

Spirituality and Health: The Art of Compassionate Medicine

Christina M. Puchalski, MD, MS

Discussions of spirituality and religion have long been considered inappropriate in the study and practice of medicine. That bias is beginning to change, however, as physicians begin to appreciate the importance of these issues to the health and well-being of their patients, as well as the role of spirituality in their own lives. This article discusses issues of spirituality and religion as they relate to medical care. Recent initiatives to expand the coverage of spirituality in medical education are discussed, and studies and surveys on the importance of incorporating spiritual discussions into medical care are reviewed. Some specific suggestions to help physicians broach the topic of spirituality in clinical practice are also provided.

ADDRESSING SPIRITUALITY IN MEDICAL SCHOOL

Interest among academic physicians regarding spirituality in medicine has grown tremendously over the past few years. In 1992, only 1 medical school had a formal course in spirituality and medicine, which was an elective course. Today, more than 70 medical schools in the United States offer courses on spirituality and medicine,^{1,2} and most such courses are required and integrated with the rest of the medical school curriculum. The Association of American Medical Colleges (AAMC) has co-sponsored, with the National Institute for Healthcare Research, 4 conferences, on curricular development in spirituality and medicine. These conferences have been held annually since 1997. There is also a growing interest in professional retreats for physicians in this country to help them explore these issues further.



In medical school courses on spirituality, students learn to work with the many facets of spirituality and focus on the clinical integration of these themes into pregnancy and childbirth, chronic pain, psychiatric illness, addiction and dependency disorders, disability, and care of the dying. Often, sessions on spirituality of the caregiver are included. The goal of these sessions is to help students recognize the spiritual dimension of their

own lives and how it affects their professional practices. These sessions are taught in various ways. Some sessions give students the opportunity to describe their own notion of what spirituality means, and how that spirituality helps them cope with the stresses of medicine and with the emotions that arise from caring for very ill patients. Other courses have practicing physicians share their concept of their personal spirituality and how it impacts their practice of medicine.

The common theme that I feel is most important, however, is how students and practicing physicians come to understand their calling as physicians, as

Dr. Puchalski is Assistant Professor of Medicine, Division of Aging Studies, George Washington University Medical Center, Washington, DC; and founder and director of George Washington University's George Washington Institute for Spirituality and Health, which develops educational programs for medical students, residents, and practicing physicians on the relationship between spirituality and health. She is also the Director of Education at the National Institute for Healthcare Research, a private, nonprofit research organization based in Rockville, MD, dedicated to exploring the relationship of spirituality with health. Dr. Newberg is Assistant Professor of Radiology, Hospital of the University of Pennsylvania, Philadelphia, PA.

servers. Serving others is at the root of our profession as physicians. In my opinion, there is no higher spiritual value than being of service to another individual. These courses emphasize the compassionate, spiritual aspect of our profession.

A variety of teaching methods are used in the courses.^{1,3} Most programs use a combination of methods to teach, including:

- Didactic sessions covering topics such as the role of spirituality in healthcare, the role of spirituality in chronic illness and in end-of-life care, addressing patients' suffering, how patients seek meaning and purpose in life and in the midst of suffering, how to do a spiritual history, and the role of chaplains/clergy as healthcare providers.
- Small group discussion
- Reflective writing
- Storytelling
- Case presentation and discussion
- Panel discussions with patients, physicians, and chaplains
- Role playing with standardized patients
- Use of poetry and literature to convey spiritual and existential themes

Specific techniques and tools for addressing spirituality in clinical practice are taught; one key technique is that of performing a spiritual assessment, which is integrated into the process of taking a patient's history.

Why is there such a strong interest in this area? Is spirituality in medicine simply a fad, or are medical educators responding to a fundamental component of how patients deal with health and illness? I believe that it is certainly not a fad. Numerous survey data and several scientific studies exist that demonstrate the importance of including considerations of spirituality in the health care of patients.

SURVEY DATA DEMONSTRATING PATIENT NEED

Several national surveys have documented patients' desire to have spiritual concerns addressed by their physicians. A 1990 Gallup Poll,⁴ showed that religion, one expression of spirituality, plays a central role in the lives of many Americans. When asked, 95% of persons surveyed espoused a belief in God, 57% reported praying daily, and 42% reported attending a worship service in the prior week. The need for attentiveness to the spiritual concerns of dying patients has been well recognized by many researchers.^{5,6} A survey conducted in 1997 by the George H. Gallup International Institute⁷ showed that people overwhelmingly want their spiritual needs

addressed when they are close to death. In the preface to the survey report, George H. Gallup, Jr., writes: "the overarching message that emerges from this study is that the American people want to reclaim and reassert the spiritual dimensions in dying."⁷ The 1990 Gallup survey⁴ found that 75% of Americans say religion is central to their lives; a majority feel that their spiritual faith can help them recover from their illness. In a 1996 *USA Today Weekend* health survey, 63% of patients surveyed believed it is good for doctors to talk to patients about spiritual beliefs.⁸ Ehman and colleagues⁹ found that 94% of patients with religious beliefs agreed that physicians should ask them about their beliefs if they became gravely ill; 45% of patients who denied having any religious beliefs still agreed that physicians should ask their patients about them. In this survey, 68% of patients said they would welcome a spiritual question in a medical history; only 15% said they actually recalled being asked by their physicians whether spiritual or religious beliefs would influence their decisions. In the *USA Today* survey, the majority of people polled felt that doctors should talk with their patients about spiritual concerns, yet only 10% reported that their doctors had discussed such issues with them.⁸ This latter statistic is understandable because until recently, spirituality has long been overlooked in medical school curricula and in the standards of medical care.

DATA SUGGESTING THE RELATIONSHIP BETWEEN SPIRITUAL BELIEFS AND ILLNESS

There is a growing body of evidence suggesting the relationship between patients' religious and spiritual lives and their experiences of illness and disease.¹⁰ In addition to surveys demonstrating that spirituality is important to people and that a significant percentage of patients 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. Reviews of the literature demonstrate statistically significant relationships between measures of religious commitment and measures of health, including morbidity and mortality, in studies of many diseases.^{2,11-13} A number of studies suggest that mortality is reduced among those who attend worship services more frequently, compared to those who do not attend worship services.¹⁴ Research suggests that mortality is reduced following cardiac surgery among those who receive comfort and support from religion.¹⁵

It has been reported that parents whose child died have found much support following their child's death in their faith and church life.¹⁶ Patients with advanced

cancer who found comfort from their religious and spiritual beliefs were more satisfied with their lives, were happier, and had diminished pain.¹⁷

The 12-step program Alcoholics Anonymous, one of the best known programs in the treatment of addiction, lists as one of the 12 steps (which were described by some of the earliest members of the group) as: “[we] came to believe that a power greater than ourselves could restore us to sanity.”¹⁸ 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.¹⁹ 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, premenstrual syndrome, AIDS, and cancer.²⁰

How spiritual modalities contribute to health and recovery is unclear. Pargament and colleagues²¹ found that religious experiences and practices, such as seeking God’s help or having a vision of God, extends the individual’s coping resources and is associated with improvement in health care outcomes.

Kenneth Pargament has studied both positive and negative spiritual coping.²² Patients showed less psychological distress if they sought control through a partnership with God or a higher power in a problem-solving way; if they asked God’s forgiveness or were able to forgive others; if they reported finding strength and comfort from their spiritual beliefs; and if they found support in a spiritual community. Patients had more depression, poorer quality of life, and exhibited callousness towards others if they saw the crisis as a punishment from God; if they had excessive guilt; or if they had an absolute belief in prayer and cure together with an inability to resolve their anger if that cure did not occur. He also noted that sometimes patients refuse medical treatment based on religious beliefs.

NEGLECT OF SPIRITUALITY IN MEDICINE

These data—indicating both the prevalence of religious and spiritual beliefs and practices as well as the positive and negative clinical outcomes associated with strong spiritual practices—suggest that patients’ spiritual beliefs should be considered relevant to their health care. But, until recently, assessing patients’ spiritual beliefs was viewed as unnecessary and inappropriate.²³ In most cultures of the world, both in ancient and in

modern times, care for the soul and body was an integrated aspect of the culture. Those who were assigned to the care of people in the culture ministered to both their physical and spiritual needs; there was no dichotomy between the needs of the body and the needs of the spirit. In many ancient cultures, the shaman was both priest and healer. In the Christian religion, Jesus was regarded as a healer of both body and spirit. Over the centuries, however, a dichotomy developed that resulted in a separation of these components—religious persons were confined to addressing spiritual concerns, while physicians and scientists were assigned to the physical concerns. Today, we are witnessing a healing of this rupture. More physicians are becoming aware of the unity of the human person—that is, body and spirit—and therefore are integrating spiritual care into their practice of medicine.

This rupture may have originated in the seventeenth century. The philosophy of modern medicine can be traced to Rene Descartes, a seventeenth-century philosopher who believed that the world operates according to mechanical laws without reference to meaning and purpose.²⁴ This has led to the biomedical model that has become the dominant way the Western world views health and healing. Our medical education is based on the biomedical model.²⁵ Physicians are trained to be objective scientists. Yet, often the art of medicine as a compassionate, caring profession has been neglected.

This biomedical model, combined with the enormous scientific and medical advances of the last 3 decades, has focused much of our medical education on the technical aspects of healing. Disease is seen as a disruption of normal physiology, and treatment attempts to restore the diseased aspect of the body to a normal state. But *healing* involves more than just technical fixes. Illness is a major life event that causes people to question themselves, their purpose, and their meaning in life. It disrupts their career, their family life, and their ability to enjoy themselves—3 aspects of life that Freud said were essential to a healthy mind.

Illness can cause people to suffer deeply. Victor Frankl wrote that “Man is not destroyed by suffering; he is destroyed by suffering without meaning.”²⁶ He noted when writing about concentration camp victims that survival itself might depend on seeking and finding meaning. In my own clinical experience, I have found that people cope with their suffering by finding meaning in their suffering. This is where spirituality plays such a critical role—the relationship with a transcendent being or concept can give meaning and purpose to people’s lives, to their joys and to their sufferings.

Downey²⁷ defined spirituality as “an awareness that there are levels of reality not immediately apparent and that there is a quest for personal integration in the face of forces of fragmentation and depersonalization.” Spirituality is that aspect of human beings that seeks to heal or to be whole. Often spirituality is expressed as religion. Foglio and Brody wrote²⁸:

For many people religion forms a basis of meaning and purpose in life. The profoundly disturbing effects of illness can call into question a person’s purpose in life and work; responsibilities to spouse, children, and parents. . . . Healing, the restoration of wholeness (as opposed to merely technical healing) requires answers to these questions.

Healing, then, is not synonymous with recovery, and indeed, it may occur at any time, independent of recovery from illness. In dying, for example, restoration of wholeness may be manifested by a transcendent set of meaningful experiences while very ill, and a peaceful death. In chronic illness, healing may be experienced as the acceptance of limitations.²⁹ A person may look to medical care to alleviate his or her suffering, and when the medical system fails to do so, begin to look toward spirituality for meaning, purpose, and understanding. Cassell wrote: “Since in suffering, disruption of the whole person is the dominant theme, we know of the losses and their meaning by what we know of others out of compassion for their suffering.”³⁰

Patients with serious or chronic illnesses endure all types of suffering—spiritual as well as physical. I believe that physicians are obliged to respond to—if not attempt to relieve—all types of suffering, including spiritual. Because people may cope with their suffering using their spiritual resources, physicians should be able to communicate with their patients about spiritual issues, and recognize the spiritual as well as the physical dimensions of suffering.

SPIRITUALITY IN CLINICAL PRACTICE

Today, medical educators and other physicians and healthcare providers are beginning to recognize the importance of spirituality in medicine and are beginning to ask patients about their spiritual beliefs.² An increasingly common view holds that although young doctors may be excellent technicians, they often lack the humanitarian skills required to be compassionate caregivers who can communicate effectively with their patients about many issues related to their medical care, including preferences for treatment, prognosis, and the patient’s lifestyle, beliefs, fears, and hopes. A

critical part of such communication skills is the ability to discuss a patient’s spiritual beliefs and how those beliefs affect the patient’s health.

The Association of American Medical Colleges has responded to concerns by the medical professional community that young doctors lack these humanitarian skills by including objectives related to empathy, communication, and compassion in its Medical School Objectives Project.^{31,32} In the first report of the Medical School Objectives Project,³² it is noted that: “Physicians must be compassionate and empathetic in caring for patients. . . . In all of their interactions with patients they must seek to understand the meaning of the patients’ stories in the context of the patients’ beliefs and family and cultural values.”

A concrete method for beginning the process of incorporating spiritual issues into one’s clinical practice is to include a spiritual history when taking a patient’s social history, which is part of the routine medical history. I recommend taking a spiritual history on each new patient visit and as part of annual examinations. Follow-up should occur as appropriate, as with any other part of the patient history. The acronym FICA—for Faith and belief, Importance, Community, and Address in care—can be helpful for structuring an interview regarding a patient’s spiritual views (**Table 1**). Performing a spiritual history has been included in coursework on spirituality and medicine.³³ The spiritual history emphasizes the practice of compassion with one’s patients, and helps the clinician learn to integrate patients’ spiritual concerns into the therapeutic plans. The acronym FICA is not meant to be a checklist of questions, but rather a guide on how to start the spiritual history and what to listen for as the patient talks about his or her beliefs.

Given the large amount of data suggesting that spirituality and religion may be important to patients who are coping with illness, health care institutions should provide a respectful and supportive clinical environment in which patients can express their spirituality and religiosity. Often, dying patients are in crowded rooms where family ritual, music, or other expressions of spirituality cannot be carried out. Physicians should strive to discuss patients’ spiritual concerns in a respectful manner and as directed by the patient. Physicians should always respect patient privacy regarding matters of spirituality and religion, and must be vigilant in avoiding imposing their beliefs onto the patients. Physicians often suggest that patients exercise or quit smoking to improve their health. Given the data of beneficial health outcomes, should physicians also encourage religious and spiritual practices? Physicians can encourage religious and spiritual practices with

Table 1. Taking a Spiritual History

The acronym FICA can help structure questions in taking a spiritual history:

F—Faith and belief

“Do you consider yourself spiritual or religious?” or “Do you have spiritual beliefs that help you cope with stress?” If the patient responds “no,” the physician might ask, *“What gives your life meaning?”* Sometime patients respond with answers such as family, career, or nature.

I—Importance

“What importance does your faith or belief have in your life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?”

C—Community

“Are you a part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?” Communities such as churches, temples, and mosques or a group of like-minded friends can serve as strong support systems for some patients.

A—Address in care

“How would you like me, your healthcare provider, to address these issues in your healthcare?”

Adapted with permission from Puchalski CM, Romer AL. Taking a spiritual history allows clinicians to understand patients more fully. *J Pall Med* 2000;3:129–37.

their patients if these practices are already part of the patient’s belief system. However, an agnostic patient should not be told to engage in worship any more than a highly religious patient should be criticized for frequent church attendance. Proselytizing is never appropriate in the clinical setting.

Thus, if a patient states that prayer helps with stress, the physician could suggest that prayer might help in dealing with a serious diagnosis. Or if a patient finds meaning and purpose in nature, a physician might suggest meditation techniques focused on nature. For example, when asked, “do you have any spiritual beliefs that help you with stress?” one of my patients in a primary care practice answered that she found meaning and purpose while sitting in the woods near her house—nature brought her peace. This was very important to her; she noted that on days when she did not meditate in the morning in the woods, her day would be scattered and tense. She has a community of like-minded friends who share her beliefs. She asked that I write in her chart that when she ever became seriously ill or was dying, that the room in her hospice overlook trees. She also asked me to teach her basic meditation techniques. In subsequent visits, when she

had stressful life events to deal with, I asked her if she still meditates. In one time of her life, she had stopped meditating with negative results; resuming meditation helped her cope better with her stress.

Another patient of mine, who died of metastatic malignant melanoma, was an Episcopalian. Her religious beliefs were central to her life and were a means to coming to peace with dying. In her last hospitalization, the residents caring for her were apprehensive about discussing advance directives and dying. However, during the spiritual history, the patient told the residents how her religious beliefs helped her come to terms with dying, and that she was ready to die naturally. She gave them her living will and asked that her church members be allowed to visit her often. She later told me that being asked about her beliefs helped her feel respected and valued by the residents, and that she felt that she could trust them more. The residents told me that once they asked a spiritual history, the nature of the interaction between themselves and this patient was changed. As one resident said, it felt “more natural, more comfortable, warmer and more honest.”

This story is supported by a research survey at the University of Pennsylvania—65% of patients in a pulmonary outpatient clinic noted that a physician’s inquiry about spiritual beliefs would strengthen their trust in their physician.³⁴

Patients often ask physicians to pray with them. A physician need not worry that it is somehow inappropriate to allow a moment of silence or a prayer if the patient requests this. In fact, walking away and not showing respect for the request may leave the patient with a sense of abandonment by the physician. If the physician feels conflicted about praying with patients, he or she need only stand by quietly as the patient prays in his or her own tradition. Or, alternatively, the physician could suggest calling in the chaplain or the patient’s clergy person to lead a prayer. Physician-led prayer is generally not recommended, as this blurs the boundary between physician and clergy and also might be construed as a physician imposing his or her beliefs on a patient.

Appropriate referrals to chaplains are important to good health care practice, and are as appropriate as referrals to other specialists. Chaplains are clergy or lay persons certified in a pastoral training program designed to train them as chaplains. Chaplains work in hospital settings, outpatient clinics, businesses, schools, and prisons. They are trained to be spiritual care providers working to help people with issues of finding meaning in life, coping with tremendous suffering, and utilizing their beliefs in helping them cope with illness

or stress. Chaplains work with people of all faiths and with nonreligious people as well. Clergy, on the other hand, are usually trained to provide religious care only to people of their specific denomination.

Where are the boundaries between what chaplains do and what physicians do? Some would argue that discussions with patients about spiritual matters should be initiated solely by chaplains. Sloan et al³⁵ note that because physicians are not trained to engage in in-depth discussions with their patients about spiritual concerns, patients seeking spiritual support should be referred to a chaplain or other clergy. However, others—including myself—disagree with this stance, and believe that the physician can work together with a chaplain, as appropriate. Furthermore, patients sometimes initiate discussions themselves regarding spiritual issues, and physicians need to be trained to respond in an appropriate manner.

Physicians can use spiritual histories as a screening tool. By inquiring about a patient's beliefs, the physician can assess whether the beliefs are helpful or harmful to the patient's health and medical care. If a patient has beliefs that support him or her and give meaning and peace of mind, the physician can encourage those beliefs. In cases in which spiritual beliefs interfere with a patient's getting needed therapy—for example, a patient who thinks an illness is a punishment caused by God and therefore refuses medicine or treatment because of a feeling that the punishment is deserved—a referral to a chaplain could be very helpful.

Patients have the right to refuse medical treatment. However, it is important that a choice be made with full informed consent. The physician should be respectful of the patient's beliefs, but explain the consequences of refusal of treatment without being coercive. If a patient refuses treatment based on a religious or spiritual belief, it may be appropriate to refer the patient to a chaplain so that the chaplain can explore these beliefs with the patient. Together, the physician and the chaplain can strive to ensure that the patient has enough medical and spiritual information to make a fully informed consent decision.

Some religious beliefs forbid certain medical practices, such as Jehovah's Witnesses' refusal to accept blood transfusions. There is an important distinction between refusal of treatment based on an established religious principle versus refusal of treatment stemming from depression, unwarranted guilt, or a misperceived sense of punishment from God. Such ethical and spiritual issues are complicated, and physicians need not feel that they must solve these dilemmas on their own. In fact, most physicians are not trained to deal with

complex spiritual crises and conflicts, whereas chaplains and other spiritual caregivers are. Chaplains, members of ethics committees, and counselors often work with physicians in the care of patients with such issues. A spiritual history is a valuable means to inquire about spiritual issues that might impact a patient, and can help physicians recognize when referral to a chaplain or clergy could benefit the patient.

Although it is of utmost importance to respect professional boundaries and not try to do the chaplain's job, there is a spectrum along which most physicians can operate. Some physicians may elect to pursue issues of religion or spirituality with a patient in greater depth than would others. Consider as an analogy the treatment of depression by a primary care physician. Some primary care physicians treat simple cases of depression, referring only the more complex ones to psychiatrists. Others refer a patient to a psychiatrist immediately upon diagnosis of depression. Each physician must be honest in recognizing his or her own professional and personal limitations. Ultimately, the goal is to do what is best for the patient. If early referral to a chaplain or other support person is in the best interest of the patient, then that is the appropriate course of action.

CONCLUSION

The goal of good medical care is to act in the best interest of the patient. It has become increasingly clear that in order to accomplish this goal it is critical to listen to the patient with empathy and respect, and to learn about the patient's needs, fears, dreams, hopes, and goals. It is important to know who one's patients are—not just what their disease is. The spiritual history is one means of accomplishing this. By asking your patients what gives them meaning in life and how they cope with their illness, you may open the door to a more trusting, deeper, and more meaningful relationship. This is at the heart of patient-centered—rather than disease-centered—medicine. Physicians, by recognizing the spiritual dimension of our professional lives, can reclaim the spiritual roots of our practice—compassion and service. This is one way to bring compassion back into the art and science of medicine. **HP**

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