

Religion, spirituality and health: an American physician's response

Assessing patients' spirituality provides important medical information



IN THIS ISSUE of the Journal, Peach examines whether the medical profession in Australia ought to consider patients' religion or spirituality in clinical practice (*page 86*).¹ There is much that Peach writes which I wholeheartedly support. This includes the important role that clergy play in medical settings, the need for further research on the health benefits (and risks) of spirituality in Australian patients, and the need to better understand the costs and benefits of Australian physicians making spiritual inquiries. However, on four points we disagree:

- Australians are not as religious as Americans and therefore religion is less important for Australian patients;
- although religion appears associated with health in the United States, there is little evidence for this in secularised Australia;
- assessing spirituality should probably be deferred to clergy or social workers; and
- until more is known, including spirituality in medical practice (in addition to addressing it in Australian medical schools) would be premature.

Although Australians may be less religious than North Americans, the difference is not that great. Belief in God has decreased in Australia, but it has not gone away. In 1948, 95% believed in God; by 1975, the figure was 80%.² In 1998, 74% believed in God, a higher spirit or life force,³ and according to the 1996 census only 0.05% of Australians are avowed atheists. When physical or emotional illness strikes, spiritual issues become even more important, as issues of meaning and purpose become relevant. This is particularly true for older adults with chronic illness, a population that will increase as Australians older than 65 years increase from 2.4 million people in 2001 to a projected 5.4 million in 2031.⁴

Even among younger patients, spiritual practices assume substantial importance. Consider a study of 108 patients (mean age 38 years) from medical practices in Sydney, in which researchers examined patients' experiences concerning the efficacy of 25 coping behaviours.⁵ Forty-one per cent of subjects indicated they would increase prayer in response to stress, 56% said prayer was helpful and, overall, prayer was ranked seventh in effectiveness, ahead of 18 other traditional coping behaviours, such as discussing the problem, seeking advice, spending time with friends, or socialising. Similar findings emerge among psychiatric patients. A study of 79 psychiatric patients at Broken Hill Base Hospital in New South Wales found that 79% rated spirituality as very important, 82% thought their therapist should be aware of their spiritual beliefs and needs, and 67% indicated that spirituality helped them cope with psychological pain.⁶

Thus, at least preliminary research suggests spiritual needs are not uncommon among Australian patients.

Is religion related to better health in Australia? Although research is less plentiful than in the US, it is not entirely absent.⁷ Australian studies have found greater marital stability, less alcohol and illicit drug use, lower rates of and more negative attitudes toward suicide, less anxiety and depression, and greater altruism among the religious. Religiosity has also been associated with less cigarette smoking, more conservative sexual practices (reducing risk of sexually transmitted diseases), lower cortisol and catecholamine levels (for meditators), lower blood pressure, lower cholesterol, longer survival (Seventh Day Adventists), and even lower risk for colon cancer.⁸ Such findings are similar to those in the US,⁷ and, although more research is needed, these findings cannot be ignored.

Because religion relates to health, and spiritual issues are important to many sick patients, deferring assessment of all such issues to clergy or social workers is probably unwise. Although physicians are not trained in this area, brief evaluation and orches-

tration of resources does not require great skills beyond what physicians already possess. Insufficient time is a problem, but it is not the main reason why physicians don't address spiritual issues. Rather, it is lack of comfort.⁹ Not knowing why or how to address such issues and feeling worried about imposing their beliefs on patients, not surprisingly they avoid the topic. Nevertheless, a brief spiritual history gathers information that is medically relevant and necessary to practice whole-person medicine.¹⁰ Are religious beliefs a source of comfort or stress in coping with illness? Does the patient have religious beliefs that could interfere or conflict with medical treatments? How might religious beliefs influence medical decision-making during serious or terminal illness? Is the patient part of a supportive faith community that can monitor and ensure compliance?

Physicians also need to know their limits. If complex spiritual issues come up during assessment, then referral to trained clergy is appropriate and necessary. Physicians should not offer spiritual advice or counselling, or try to solve a patient's spiritual dilemmas. A patient who is not religious or does not wish to talk about such issues should not be pressed. Such inquiries must always be patient-centred, guided by the patient's wishes and religiosity, not the physician's. Nevertheless, taking a moment to listen, validate concerns, and mobilise spiritual resources are actions that physicians can do. Likewise, if the patient is a member of a faith community, then working with a parish

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nurse after discharge may ensure successful transition from hospital or medical office to home and community life.¹¹

Exposing medical students in Australia to the role that religion plays in coping with illness and the research connecting religion and health should not be delayed. There is ample evidence to support some cautious first steps.¹² Certainly, as Peach suggests, ongoing research is necessary. Nevertheless, religion is a powerful factor that can influence health, wellbeing, and medical decisions for better or worse. It should not be ignored or neglected by physicians.

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Researchers as guinea pigs

Self-experimentation in Australia is alive and well

MANY ADVANCES IN MODERN MEDICINE owe a great deal to human experimentation. Indeed, much of biomedical research is irrelevant to mainstream medicine unless its clinical utility is established through human experimentation, for, as observed by the English essayist Alexander Pope, "the proper study of mankind is man."¹

Today the circumstances and conduct of human experimentation are painstakingly policed by ethics committees, but even such strict surveillance cannot guarantee safety: "because experiments with humans are voyages into the unknown, an element of risk is always involved; the potential for death, injury, or illness can be reduced, but it can not be eliminated."² It is this very uncertainty that presents a dilemma for researchers. Sir George Pickering, past Regius Professor of Medicine at Oxford, delineated this quandary: "The experimenter has one golden rule to guide him . . . Is he prepared to submit himself to the procedure? If he is, and if the experiment is actually carried out on him, then it is probably justifiable. If he is not, then [it] should not be done."² In short, the researcher should be the guinea pig.

Risk-laden stories of researchers being guinea pigs abound in medicine's heritage. They include that of John Hunter, the 18th-century English anatomist and surgeon, who allegedly inoculated himself with venereal pus. The symptoms of gonorrhoea and primary syphilis were soon apparent and during the last 15 years of his life he was plagued by a legacy of angina pectoris presumably due to tertiary syphilis.^{2,3} Other celebrated accounts include that of Werner Forssmann, who, in the 1920s, catheterised his heart with ureteric tubes. This risk-laden technique lay fallow until the 1940s, when Cournand and Richards in the United States refined and employed it in ground-breaking work in cardio-respiratory physiology. In 1956, all three were awarded the Nobel Prize in Medicine or Physiology.²

In the 1950s the enthusiasm for self-experimentation within the Department of Internal Medicine at Washington University, St Louis, earned it the name the "Kamikaze School of Medicine".² Bill Harrington, a young researcher, courted death from cerebral haemorrhage with profound thrombocytopenia after being infused with plasma from a patient with idiopathic thrombocytopenic purpura (ITP).² A fellow researcher, Tom Brittingham III, repeatedly injected himself with leukaemic white cells in an attempt to produce white-cell antibodies. He almost killed himself when he had an anaphylactoid reaction accompanied by profound hypotension and severe pulmonary oedema after being infused with plasma from a patient with aplastic anaemia.²

Nonetheless, these unsettling self-experiments established the immune basis of ITP and white-cell-associated transfusion reactions. Harrington's work inspired Jan Dausset of Paris to pursue research into the immunology of ITP and white cells, which culminated in his being awarded the 1980 Nobel Prize for demonstrating human leukocyte antigen (HLA; the transplantation antigen) in white cells.²

Australian researchers have also succumbed to the human guinea pig syndrome.

In 1951, as the first wave of myxomatosis raced along the Murray River, its arrival in Mildura coincided with an outbreak of Murray Valley encephalitis in the surrounding district. The public was gripped by fear that the myxoma virus was responsible for the outbreak of encephalitis. This fear reached such heights that the chairman of Mildura Base Hospital challenged R G Casey, the Minister responsible for the Commonwealth Scientific and Industrial Research Organisation (CSIRO), and Sir Frank Macfarlane Burnet, Director of the Walter and Eliza Hall Institute (WEHI), to test the harmlessness of the myxoma virus on themselves!