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TOWARD AN ETHICS OF MEDICAL CARE THAT INCLUDES CARE FOR THE SPIRITUAL

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Toward an Ethic of Medical Care That Includes Care for the Spiritual

Caring is a spiritual act, thus, all clinical care has a spiritual component. All health care includes spiritual care, albeit, often without intentionality. Spiritual care provided without diagnostic and therapeutic intent may be harmful. Many assign the harmful effects associated with casual spiritual care to spiritual care *per se*. However, spiritual care, as any form of clinical care, given without proper diagnosis and therapeutic intent can cause injury, i.e. it may have "toxic side effects"! Spiritual care has been intentionally ignored. For the past half century, religion and spirituality have been largely excluded from medical care. Spiritual care should be included as an integral part of scientific medical care. In fact, I argue that the absence of intentional spiritual care is patient negligence!

I. INTRODUCTION:

Medical care needs to address the spiritual as well as the physical, emotional, cognitive, social and religious for several reasons. 1) The spiritual permeates every aspect of a person and influences health and wellness; 2) pragmatic studies show that an active religious/spiritual life is associated with better health and decreased morbidity; 3) unless directly addressed, patients rarely volunteer the spiritual aspects of their illness.

Illness profoundly alters the way people view today and anticipate tomorrow. Patients frequently deny the significance of symptoms. When denial no longer suppresses symptoms fear emerges and patients demand health care that calms their fears and heals their symptoms. Not symptoms *per se* but potential meanings cause fear. Though patients usually deny fear they want it eliminated. Patients need help to face present fears and find courage for the future. Patients need care adequate for their fears, care that assists them deal with fear. Several illustrations follow:

Mrs. S loved to dance. She has just been diagnosed with amyotrophic lateral sclerosis. When asked "What do you hope for?" she answered, "I just want to dance again!"

Alfred, a heavy smoker, had carcinoma of the lung. When asked, "Why did you get this cancer?" answered, "I ran around with loose women when I was young."

Peter, a heavy smoking 46 year old truck driver, had carcinoma of the lung. When asked, "Did you ever believe that Someone was looking after you?" answered, "Yes, driving truck when drunk through the mountains of Tennessee Someone took care of me. Doc, go ahead with the surgery, the same Person is caring for me now."

When the Vietnam veteran was asked, "If you were to die at home, who would know?" answered "Nobody!"

John, age 19, recovered from infectious mononucleosis. When asked, "What did you learn from this illness?" replied, "I didn't know I could get sick!"

After a prolonged drunk Bill's ex-wife admits him for acute alcohol toxicity. Later when asked, "Does she forgive you?" said, "No, she can never forgive me!" His ex-wife had been holding and assuring him of her care and forgiveness.

II. ISSUES

A. Relationship between medical care and the religious/spiritual[1]

In earliest recorded history, priests were also the medicine men. Hebrew priests not only performed religious services, they also diagnosed illness.[2] Early Christian Churches provided hospice care for the sick and dying[3] and at a later time, monasteries set up hospitals. Earliest

[1] Matthews, Dale A. "Religion and Spirituality in Primary Care." 1997; *Mind/Body Medicine* 2:9-19.

[2] Leviticus 13:1-44

[3] Allan, Nigel. "Hospice to hospital in the Near East: an Instance of Continuity and Change in Late Antiquity." *Bull Hist Med* 1990; 64:446-462.

medical schools were "Church related.[4]"

Emerging science confronted authoritarian religion during the renaissance. This conflict increased during the enlightenment epitomized by the teachings of Darwin and rationalistic philosophy. Scientists uncomfortable with a divine basis for morality developed a utilitarian basis. "Educated" people viewed religion as a pre-modern notion[5] used to bring order to the pre-scientific mind, a creation of human thought useful for comfort, but lacking in relevance.

The first and second world war which documented human inhumanity destroyed the optimism of the enlightenment. The continuing threat of nuclear annihilation and the Vietnam war added disillusionment. Economic advances did not eliminate poverty. Increased knowledge has not controlled violence, decreased drug addiction or stopped epidemics of sexually transmitted diseases. Derek Bok, president of Harvard University commented "Relativism and individualism have rewritten the rules of the game; they have extinguished the motive for education –to understand the interwovenness of the facts/values and objectivist/relativist pathologies and the cultural consequences of the loss of purpose and meaning."[6] Because rationalism failed at the time of need, people turned to "spirituality." This manifests in the growth of religions that highly value spirituality, increasing interest in Native American and eastern religions, the popularity of "New Age" and the rise of spiritism and witchcraft[7].

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[4] Paxton, Frederick S. "Curing Bodies – Curing Souls: Hrabanus Maurus, Medical Education, and the Clergy in Ninth-Century Francia." *J Hist Med Allied Sc* 1995; 50:230-252.

Goldberg, Abraham. "Towards European Medicine: an Historical Perspective: The FitzPatrick Lecture 1988." *J Roy Col Phys London* 1989; 23:277-286. Leiser, Gary. "Medical Education in Islamic Lands from the Seventh to the Fourteenth Century." *J Hist Med Allied Sc* 1983; 38:48-75

[5] Aleksandr Solzhenitzyn in "The Relentless Cult of Novelty and How it Wrecked the Century," quoted in *New York Times Book Review*, February 7, 1993, pp. 3,17 "Looking intently, we can see that behind these ubiquitous and seemingly innocent experiments of rejecting 'antiquated' tradition there lies a deep seated hostility toward any spirituality. This relentless cult of novelty...conceals an unyielding a long-sustained attempt to undermine, ridicule and uproot all moral precepts. There is no God, there is no truth, the universe is chaotic, all is relative, 'the world as text,' a text any postmodernist is willing to compose. How clamorous it all is, but also—how helpless."

[6] quoted by Robert Fryling in "Campus Portrait." Address presented at the national Staff Conference of InterVarsity Christian Fellowship, December 1992

[7] Kaplan, Marty. "Ambushed by Spirituality." Time 1996 June 24, 1996); 147:62.

For many, spiritual is their "walk" with God. For others it is experiencing the Transcendent, or the "Ground of our Being." Alcoholics Anonymous and other 12 step programs refers to "Higher Power." For some, spiritual is the essence of the universe. Spirituality "has to do with man's search for a sense of meaning and purpose in life. . . [I]t strives for transcendental values, meaning and experience. . . . [It] is that aspect or essence of a person . . . that gives him or her power and energy, and motivates the pursuit of virtues such as love, truth, and wisdom. . . . Religion, on the other hand, is any specific system of belief, worship, conduct, . . . often involving a code of ethics and a philosophy. It may include dogma, metaphors, myths, and a way of perceiving the world.[8]"

B. Our patients have religious and spiritual dimensions

In health most people give little thought to who they are, they simply live life. With illness many questions emerge. Symptoms identify mortality and our patients fear death. They fear the present and future. They fear loss of identity with disfigurement, loss of ability to perform and earn a living. They fear abandonment including abandonment by life i.e. death. Memories of illness include not only the facts but also the meanings assigned by patients and their heritage. Patients listen to the memories assigned by meaning. They believe that their memories predict their future.

Illness distorts patients' physical, mental, emotional, social, religious and spiritual realities and engenders chaos. It creates neediness and patients want help; medical help, emotional and social help and help from their religious and spiritual roots. Neediness overwhelms every dimension and facet of patients' lives. They need help with the physical manifestations of illness. They need education regarding their diseases. They need help with the isolation and loneliness, with the anger, fear, loss and grief. They need help dealing with relationships. They need help with their religious heritage and their spirituality, i.e. their self perceptions, and their encounter with the Transcendent.

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[8] McKee Denise D, Chappel John N. "Spirituality and Medical Practice." *The Journal of Family Practice* 1992; 35:201-208

1. *Patients need "Spiritual Care",*

For millennia, physicians knew their patients including their cultural expectations, religious heritage, spiritual insights and memories. Without a useful pharmacopeia they met patients' medical needs by optimizing cognitive, emotional, social, religious and spiritual health and guided patients into responsible self care. Scientific medicine focused the medical community (as well as patients) on the physical and molecular, and away from the religious and spiritual. However, the spiritually healthy patients (because their life has meaning) incorporate the disciplines of responsible self-care. Scientific medicine tries but fails to heal irresponsible patients, instead it mutilates them with repeated surgeries or provides drug side effects via its pharmacopeia. Patients who loathe themselves, who lack social support, who break natural laws with impunity and who live in guilt and shame are unable to implement change and care for their health.

Patients need spiritual care. They need to find meaning for their illness, courage to be responsible, and hope for the future. As broken people, they need openness so they can have a community of support. In their suffering and hurt they need to forgive and let go, thus ending bitterness.

2. *Physicians need to be sensitive to patients' spiritual status*

The arrogant professionalism of sophisticated scientific success offends patients. They resent the "M-Deity," the cold authoritarianism, the exclusivity maintained by professional language. Feeling demeaned, infantilized and devalued they become angry. Patients wish their physicians were open, listening to their heart, hearing them as worthy reporters of important information. Patients want physicians to be more than mere practitioners of medical science, they want them to practice medicine as a divine calling[9].

The demands of medicine can become resented drudgery unless physicians have a central mission validating their commitment to both medicine and patients. They need a purpose more grand than professionalism with its perks, they need a mission large enough to validate the hours, the "on call" nights, and the frequent "life or death" decisions. Physicians need a mission big enough to keep them sensitive to and focused on patients as precious human beings.

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[9] Osmond Humphry. "God and the Doctor." *N Eng J Med* 1980; 302:555-558

C. What is the nature of the Physician-Patient relationship?

There are multiple models of the Physician-Patient relationship[10]. With respect to the role of spiritual care they polarizes about two disparate foci.

1. Biotechnical models

Biotechnical models of health describe disease in cellular terms. Sick patients have defective cells with deranged chemicals and impaired communication between cells. In such models, medical care simply corrects biologic imbalances and restores or removes malfunctioning cells. These models have provided most of the scientific advances in medical care. Though excellent these models ignore patient fears as well as the meaning and symbolic significance of illness - for these do not reside in the physical domain. Health care that ignores personal, relational and spiritual needs misses the human aspects of disease.

2. Virtue based altruistic models

Virtue based altruistic models are more humanistic. They assume that clinicians are moral people with nurtured and trained character. These models support patients' desire for virtuous people they can hold "morally accountable for ... [their] actions[11]." Within the limits of science and clinical arts, patients expect their physicians to do what is best for them. These models say that a clinical "need...constitutes a moral claim on" physicians[12]. They describe patients as uniquely dependent, vulnerable, exploitable and relatively powerlessness before their physicians. They are "forced to trust" physicians. According to these models, physicians hold "knowledge in trust for the good of the sick." Virtue-based altruistic models call physicians to include physical, mental, emotional, social, religious and spiritual dimensions in their clinical care.

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[10] Zuger, Abigail and Steven H. Miles. "Physicians, AIDS, and Occupational Risk: Historic Traditions and Ethical Obligations." Oct 9, 1987; JAMA 258:1924-1928.

[11] Macintyre, A. *After Virtue* 1981. Notre Dame, Ind. University of Notre Dame Press, 1981

[12] Pellegrino, Edmund D. "Altruism, Self-interest, and Medical Ethics." Oct 9, 1987; 258:1939-1940.

D. Who is the patient?

Integrated wholeness characterizes person-hood. For millennia, each person was seen as an integrated multi-dimensional, multi-faceted whole. More recent poets speak of "body, soul and spirit" while the more pedantic refer to physical, cognitive, emotional, social, religious and spiritual. Most patients believe that the cognitive, emotional, social, religious and spiritual facets of life significantly modify health. To speak of "body, mind and spirit" is to speak of different perspectives of a person not different parts. The perspectives are interactive, none can be dissected out, none function separate from the other. They are foci, not parts. The physical, cognitive, emotional and social affect the religious and spiritual. The religious and spiritual affect the physical, cognitive, emotional and social. Patients are more than physical structures with cells integrated by neurons, hormones and other effector molecules. Patients want their physicians to be aware that symptoms have multidimensional complexity.

Jewish Scripture says that God made humans "in His image[13]." Other ancient perspectives use similar terms to identify humans by their relationship with "God." The universality of notions of God suggests that these are useful[14]. However, illness complicates a person's relationship with their God. The sick become very self-centered while loathing their own bodies! They attend to the ever-present screams of disease rather than their relationship with God.

E. What is illness?

Illness is multidimensional brokenness with loss of integration. The sick suffer physically, have unreasonable thinking and unreasonable expectations based on deficits in knowledge and illogical thoughts about cause and effect. Frequently fear, loneliness, anger, loss, and grief accompany illness. Often illness strains social relationships[15] and threatens cultural and family expectations. It stresses peoples' belief in a loving and beneficent God causing crises of religious faith. Illness

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[13] Genesis 1:26,27

[14] Lawrence, Robert S. "The Physician's Perception of Health Care." *J Roy Soc of Med* 87, Supp 22:11-14

[15] Coles, Robert. "Medical Ethics and Living a Life." *N Eng J Med* 1979; 301:444-446

dehumanizes and destroys person-hood. It clouds the future, hiding meaning and purpose thereby threatening spiritual health. Sick people wonder if their illness was caused by past actions. Many believe, "I am being punished!"

Illness raises frightening questions that demand answers: "Given these symptoms, who am I? I will be useless (and therefore worthless)! What is the meaning of this? What should I expect? Am I loosing it? Do I need help, or do I need to calm down?" Patients want more than physiological homeostasis they want answers, words that restore meaning, hope and purpose[16].

Patients see themselves on multiple spectra between positive and negative foci: between worthwhile and worthless, in community and isolated, in harmony with and exception to natural law, peace with and condemned by their past. Illness usually damages self-perceptions shifting them toward negative foci. With jaundiced hindsight patients see themselves as useless and worthless. Dependent on, though separated from, those who love them they feel alone. When illness follows specific risk behaviors patients often say, "I thought it wouldn't happen to me!" That is, "I thought I was an exception to natural law!" Many patients find it difficult to forgive their own past, some blame others for untoward consequences of their behavior while rejecting personal responsibility. Patients want and need more than just physical help[17].

F. What is healing?

Classical Greek, the language of medicine's birth, does not differentiate "healing" and "saving" or "health" and "salvation." Translators interpret the Greek verb *sozo* as "to heal" or "to save" and the noun *soteria* as "health" or "salvation" depending upon the setting[18]. Salvation notions such as "rescue from death," "restoration to relationship" and "wholeness" also apply to healing and health. From recorded history until the first half of this century healing restored thinking,

[16] Wallis, Claudia. "Faith and Healing." *Time*, June 24, 1996:60-68

[17] Gallop George Jr. *Religion in America*: 1990. Princeton, NJ: Princeton Religious Research Center, 1990

[18] Vine, W.E. *An Expository Dictionary of New Testament Words*, 1952.Thomas Nelson, Nashville Tn. p 993.

emotions and social relationships. It moved religious ideation towards truth and restored patients' sense of value and community. It provided forgiveness and reinforced patients' laws and taboos. Today, healing should reestablish person-hood and restore a sense of value, saving people from being "nobody" and establishing them as "somebody." Healed people become "whole." They accept their past, live in the present and look to the future with hope and courage, regardless of problems. They know they are precious and share their precious-ness in caring and loving relationships. Healed people provide responsible self-care and do what is right for their community and planet Earth.

For health care to be healing, it must improve and integrate the multiple facets of life. When cure only improves the physical, then broken people simply have stronger bodies in which to experience their brokenness! Physical improvement passively received via pharmaceuticals or surgery often increases dependency on others allowing patients to abandon health laws and ignore responsible self care.

III. HOW CAN PHYSICIANS PROVIDE SPIRITUAL CARE?

Ambroise Paré the famous medieval surgeon said, "I dressed him and God healed him[19]." Many patients are awed by healing's magnificent mystery. To them scientific medicine provides conditions that allow or encourage healing.

A. Be healers

At its noblest, physicians minister to the suffering of frightened people. They support them with science, comfort them with presence and care for them as precious human beings. The words describing physician-patient relationships have significant derivations. "Physician" means healer, "doctor" means teacher and "patient" identifies one who suffers. These words speak of body, mind and spirit. They imply more than anatomic and physiologic repair of malfunctioning cells. To be healers, physicians must evaluate and treat the whole patient, body, mind and spirit. Physicians

[19] Paré, Ambroise. *The Apologie and Treatise of Ambroise Paré*, Pt. I; as quoted in *Familiar Medical Quotations*, Maurice B. Strauss, ed. Little, Brown and Company, Boston, 1968. P 627.

must responsibly apply science in the care of their patients. Even when they can not cure, they are expected to encourage, comfort and relieve pain.

Physicians should know the religious ideation patients use to cope with illness. Some religious ideas destroy patients' spirituality, including their self-esteem and hope. Physicians, who usually lack theological training, can support patients seeking freedom from destructive ideas[20].

Physicians need to listen while patients story how illness altered their perception of what is ultimate. Physicians need to know how illness affects not only their patients' relationship with "God" and but also their view of self and their world. Only then can physicians assist in healing the whole person.

B. Serve their communities

Society provides medical education and licenses physicians. These are provided so society's members can receive caring and timely medical services of high quality. For several millennia, model physicians have been those who serve at the call of their communities incorporating available science into clinical art[21]. Society expects physicians to do more than care for cells and chemistry[22]. Society calls physicians to care for each patient as a person of infinite worth, to validate hope and help patients live lives of dignity with self worth despite anatomic brokenness. Society calls physicians from professionalism to be healers (physicians) of the sick, comforters of those who suffer (patients), teachers (doctors) of those who do not know how to live healthful lives, and comfort for those worrying about symptoms or grieving from loss. Society calls physicians, individually and collectively, to guide to health: physical, mental, emotional, social, religious and spiritual health. Physicians must value society's call.

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[20] Cabot RC, quoted in Barnard D, Dayringer R, Cassel CK. "Toward a Person-centered Medicine: Religious Studies in the Medical Curriculum." *Academic Medicine* 1995; 70:806-813.

[21] Ingelfinger, Franz J. "Medicine: Meritorious or Meretricious. *Science* 1978; 200:942-946

[22] Hill, Robert F. "Culture in Clinical Medicine." *South Med J* 1990; 83:1071-1080

IV. PHYSICIANS NEED TO IDENTIFY AND PROVIDE FOR THEIR PATIENTS' SPIRITUAL NEEDS

A. Reasons:

1. Illness has great symbolic significance

Previous experiences modulate patients' interpretations of illness[23]. Spirituality integrates and focuses interpretations and gives meaning. People respond to the meanings altering personal identity and future plans being willing either to hope and trust or refusing such. Spiritual interpretations of physical facts dominate patients' expectations and their responses to illness, diagnoses and therapies. To answer society's call physicians must learn the spiritual meaning patients give illness.

2. Physicians need to take an active interest in their patients' spiritual health

Most patients do not know how to deal with guilt and shame, how to find meaning in the present or how to restore hope for their future. Physicians best treat patients' shame, intimidation, distorted meanings and destroyed hope by examining their spiritual domain. Physicians need to investigate the spiritual as well as the physical components of illness. The spiritual significance may be greater than the physical significance of symptoms. Physicians need[24] to help patients deal with meaninglessness, despair, shame and guilt. When compassionate physicians provide non-judgmental treatment with integrity and courage patients are empowered to deal with spiritual dis-ease. Physicians lacking training and experience to deal with spiritual needs should consult with those possessing these skills. Physicians providing primary care need the expertise to provide spiritual care.

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[23] Thomasma, David C. "The Basis of Medicine and Religion: Respect for Persons." *Hospital Progress* 1979; 60:54-57, 90

[24] Knapp RJ, Peppers LG. "Doctor-Patient Relationships in Fetal/Infant Death Encounters." J Med Ed 1979; 54:775-780

McCormick TR, Conley BJ. "Patients' Perspectives on Dying and on the Care of Dying Patients." WJM 1995; 163:236-243

In earlier times spiritual care was relatively simple for physicians were part of their patients' heritage and ethos. No longer is this true. Only rarely do physicians share either their patients' heritage or their community[25]. Physicians need to learn the source of patients' spiritual strength. Those possessing spiritual care skills more effectively guide patients to responsible self-care. Whether or not they want their physician to understand them, patients do not volunteer their social, religious and spiritual relationships. Instead patients elaborate on peripheral issues and are pleased when their physicians pick up on cues and explore withheld information. Respect and cooperation increase. Disappointed when physicians do not pursue cues they often ignore their advise[26].

3. *Spiritual care decreases the cost of patient care*

Physicians who do not evaluate patients' spiritual domain miss the spiritual brokenness. Often these patients are treated for depression because of their despair, loss of meaning and hopelessness. Though their physiology may improve, they do not "feel better" causing many physicians to order additional tests, medication or both. This adds to the cost of medical care and may increase morbidity. Such patients will not "feel better" while their spiritual brokenness is ignored. They need spiritual help.

4. *Pragmatic science documents that attention to the religious and/or spiritual improves health*

A review of 212 articles examining the role of religion in health found that 75 percent showed a positive benefit of religious practices on health[27]. Religion has a profound positive effect on the

[25] Hiok-Boon Lin, Elizabeth. "Intraethnic Characteristics and the Patient-Physician Interaction: 'Cultural Blind Spot Syndrome.'" J Fam Pract 1983; 16:91-98

[26] Rogers David E. "On trust: a basic building block for healing doctor-patient interactions." J Roy Soc Med 1994; Supple 22:2-5

[27] Matthews, DA, Larson DB, Barry CP. *The Faith Factor: an Annotated Bibliography of Clinical Research on Spiritual Subjects.* Vol I. Rockville, MD: National Institute for Health Care Research. 1993.
Larson DB. *The Faith Factor: an Annotated Bibliography of Systematic Review and Clinical Research on Spiritual Subjects. Vol. II.* Rockville, MD: National Institute for Healthcare Research, 1993
Matthews DA, Larson DB. *The Faith Factor: an Annotated Bibliography of Clinical Research on Spiritual Subjects. Vol. III.* Rockville, MD: National Institute for Healthcare Research, 1995

treatment of substance abuse, mental illness and quality of life. In a study of college students[28] those who were highly religious enjoyed better health, had less illness and fewer injuries. In addition they had a better lifestyle. Byrd showed that intercessory prayer for post-myocardial infarction patients in a coronary care unit in San Francisco was associated with less frequent complications[29]. Church members had significantly lower mortality rates than non-church members in Alameda County, California[30]. When, because of illness, elderly people were forced to leave their homes, those with most religious commitment had less mortality[31]. Survival from coronary artery bypass surgery is higher among regular church attenders[32]. Intensity of religious practices predicted decreased depression among patients with severe disability[33].

B. What ethical issues are involved?

Some physicians believe that patients do not want physicians to bring religion into their clinical practice[34]. However, nearly half of hospitalized patients want their doctors to pray with them[35].

Patients are dependent, vulnerable and exploitable. It is wrong to dominate and control patients so that they think, believe and follow their physicians' will. It is also wrong to ignore the human

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[28] Oleckno William A, Blacconiere Michael J. "Relationship of Religiosity to Wellness and Other Health-related Behaviors and Outcomes." *Psychol Rep* 1991; 68:819-826.

[29] Byrd Randolph C. "Positive Therapeutic Effects of Intercessory Prayer in a Coronary Care Unit Population." *South Med J* 1988; 81:826-829

[30] Berkman Lisa F, Syme S Leonard. "Social Networks, Host Resistance, and Mortality: a Nine-year Follow-up Study of Alameda County Residents." *Am J Epidemiol* 1979; 109:186-204

[31] Zuckerman Diana M, Kasl Stanislav V, Ostfeld Adrian M. "Psychosocial Predictors of Mortality among the Elderly Poor." *Am J Epidemiol* 1984; 119:410-423

[32] Oxman TE, Freeman DH, Manheimer ED. "Lack of Social Participation or Religious Strength and Comfort as Risk Factors for Death After Cardiac Surgery in the Elderly." Psychosom Med 1995; 57:5-15

[33] Koenig, Harold G. "Use of Religion by Patients with Severe Medical Illness." *Mind/Body Medicine* 1997; 2:31-36

[34] Dossey, Larry. *Healing Words: The Power of Prayer and the Practice of Medicine*, 1993 HarperSanFrancisco.

[35] King, Dana E, Bushwick Bruce. "Beliefs and Attitudes of Hospital Inpatients about Faith Healing and Prayer." *J Fam Pract* 1994; 39:349-352.

domain. Skipping the spiritual dimensions of illness is just as wrong as skipping the physical, mental, emotional or social domains. As physicians learn the spiritual aspects of patients' illness they understand the anatomy of their suffering and are able to respond with wisdom and courage. They will know gentle words to speak to a hurting friend. When physicians intentionally provide spiritual care for illness, they empower patients to responsibly solve their own needs and intelligently follow valid therapies.

1. Bioethical principles

Four principles dominate biomedical ethics[36]. These are 1) *autonomy* - respect for each person's capacity to make informed decisions and the right to be held accountable for them. 2) The principle of *non-maleficence* expands Hippocrates' aphorism, "First, do no harm." 3) *Beneficence* requires physicians to do good to use their clinical skills benefiting patients. Society expects physicians to render clinical assistance when that is within their purview and when such help is not provided this is called negligence. 4) *Justice* requires equal opportunity for all. This means that physicians give competent care equally to each patient.

2. Autonomy

Autonomy requires that patients be able to make free informed decisions. They need to understand the meaning of their illness and the possible treatments. Only when physicians and patients dialogue openly including the religious and spiritual dimensions of the illness can they acquire the critical information necessary to make informed and free decisions. Spiritual care increases patient autonomy and enables patients to move toward wholeness despite their physical abnormalities. Without attending to the spiritual, medical advise is limited in focus and many unanswered questions remain causing patient uncertainty and anxiety. This limits their ability to make appropriate health care decisions. Patients who know that their physicians will accompany them as they explore their illness, including the spiritual implications, become willing to take responsibility for their needs. Not providing spiritual care limits patient autonomy.

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[36] Beauchamp, Tom L, Childress, James F. *Principles of Biomedical Ethics*, 1983. Oxford University Press, Oxford p x.

3. Non-maleficence

When physicians do not evaluate the spiritual dimension they limit their knowledge of their patient's illness and miss major aspects of patient suffering. When physicians prescribe therapy after evaluating only the physical or emotional dimensions of symptoms, they treat without identifying underlying causes. This is akin to the outmoded practice of using analgesics for abdominal pain without appropriate evaluation or plans for such. By neglecting spiritual dimensions, physicians break the principle of non-maleficence and may harm their patients.

4. Beneficence

The principle of beneficence requires physicians to do the good of which they are capable. Physicians who do not provide this good are negligent. To arbitrarily limit patient evaluation and therapy to the physical or emotional ignoring the religious or spiritual is to neglect patients' deepest needs. All physicians can offer spiritual care regardless of their belief system either by skillfully responding or by calling an appropriate consultant. Physicians who ignore areas of brokenness that they (or available consultants) could help break the principle of beneficence. In this they are negligent.

5. Justice

The principle of justice demands that all patients receive equal opportunity for care of the physical, cognitive, emotional, social, religious and spiritual aspects of their illness. Justice is not served when the religious and spiritual needs of some patients are neglected.

6. To be ethical

Physicians (healers) are called to treat patients (sufferers). In this they supervise the total care of their patients. The multidimensional requirements for healing oblige physicians (healers) to address spiritual needs. They may not ignore major areas of suffering just because they lack training and skill in that area. Ethical physicians are obliged to identify all areas of brokenness whether physical, cognitive, emotional, social, religious or spiritual. When they identify religious or spiritual brokenness, what then? They are obliged to offer rational effective therapy. Those unable to provide religious or spiritual care should consult with other physicians, chaplains, patient's spiritual counselor; someone who can meet the patient's spiritual needs. Primary care

physicians, and others, will want to obtain additional training so they can better meet patients' religious and spiritual needs.

V. INITIAL RELIGIOUS AND SPIRITUAL QUESTIONS

Asking religious and spiritual questions is straight forward and readily accepted by patients. The following questions are part of the author's initial patient work-up. I ask the following without any special permission: 1) After "Past Medical History," I ask, "How is your glue holding? What sustained you during these crises?" Sometimes I include a modification "What was your source of strength? How has this illness altered the way you see yourself?" Answers to these questions evaluate patients' spiritual strength. 2) Classic social history includes social, cultural, and religious heritage. I add "Have these helped you? How have they helped you deal with your illness?" 3) After I finish examining the patient I ask, "What are you famous for?" Patients respond with a demur "Nothing," and then share. By taking an extra 10-30 seconds I learn something about my patients' religious practices, the source of their spiritual strength and how they see themselves.

Patients do not expect physicians to query and may prefer not to expose parts or all of their religious or spiritual lives. Therefore, I ask and receive specific permission before follow up to their responses or asking additional questions. Requests for permission are of the nature, "You said …, I was wondering …. Would you like to discuss that further? For example, "You said that you attend church regularly, but did not indicate that it was a source of strength during this illness. Would you like to say more?" I seek to understand my patients' journey prior to this illness and how this illness effected their life. In this manner I learn about the destruction to their person-hood brought by illness. When I learn their values and concerns, I can discuss therapy and expectations in the "language" of my patients and help them set realistic goals.

VI. CONCLUSION

To be truly human, physicians need to give spiritual care. In addition, physicians need to give spiritual care because their patients need spiritual care. The face of illness is very complex. It includes more than physiologic, immunologic and anatomic disruption. It also threatens the cognitive, emotional, social, religious, and spiritual life.

For millenaries physicians, without scientific medicine, met patient needs by meeting their emotional, social, religious and spiritual needs. "Scientific medicine" left these valuable therapies because it forgot its history. "Scientific medicine," divorced from patients' spirits and souls may improve patients physically but leaves them emotionally, socially, religiously and spiritually bereft. In this chaos, patients attack scientific medicine and seek healing through alternative medicine and new age enlightenment.

In this paper I argue that people are multi-dimensional, actually have multiple foci. They can not be dissected into multiple parts. Based on a virtue based model of patient care, I show that physicians are obliged to treat the "whole patient," i.e. not only the physical but also the mental, emotional, social, religious and spiritual. I conclude that when physicians neglect intentional spiritual care they run afoul the principles of biomedical ethics and are guilty of patient abandonment. In fact, the absence of intentional spiritual care is tantamount to patient neglect.