Virtual Mentor
American Medical Association Journal of Ethics
October 2009, Volume 11, Number 10: 804-815.

OP-ED

Physicians and Patients' Spirituality

Christina M. Puchalski, MD, MS, Stephen G. Post, PhD, and Richard P. Sloan, PhD

Editor's Note: In this series of op-ed articles, three authors explore a range of perspectives on the question of whether physicians should engage patients on the topic of spirituality.

Ethical Concerns and Boundaries in Spirituality and Health

Christina M. Puchalski, MD, MS

Spirituality has become an increasingly prevalent topic in current models of health care. More than 75 percent of medical schools teach topics related to spirituality and health, and hospitals are beginning to develop spirituality programs to increase the delivery of compassionate care [1, 2]. Spirituality can be defined as "the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred" [3]. Illness can trigger profound existential questions for the patient and family, as well as for health care professionals, and questions about why people suffer, die, or have to deal with unbearable stress are often at the heart of the clinical encounter.

Spirituality and religious beliefs and practices have been shown to have an impact on how people cope with serious illness and life stresses [4, 5]. Spirituality often gives people a sense of well-being, improves quality of life, and provides social support [6, 7]. Spiritual beliefs can also affect health care decision making [8]. Numerous surveys indicate that patients want their clinicians to talk with them about their spiritual needs and integrate spirituality into their treatment plans [9, 10].

Healing Clinical Relationships

An integral part of spiritual care is the focus on the patient-clinician relationship in which care is viewed from a humanistic as well as technical perspective. Differentiation is drawn between cure and healing and between disease and illness. An emphasis on cure or disease relies primarily on the scientific model of care. Focusing on healing or illness brings the patient and the physician into the clinical context. The patient's wishes, beliefs, and values play a role in decision making and in the treatment plan. And the clinician's ability to form a compassionate relationship with the patient is as important as that clinician's ability to diagnose and treat the patient scientifically. Central to this healing relationship is recognition of and attention to the support that is available to patients in the midst of their illness. Studies have shown that ability to support patients in their suffering requires health care professionals to know how to be a compassionate presence, convey dignity, and

attend to spiritual needs of families [11]. If they are to be fully present to the patient, health care professionals must prepare through reflection on their own sense of transcendence, meaning, purpose, call to service, and connectedness to others.

The focus on relationship-centered care implies that both parties are equal partners in the clinical healing relationship. Conversations about existential and spiritual issues transform the clinical encounter and its participants, as the clinician and patient move into a nontechnical and personal domain of experience. Clinicians have to recognize that they have the capacity to be deeply influenced by their patients just as they (clinicians) influence patients. There is an intimacy in these healing relationships and in spiritual care—one that must be engaged in with formality. Ethical guidelines are of paramount importance in relationship-centered care where boundaries are not explicitly clear [12].

Intimacy with Formality

Intimacy with formality recognizes that there is a power differential between the clinician and the patient. Patients feel a sense of vulnerability and lack of control and view the power and control as belonging to the clinician. Clinicians have a moral obligation to never exploit a patient, to be trustworthy, and to use their expertise and power with the best interests of their patients in mind. Conversations about spiritual and existential issues are deeply personal. In this context, the clinician must recognize that she is not an expert in the patient's spiritual beliefs. Therefore, it is best to follow the patient's lead in these conversations. Proselytizing by clinicians or dismissing patients' spiritual or religious beliefs is unethical under all circumstances within the clinical encounter. Forcing a patient to share his or her beliefs or values is also discouraged, and patients' privacy must be respected. Questions should be asked in a manner that conveys openness to all types of beliefs—humanistic, religious, and nonreligious alike. Some patients may have had traumatic experiences with religious or spiritual organizations and may be resistant to disclosing their backgrounds. Thus, a spiritual history or assessment should be sensitive enough to identify concerns in all patients and ask general questions that invite them to share what is important to them and their care [13-15].

Respect, patient-centeredness, and inclusivity are key ethical guidelines for medical practice [16, 17]. Respect means valuing the patient's views even when they differ from more frequently encountered belief systems. Respect also extends to the recognition that individuals are unique—two people with the same religious affiliation do not necessarily treat all dogma of that religion in the same way [18, 19].

Boundaries

> Appropriate therapeutic relationships with patients and families adhere to boundaries. This is for the benefit of the patient, family, and clinician. Boundaries are mutually understood, unspoken, physical, emotional, social, and spiritual limits to the professional relationship. Where the clinician ends, the other person begins. Observing boundaries shows a healthy recognition of the

purpose of the relationship and, at the same time, avoids building walls. Boundaries allow clinicians to be in the present and to passively enable emotional, physical, or social distractions to flow freely, not interrupting the patient-clinician interaction. Suppose, for example, the patient verbalizes thoughts that for some reason make the clinician uncomfortable. Recognizing the professional boundary allows the physician to focus on the clinical issue rather than on the patient's potentially distracting words or emotions, so the encounter can continue. Distancing, which many clinicians use to protect themselves, is based on a fear of entanglement and actually jeopardizes the clinical relationship in that it breaks the potential for a compassionate connection. Respect for boundaries, on the other hand, allows for compassionate presence in the healing encounter. Clinicians are more vulnerable to crossing boundaries when they are overworked, stressed, or have experienced losses or grief, so it is essential that they have avenues for self-care and reflection.

Conclusion

Spiritual care supports the relationship-centered model of health care. Clinicians who open the door to spiritual questions of meaning and purpose, suffering, and issues at the boundaries of life and death gain intimate relationships within the clinical context. To sustain this relationship effectively, ethical guidelines must be honored and boundaries observed for the sake of both patient and clinician.

References

1. Puchalski CM. Spirituality and medicine: curricula in medical education. *J Cancer Educ.* 2066;21(1):14-18.
2. Puchalski CM, McSkimming S. Creating healing environments. *Health Prog*. 2006;87(3):30-35.
3. Puchalski CM, Ferrell B, Virani R, et al. Improving the spiritual domain of palliative care. *J Palliat Med*. In press.
4. Koenig HG, McCullough ME, Larson DB. *Handbook of Religion and Health.* New York, NY: Oxford University Press; 2001.
5. Roberts JA, Brown D, Elkins T, Larson DB. Factors influencing views of patients with gynecologic cancer about end-of-life decisions. *Am J Obstet Gynecol*. 1997;176(1 Pt 1):166-172.
6. Cohen SR, Mount BM, Tomas JJ, Mount LF. Existential well-being is an important determinant of quality of life. Evidence from the McGill Quality of Life Questionnaire. *Cancer*. 1996;77(3):576-586.
7. Burgener SC. Predicting quality of life in caregivers of Alzheimer's patients: the role of support from and involvement with the religious community. *J Pastoral Care*. 1999;53(4):433-446.
8. Silvestri GA, Knittig S, Zoller JS, Nietert PJ. Importance of faith on medical decisions regarding cancer care. *J Clin Oncol*. 2003;21(7):1379-1382.
9. Ehman JW, Ott BB, Short TH, Ciampa RC, Hansen-Flaschen J. Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill? *Arch Intern Med.* 1999;159(15):1803-1806.

10. McCord G, Gilchrist VJ, Grossman SD, et al. Discussing spirituality with patients: a rational and ethical approach. *Ann Fam Med*. 2004;2(4):356-361.
11. Puchalski CM, Lunsford B, Harris MH, Miller RT. Interdisciplinary spiritual care for seriously ill and dying patients: a collaborative model. *Cancer J*. 2006;12(5):398-416.
12. Astrow AB, Puchalski CM, Sulmasy DP. Religion, spirituality, and health care: social, ethical, and practical considerations. *Am J Med*. 2001;110(4):283-287.
13. Bergin AE. Values and religious issues in psychotherapy and mental health. *Am Psychol*. 1991;46(4):394-403.
14. Strada EA, Sourkes B. Principles of psychotherapy. In: Holland J. *Psycho-oncology*. 2nd ed. New York, NY: Oxford University Press; 2009.
15. Bergin AE, Strupp HH. *Changing Frontiers in the Science of Psychotherapy*. Chicago, IL: Aldine Atherton; 1972.
16. Canda ER, Furman L. *Spiritual Diversity in Social Work Practice: The Heart of Helping*. New York, NY: Free Press; 2009.
17. Nelson-Becker H, Nakashima M, Canda ER. Spirituality in professional helping interventions with older adults. In: Berkman B, Ambruoso S. *Oxford Handbook of Social Work in Health and Aging.* New York, NY: Oxford University Press; 2006: 797-807.
18. Karier CJ. *Scientists of the Mind: Intellectual Founders of Modern Psychology*. Urbana, IL: University of Illinois Press; 1986.
19. Watson JB. *Psychology, From the Standpoint of a Behaviorist*. London, UK: F. Pinter; 1983.

Christina M. Puchalski, MD, MS, is an assistant professor in the Department of Medicine and Division of Geriatrics and director of clinical research and education at the Center to Improve Care of the Dying at George Washington University School of Medicine, Washington, D.C. She also serves as a consultant with the National Institute for Healthcare Research as director of education, where she develops programs for undergraduate, graduate, and postgraduate medical education on spirituality, end-of-life care, and cultural issues in medicine. Dr. Puchalski co-chaired a national education conference: Spirituality, Cross-Cultural Issues and End-of-Life Care: Curricular Development.

The Perennial Collaboration of Medicine and Religion
Stephen G. Post, PhD

From the dawn of civilization spirituality and religion have defined human experience. It is from religious worship, beliefs, rituals, and practices that cultures emerge and that the great majority of lives are still shaped in most parts of the world, especially in times of severe illness or catastrophe when people tend to ask deep questions about their lives. These big questions do not go away: Is there a purpose to life? Is there hope for humanity? Do love and compassion go with or against the grain of the universe? Is there a higher power and can our lives be lived in accordance with it? Are we morally accountable to it? Can we be forgiven in some

ultimate sense? Is our nature merely biological, or is there a nonmaterial soul that points toward eternity?

The intensity and pervasiveness of these and other big questions about human nature and destiny in the cosmos have in no way subsided in our scientific age. Indeed, from New Age spiritualities to the global rise of Christian Pentecostalism, from the undiminished appeal of religious traditionalism to the pervasiveness of faith-based philanthropies, modern times are as defined by spirituality and religion as any other in history, perhaps more so insofar as technological innovations force us to ask questions about our growing capacities to modify the essential nature of humans and to bring our species to an end through massive violence and ecological perils. Physicians who interact empathically with patients understand that such questions are very much a part of the illness experience.

We all know that religions can bring out the very best in people and the very worst, like marriage and parenthood, like corporations, politics, and even the profession of medicine itself. And yet these are all institutions that will remain with us and, at their best, contribute to human flourishing. The spate of neo-atheist best-selling books calling for the end of religion and spirituality in favor of a pure secularism can only be understood as the frustrated gasp of those who observe the continued modern importance of spirituality and religion, despite elite secular philosophies.

Medicine arose in theological contexts. The ancients swore their healing oaths to the gods and goddesses, thereby adding an aura of sacred depth to the task of preserving life and ameliorating suffering. A revolution in medicine occurred with the Abrahamic faiths, all of which gave rise to a more deeply impassioned concern for the ill than had been seen in classical antiquity. From the Prayer of Maimonides to the Christian founding of the first hospitals, from the advances made by Muslim physicians to the establishment of great medical schools in Europe and the Middle East, from Florence Nightingale's founding of modern nursing to Dame Cicely Saunders' establishment of the Hospice movement, from Albert Schweitzer's "reverence for life" to Paul Farmer's "theology of liberation," medicine has never been secularly grounded. Rather, medical science has been energized with the noble religious commitment to healing. In this there has been no contradiction, but rather a great synergy whereby empirical methods devised by Christian Renaissance humanists like Francis Bacon merged with a religious stewardship for human lives. To think that modern medicine can be explained in secular terms is to be neglectful of its spiritual history.

Good healers have always understood that the art of medicine requires empathic attentiveness to patient spirituality. The patient who is loved feels that his or her life has value and significance in the eyes of the nurturer. Compassionate love responds to the deepest of human needs—the need for *significance*. It reflects back to the beloved the significance, dignity, and even sacredness that would otherwise be obscured. The need for significance is not the quest for fame or renown. Rather, in

navigating through life, all people need to feel that their existence is not an error. The affirmation of significance is profoundly important in times of severe illness.

In December 2006, I walked through the Johns Hopkins University Hospital's Broadway entrance in Baltimore. Built in 1889, this historic entrance is breathtaking, in large part because of a 10-foot-high marble statue of Christ entitled *The Divine Healer*—a replica of Danish sculptor Albert Thorvsaldsen's *The Christ.* Donated to the hospital in 1896, its massive base reads, "Come Unto Me All Ye That Are Weary and Heavy Laden and I Will Give You Rest." Bathed in light, the lowered arms depict divine compassion encircling the ill and the grieving, as if to say, "I understand your travail." How many people over more than a century have walked by that statue with a feeling of complete insignificance before the power of illness and death, only to be uplifted by a renewed sense of self worth?

Granted, things have changed over the last century, and many American hospitals that had their origins in the religious promptings of Judaism and Christianity have loosed themselves from these identities. But even in secular settings, whether in the Cleveland Clinic or at Stony Brook, clinical pastoral care is thriving, interfaith chapels can be found, and attentiveness to patient spirituality and religion are considered part of good medical practice. Indeed, much research indicates that health is enhanced when patient spirituality is taken at face value and respected as such. Medical schools such as Duke, the University of Chicago, and Yale University are the norm rather than the exception with their flourishing programs that link to divinity schools. Johns Hopkins University might not wish to build a marble statue of Christ today, but its chapel is open to people of all faiths.

Spirituality and religion are especially important to people with serious diagnoses. This is an existential reality—most people who have to cope with a serious threat to their health or that of a loved one get down on their knees and seek the assistance of a higher power of their own understanding. A surgeon may be a committed atheist, but that does not stop the average patient awaiting major surgery from praying that God will guide that surgeon's hands. Many are the surgeons who report requests from patients to join them in prayer before a major operation, and the best either do so or bow their heads in silence while the patient prays. Spirituality and religion do not "creep in" to the patient-physician encounter, but are constitutive of it now no less than when the first shaman healers walked the earth.

What links healing to the spiritual and religious aspects of patients and physicians lives? Patients need hope and a sense of meaning in life if they are going to cope successfully with a serious illness. Hope and meaning impact treatment decisions and adherence, relationships with caregivers, and even physiology itself, as Dr. Jerome Groopman has summarized in his book *The Anatomy of Hope.* For most people, hope and meaning are not just matters of individual subjectivity or of interpersonal relations—they are contextualized within a spiritual-religious framework. It is one thing to be dispositionally optimistic, a quality that may quickly fade in hard times. But hope is deeper; it endures even the lowest valley. For many

people, such hope requires faith in a higher power. To dismiss the spirituality and religion of a patient is often to dismiss the emotional conditions under which healing optimally occurs.

Respect for patient spirituality should be coupled with respect for physician spirituality at those times when a physician adheres to religious prohibitions against, for example, declaring brain death if the physician is an Orthodox Jew, or performing abortions if he or she is Roman Catholic. Over my 21 years teaching in medical schools at Case Western and Stony Brook, I have encountered many medical students who are deeply shaped by their religious traditions in wanting to practice the healing art. Many of the finest physicians with whom I have worked are deeply faith-based in their lives, although they are rightly not explicit about this in daily practice. They worship regularly, pray for their patients early in the morning, and make every effort to practice with compassion. Virtues such as compassion, commitment, diligence, and self-improvement are rooted in a faith-based perspective on the value of human lives.

Of course the clinic is no place for a physician to be explicit about the importance of spirituality and religion in his or her practice, nor should such faith be imposed in any way on patients. But a general openness toward and appreciation of patient spirituality is likely to flow from a physician who recognizes the importance of spirituality in his or her own life.

Contemporary medical ethics has a decidedly secular tone. Most people who are involved professionally in the field have little or no understanding of the religious traditions that shape the lives and decisions of patients and their families. For this reason, patients and their families usually prefer to discuss significant issues of medical ethics with the appropriate clergy. In many institutions I have engaged in conversation with ethics committee members who are disturbed that patients prefer to consult with clinical pastoral care. But such a preference makes great sense—why would a patient who is religious suppose that anyone on an ethics committee would understand his or her values, much less share them? Oftentimes, legal cases on medical futility or other topics involving medical ethics arise primarily because ethicists have no understanding of religious traditions and perspectives, and may even show some degree of hostility.

How can we do better? First, we need to recognize that religious values are often constitutive of patient identity in fundamental ways. These values therefore cannot be privatized (i.e., left in the purely inner domain of the patient without any actual implementation in the world). Such values need to be taken seriously. Second, clinical pastoral care should, with adequate training, become centrally involved in hospital ethics consultations.

Medicine and religion are as linked today as they ever were. They are brothers under the skin, for at their best both promote a reverence for life as a gift to be cared for, healed when possible, and freed from physical pain.

Stephen G. Post, PhD, is director of the Center for Medical Humanities, Compassionate Care, and Bioethics of the Stony Brook University School of Medicine in Stony Brook, New York. He is the author of *Why Good Things Happen to Good People* and, from 1988 to 2008, he was professor of religion and bioethics at Case Western Reserve University. Dr. Post is also a trustee of the John Templeton Foundation.

Why Patients' Religion Is Not Their Doctor's Business

Richard P. Sloan, PhD

The possibility that religious devotion is associated with better health—a belief held widely by the general public and increasingly within medicine—brings with it a growing demand that physicians address the religious and spiritual concerns of their patients in clinical settings. While no one disputes that religion provides comfort to a great many in times of distress, the question is whether physicians can make any additional contribution to this and if so, how? This brief essay summarizes the evolution of the recent move to reconnect spirituality and medicine and examines the empirical, practical, and ethical implications of physician involvement in the religious lives of patients. I conclude that (1) the evidence supporting a connection between religious devotion and better health is at best weak, (2) physicians lack the time and training to engage in anything more than the most superficial inquiry into their patients' religious and spiritual concerns, and (3) there are significant and unresolved ethical impediments that make physician involvement in the religious and spiritual lives of their patients unjustified, impractical, and misguided.

Many factors have contributed to the growing interest in connecting religion and medicine. They include cyclical waxing and waning of religious sentiment throughout U.S. history, a rise in irrationality over the past 40 years, the influence of advocacy foundations, and patient dissatisfaction with technology in contemporary medicine. Regarding the latter, many see physician attention to the religious and spiritual lives of their patients as a solution to this problem, a way of "humanizing" the medical encounter. But as H.L. Mencken put it, for every complex problem there is a solution that is simple, neat, and wrong.

It is wrong for any number of reasons. First, despite the claims of proponents, the evidence linking religious devotion to better health is weak and inconclusive [1, 2]. The strongest evidence shows associations between increased attendance at religious services and reduced mortality [3]. But even this evidence is mixed and difficult to interpret.

People attend services for a great many reasons—out of religious devotion, certainly. But also out of loneliness or habit, to make business contacts, or to find friends. It is impossible to determine which of these religious or social benefits of church-going is responsible for the association with reduced mortality, assuming the association is

solid. As Garrison Keillor remarked, "Anyone who thinks that sitting in church makes you a Christian must also think that sitting in a garage makes you a car."

Second, practical constraints make it extremely difficult for physicians to do anything more than determine whether patients' religious beliefs will influence their care. Advocates recommend conducting a "spiritual history," a series of questions designed to inform the physician about patients' religious and spiritual concerns [3, 4]. Different versions of these histories exist, but even the briefest reduces the limited time physicians have with patients. This is a significant problem, since many recent investigations have determined what practicing physicians know too well already: there is far too little time in the day to address all the medical matters that, on the basis of solid empirical support, are considered standard patient care. To take only one example, an *American Journal of Public Health* paper reported that for physicians to provide all services recommended by the U.S. Preventive Services Task Force at the recommended frequency would alone take 7.4 hours per day [5]. Physicians' valuable time should be devoted to matters they are trained to manage and that make a difference to their patients' health outcomes.

This leads me to the related point that physicians are untrained in religious and spiritual matters. Largely in response to funding from the John Templeton Foundation, medical schools have added training in these matters. In 1993, fewer than five schools offered some training in religion and spirituality; now 70 percent do [6, 7]. No one has tracked precisely what this training consists of, and there must certainly be considerable variation. Given medical school curriculum requirements, it is unlikely to consist of more than a few hours during the first 2 years. Exposure to such training does not qualify physicians to respond to the often complex religious and spiritual matters that arise for patients when they are ill. Health care chaplains study for years to be qualified to discuss such matters with patients. Indeed, in matters of religion and spirituality, the physician has no more expertise than the patient.

Third, attempts to bring religious matters into clinical medicine raise significant ethical concerns, including manipulation and outright coercion, invasion of privacy, and causing harm. Regarding the first, religious intrusion into medical practice threatens to violate the norm of patient autonomy. For example, the Christian Medical and Dental Association, a professional society with more than 17,000 members, publishes a handbook that instructs physicians on how to use their practices to evangelize. Because medical patients are very often in pain and fearful, they are especially vulnerable to manipulation by physicians who, even in these days of patient consumerism, retain positions of authority in the patient-physician relationship. When doctors capitalize on this authority to pursue a religious rather than medical agenda, they violate ethical standards of patient care.

Religious influence on medicine is pernicious in another way. Recently, the *New England Journal of Medicine* reported that 14 percent of U.S. physicians, representing different regions of the country and different medical specialties,

believe that their personal religious views rather than the needs of their patients should determine which legal medical treatments they offer and, more distressingly, that they are under no particular obligation to disclose this bias to their patients or to refer them to other physicians who will offer the treatment. Ethicists have noted that, because doctors have state licenses that grant them exclusive rights to practice medicine, they have an obligation to deliver medical care to all those who seek it, not just to those who share their religious convictions. That means understanding the best scientific evidence about which factors contribute to health and which don't and practicing medicine accordingly. It means not permitting personal values, religious or otherwise, to supersede the best interests of patients. As epidemiologist Petr Skrabanek noted, allowing doctors' religious values to interfere with the care patients receive is "a social movement dressed up in scientific language" [8].

Proponents of bringing religious practices into medicine frequently claim that patients want their physicians to inquire about their religious and spiritual concerns under the guise of more patient-centered care. Some have remarked that, regardless of the evidence about relationships between religion and health, "we should address [religion in medical practice] because the patient surveys are saying that we should be addressing it" [9]. "Most patients desire to be offered basic spiritual care by their clinicians and censure our professions for ignoring their spiritual needs" [10].

Close inspection indicates that these claims are substantially exaggerated. With a single exception, the studies on which these claims are based ask general questions about patients' interest in having physicians raise religious and spiritual matters in clinical medicine. In one study, for example, 456 patients from primary care clinics in six academic medical centers from North Carolina, Florida, and Vermont were surveyed about a variety of topics including their preferences for religious or spiritual involvement in their own medical encounters [11]. While two-thirds thought that their physician should be aware of their religious or spiritual orientation, only one-third wanted to be asked about it during a routine office visit. Not surprisingly, the more severe the medical condition, the more willing patients were to consider a spiritual or religious interaction. But when asked whether they would want their doctor to discuss spiritual issues *even if it meant spending less time on their medical problems*, the numbers of patients who wanted these discussions plummeted: only 10 percent were willing to make this trade-off while 78 percent were not.

Finally, bringing religious and spiritual matters into medicine raises a more basic question that derives from broader American societal trends: the apparent willingness to subordinate other interests and virtues to religious values. Advocates contend that religion and spirituality are important aspects in the lives of many of their patients and therefore, physicians should engage in discussing them. While it is certainly true that religion and spirituality are important to many patients, they are no more so than many other aspects of our lives: family, friends, work, hobbies, and so on. Religion or spirituality, like sports, or finances, or music, make up one of many essential concerns in the lives of patients [12].

To conclude, no one disputes that for a great many people, religion provides comfort in times of difficulty, illness-related or otherwise. However, because (1) the evidence of a connection between religious devotion and better health is weak and difficult to interpret; (2) there is far too little time in clinical practice to take on religious matters; (3) physicians are not trained to do so; and (4) doing so raises significant, unresolved ethical issues, the best approach for physicians is to respectfully note patients' interests, religious or otherwise, and move on.

References

1. Sloan RP, Bagiella E, Powell T. Religion, spirituality, and medicine. *Lancet*. 1999;353(9153):664-667.
2. Sloan RP, Bagiella E, VandeCreek L, et al. Should physicians prescribe religious activities? *N Engl J Med*. 2000;342(25):1913-1916.
3. Koenig HG. An 83-year-old woman with chronic illness and strong religious beliefs. *JAMA*. 2002;288(4):487-493.
4. Puchalski CM. Spirituality and health: the art of compassionate medicine. *Hosp Physician*. March 2001;30-36. http://turner-white.com/pdf/hp_mar01_spirit.pdf. Accessed September 4, 2009.
5. Yarnall KS, Pollak KI, Ostbye T, Krause KM, Michener JL. Primary care: is there enough time for prevention? *Am J Public Health*. 2003;93(4):635-641.
6. Koenig HG, McCullough ME, Larson DB. *Handbook of Religion and Health*. New York, NY: Oxford; 2001.
7. 2. Puchalski CM. Spirituality and medicine: curricula in medical education. *J Cancer Educ*. 2006;21(1):14-18.
8. Skrabanek P. Preventive medicine and morality. *Lancet*. 1986;1(8473):143-144.
9. Gunderson L. Faith and healing. *Ann Intern Med*. 2000;132(2):170.
10. Mann JR, Larimore W. Impact of religious attendance on life expectancy. *J Am Board Fam Med*. 2006;19(4):430.
11. MacLean CD, Susi B, Phifer N, et al. Patient preference for physician discussion and practice of spirituality. *J Gen Intern Med*. 2003;18(1):38-43.
12. Scheurich N. Reconsidering spirituality and medicine. *Acad Med*. 2003;78(4):356-360.

Richard P. Sloan, PhD, is the Nathaniel Wharton Professor of Behavioral Medicine, and chief of the Division of Behavioral Medicine at the New York State Psychiatric Institute in New York City. Dr. Sloan's principal work focuses on identifying the autonomic nervous-system mechanisms that link psychological risk factors such as depression, hostility, and anxiety to heart disease.

Related in VM

Doing a Culturally Sensitive Spiritual Assessment: Recognizing Spiritual Themes and Using the HOPE Questions, May 2005

The Other Side of Complexity: Faith, Health, and Humility, May 2005

When Patients Say, "It's in God's Hands." October 2009

The Patient Who Says He Is Ready to Die, October 2009

Recognizing the Mind/Body/Spirit Connection in Medical Care, October 2009

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.