EDITORIAL

Spirituality, Medicine, and the Possibility of Wisdom

It may be no surprise that, after a year in which films like Mel Gibson's *The Passion of the Christ* and Michael Moore's *Fahrenheit 9/11* symbolized starkly opposed value systems in American public discourse, questions regarding the proper place of religion and spirituality in medicine remain so vexing. Like politics, medicine is an arena in which public accountability and private conviction must somehow be made to coexist. Farr Curlin and Daniel Hall,¹ in the ethic of spirituality and medicine presented in this month's *Journal of General Internal Medicine*, astutely diagnose the beleaguered state of interpersonal relationships in contemporary medicine and propose an alternative. Specifically, they identify a supposedly excessive and narrow emphasis upon competence, attention to patient autonomy, and physician neutrality in clinical encounters; let us briefly consider each in turn.

As regards the medical obsession with competence, Curlin and Hall point out that the persistent and widespread emphasis upon clinical technology, efficiency, and quantifiable quality of care (the last perhaps an oxymoronic notion to begin with) promotes an increasingly impersonal medicine in which patients act primarily as consumers of services. In addition, managed care further distances physician and patient by threatening the continuity of relationships—one is more likely to view one's physician, or one's patient, as a stranger if he or she at any time may disappear from a preferred provider organization (PPO) list or change jobs and therefore insurance coverage.

Another factor in the growing sterility of medical encounters may be a contemporary distrust of the very notion of wisdom, which is viewed by many these days as paternalistic and presumptuous. It is often observed that physicians are not the widely revered figures of a generation ago. At a time when truth is often seen as pluralistic, partial, and arrived at individually, many hesitate to venture beyond their narrow range of specialized expertise. It is bold merely to argue, as Curlin and Hall do, that physicians, in order to fill a meaningful professional role with respect both to individual patients and to society as a whole, must aspire to some ideal of general wisdom in which purely technical considerations are secondary to wider human concerns. The article in this issue admirably presents a case for the physician as (potentially) wise professional rather than mere technician.

Arguably, patient autonomy and physician neutrality are really two sides of one coin, and with respect to these issues in general medical encounters, we might learn much from the specific example of psychotherapy, a kind of clinical encounter about which a decades-old dialogue already exists regarding the relative roles of technique and religious and other values. In psychotherapy, even more than in most general medical contexts, illness is inextricable from life situations. Not only religious matters, but broader questions regarding the relative meanings of family, sexuality, relationship, work, and money cannot be easily bracketed off from some ideal of pure therapeutic technique. Like a nonpsychiatrist physician but probably more often, a psychotherapist often feels implicated

somehow in a patient's major life decisions. Should a patient have an abortion, get married, continue an affair, leave a spouse, quit a job, or not?

As may be well known, for decades the ideal of psychotherapy was a process in which the clinician acted as impartial—and largely impassive—investigator of the patient's symptoms (while the stock psychoanalyst of countless films is a stereotype, it is obvious that stereotypes contain a kernel of truth). Because of clinical considerations not relevant here, but also for ethical reasons, the idea was that the patient needed to remain free of any interference from a clinician's personal views (traditionally this has differentiated psychotherapy from advice giving). For years the hallowed psychoanalytic apparatus, like contemporary medical technology, left little room for any meaningful relationship between clinician and patient.

However, in the past 20 years or so it has become increasingly apparent that patients often *want* a more genuine connection with their therapists, and that the most beneficial aspects of psychotherapy may have little to do with pure technique; the parallel with patients' desire to incorporate spirituality into their medical care is obvious. Lo and behold, it appears that many patients seek human *guidance*, not just expert technical manipulation of pathology! One now wonders how it was ever thought that in a treatment involving so many crucial life issues, values could somehow be ignored and assumed to work themselves out. Even a psychoanalyst, Nancy McWilliams,² can now argue that a patient has the right to know certain vital aspects of a therapist's worldview, such as his or her positions on religion, homosexuality, and perhaps even politics. And Eric Johnson and Steven Sandage³ claim that because of a culture-wide loosening of moral conviction, and because many patients come into treatment *unsure* of what they believe about ultimate concerns, psychotherapy can be as much hermeneutic dialogue as strict technique. To use the terms of Curlin and Hall, therapist and patient are not friends exactly, but neither are they wholly strangers.

A fully realized clinical relationship therefore entails more than autonomy in its most minimal sense, that is, the avoidance of frank intrusion or violation of the values that the patient brings to the encounter. More basic is the project of nurturing a patient's autonomy or capacity to make decisions based upon authentically self-determined values; in other words, respect for autonomy has beneficent as well as non-maleficent aspects. Some patients do arrive to treatment with fully articulated value systems, such that clinicians need do little more than step out of the way, morally speaking. However, other patients may arrive in a state of some moral turmoil or at least perplexity and may benefit from the judicious kind of "moral friendship" Curlin and Hall propose. Only by not treating patients at all could we be absolutely certain of exercising no undue influence. In moral as in technical matters, beneficence is not risk free; if to "do no harm" were everything, we would never do anything.

But the problem with such situations, as with psychotherapy, is that they are complex and irreducibly diverse, and unequivocal guidelines are difficult to set forth. There is an extensive psychotherapy literature on "boundary violations" and "boundary crossings" that seeks to delineate the interpersonal terrain. To endeavor to be wise is to undertake great responsibility, and also to risk grandiosity. Where exactly are the dividing lines between generous capacity building, gentle persuasion, and gross moral paternalism (or proselytizing, its religious analogue)? And in the era of evidence, how do we inculcate wisdom, a most unquantifiable quality? The avid interest over the past 20 years in narrative and literature in medicine⁴ has offered one perspective on the problem.

Finally, Curlin and Hall object to the widely held assumption that secularism is value neutral, and I think they are right to do so. However, the proper solution does not seem to be nostalgia for medieval Europe or other premodern cultures, where private and public lives were congruent precisely because nearly everyone believed the same thing. With modernity, and even more with postmodernity, comes the coexistence of diverse perspectives on matters of ultimate concern, which is why we are having this debate. We should not seek some mythical value-neutral perspective, but rather find that perspective which, all things considered, is least likely to intrude on other points of view. Arguably, secularism simply is not "totalizing" in the same way that many religions are; it is less likely *on average* to entail the view that certain beliefs demand correction or may doom one to eternal damnation (*on average* is a crucial qualifier, as there are plenty of tolerant monotheists and intolerant atheists, and obviously not only individuals but also traditions and denominations differ greatly in their openness to other points of view).

The United States Constitution is secular because more harm is thought to be done to nonbelievers by a religious state than to believers by a state which does not grant religion pride

of place. So in my view medicine, inasmuch as it is taught in institutions largely supported by the state, can no more *encourage* more active expression of private religious convictions than public elementary schools can allow teachers to post the Ten Commandments in the classroom. Obviously clinicians and patients who desire an explicitly spiritual approach to treatment are free to seek one another out, just as private religious schools are free to attract religious students. The question, of course, is whether such activities should be supported by public funds. Those who are dismayed by a secular basis for medicine as a profession presumably, if they are consistent, are averse to secular assumptions in public affairs in general.

But this objection aside, Curlin and Hall commendably describe the uncanny way in which the messy uncertainties of lived experience continually escape the Procrustean beds that medical and other technologies devise for it. A personal issue like this holds the temptation of inflammatory rhetoric; as one should do with any complex issue, they wisely present the case for moderation. The overwhelming consensus of the spirituality and medicine debate seems to be neither "never" nor "always," but rather "it depends." The devil is in the details (so to speak), and therein much work remains to be done.—**Neil Scheurich, MD**, *Department of Psychiatry, University of Kentucky, Lexington, KY*

REFERENCES

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