Afr J Psychiatry 2009;12:103-107

Spirituality as an element of health science education and practice

Each profession has unique elements. It has its own scope of practice and service, its own body of knowledge and skills, its own way of regulating itself. One way of classifying the professions is according to the primary focus of their practice – whether it is the material world (such as engineers, architects and laboratory scientists) or whether it is people, human beings (such as teachers, lawyers, social workers, ministers of religion and, of course, health care professions). The people centred professions serve their fellow humans in different ways. They provide help with tasks which oil the wheels of society (such as educating the new generation, drawing up legal contracts, or even keeping people healthy). But what particularly distinguishes the health care professions (together with social workers and psychologists) is that for much of the time they deal with people who are suffering in some way, who are in some kind of personal need.

There is an aphorism which can be traced back to the 15th century, which says that the role of the healer is 'to cure sometimes, to relieve often, to comfort always.'[1] It has often been quoted since because it is so apt – it so neatly captures the tensions between cure (and life) on the one hand, and comfort (and death) on the other, and relief (and suffering) somewhere in the middle. These tensions have been embedded in the health care professions since their distant beginnings: the great Hippocrates made it clear that it is the suffering individuals that physicians must face, not just their pain – a holistic view of the work of healing, placing the whole individual in the centre. But as the healing professions advanced in science and skill over the last century this began to change: curing came to seem the rule rather than the exception, and it was as if humans were finally conquering disease and cheating death. Many of us were trained in this paradigm – that of the powerful doctor, the master of biomedical science who could heal the body and the mind, who was not overly concerned by other aspects of human suffering or at least didn't associate those with the practice of her or his profession. Within this paradigm we were taught few if any skills to deal with anything outside the biological sphere, and therefore only used those which came naturally to us (or did not). Yet at the same time we encountered those special teachers who exemplified a more holistic approach in their practice, and felt intuitively that theirs was a better way.

As so often happens in human history it was inevitable that the pendulum should swing back from this kind of biomedical reductionism in practice and training. It is instructive to take a brief look at two of the leading figures in this return to holism, George Engel and Cecily Saunders.

George Engel practised and taught medicine in Rochester, New York, in the latter half of the 20th century. His reaction to the reductionism of his time was a return to the understanding of medicine as an art as well as a science, and it was he who in the 1970s developed the 'biopsychosocial' paradigm of health care practice[2] – the word is self-explanatory and is set in opposition to 'biomedical'. Engel's seminal work was taken up with enthusiasm by the burgeoning discipline of Family Medicine which continued to develop and popularize it[3] – so much so that medical students in many parts of the world now imbibe this approach as it were with the mother's milk of their undergraduate training (although it must be said that some of their older teachers still regard it with a measure of skepticism as 'that soft stuff'). Students now learn that many patients 'somatise', that they present with physical complaints when their real issue is one of unhappiness; they learn to identify and deal with such 'help-seeking behaviour' in a consultation. They learn the importance of the role of the family in maintaining health and dealing with illness; they learn how a person's community and physical environments affect health and how such influence needs to be considered in a management plan. They are constantly confronted with the need to examine the ethical implications of medical practice and to analyse situations where these are operating. These new young health professionals are now comfortable with the fact that the suffering they will encounter has at least three dimensions – the physical, the psychological and the social. They are more or less comfortable with these dimensions, have some skills to deal with them and expect to include them in their practice. One of our fifth year students recently told me of an experience that he had had earlier that day in one of the wards. He said that a consultant had just informed a woman that she had inoperable cancer, 'and Prof., he did it so badly! She started crying and he just walked away. If only he'd asked me to do it I could have done it so much better!'

But there is a further element to the suffering that our patients encounter – and note that I am deliberately using the word 'patient': our Roman predecessors had it right when they termed those who came to them for help 'patientes'. The fact of the matter is that the people who entrust themselves to health professionals do so because they are suffering in some way and not because they are entering into a business transaction with us as 'clients'. A pioneer in bringing this fourth element to the forefront is the admirable Cecily

Saunders, who as we all know founded the modern hospice movement. Her epiphany took place against the background of the increasing technical success of the health care professions, of situations where in the words of T.F. Main, 'The sufferer who frustrates a keen therapist by failing to improve is always in danger of meeting primitive human behaviour disguised as treatment.'[4] At the same time this success had led to a distancing of the average person (and the healer) from the unpalatable reality of death and dying, and this at a time when a widespread loss of religious faith in some communities had diminished the traditional avenues of solace available to people confronted with suffering and death. The story is well-known, of how the young social worker met a refugee from the Warsaw ghetto who was dying in hospital in London. As she and David Tasma became friends and were able to talk about his coming death it became clear to her what people like David really needed: holistic care, based on the understanding that they were suffering from 'total pain' (a phrase she coined) – a complex of physical, emotional, social, and spiritual elements.[5] She spent the rest of her life responding to this understanding by working out how to respond practically to it. As we know the small start at St Joseph's and St Christopher's Hospices gave a name to this art (which had never completely disappeared) and palliative care has mushroomed into an international movement which has attracted thousands to its cause and has been a blessing to millions. And as a result the paradigm of training of young health professionals today has been even further enriched, by the inclusion of the science and art of palliative care.

It is not hard to understand why Dame Cecily included the spiritual dimension in her understanding of suffering. It is surely when people suffer greatly, and witness the suffering of people they love, and when death is clearly approaching, that the great questions around the mystery of existence inexorably present themselves: 'Why was I born?' 'Why has this suffering come to me?' 'Have I done the best I could with my life?' 'What about the people I've harmed, wittingly or unwittingly?' 'How will the people I love remember me?' 'How will the people I love cope when I am gone?' 'When will I die, and how?' 'Will I die courageously?' 'What kind of suffering will I have to go through in the process of dying?' Then there is the mystery of what follows death, the Great Unknown: 'What is going to happen afterwards?' 'Will there be an existence to follow?' 'Will there be some kind of judgment on my life?' Humans through the ages have placed their hopes on answers to these questions developed by spiritual leaders and thinkers: from the ancient Egyptian belief that the heart would be weighed against the feather of Ma'at, the Truth, leading to eternal bliss or eternal oblivion; to the Epicurean's expectation of eternal extinction; to the certainties of reincarnation of the Hindu and Buddhist faiths; to the Christian and Muslim promise of eternal life as a reward for faith or good deeds, in the Celestial City or in Paradise.

Although we see examples of militant atheism in celebrities such as Richard Dawkins[6] the fact is that the large majority of the patients that health professionals in Africa will have the privilege of serving identify themselves with a religion and practise it with greater or lesser devotion and orthodoxy. As a result many health professionals regularly find themselves in the presence of the fourth element of 'total pain', even if they are not aware of it. Even more than that there is (admittedly anecdotal) evidence that many people no longer talk about these issues with religious leaders and bring such problems to their health practitioners, even if subconsciously. These professionals may have the skills and the confidence to deal with their patients 'biopsychosocially' but may in many cases not even consider that they have a role to play in dealing with what Dame Cecily called the spiritual side of suffering; it has been the tradition among us that this is the almost exclusive domain of religious leaders and ministers. But surely what we want of our doctors and other health professionals is for them to be aware of the spirituality of their patients and to be comfortable with it – not only in situations of severe suffering and death but also in the way patients understand disease and the nature of an appropriate healer-patient relationship.

Happily there are many movements afoot to fill this important gap, to provide resources that health professionals and their teachers can use to open up the area of patient spirituality in an appropriate way. There is a rich literature on approaches to spirituality into the clinical setting, reflecting an increasing interest and capacity among health professionals.[7,8,9,10] The topic of spiritual suffering and care has been widely introduced in the undergraduate curricula of different health professionals in different settings.[11,12,13] Resources are also being developed in Africa: a recent South African publication sets out to demystify the spiritual in patients by providing solid information about it in all its local variety and richness, and also suggests a practical way of bringing the issue into the open in a way which fully respects patient autonomy – 'simply asking' courteously if the patient would like any particular religious practices to be borne in mind, or needs spiritual assistance from any source.[14] And doing this with an open mind, 'seeking the patient's view', the golden rule being 'not to assume anything when it comes to religion.' So the health professional becomes not a guru but a sounding board and if necessary a bridge, responding sensitively to any information provided.

There will undoubtedly be a continued debate about whether this 'fourth element' is an 'add-on' or a necessity. Those who take the latter stance (as I do) believe that if health professionals and their teachers embrace it their practice will be greatly enriched: they will no longer have to feel nervous or embarrassed or ignorant, and in stead will be able to approach the spiritual dimension in their patients with sensitivity and insight, and an increasing measure of confidence.

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