The Critical Need for Spirituality in Our Healthcare System

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Human suffering is something that needs to be attended to in our healthcare systems and our society. Finding meaning in the midst of suffering is spiritual at its core. We should have systems of care which support people as they cope with suffering, with illness and with dying. We need systems of care where people can take the time to reflect on their suffering and to engage their spiritual resources.

Suffering, illness, and dying are normal parts of life. In the last century, however, we have seen a dramatic change in how illness and death are handled. Medical technology has made tremendous advances and has as a result increased the average American’s life expectancy. At the turn of the century, Americans’ life expectancy was fifty years. Now, 73 percent of deaths are among people at least sixty-five years old and 24 percent of deaths are among those at least eighty-five years old, according to an end-of-life committee of the Institute of Medicine (Institute of Medicine, 1997). Technology has given people cause to hope for and often attain cures. While this has been a very important and laudable advance in medical science, perhaps this success of technology has also contributed to the denial of death and even illness that is so prevalent in American society.

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Medical education has also been influenced by this technology. In the last half century the medical school curriculum has changed vastly, including new scientific information reflecting this technological advance. As a result, the parts of the curriculum that emphasize the doctor-patient relationship have diminished to allow room for this new scientific knowledge. These changes have contributed to a focus on cure and on fixing. The emphasis in much of medical education has been on making a good diagnosis and being able to fix the problems. While this is clearly necessary, people still must eventually deal with chronic problems such as diabetes, cancer, hypertension, dementia, and finally, death.

Medical education has not traditionally focused its courses on how to help patients deal with the issues that arise in those situations: issues of suffering, dependence, fear, anxiety, and grief. These issues cannot often be quickly diagnosed and fixed. The response to a broken bone may be one of fixing, but the response to suffering is one of service and support as patients try to find meaning in the midst of pain. Death is often seen by healthcare providers and patients alike as an unacceptable alternative and that any treatment, no matter how aggressive, has to be better than death. But in the midst of pursuing a cure, patients are not given the opportunity to face their own issues about their suffering, their mortality, and their meaning in life especially in the midst of chronic illness. These are inherently spiritual concerns that have not been emphasized in medical education nor reflected in our systems of care. Medicine is a service profession at its roots and the focus on technology alone may have diminished the compassionate aspects of our profession.

Observers of medical education have noted an increasing dissatisfaction on the part of society with today’s physicians and in our medical system of care. Physicians are seen as too technical and too distant. Medical care is seen as rushed and impersonal. Other studies such as the SUPPORT study (SUPPORT) and a Gallup survey (Gallup International Institute) have indicated that people would like to die in different environments such as home or hospice, and would like to have their wishes at the end of life respected. Yet this does not happen very often. The Gallup survey further showed that people would like warm, caring relationships with their physicians, and would like to be spiritually attuned with their doctors.
How can we better meet patients' needs, where they can have compassionate care, their wishes respected, and have the time to reflect on their life, suffering, and their eventual death? How can we, as healthcare providers and as a society, give people the opportunity to have a peaceful, meaningful death? There are no easy answers, but it is clear that spirituality is a very important part of the solution.

**Struggle with Illness and Dying: Finding Meaning**

It is our responsibility to listen to people as they struggle with their illnesses and with their dying. We need to be willing to listen to their anxieties, fears, unresolved conflicts, hopes, and despairs. If people are stuck in despair, they will suffer deeply. It is through their spirituality that people become liberated from despair. As people are faced with serious illness or the prospect of dying, questions often arise:

- Why did this happen to me?
- What will happen to me after I die?
- Why would God allow me to suffer this way?
- Will I be remembered?
- Will I be missed?

Victor Frankl wrote that "man is not destroyed by suffering; he is destroyed by suffering without meaning" (Frankl, 135). Spirituality helps give meaning to people's suffering. Similarly Rabbi Cohen writes:

> When my mother died, I inherited her needlepoint tapestries. When I was a little boy, I used to sit at her feet as she worked on them. Have you ever seen needlepoint from underneath? All I could see was chaos; strands of thread all over with no seeming purpose. As I grew, I was able to see her work from above. I came to appreciate the patterns, the need for the dark threads as well as the light and gaily colored ones. Life is like that. From our human perspective, we cannot see the whole picture, but we should not despair or feel that there is no purpose. There is meaning and purpose even for the dark threads, but we cannot see that right away (Cohen, 31).

Spirituality helps people find hope in the midst of despair. We as caregivers need to engage with our patients on the same spiritual level (Puchalski, 1999).
Spirituality as a Patient Need

Several national surveys have documented patients’ desire to have spiritual concerns addressed by their physicians. A Gallup Poll found that 75 percent of Americans say religion is central to their lives; a majority feel that their spiritual faith can help them recover from their illness (Gallup, 1990). Additionally, it was found that 63 percent of patients surveyed believe it is good for doctors to talk to patients about spiritual beliefs (McNichol). The need for attentiveness to the spiritual concerns of dying patients has been well recognized by many researchers (Conrad; Moberg). Ehman and colleagues found that 94 percent of patients with religious beliefs agreed that physicians should ask them about their beliefs if they became gravely ill; 45 percent of patients who denied having any religious beliefs still agreed that physicians should ask their patients about them (Ehman, et. al.). In this survey, 68 percent of patients said they would welcome a spiritual question in a medical history; only 15 percent said they actually recalled being asked by their physicians whether spiritual or religious beliefs would influence their decisions.

There is a growing body of evidence documenting the relationship between patients’ religious and spiritual lives and their experiences of illness and disease (Levin and Schiller). In addition to surveys demonstrating that spirituality is important to people and that many would like their physicians to discuss their spiritual beliefs with them, a number of studies show that having spiritual beliefs is beneficial to patients, particularly those with serious illnesses. There is data that suggests that spirituality may be helpful to people as they cope with dying or with loss. It has been reported that parents who have lost a child have found much support following their child’s death in their faith and church life (Cook and Wimberly). Patients with advanced cancer who found comfort from their religious and spiritual beliefs were more satisfied with their lives. They were happier and also had diminished pain (Yates, et. al.). Women with gynecological cancer reported becoming more spiritual after their diagnosis (Roberts, et. al.).

The twelve-step program Alcoholics Anonymous lists one of the steps as belief in a higher power. In this view, addicts see their drug of choice as central
in their lives; recovery hinges on the ability to find a meaning and purpose outside of oneself. In a study asking older adults about God’s role in health and illness, many respondents saw health and illness as being partly attributable to God and, to some extent, God’s interventions (Bearon and Koenig). Prayer, in this study, appeared to complement medical care rather than compete with it. Meditation has been found to be a useful adjunct to conventional medical therapy for chronic conditions such as headaches, anxiety, depression, AIDS, and cancer (Benson).

That spirituality is central to the dying person is well-recognized by many experts, the most important of which are our patients. People overwhelmingly want to reclaim and reassert the spiritual dimensions in dying (Gallup International Institute). In the study, survey respondents said they wanted warm relationships with their providers, to be listened to, to have someone to share their fears and concerns with, to have someone with them when they are dying, to be able to pray and have others pray for them, and to have a chance to say goodbye to loved ones. When asked what would worry them, they said not being forgiven by God or by others, or having continued emotional and spiritual suffering. When asked about what would bring them comfort, they said they wanted to believe that death is a normal part of the life cycle and that they would live on, either through their relationships, their accomplishments, or their good works. They also wanted to believe that they had done their best in their life and that they will be in the presence of a loving God or Higher Power. It is as important for healthcare providers and other caretakers to talk with patients about these issues as it is to address the medical-practical side of care.

How does spirituality work to help people cope with their dying? One mechanism might be through hope. Spirituality and religion offer people hope. It helps people find hope in the midst of despair that often occurs in the course of serious illness and dying. Hope can change during the course of an illness. At an early stage, the patient may hope for a cure. Later when a cure becomes unlikely, the patient may hope for time to finish important projects or goals, travel, make peace with loved ones or with God, and experience a peaceful death. This can result in a healing, which can be manifested as a restoration of one’s relationships or a sense of self. Often our society thinks in terms of cures.

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Beyond Data: Patient Stories

There have been an increasing number of books, publications, and television programs dealing with the issues of dying patients (Moyers; Puchalski, 1999; Nuland; Singh). In these venues, one can hear stories of personal transformation as a result of the struggle that often accompanies serious illness and dying. In my own experience as a physician who cares for patients with chronic and terminal illness, I feel privileged and honored to care for people who are facing death. Their strength and courage in the midst of suffering is inspiring. My patients are greater teachers to me and to my students on life than any philosophical text. The stories they share are ones of personal transcendence, courage and dignity. My patients continually live with dying, in the midst of which they are often able to face their losses, fears, and pains. They come to a point where they see their lives as rich and fulfilling. They re-order life's priorities and find a place of deep meaning and purpose.

It is often humbling for me to recognize that things in life on which I place importance now may have little or no importance in the end, when facing my own mortality. My annoyance at rush hour traffic or emphasis on academic success pale by comparison to my patients' descriptions of a glowing sunrise or the deep love they feel for another. Not every person finds meaning in illness, and even those people who can transcend their illness still have times of intense suffering and conflict. Sometimes that is just part of a person's spiritual path in which the darkness of dying obscures their faith vision of meaning. But sometimes it may be the result of medical systems of care that do not provide the opportunity and resources for people to explore meaning in their suffering. We need systems of care including spiritual care, where people are able to search for their sense of meaning and purpose in the midst of suffering, and where they can find peace if that is what they choose to do.

Spiritual Care

Spiritual care at its essence is relational. Spirituality can include not only the relationship with the transcendent but also with others. The connection physicians, other healthcare providers, and families make with the patient who is ill and dying is at its root spiritual. The care that a physician provides is rooted in spirituality through compassion, hopefulness and a recognition that although a person's life may be limited or no longer productive it remains full of possibility.
So, even though a person can no longer have curative therapy, they can still find meaning and purpose in their lives, they can still have relationships and they can still heal. The physician and other care providers can offer the opportunity for healing by being present to the patient. The patient and the physician, or other healthcare provider, connect with each other in the context of this healing relationship. There are numerous studies that document the importance of the doctor-patient relationship (Bensing; Backmeyer; Carter, et. al.; Inui, et. al.).

Spiritual care emphasizes the importance of the relationship between two people. Physicians or healthcare providers may be the professional expert in the encounter but we are still human beings. By relating from our humanness we can help to form deeper and more meaningful connections with our patients. What this requires is an awareness of the physician’s or other caregiver’s own values, beliefs and attitudes particularly toward one’s own mortality. By confronting one’s own mortality, one can be better able to understand what the patient is facing. Also, the stress of caring for seriously ill and dying patients can be better handled by an attentiveness to one’s own spiritual and values framework. Many physicians speak of their own spiritual practices and how those practices help them in their ability to deliver good spiritual and good medical care (Sulmasy; Puchalski, 1999). Studies have suggested that family caregivers are better able to cope with the stresses of caregiving by having spiritual practices (Cupertino).

One of the key components of this relationship is the ability of the physician to be totally present to the patient, that is, the practice of compassionate presence. This means that the physician brings his or her whole being to the encounter and places full attention on the patient disallowing distractions such as time pressures or other thoughts from interfering with that attention. Integral to this is the ability to listen to the patient’s fears, hopes, and dreams and being attentive to all dimensions of a patient’s life: the physical, emotional, social and the spiritual.

Obtaining a spiritual history is one way to listen to what is deeply important to the patient (Puchalski, 2001; Puchalski, 2000). When one begins to discuss patient spirituality, one enters the domain of meaning and purpose and how the person copes with stress, illness and dying. The spiritual history affords patients the space and opportunity to address their suffering and their hopes. Having the
physician inquire about the patient’s spiritual beliefs gives the patient an opening and an invitation to discuss beliefs if that is what the patient would like to do.

The spiritual history also enables the physician to connect with the patient on a deep, caring level. In fact, many physicians who obtain spiritual histories remark that the nature of the doctor-patient relationship changes. As soon as they raise these questions they feel that it establishes a certain level of intimacy in terms of really understanding who that person is (Puchalski, 2000). Patients note that they feel more trusting of a physician who addresses and respects their spiritual beliefs. In a research survey at the University of Pennsylvania—65 percent of patients in a pulmonary outpatient clinic noted that a physician’s inquiry about spiritual beliefs would strengthen their trust in their physician (Ehman, et al.).

Once the physician learns about the patient’s spiritual beliefs, he or she can then inquire if there are spiritual practices that are important to the patient—these might be prayer, meditation, listening to certain music, enjoying solitude, writing poetry. One can then incorporate those practices as appropriate. Finally and perhaps most importantly, chaplains and other spiritual care providers are experts trained in the area of spirituality and religion. Working with these spiritual care providers is essential to holistic care. Chaplains should be integrated into interdisciplinary healthcare teams, not only in hospice and hospital settings, but also in outpatient settings as well.

### Changing Healthcare to Include Spiritual Care

We have survey data showing that our patients think spiritual issues are central in life, particularly in death and dying. We have some data suggesting that people use their spiritual beliefs in coping with chronic illness and loss, and we have patients’ stories of personal transformation. Yet we have systems of care that do not incorporate spirituality into the care of patients.

Medical professionals are recognizing these inadequacies in the healthcare system. The American College of Physicians convened an end-of-life consensus panel where they concluded that physicians should extend their care for those with serious medical illness by attention to psychosocial, existential or spiritual suffering (Lo, et. al., 1999). Other national organizations have also supported the inclusion of spirituality in the clinical setting. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has a policy that states: “Pastoral Counseling and other spiritual services are often an integral part of the patient’s daily life. When requested the hospital provides, or provides for, pastoral counseling services” (JCAHO, 1996).

The interest in spirituality in medicine among medical educators has been growing exponentially. Medical schools are now teaching courses in end-of-life care and in spirituality and medicine (Puchalski, et al., 1998; Puchalski, 2001).
Only one school had a formal course in Spirituality and Medicine in 1992. Now over seventy medical schools are teaching such courses. The key elements of these courses involve listening to what is important to the patient, respecting their spiritual beliefs, and being able to communicate effectively with patients about their spiritual beliefs and their preferences at the end of life.

The Association of American Medical Colleges (AAMC) has undertaken a major initiative—the Medical School Objectives Project (MSOP)—to assist medical schools in their efforts to respond to the concerns of the medical community that young doctors lacked these humanitarian skills. The report notes that “Physicians must be compassionate and empathetic in caring for patients . . . they must act with integrity, honesty, respect for patients’ privacy and respect for the dignity of patients as persons. In all of their interactions with patients they must seek to understand the meaning of the patients’ stories in the context of the patients’ family and cultural values” (AAMC, 1998, 4). In recognition of the importance of teaching students how to respect patients’ beliefs, AAMC has supported the development of courses in spirituality and medicine. In 1999, a consensus conference with AAMC was convened to determine learning objectives and methods of teaching courses on spirituality, cultural issues and end-of-life care. The findings of the conference are published as Report III of the Medical School Objectives Project. A part of this report developed a definition of spirituality relevant in the clinical setting:

Spirituality is recognized as a factor that contributes to health in many persons. The concept of spirituality is found in all cultures and societies. It is expressed in an individual’s search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All of these factors can influence how patients and health care professionals perceive health and illness and how they interact with one another (AAMC, 1999, 25).

The outcome goals established by the AAMC are:

They [the medical students] will recognize that their own spirituality and cultural beliefs and practices might affect the ways they relate and provide care to patients. Students will be aware of the range of end-of-life care issues and when such issues have or should become a focus for the patient, the patient’s family, and members of the health care team involved in the care of the patient. They will be aware of the need to respond not only to the physical needs that occur at the end of life, but also the emotional, socio-cultural, and spiritual needs that occur (AAMC, 1999, 26).

Most of the medical school courses in spirituality and medicine are required and integrated into the curriculum. The response to these courses has been positive.
Students and practicing physicians find their relationships with their patients to be warmer, more meaningful and deeper once they talk with their patients about their spiritual beliefs. Medical students and residents are finding it easier to address end-of-life issues in the context of a spiritual history (Puchalski, 2000). Doctors stressed by the hectic schedules of managed care now feel that spiritual discussions give them a way to reconnect with their patients and bring compassionate care back into the practice of medicine. Most importantly, patients are more satisfied because their whole person (body, mind and spirit) is treated, not just their illness.

**Conclusion**

Our culture, as a whole, needs to look at dying very differently from the way it currently does. We need to see dying not as a medical problem but as a natural part of life that can be meaningful and peaceful. By thinking about our mortality early in life, we will not be caught off guard and pressured by the dilemmas of choice at the end of life. We will have had a chance to think about some of those choices sooner and to come to peace with our mortality. This is where religious communities can be particularly helpful. They can facilitate our discussions of suffering and dying and what illness and death means to us. They can educate their members about the importance of preparing themselves for the choices, both spiritual and medical, that need to be made throughout life and near the end of life.

There are changes occurring in medical education today which will affect the way we treat patients more holistically in the future. We are training young doctors to be able to deliver excellent technical care but also compassionate and holistic care so that the doctors of the future will not only be able to fix but also serve. But our healthcare systems need to mirror that change. We need to see our healthcare systems as multidisciplinary with physicians, nurses, social workers, chaplains, clergy, family and others all working together to deliver the most compassionate care to our patients. By recognizing that all dimensions of care (physical, emotional, social and spiritual) are important and by creating care environments where all these dimensions can be addressed, we will reclaim the most honorable of our profession’s values: to serve others and to help them heal.

**References**


