Institute for Christian Teaching
Education Department of Seventh-day Adventists

HEALING, SALVATION AND EVANGELISM

Harvey A. Elder, MD,
Professor of Medicine,
School of Medicine, Loma Linda University

A paper presented on June 25, 1999
at the
24th International Faith and Learning Seminar
held at
Andrews University
Berrien Springs, Michigan, USA

I. INTRODUCTION

A. God calls us to evangelism

God commissioned us to spread the good news of the Kingdom of God everywhere. "**All authority** in heaven and on earth has been given to me. **Therefore go** and **make disciples** of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, and **teaching them** to obey everything I have commanded you. And surely I am with you always, to the very end of the age[1]." This is what Jesus did, it is how He characterized His mission, "For the Son of Man came to **seek and to save what was lost**[2]." At the close of His ministry in prayer to His Father, Jesus said, "**I have revealed you** to those whom you gave me out of the world. . . For **I gave them the words you gave me** and they accepted them. **They knew with certainty that I came from you**, and they believed that you sent me[3]." For Jesus, obedience to His Father included sharing words, words given by His Father that identified who He was and Who sent Him. During His Earthly ministry, Jesus sent His disciples with instructions to combine healing with preaching about "the Kingdom[4]." This is what all Christians are commissioned to do.

B. We need to be evangelistic

As we observe people who know not Jesus, we observe their sadness and are overwhelmed by sadness as we observe their suffering. They suffer from what we suffered from before we knew who Jesus is and experienced His healing. We know how they can be healed—we know that they don't need to suffer, they need to know Jesus and Who sent Him. As we share what Jesus did for us, the healing that we received and who Jesus is, we bring health and healing to others. Their response documents God's power to heal—spiritually as well as in other domains. Our suffering is redemptive! We need to share God's goodness in sending Jesus so our healing will continue.

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[1] Matthew 28:18-20, NIV

[2] Luke 19:10, NIV

[3] John 17:6-8, NIV

[4] Luke 9:3, NIV

Our patients have the same deep longing we had. Often they resolve this by "quick fixes," destructive acts that give immediate relief but then, increase their longing. They are in a frantic downward cycle—seeking immediate relief they increase their longing. They do not know that the source of their longing is a desire to know Jesus and Who sent Him. They do not know that they are God's "beloved child." If only they knew Hiim, their longings would be satiated and their destructive behavior ended. Our patients need to hear the Gospel presented by someone they respect and trust.

The Gospel "is the power of God for the salvation of everyone who believes.[5]" This change from death to life gives meaning and hope, value and a future. I argue in this paper that clinical care of people, by whatever discipline, should include evangelism—sharing Jesus and the "good news" of who they are in Him.

II. HEALING USED TO INCLUDE THE SPIRITUAL

Historically, medical care provided comfort, emotional support, reinforcement of the supplicant's religious tradition and limited physical benefit. In bygone eras, the spiritual component of medical care assisted more with healing than the physical modalities. Today's patients appreciate the strides made in anesthesia, surgery, pharmacologic agents, transplantation and other therapeutic advances. Yet, our patients still long for the comfort[6], support and religious validation that were medicine's heritage. Patients seek medical care at a time when they are vulnerable, impotent, and dependent. They receive physical care with hope (for cure), awe (this works in some mysterious manner) and the responsiveness of a sincere supplicant (they obey, even to sacrificing their comfort or even part of their anatomy!). In reality, all clinical care has a spiritual component; a component that often controls the effectiveness of the physical components. Spiritual care happens with or without intent. Since it has potential toxic side effects spiritual care needs to be intentional so it may have therapeutic intent, so it does not dehumanize patients and retard healing.

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[5] Romans 1:16, NIV

[6] Bauer, Irvin S., "Star Treatment." Ann Intern med 1999;130:447-449

Excluding religion and spirituality from academic thought excluded spiritual care from the medical arena for more than half a century[7]. I believe that the absence of an intentional spiritual component is a major reason for patients' dissatisfaction with current medical care. In this paper I argue that spiritual care should be included as an integral part of scientific medical care. The standard of clinical care should include spiritual diagnosis and therapy intentionally formulated to meet patients' spiritual needs aggravated by illness.

III. MEDICAL CARE NEEDS TO INCLUDE THE SPIRITUAL

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[8]; 3) unless directly addressed, patients may be unaware of and rarely volunteer the religious/spiritual aspects of their illness.

Illness engenders fear. It profoundly alters the way people view today and anticipate tomorrow. Patients frequently deny the significance of symptoms. Patients expect health care to heal the symptoms that support their fears. The meaning assigned symptoms, not symptoms *per se* cause fear. Patients need help to face present fears and find courage for the future. Patients need care adequate for their fears, care that assists as they deal with fear. The following illustrate patients' responses to illness:

> *Mrs. S loved to dance. She has just been diagnosed with amyotrophic lateral sclerosis (Lou Gehrig's Disease). When asked "What do you hope for?" she answered, "I just want to dance again!"*

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[7] 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."

[8] 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.

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 admitted 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.

IV. ISSUES

A. Relationship between medical care and the religious/spiritual[9]

In earliest recorded history, priests were also medicine men. Hebrew priests not only performed religious services, they also diagnosed illness.[10] Early Christian Churches provided hospice care for the sick and dying[11] and at a later time, monasteries set up hospitals. Earliest medical schools were "Church related.[12]"

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

[10] Leviticus 13:1-44

[11] 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.

[12] 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

During the renaissance, science became increasingly restive under religion culminating in "the enlightenment" with its rationalistic philosophy. Rational scientific medicine was and continues to be responsible for most of the great advances in medical care during the past half century. As medicine became more and more scientific it abandoned its humane soul.

Scientific advances plus associated relativism and individualism solved neither social problems nor their medical consequences. In fact, "they have extinguished the motive for education—to understand the interwoveness of the facts/values and objectivist/relativist pathologies and the cultural consequences of the loss of purpose and meaning."[13] Societal weariness with scientism manifests in the growth of religions that highly value spirituality, i.e. increasing interest in Native American and eastern religions, the popularity of "New Age" and the rise of spiritism and witchcraft[14].

What do I mean by "spiritual?" "Spirituality, in the strict and profound sense of the word, is the dominion of the spirit.[15]"

> A "spiritual life" consists in that range of activities in which people cooperatively interact with God—and with the spiritual order deriving from God's personality and action. . . Spirituality is a matter of *another reality*. . . [I]t is not a "commitment" and it is not a "life-style," even though a commitment and a life-style will come from it.[16]"

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 refer 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

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

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

[15] Gutierrez, Gustavo. *A Theology of Liberation*, trans. Caridad Inda and John Eagleson 1973; Orbis New York. P 203.

[16] Willard, Dallas. *The Spirit of the Disciplines*. 1988; Harper & Row, San Francisco p 67.

and a philosophy. It may include dogma, metaphors, myths, and a way of perceiving the world.[17]" Spirituality deals with meaning and hope[18], value and worth, preciousness as a person of worth and related to the Supreme Being of the universe

B. Our patients have religious and spiritual dimensions

In health, most people give little thought to identity, hope or to the meaning of life; they simply live life. With illness many questions emerge. Symptoms bring mortality to conscious thought causing patients to fear death. They question why they suffer and seek for meaning in their suffering. Many loose hope and fear both their 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 itself. They may fear extinction or punishment after death. These fears are spiritual.

Families and ethnic groups respond to symptoms in culturally described ways. Illness has additional memories based on previous personal or family experiences. These memories include not only the physical facts but also the outcomes and the meanings assigned by history and heritage. Patients define illness as trivial or serious, acute or chronic based on their illness memories. They listen to their illness memories and trust them to predict outcomes.

Illness distorts patients' physical, mental, emotional, social, religious and spiritual realities and engenders chaos. It exposes neediness. Patients want help—external help for their medical, emotional and social needs, and internal help from their religious and spiritual needs. Their neediness overwhelms every dimension and facet of their lives. They need help with the physical manifestations of illness. They need education regarding their diseases. They need help with their isolation and loneliness, with their anger, fear, loss and grief. They need help dealing with relationships. Illness presents new challenges to their religious heritage, self perceptions, and encounters with the Transcendent. They need to find meaning in their illness other than that

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

[18] Hope is not the conviction that things will turn out all right; it is the certainty that I, though ill and dying, will have meaning, I have a purpose and will be valued regardless of how events turn out.

assigned by their illness memories, they need to find a hopeful future and the power to persist despite the burden of illness. For all this they need help.

1. *Patients need "Spiritual Care",*

For millennia, physicians knew their patients including their cultural expectations, religious practices, spiritual insights and memories. Without a useful pharmacopeia they met patients' medical needs by optimizing 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 aspects of illness while ignoring its religious and spiritual aspects. Scientific medicine anticipates responsible self care by patients and those who are not responsible[19] frustrate therapeutic outcomes. Spiritually healthy patients practice the disciplines for responsible self-care because their life has meaning and they value themselves, they have hope and to them, life is worth living. Responsible self-care is part of spiritual health. In contrast, patients who are spiritually broken loathe themselves and have neither hope nor a future. Unable to implement change and responsibly care for their health they live out of harmony with natural laws. They live meaningless lives. Many also live in guilt and shame and lack social support.

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 develop a community of support. In their suffering and hurt they need to forgive and let go, thus ending bitterness[20].

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

Arrogant professionalism,[21] which emerged from the pride of 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[22]. Patients wish their physicians were open, listening to their heart, hearing them as worthy reporters of important

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[19] Most physicians shun chemical addicts and patients with compulsive disorders

[20] Anderson, Donald, Chairman Department of Psychiatry, School of Medicine, Loma Linda University.

[21] Kraybill, Donald B. and Good, Phyllis Pellman, "Introduction." *Perils of Professionalism; Essays on Christian Faith and Professionalism*, Donald B. Kraybill and Phyllis Pellman Good editors, 1982. Herald Press, Scottdale, Pa. p 10

[22] Horn, Mary O'Flaherty "The Other Side of the Bed Rail." *Ann Intern Med* 1999;130:940-941.

information. Patients want physicians to be more than mere practitioners of medical science, they want them to practice medicine as a high calling[23].

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 a successful practice that brings status and power, they need a mission large enough to validate the drudgery of their training, 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.

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

The multiple models of the physician-patient relationship[24] polarize over the role of spiritual care.

1. Biotechnical models

Biotechnical models of health describe disease in cellular terms. Deranged chemicals and defective cells with and impaired communication between them cause disease. According to these models, medical care simply corrects chemical and biological imbalances by restoring or removing malfunctioning cells. These models have provided most of the scientific advances in medical care. Though excellent for laboratory studies of the physical, these models by pass the meaning and symbolic significance of illness—for these do not reside in the physical domain, they are not subject to objective measurement. Health care that ignores personal, relational and spiritual needs misses the human aspects of disease.

2. Virtue based altruistic models[25]

Virtue based altruistic models are more humanistic. They anticipate moral humane clinicians with nurtured and trained characters. These models support patients' desire for virtuous people they can hold "morally accountable for ... [their] actions[26]." Within the limits of science and clinical

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

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

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

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

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. 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 and religious dimensions in their clinical care. Spiritual care, though ignored in biotechnical models, should be included in virtue based models.

D. Who is the patient?

People are more than the moment by moment structure and function of their bodies and minds. Memory incorporates and integrates history giving people identity in their world and a relationship with who/what they consider ultimate. This gives joy to the present, perspective for the future and courage to hope.

To be a whole person is to be integrated and whole. 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 emotional, social, religious and spiritual facets of life significantly modify health. When we speak of "body, mind and spirit" we speak of different perspectives not different parts, functional entities, or distinct parts. This convenient artifacts assists discussion, however, the parts cannot be dissected out, they cannot function separately. 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 physicians who understand the multidimensional complexity of patient's complaints[27].

Jewish Scripture says that God made humans "in His image[28]." Other ancient perspectives use similar terms to identify humans by their relationship with "God." The universality of notions of

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[27] A symptom in some people causes multidimensional distress, in others the same severity of the same symptom may cause minor distress limited to the physical

[28] Genesis 1:26,27

God suggests that these are useful[29]. However, illness complicates peoples' relationships with their God. The sick become very self-centered while loathing their own bodies! Their focus attends to the ever-present screams of pain and disability rather than a relationship with "God."

E. What is illness?

Illness is multidimensional brokenness with loss of integration[30]. The sick suffer physically, have unreasonable thinking and expectations based on deficits in knowledge. They assign cause and effect without a logical basis. Frequently fear, loneliness, anger, loss, and grief accompany illness. Often illness strains social relationships[31] and frustrates cultural and family expectations. It causes a crisis of religious faith by stressing peoples' belief in a loving and beneficent God. Illness dehumanizes and destroys the sense of being precious. It clouds the future, distorts meaning and purpose obliterating hope thereby threatening spiritual health. Sick people wonder if their illness was caused by past actions. Many believe, "I am being punished!"

Illness confronts sufferers with frightening questions: "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 just need to calm down?" Patients want more than physiological homeostasis, they want answers, words that restore meaning, hope and purpose[32].

Patients see themselves from multiple viewpoints, each viewpoint spans from negative to positive: self as worthless vs. worthwhile, living in isolation vs. community, I am an exception to natural law vs. I live in harmony with law and guilt laden vs. forgiveness and peace. Illness usually damages self-perceptions shifting them toward the 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!" i.e., "I thought I was an exception to natural law!" Many patients find it

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

[30] Patients who have meaning and purpose in life understand their illness. It causes only minor distortions to their life. However, for patients lacking purpose who live meaningless lives illness threatens their intactness causing them to confront their mortality.

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

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

difficult to forgive their own past, some blame others for untoward consequences of their behavior while rejecting personal responsibility. Based on these four spectra, patients want and need more than just physical help[33].

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 *sózó* as "to heal" or "to save" and the noun *soteria* as "health" or "salvation" depending upon the setting[34]. Salvation notions such as "rescue from death," "restore to relationship" and "wholeness" also apply to healing and health. For thousands of years most cultures regarded healing as a gift, a favor bestowed by their "gods", a reward for goodness. Thus, healing restored patients to community. Death was so common that healing was cause for celebration by family and community. Health and healing reinforced religious beliefs. They documented forgiveness and reinforced society's laws and taboos. From early history until the first half of this century healing included healing of emotional, social, religious and spiritual relationships.

During the end of this century, science became the healing "god." We can "explain" healing so we no longer celebrate it. Scientific medicine cures but does not heal. It restores the anatomy and physiology, but not broken relationships and broken hearts. It cannot restore people to community. Cures do not establish us as "somebody" rescuing us from being "nobodies[35]." A course of therapy can provide physical wellness, it can make us well. Freed from the consequences of our dysfunctional life, we continue without symptoms and without celebration.

But we have not become "whole." We have been cured, as if by magic, we do not know what else may "attack" us. Thus we hide from our past and live fearfully facing the future without hope or courage because we have no healer. Without appreciation for our preciousness we do not value ourselves. We face our powerless futures without hope. As cured people we do neither provide

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

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

[35] Wagner, Maurice E. *The Sensation of Being Somebody*, 1975. HarperPaperbacks, New York, NY

responsible care for self nor care for planet Earth. In contrast, healed people know that they have an important place in this vast universe. Their lives are meaningful, they look to the future with hope knowing that they are cared for and precious. This knowledge empowers them, they share their preciousness in caring loving relationships. Empowered by their relationship to the universe, they 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. If cure only alters 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, fostering the attitude, "Society (scientific medicine) owes me a method (or therapy) so I may continue my addictions without personal risk (though I may harm others)."

V. HOW CAN PHYSICIANS PROVIDE SPIRITUAL CARE?

Ambroise Paré, the great medieval surgeon said, "I do the sewing, God does the healing[36]." Many patients are awed by healing's magnificent mystery. To them scientific medicine alters body conditions to 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 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 in their search for freedom from destructive ideas[37].

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[36] 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

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 patient's relationships with "God" and also how each views self and his (her) place in the 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[38]. Society expects physicians to do more than care for cells and chemistry[39]. Society calls physicians to place the interests of patients first, 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 to comfort those who worry about symptoms or grieve from loss.

Many physicians hear a call to heal patients guiding them to health: physical, mental, emotional, social, religious and spiritual health. Society would like their 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. As physicians we must value society's calls ever striving to the highest possible service.

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[37] 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

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

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

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

A. Reasons:

1. Illness has great symbolic significance

Illness has great symbolic significance. Previous experiences affect the meanings patients' assign symptoms and illness[40]. Discovering meanings and assigning values are spiritual activities. The meanings assigned to illness alters perceptions of identity as well as the future. Meanings cause people to either face their futures with hope and courage because they trust or to refuse hope and faith. 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 not only the physical but also the spiritual components of illness because the spiritual significance of symptoms may be more important than their medical import. Physicians need[41] to help patients deal with meaninglessness, hopelessness, 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 who lack 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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[40] Thomasma, David C. "The Basis of Medicine and Religion: Respect for Persons." *Hospital Progress* 1979; 60:54-57, 90

[41] 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 shared their patients' heritage and ethos. Now, physicians rarely share either their patients' heritage or community[42]. Physicians need to learn the source of patients' spiritual strength. Those possessing spiritual care skills more effectively guide patients to responsible self-care. Respect and cooperation increase. Disappointed when physicians do not pursue cues of relational or spiritual distress, patients often ignore medical advise[43].

3. Spiritual care decreases the cost of patient care

Physicians who do not evaluate patients' spiritual domain miss evidences of 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 and consultations. These increase medical costs and may increase morbidity. Without spiritual therapy such patients will not "feel better." They need spiritual help.

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

In a review of 212 articles which examined the role of religion in health Matthews, *et al* found that religious practices[44] had a positive health benefit in 75 percent[45]. Religion has a profound positive effect on the treatment of substance abuse, mental illness and quality of life. Highly religious college students[46] enjoyed better health, had less illness and fewer injuries than the less

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

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

[44] Religious practices were the external manifestations of religion, not internal religiosity

[45] 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

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

religious. 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[47]. Church members had significantly lower mortality rates than non-church members in Alameda County, California[48]. When, because of illness, elderly people were forced to leave their homes, those with the most religious commitment had less mortality[49]. Survival from coronary artery bypass surgery is higher among regular church attenders[50]. Intensity of religious practices predicted decreased depression among patients with severe disability[51].

B. What ethical issues are involved?

Some physicians believe that patients do not want physicians to bring religion into their clinical practice[52] however, nearly half of hospitalized patients wanted their doctors to pray with them[53]!

Patients are dependent, vulnerable and exploitable. It is wrong to dominate and exercise control so they follow their physicians' will. It is also wrong to ignore the human domain. In this paper I argue that spiritual care is a necessary component of medical care. I believe that care directed to the spiritual consequences of illness is crucial as is care for the physical, mental, emotional and social consequences. As physicians learn the spiritual aspects of patients' illness they better understand their suffering and are able to respond with wisdom and courage. They will know how to speak gentle words to hurting friends—their patients. When physicians intentionally provide

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spiritual care for illness, they empower patients to responsibly solve their own needs and intelligently follow valid therapies.

1. Bioethical principles

In the past 20 years, four primary principles have come to dominate discussion of medical ethics. They are autonomy (self-determination), non-maleficence ("do no harm"), beneficence (do good), and justice (treat like patients alike).In the past, beneficence was dominant, autonomy has come to be the dominate of the four, probably as a result of societal changes during the 1960's with focus on individual rights.

2. Autonomy

Autonomy does not equal respect. Autonomy is internal, i.e. autonomy belongs to the patient and includes self-governance, liberty rights, privacy, individual choice, self-determination, and accountability. Respect, on the other hand, is attributed by someone else, e.g., physicians. Autonomy is the basis for informed decisions. It requires respectful treatment of patients so that they will be able to make free informed decisions. For this, they need to understand the meaning of their illness and the possible treatments. Only when patients dialogue openly regarding their illness including the religious and spiritual dimensions can they acquire the critical information necessary to make informed and free decisions. Spiritual care increases patient autonomy enabling them to move toward wholeness despite their physical abnormalities. Without attending to the spiritual, medical advise is limited in scope and many unanswered questions remain causing uncertainty and anxiety in patients. 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, are more likely to take responsibility for their needs. Not providing spiritual care limits patient autonomy.

3. Non-maleficence

Non-maleficence, an obligation not to inflict harm, is regarded by some as the foundation of social morality. It is a basic obligation that all individuals have to all others. In the practice of medicine, it requires the physician to not intentionally cause harm. Physicians who ignore the spiritual component limit their knowledge of patients' illness and miss major aspects of suffering. When they prescribe therapy after evaluating only the physical or emotional dimensions of illness, they

treat without identifying significant aspects and possibe underlying causes. This is akin to the outmoded practice of injecting analgesics for abdominal pain with neither appropriate evaluation nor 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 intentional spiritual care provide sub-optimal care to their patients. To arbitrarily limit patient evaluation and therapy to the physical or emotional ignoring the religious or spiritual is to ignore 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 a consultant) could help, break the principle of beneficence. Provision of spiritual care should become the standard of care.

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, "to each according to his (her) need and willingness." Justice is not served when the spiritual needs and desires of 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.

VII. INITIAL RELIGIOUS AND SPIRITUAL QUESTIONS

Religious and spiritual questions is straight forward and readily accepted by patients. The following questions are part of my initial patient work-up and I ask them without special permission. 1) After "History of Present Illness" and "Past Medical History," I ask, "How is your glue holding? What sustained you during these crises?" Sometimes I expand the question with "What was your source of strength? How has this illness altered the way you see yourself?" When answering these questions patients identify their sources of spiritual strength. 2) Classic social history includes ethnic heritage. I ask about their parents' religious heritage and add "Do you still practice?" If the answer is "yes" I query further, "Has it helped you? How has it helped you deal with your illness?" 3) After I finish examining patients 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 about the sources of my patients' spiritual strength, their religious practices, and their identity.

Patients do not expect physicians to query and may prefer not to expose parts or all of their religious or spiritual lives. Therefore, at subsequent visits I ask and receive specific permission before asking additional questions. Requests for permission are of the nature, "You said ...(referring to earlier statements), I was wondering . . . . Would you like to discuss that further?" e.g., "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?"

In general, I want to understand how illness has impacted the patient's journey through life. I seek to learn about the destruction experienced because of illness. I want to learn of values and concerns. With these as a basis, I can discuss therapy and expectations in the patient's "language" helping them set realistic therapeutic goals.

VIII. CONCLUSION

Physicians need to give spiritual care because their patients need spiritual care and to maintain their humanity. The face of illness is very complex. It includes more than physiologic changes, immunologic memory and anatomic disruption. Illness also threatens patients' cognitive, emotional, social, religious, and spiritual life.

From the beginning of time physicians, without scientific medicine, met patient needs by meeting their emotional, social, religious and spiritual needs. Scientific medicine ignored its history leaving these valuable therapies. Scientific medicine, divorced from patients' spirits and souls may improve patients physically but leaves them emotionally, socially, religiously and spiritually bereft. In this chaos, many patients abandon scientific medicine and seek healing through alternative medicine and new age enlightenment.

In this paper I argue that people are multi-dimensional and have multiple foci. They cannot be dissected into multiple parts. Using 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 provide inadequate care to their patients. I believe that the absence of intentional spiritual care is a form of patient neglect.