Religion, Spirituality, and Medicine: How Are They Related and What Does It Mean?

A long historical tradition connects religion, medicine, and health care. Religious groups built the first hospitals in Western civilization during the fourth century for care of the sick unable to afford private medical care. For the next thousand years until the Reformation and to a lesser extent until the French Revolution, it was the religious establishment that built hospitals, provided medical training, and licensed physicians to practice medicine. By the end of the 17th century, however, the scientific profession of medicine had nearly completely separated away from its religious beginnings. Likewise, the profession of nursing emerged directly from religious orders that until the early 1900s staffed the majority of hospitals both in the United States and other Western countries.

Over the past decade, the medical community has become increasingly interested in the possibility of bringing down the wall that has separated religion from medicine for more than 2 centuries. The discussions for and against this reconnection have intensified of late, and the debate is now raging both within the medical field and outside it. Research appearing in mainstream medical and public health journals reports a connection between religion and health. Even the National Institutes of Health has held several consensus conferences on the topic and is now beginning to fund investigations, including randomized controlled trials, to understand the effects of religion on health. Furthermore, all major US Department of Health and Human Services divisions this year have been given a presidential mandate to encourage research on and remove the barriers from faith-based community organizations delivering mental health and substance abuse services.

Controversy

Many physicians question the appropriateness of addressing religious or spiritual issues within a medical setting, and almost all are uncertain on how to go about this. Opponents of integration argue that the research base connecting religion with better health is weak and inconsistent, depending primarily on epidemiological studies that demonstrate association, not on clinical trials that prove causation. They claim that religion is a personal and sensitive area of most patients’ lives, too private for physicians to inquire about, regardless of whether it is connected with health. Worse still, they see any involvement by physicians in this area as potentially coercive—physicians imposing their own religious beliefs on vulnerable patients dependent on them for care. Furthermore, if physicians imply that religious involvement helps people stay healthy, then people who become sick may feel guilty for not having enough faith, thus adding to the burden of suffering. An important minority of patients (at least one third) do not want physicians delving into spiritual issues with them. Finally, addressing spiritual issues takes physicians outside their area of expertise, and most do not have either the training or the time to explore this area with patients. All of these are valid and important concerns.

See also pages 1192 and 1225.

Two Approaches

In this issue of the Proceedings are reported 2 different approaches to studying the relationship between religion and health. One is a review by Mueller and colleagues of research exploring the effects of religion on mental and physical health. In that review, religious beliefs and practices are thought to evoke health effects through psychosocial, behavioral, and physiological mechanisms that are known, understood, and accepted within the field of traditional science. The strength of this review is its comprehensive nature and its focus only on research studies that had findings explainable through scientifically rational pathways. The weakness of this approach is that most of the studies reviewed were either cross-sectional or prospective
Cautious Progress

Without appropriate knowledge, addressing spiritual issues in clinical practice can be a risky undertaking. Some of the dangers and pitfalls have already been mentioned, and some may be hard to predict, given the lack of data. However, physicians are beginning to appreciate that the majority of their patients are religious and use religious beliefs to cope with sickness, that existential issues and spiritual struggles are common among patients, that religious beliefs influence the medical decisions that patients make, and, for all these reasons, that religion might ultimately affect both psychological health and medical outcomes. Patients who have an optimistic belief system that gives life meaning and purpose in the setting of pain and suffering, those who have a large group of supportive friends committed to their welfare, and those who live healthier lifestyles and abuse their bodies less often with drugs, alcohol, and cigarettes, are bound to be healthier and recover more quickly from illness. Who could deny that such factors are relevant to the practice of medicine? How, then, might a sensible clinician proceed?

Despite the many unknowns and the need for further research and greater understanding of these relationships, physicians can even now begin to address the spiritual needs of patients and yet avoid most of the dangers and pitfalls. The following recommendations are based on clinical experience and common sense, not systematic research. As Mueller and colleagues suggested, physicians can take a spiritual history—find out whether religious or spiritual beliefs are used to cope, are evoking religious struggles, are likely to influence medical decisions, or are responsible for other special needs that trained clergy may help with. A spiritual history should be taken in a way that does not endorse religion as either desirable or undesirable, but rather sends the message that religion and spirituality are an important area that may influence health for better or worse. Spiritual assessment need not be done at every visit, but rather on occasions when there is more time, such as during a new patient evaluation or on hospital admission. It
should not replace a comprehensive and competent evaluation of medical problems.

As Mueller and colleagues point out, the research is not good enough (and may never be good enough) to justify physicians’ prescribing religion to nonreligious patients. If the patient is not religious or does not want physician involvement in this area, then questioning should quickly move away from religion and toward what helps the patient cope and gives life meaning. In the majority of cases, the physician should not attempt to address complex spiritual needs of patients. However, when the patient is reluctant to talk with clergy and prefers to discuss spiritual matters with a trusted physician, taking a little extra time to listen and be supportive is usually all that is required. Providing support for religious beliefs and practices that do not conflict with medical care is appropriate. When beliefs conflict with medical care, however, it is important not to criticize the belief, but rather to listen, gather information, enter into the patient’s world view, and maintain open lines of communication, perhaps enlisting the help of the patient’s clergy. Religious beliefs may have a powerful influence on the health of our patients, and we need to know about them.

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7. Prayer in Black Women With Breast Cancer. A 5-year project (randomized controlled trial), funded by the National Center for Complementary and Alternative Medicine and awarded to the Johns Hopkins Center for Alternative and Complementary Medicine, August 2000.
8. Mechanisms and Therapeutic Effects of the Relaxation Process. A 3-year project (randomized controlled trial) to evaluate the effects of meditation on withdrawing hypertensive medications in elderly patients, funded by the Centers for Disease Control and Prevention and awarded to the Mind/Body Medical Institute, Harvard University, October 2000.