

# Virtual Mentor

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## MEDICINE AND SOCIETY

### Recognizing the Mind/Body/Spirit Connection in Medical Care

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For many centuries, conventional wisdom proclaimed the healing power in the doctor-patient relationship. In “Precepts,” Hippocrates declared: “...where there is love of man, there is also love of the art. For some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician” [1].

By the middle of the 20th century, with the impressive triumphs of modern biomedicine, a new paradigm declared that, in an age of sophisticated diagnostic tests, pharmaceutical magic bullets, and super surgery, only the quality of the biomedicine physicians mastered and applied determined medical outcome.

But during the past 25 years or so another mindset has emerged which maintains that the clinician/healer must both address the disease and know the patient as person. The physician should seek to know how the medical condition is being experienced by the patient and what impact it has on his or her life and spirit. Because of the mind/body/spirit connection the quality of that understanding can actually affect medical outcome. We have recovered the insight of Hippocrates [2, 3].

As a result, the web surfer will discover a plethora of programs in medical centers bearing such names as medical humanities, spirituality in medicine, and health and the human spirit. Our program at the Center for Health, Humanities and the Human Spirit defines spirit or spirituality as a person’s inner world of values, vital beliefs, strivings, and goals—in other words, all that gives meaning to a human life. Meaning is the sense that there is purpose in my life even when I face its darker side, including serious, chronic, or terminal illness. The human spirit drives the quest for meaning, and meaning sustains our will to live.

There are multiple sources of meaning: the giving and receiving of love; our daily work; feeling connected to the mystery, beauty, and grandeur of nature; love of music, and, for a significant number of people in our nation, the beliefs and spiritual disciplines of a religious community [4]. The majority of patients welcome a physician’s inquiry into their spiritual or religious belief in the context of medical care [5].

Eric Cassell has taught us that there can be pain without suffering. He defines suffering as pain devoid of meaning [6]. A third-year student at our medical school visited with a couple in the hospital immediately after the expectant mother

experienced a miscarriage in her 7th month. Hardly able to contain his bitter tears, the husband explained this was their third miscarriage. “Why is this happening to us doctor? What did we do wrong?” The student physician explained the possible biomedical triggers of a miscarriage without realizing that the couple was also asking a deeper question. This cumulative assault on their hopes shattered their sense of meaning. How could this happen in a world governed by a powerful and gracious God?

Whether religious or not, a sensitive physician should recognize that the biomedical level of understanding may be inadequate. In such instances the physician should connect the couple to an appropriate clergy person for additional counseling.

To ascertain a patient’s spiritual beliefs, Dr. Christina Puchalski suggests that physicians ask a set of questions that can be integrated into the patient’s history. Among the questions, she suggests: “What is your faith or belief? Do you consider yourself spiritual or religious? What things do you believe in that give meaning to your life” [7]?

Such inquiries are best reserved for serious medical situations in which the doctor is likely to be part of the ongoing treatment. The physician may want to begin more nondirectedly by acknowledging that, “This is a difficult time in your life. What helps you get through such times?” If the patient mentions his or her religious faith, the doctor should validate the potential helpfulness of such support; if no indication of religious belief is given, Cynthia Cohen et al. suggest the following: “Some people also find that their religious or spiritual approach to life is a great source of support to them when they are ill. Do you have a religious or spiritual connection that is important to you” [8]? If the response is negative, further inquiry would be inappropriately intrusive.

We seek to help medical students understand that even when their personal attitude toward religion is negative, they should guard against depreciating the patient’s faith by word or body language. Without any violation of conscience, nonreligious physicians should be able to say: “I know that many have found their faith very helpful.” Such validation is important not only because the physician is an authority figure, but as an expression of elemental respect for the patient.

If a physician’s nonbelief is one potential source of conflict with the patient’s values, the devoutly religious physician’s inclination to bear witness to his or her faith is another. Any proselytizing gesture is a gross abuse of the patient’s vulnerability and a serious violation of professional boundaries. Nor should the religious physician initiate prayer with the patient. The most unobjectionable testimony to personal faith I have heard from a physician came in a conversation with Dr. Andrew von Eschenbach, a distinguished urologist at MD Anderson Cancer Hospital and most recently the head of the FDA. He told me that whenever he gives a serious diagnosis he says to the patient: “I promise to get you the best treatments available; I will be

with you through this journey, and, since I am a believer, I will be praying for a positive outcome.”

If the physician and patient share a common faith, an offer to pray together may be appropriate. But periodically, a nonreligious medical student or physician will be asked by a patient to pray at the bedside. How may the clinician be supportive of the patient without violating his or her conscience? He may respond: “Let me hold your hand and be with you, but why don’t you offer the prayer.” That response expresses solidarity and is less distancing than, “Sorry, this is not my thing. I will request that a chaplain come to pray with you.”

Some religiously grounded patient requests may not be accommodatable. When a male resident entered the labor and delivery room, the patient’s mother confronted him: “We are Muslim and it is not fitting for our daughter to be exposed to a male who is not her husband. We need a female doctor to deliver our baby.” The resident validated the mother’s concern and promised he would try to accommodate her, but he cautioned that a female resident might simply not be available at delivery. As it happened, the female residents were involved in other deliveries. The male resident walked into the “lion’s den” with great sensitivity. He affirmed the family’s concern and expressed regret that he could not accommodate their request. He assured the family he would seek to minimize exposure, that members of the family could be present in the delivery room, and that he knew the family’s primary desire was for the delivery of a healthy baby. The family showed appreciation and relief.

In retrospect, the family’s initial objection could have been totally disarmed if the resident had suggested that a chaplain be summoned to visit with the family. Armed with knowledge and spiritual authority, the chaplain could explain to the family that, in all major religious traditions including Islam, when life or health is at stake, normal religious prohibitions may be suspended. Surely this would not be the first time a male physician delivered a Muslim baby.

In most situations of potential conflict between religious and medical values, a chaplain or other clergy can be helpful. A physician faced such a challenge when an elderly woman was judged by the medical team to have crossed the boundary between prolonging life and prolonging dying. For weeks, the woman was confined to bed, totally unresponsive, unable to communicate, and sustained by a respirator. While the medical team determined that this was a case of medical futility and suggested the removal of all artificial support systems, the woman’s daughters steadfastly insisted on “Doing everything to give God time to perform a miracle.”

One daughter acknowledged that some months earlier, her mother had said she would prefer death to what her life had now actually become. At that point, the student physician requested that the daughters speak to a chaplain. Hearing the daughters’ concern, the chaplain explained that, “God heals through the doctors He sends and the medicine and machines He enables us to discover or fashion. Sometimes, God heals in His own special way, and we call that a miracle. If God

wills a miracle, He does not rely on artificial support systems. You may still pray for a miracle, but you should allow your mother to receive palliative care.” In effect, the chaplain explained that the daughters misunderstood the nature of a miracle. After this conversation, the family consented to palliative and hospice care.

A woman told her physician that since her adolescence she had observed a complete fast during the 24-hour period of Yom Kippur, the holiest day in the Jewish year. She insisted on observing the fast without hydration. When the physician admonished that in her condition such observance could endanger her life, she held fast to her intention. Fortunately, the physician asked for a clergy consultation. A Jewish chaplain explained to the patient that in Jewish law it is a sin to fast if doing so endangers your life. The woman agreed to receive hydration.

Whether religious nor not, we live our lives without being fully in control and face an uncertain future. Religious persons seek comfort in the faith that beyond the mystery there is an ultimate source of power and goodness to whom they may turn for strength and healing. At such times they want the best biomedical resources available, but they also seek intimations of God’s presence. Before serious surgery such patients will welcome a visit from both surgeon and clergy.

Suppose a physician knocks on the patient’s door and discovers that a minister is either in discussion or prayer with the patient? Should the physician ask the clergy to leave for a few minutes so he or she may visit with the patient, or should the doctor, wherever possible, excuse himself or herself and return after visiting other patients? In my early ministry, physicians and clergy assumed that the doctor’s visit should always take precedence. Perhaps it is a measure of a cultural shift and of the impact of our health and human spirit program that when we ask this question of our medical students today they almost invariably say: “I would excuse myself and say that I will return after visiting other patients.”

## References

1. Hippocrates. Precepts VI. In: Reiser SJ, Dyck AJ, Curran WJ. *Ethics in Medicine: Historical Perspectives and Contemporary Concerns*. Cambridge, MA: MIT Press; 1977:5.
2. Engel G. The need for a new medical model: a challenge for biomedicine. *Science*. 1977;196(4286):129-136.
3. Suchman AL, Matthews DA. What makes the patient-doctor relationship therapeutic? Exploring the connectional dimension of medical care. *Ann Intern Med*. 1988;108(1):125-130.
4. Gallup G Jr., Lindsay DM. *Surveying the Religious Landscape: Trends in U.S. Beliefs*. Harrisburg, PA: Morehouse; 1999:21.
5. Daaleman TP, Nease DE Jr. Patient attitudes regarding physician inquiry into spiritual and religious issues. *J Fam Pract*. 1994;39(6):564-568.
6. Cassell EJ. *The Nature of Suffering and the Goals of Medicine*. New York, NY: Oxford University Press; 2004.

7. Puchalski C, Romer AL. Taking a spiritual history allows clinicians to understand patients more fully. *J Palliat Med.* 2000;3(1):129-137.
8. Cohen CB, Wheeler SE, Scott DA; Anglican Working Group in Bioethics. Walking a fine line. Physician inquiries into patients' religious and spiritual beliefs. *Hastings Cent Rep.* 2001;31(5):29-39.

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