when we unlearn our need to fix and control and simply learn to be present to another, to ourselves, to the mystery.

Probably, one of the greatest stressors around illness and dying for both patient and caregivers is created by the ambiguity regarding the patient's health, including the prognosis, capacity of family to provide support and care and financial concerns.[9] [10] [11] There is a tremendous amount of uncertainty with any illness and in life in general. While science and medicine may have some answers to many of the physical aspects of disease and illness, there are so many aspects of being ill for which there are no answers. Some of the questions both patients, professional and family caregivers ask are:

- When will my loved one or I and how?
- How long can I or my loved one function like this?
- Why can't this illness be cured?
- Why am I or is she or he suffering?
- Why do I feel angry, sad, and afraid?
- How will I cope with my or his or her death?
- What is the meaning and purpose of my life in the midst of this experience and stress?
- Why can't I do and be everything to another person? Why can't I be what I use to be?

These questions of uncertainty, limitations, meaning and purpose are essentially existential or spiritual questions.[12] Larry Burton writes, "Spirituality is the expression of self-in- relation, incorporating both material and non--material realities, and reflecting the tension between the possibilities and

limitations of human existence in history." Henry and Henry suggest that people need mystery. They write, "If there is no wonder there is no holy."[13] Uncertainty may trigger those spiritual questions that lead to an awareness of mystery. It is then the struggle of the spiritual journey that may lead to an honoring or acceptance of the mystery.

4. Superfino and Illness

What can the physicians and other healthcare providers do to help people in the midst of their suffering? Is it even the role of physicians to address existential or spiritual suffering? These are questions that are at the heart of the debate about the role of physicians in addressing spiritual issues of patients.[14] The American College of Physicians consensus panel on end--of-life care concluded that it is the responsibility of physicians to address all dimensions of patients' suffering—the physical, psychosocial, existential and spiritual suffering.[15] Patients experience deep suffering in the midst of illness. The existential questions often come up for the first time in the clinical setting in the presence of the physician and other healthcare provider. Foglio and Brody wrote:

> For many people religion [spirituality] forms a basis of meaning and purpose in life. The profoundly disturbing effects of illness can call into question a person's purpose in life and work; responsibilities to spouse, children, and parents…Healing, the restoration of wholeness (as opposed to merely technical healing) requires answers to these questions. [16]

Healing, then, is not synonymous with recovery. Indeed, healing may occur at any time, independent of recovery from illness. In dying, for example, restoration of wholeness may be manifested by a transcendent set of meaningful experiences while very ill. It may be reflected by a peaceful death. In chronic illness, healing may be experienced as the acceptance of limitations.[17] Spirituality is that aspect of human beings that seeks to heal or be whole.

The questions that arise for our patients as they face serious illness do not have answers. Patients need to find those answers for themselves. But, as our patients struggle with their suffering we need to be supportive and

attentive to their needs. Viktor Frankl wrote of his experiences that "People are not destroyed by suffering; they are destroyed by suffering without meaning."[18] The most common sources of meaning provide connections with something larger than the individual's own life. This could be work, family, religious belief, or other spiritual belief. To be satisfying, meaning needs to provide as sense of purpose and value to one's life. What gives people meaning changes over one's lifetime? Illness, as Foglio and Brody noted, causes people to question that sense of meaning. Usually people search for a deeper meaning that can give them value, purpose and self--worth.[19] It is not uncommon for people to turn to religion or the transcendent realm for that source of meaning. Spiritual beliefs, however they are expressed, become critical for patients in coping with suffering. In one study of women with gynecological cancers, ninety-three percent of these patients noted that their spiritual beliefs helped them cope with their illness.[20] In that same study, forty-nine percent noted becoming more spiritual after their diagnosis. In studies of patients with terminal illness, three items correlate with good quality of life for patients with advanced disease: If the patient's personal existence is meaningful; if the patient finds fulfillment in achieving life goals; and if life to this point has been meaningful.[21] This supports the importance of addressing meaning and purpose in a dying person's life.

5. New Meaning

Many patients are able to transcend their suffering and find new meaning which they describe as deeper and more fulfilling than the meaning they had in their lives before their illness. They describe being more present to others, to the beauty around them and to the transcendent or God. One patient of mine reveled in the warmth and beauty of the sunrises each morning with an intensity she never experienced before. In a study of the effect of spirituality on the will to live in HIV patients, we are finding that greater than one-third of patients with HIV find that there lives are better after being diagnosed with the illness than before. Spirituality and non-organized religious measures (relationship with God) have a positive impact on patients feeling that their life is better after diagnosis than before. Organized religious measures (church attendance, frequency of prayer) have

no effect.[22] [23] [24]This supports what I have observed in my clinical practice; spirituality has a strong influence on how patients come to understand their suffering and illness. Furthermore, patients may find deeper and more fulfilling meaning in their lives in the midst of suffering. It is critical that our systems of healthcare afford patients the opportunities to find this meaning for themselves.

6. Spiritual Care

There are four key elements of spiritual care

- Compassion and Love for Another
- Healing Partnerships
- Reverence of Mystery
- Self-care of the Caregiver; Having a Spiritual Practice

6.1. Compassion and Love for Another

Compassion comes from two Latin words: from the Latin, 'cum' which means with, and 'pati' which means to suffer.[25] So the act of compassion is to suffer with another. The Dalai Lama talks of compassion as "defined in terms of a state of mind that is nonviolent, nonharming, and non-aggressive. It is a mental attitude based on the wish for others to be free of their suffering and is associated with a sense of commitment, responsibility and respect towards the other."[26] In being compassionate with others, we, in essence, love them unselfishly and without demand or expectation. We love them for who they are at their very core. Many of my patients suffer deeply and often in the midst of that suffering, they feel alone and unloved. By loving them, I see myself as holding them in a type of love that eventually allows them to heal and see themselves as loving beings in the midst of their brokenness. It is then that they can see how others in their lives love them. They can then be open to healing the spiritual woundedness that they feel by finding some hope in the midst of despair. Compassionate care involves the caregivers ability to share the patients' pain and suffering without becoming overwhelmed and disabled by that suffering. So the love stems from an intimacy in which boundaries are respected for both the patient and

the caregiver…an intimacy with formality. The caregiver feels the pain and suffering of the other by being empathic, is able to help the other by understanding that suffering at an intuitive and felt level but then is able to detach enough to be able to help guide the patient toward a self-healing of that suffering.

6.2. Healing Partnerships

How can we help our patients find meaning for themselves in the midst of their suffering? Physicians and other healthcare providers need to re-frame their roles not as fixers but as servers. Dr. Rachel Naomi Remen writes:

> "Helping, fixing and serving represent there different ways of seeing life. When you help you see life as weak. When you fix you see life as broken. When you serve you see life as whole. Fixing and helping may be the work of the ego; and service the work of the soul."[27]

By serving others we enable them to feel connected and supported in the midst of their suffering and distress. In serving, the physician and healthcare provider becomes a partner to the patient rather than an expert that fixes or solves. Patients will find solace in the process of exploring spiritual questions of meaning with caring and supportive physicians and other healthcare providers. By being present to our patients in the midst of suffering we can help them feel less isolated and alone; we can listen to their fears, their dreams and their hopes. We can hold them in the midst of their pain and acknowledge their suffering without ignoring it. This provides the support patients need to find a sense of meaning for themselves, to become whole again, and to heal. Thus, the partnership between physician and patient or healthcare provider and patient becomes healing in and of itself.

Dr. Francis Peabody wrote in his 1927 medical classic, The Care of The Patient, "One of the essential qualities of the clinician is interest in humanity, for the secret care of the patient is in caring for the patient."[28] This relationship can have potential positive impact on healthcare outcomes, compliance and patient satisfaction.[29] [30] [31] [32] [33] [34]Vailoot suggests that it is the relationship between the caregiver and the patient, which sustains the presence of hope.[35]

> "Who is there in all the world who listens to us? Here I am—this is me in my nakedness, with my wounds, my secret grief, my despair, my

> betrayal, my pain, which I can't express, my terror, my abandonment. Oh listen to me for a day, an hour, a moment least I expire in my terrible wilderness, my lonely silence. Oh God, is there no one to listen?"[36]

The essence of spiritual care is therefore about listening and being present to another in their time of need. Medicine is therefore not just science and technology. The art of Medicine is about service to another. In that way, Medicine is a spiritual practice since it is routed in altruism for another.

6.3. Reverence of Mystery

By accepting and even honoring the mystery of life, the physician acknowledges that he/she is not all knowing. It helps the physician become humble in the face of something greater than science can explain— the unknown, the answerable questions. But it also helps humanize the physician and the medical profession as a whole and allow physicians to become more attainable to patients. In this way, compassionate partnerships becomes more of a model of care than distant stances of expertise. It is well established that physicians who have warm and caring relationships with patients are less likely to be sued. That may be because they are honest about their limitations as physicians and as human beings. While patients need physicians' expertise in technical matters, they also need honest appraisals of what is not possible to fix or answer. And more importantly, they need the assurance of support especially in the face of confusion and ambiguity.

6.4. Self-Care

The process of caring for or being compassionate to another who is suffering, means opening oneself up to another's suffering. In order to do this, it is critical that one is first honest with oneself about his or her own experience with suffering as well as an awareness of our own mortality. Once we face our own issues we can then recognize and help another with theirs. So in spiritual care, a pre-requisite is to reflect on what suffering and loss you have encountered in your life and how you handled it, to recognize that you too will die and what that means to you, and to ponder what values you have in your life that give you meaning.

In being compassionate, as described above, you allow the person's suffering to touch you and affect you but not debilitate you. What allows you to do this is the intent with which you open yourself up to another's suffering. As a caregiver you love another out of the intent to serve and do something for the higher good of another person. A compassionate partnership with the patient results in a sense of connection and commitment to the good of another. The positive aspect of service to another overrides the negative experience of suffering. The spiritual nature of the work and the commitment that comes from that gives one the strength to be able to support another's pain. Many physicians talk of being called to the profession of medicine. Many physicians and other healthcare providers find meaning in their work in the context of their spiritual beliefs and values. In the Jewish tradition for example it is written in the Talmud, "Who hath compassion for others receives compassion from Heaven."[37]

Another pre-requisite of doing spiritual care is having a spiritual practice. For the religious physician or healthcare provider, it may be a practice in that tradition such as prayer or service attendance. For others, their practice may be meditation, yoga, rituals, relationship with others or the divine, or art and music. A spiritual practice can help one encounter the transcendent and realize a higher value or meaning in life and enable one to be truly compassionate to another. Most mystics, such as Teresa of Avila, see spiritual practices as leading them beyond themselves to the practice of charity and love of neighbour. [38]

It is essential that when we care for others we also care for ourselves. So in addition to a spiritual practice, exercise, proper nutrition and sleep are critical. It is also important to have as support system for the caregivers. Working with the ill and dying can be enriching and that often gives meaning to our lives. But it can be draining as well. It is important to have people with whom you as the caregiver can share your feelings—grief as well as joy and awe.

7. Spirituality in Clinical Practice

Medical professionals are recognizing that there are inadequacies in the healthcare system in terms of care of chronically ill and dying patients. Several national organizations have also supported the inclusion of spirituality

in the clinical setting. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has a policy that states that: Pastoral Counseling and other spiritual services are often an integral part of the patient's daily life. When requested the hospital provides, or provides for, pastoral counselling services.[39]

The interest in spirituality in medicine among medical educators has been growing exponentially. Medical schools are now teaching courses in end-of-life care and in spirituality and medicine. Only one school had a formal course in spirituality and medicine in 1992. Now, over seventy medical schools are teaching such courses.[40] [41]The key elements of these courses have to do with listening to what is important to the patient, being present to their suffering, respecting their spiritual beliefs, and being able to communicate effectively with patients about their spiritual beliefs and values.

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."[42]

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 Medical School Objectives Project (MSOP). This report included a clinically relevant definition of spirituality:

> "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 the interact with one another."[43]

Spirituality, or that which gives us meaning, can be expressed in many ways. When approaching patient's spiritual issues, it is important to recognize that the definition of spirituality is broad and all encompassing. It is critical to allow the patient to inform the physician and other care providers what spirituality means to that patient. The outcome goals stated in MSOP III are that students will:

- Be aware that spirituality, and cultural beliefs and practices, are important elements of the health and well being of many patients.
- Be aware of the need to incorporate awareness of spirituality, and culture beliefs and practices, into the care of patients in a variety of clinical contexts.
- Recognize that their own spirituality, and cultural beliefs and practices, might affect the ways they relate to, and provide care to, patients.
- 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.
- Be aware of the need to respond not only to the physical needs that occur at the end of life, but also the emotional, socio-cultural, and spiritual needs that occur.[44]

As mentioned above, more than half of U.S. medical schools have courses in spirituality and medicine, many of which are required and integrated into the curriculum. The response to these courses has been positive. Students and practicing physicians find their relationships with their patients are warmer, more meaningful, and deeper once they talk with their patients about their spiritual beliefs. Medical students and residents are finding it easier to address issues of suffering and meaning in the context of a spiritual history. Doctors who felt burned out by the hectic schedules of managed care now feel a way to reconnect with their patients and bring compassionate care giving back into the practice of medicine. Most

importantly, the patients are happier because their whole person is treated (body, mind and spirit) and not just their illness. Thus, by educating physicians about spirituality in patients' lives, we are hoping to develop more compassionate and caring models of healthcare.

8. Spiritual History

One way to address suffering and issues of meaning and purpose is by doing a spiritual history. The main elements of a spiritual history that has been developed for physicians and other healthcare providers can be recalled by using the acronym, "FICA."[45] [46] [47]The spiritual history is that part of the patient encounter where the patient can tell his or her story and share his or her values. It is that part of the exam that is less technical. Many people feel it is the place where compassionate care can be a felt experience. It is also the place that helps reveal what sources of strength, hope and meaning and what kind of coping mechanisms the patient has. Spirituality may enhance well being in a person' s life by providing one with the language of hope and meaning and purpose, through social support and integration within a religious or other community or through enhanced coping mechanisms. Thus the assessment tool asks the person about these areas of their life.

F – Faith and Belief

"Do you consider yourself spiritual or religious?" or "Do you have spiritual beliefs that help you cope with stress?" If the patient responds "no," the physician might ask, *"What gives your life meaning?*" Sometimes patients respond with answers such as family, career, or nature.

I – Importance

"What importance does your faith or belief have in your life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?"

C – Community

"Are you a part of a spiritual or religious community? Is this a support to you and how? Is there a group of people you really love or who are important to you?" Communities such as churches, temples, and mosques

or a group of like-minded friends can serve as strong support systems for some patients.

A – Address/Action in Care

The physician and other healthcare providers can think about what needs to be done with the information the patient shared – referral to chaplain, other spiritual care provider, or other resource such as yoga, meditation, spiritual direction, or pastoral counselling. Some patients use rituals or journaling as a spiritual intervention. Others will talk about prayer, walking in nature or other person rituals as important in coping. Listening to the concerns, feelings and beliefs of the patient as well as providing a safe environment so that the patient can express feelings and experiences associated with illness and suffering is one of the most important parts of the action plan.

FICA is not meant to be used as a checklist, but rather as a guide on how to start the spiritual history and what to listen for as the patient talks about his or her beliefs. Mostly, FICA is a tool to help physicians and other healthcare providers know how to open a conversation to spiritual issues and issues of meaning and value. In the context of the spiritual history, patients may relate those fears, dreams, and hopes to their care provider. The spiritual history can be done in the context of a routine history or at any time in the patient interview, usually as a part of the social history. In addition to religious or spiritual beliefs and values and other aspects of the spiritual history, the social history should address: lifestyle, home situation and primary relationships; other important relationships and social environment; work situation and employment; social interests/avocation; life stresses; and lifestyles risk factors: tobacco, alcohol/illicit drugs. As with any part of the history sometimes issues come up that require more attention. If a patient shares symptoms of depression, it is likely the visit will center on that and therefore the depression assessment will take longer. For some patients the spiritual history may take a brief amount of time; for others, spiritual issues may be the predominant part of the discussion for that visit. In patient care, spirituality is part of ongoing spiritual care both in the context of the caring relationship as well as active conversation about spiritual issues. As part of the history the conversation might be lengthy or be something the patient shares at the first visit and then brings up only at subsequent visits as appropriate to the circumstance.

The spiritual history is patient-centered and family-centered. One should always respect patient's and families' wishes and understand appropriate boundaries. Physicians and other healthcare providers must respect patients' privacy regarding matters of spirituality and religion and should avoid imposing their own beliefs onto the patient.[48]

The following case illustrates how FICA can be used. A patient who died of metastatic malignant melanoma was an Episcopalian. Her religious beliefs were central to her life and, in fact, the way she came to be at peace with dying. During her last hospitalization, the house officers caring for her were apprehensive about discussing advance directives and dying. However, during the spiritual history, the patient told them how her religious beliefs helped her come to terms with dying and how she was ready to die naturally. She handed them her living will. She also asked that her church members be allowed to visit her often. She later told me that being asked about her beliefs helped her feel respected and valued by the physicians and she felt that she could trust them more. The physicians stated that once they asked a spiritual history, the nature of the interaction between themselves and this patient was changed. It felt "more natural, more comfortable, warmer and more honest."

Another case illustrates the variability encountered in practice. When asked "if you have any spiritual beliefs that help you with stress," a patient undergoing a routine examination answered that she found meaning and purpose while sitting in the woods near her house – that nature brought her peace. This was very important to her, as she noted that on days when she did not meditate there in the morning, her day would be scattered and tense. Her community was a group of like-minded friends who shared her beliefs. She asked that her medical records indicate that when she became seriously ill or dying, that the room in her hospice overlook trees. She also asked to learn basic meditation techniques. In a subsequent visit, many months later she reported that she had stopped meditating, with negative results; resuming meditation helped her cope better with her stress.

9. Ethical Issues

In discussing spiritual issues with patients it is important to recognize that the spiritual history is patient-centered not physician centered.[49] [50]

Physicians and other healthcare providers should strive to discuss patients' spiritual concerns in a respectful manner and as directed by the patient. A physician or other care provider should always respect patients' privacy regarding matters of spirituality and religion, and must be vigilant in avoiding imposing his or her beliefs onto the patients. The relationship between physician and patient is not an equal one and in the professional setting neither is the relationship between other professional caregivers with their patients. There is an intimacy in the relationship but it is intimacy with formality. The patient comes to the physician/healthcare provider in a vulnerable time of his or her life, often looking to the physician as a person of authority. The physician/healthcare provider should not abuse that authority by imposing his or her own beliefs, or lack of beliefs, onto patients. A vulnerable patient may adopt a physician's/healthcare provider's belief simply because the patient is fearful and assumes the physician/healthcare provider knows more. In terms of spiritual intervention, physicians/healthcare providers can recommend a variety of interventions: chaplain referral, meditation, yoga, prayer or other spiritual practice, but, the decision to recommend these comes from the patient. For example, the physician/healthcare provider can recommend religious and spiritual practices to their patient if these practices are already part of that patient's belief system. However, an agnostic patient should not be told to engage in worship anymore than a highly religious patient should be criticized for frequent church attendance. Thus, if a patient states that prayer helps with stress, the physician/healthcare providers could suggest that prayer might help in dealing with a serious diagnosis. Or if a patient finds meaning and purpose in nature, a physician/healthcare provider might suggest meditation techniques focused on nature.

Patients often ask physicians/healthcare providers to pray with them. It is not inappropriate to allow a moment of silence or a prayer if the patient requests this. In fact, walking away and not showing respect for the request may leave the patient with a sense of abandonment by the physician/healthcare provider. If the physician/healthcare provider feels conflicted about praying with patients, he or she need only stand by quietly as the patient prays in his or her own tradition. Or, alternatively, the physician/healthcare provider could suggest calling in the chaplain or the patient's clergy person to lead a prayer. Physician-led prayer or healthcare provider-led prayer is generally not recommended, as that is usually the role of a clergy or chaplain. In addition, having the physician/healthcare provider lead a prayer

opens the possibility of having the prayer be of the physician's/healthcare provider's belief, not of the patient's. Furthermore, clergy and chaplains are trained specifically in techniques of leading prayer in ecumenical and healthcare contexts. However there is disagreement amongst experts in this area. Some say that physician-led or healthcare provider-led prayer may be permissible if the physician/healthcare provider and patient share a long-standing relationship, have similar beliefs or religious background or if the patient requests it. It is still recommended however to be mindful of respecting the patient's belief system.

10. The Interdisciplinary Team

Addressing suffering and spiritual issues of patients does not belong in any one person's domain. It is the responsibility of all members of the healthcare team – physicians, nurses, social workers, psychologists, therapists and others – to be sensitive and caring to the spiritual needs of patients. One of the members of that team, the chaplain, is the trained spiritual care provider. One of the most important elements of the courses on spirituality and health is the recognition of trained spiritual care providers—chaplains, pastoral counselors, spiritual directors and clergy. We are not training physicians to be chaplains. We recognize that spiritual care providers are the experts and the ones to whom we refer if our patients need more in-depth spiritual counselling. The spiritual history is simply a way that physicians can invite patients to discuss issues of meaning, purpose and value in their lives. Physicians are trained to be present to patients in the midst of their suffering and to be supportive to patients in this process. Physicians are also trained to work with experts in spiritual care to deliver the best possible care for their patients. In many of the medical school courses, chaplains are involved in teaching the students how to listen effectively to patients, how to be present in the midst of suffering and how to attend to the students own spiritual needs.

Conclusion

As people encounter serious illness they often face profound questions of meaning and purpose in their lives. If left unattended, people can experience tremendous isolation and suffering. Spirituality is at the core of who we are as human beings. It is that part of us that helps us find meaning especially in the midst of confusion and suffering. It is the connections we form with each other in a profound sense of community that helps all of us survive in an often isolating and dehumanizing world. It is the responsibility of the physicians, other healthcare providers and healthcare systems to provide the opportunities for patients to be supported in the midst of their pain and suffering. By addressing spiritual issues and by being compassionate and loving to patients, physicians and other healthcare professionals will be able to help people heal and find new meaning in their lives. Patients may then be able to find a sense of wholeness, wonder and grace. The healing force for both body, mind and soul is the spiritual dimension. By facing this dimension patients and caregivers alike will be able to achieve a therapy for being.

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