

A Symposium on Meditation, Prayer and Spiritual Healing



Tom Janisse, MD
Editor-in-Chief

At the 2005 Kaiser Permanente National Primary Care Conference in Maui, I convened a distinguished panel, diverse in disciplines, to address the topic of meditation, prayer, and spiritual healing. The following symposium is an edited transcript of that session.

Meditation in the form of a relaxation response was first brought to conventional medicine by Herbert Benson, a Harvard cardiologist in the 1970s. *Prayer*? Isn't that something people do in church or on their knees by their bedside? *Spiritual*? Is that different from

religion? How is it experienced now? *Healing*? The only reference to healing when I went to medical school was wound healing. Can meditation, prayer, and spiritual healing be part of clinical practice? And what are the outcomes of their use?

This panel was brought together in Maui to illuminate the areas of mind, body, and spirit in clinical practice. We feel that this subject is so important that we are publishing it in this issue on health and healing. ❖

Ode to Physicians

By Tom Janisse, MD

At day's end, who do I
see in my patient's eyes
as I look in to listen?
Automated chart note?
CPT 99214?
or overbook five?

I view in her face
Mrs Yinder's twitch,
Mrs Olive's tear,
Mr Sila's droop,
Mr Garren's wink;
all visit for care.
Close air clouds our face.

A spot of blue! Ryan,
blinks then winces, clutches
his ear, his sole concern.
I too am a parent,
a child, and a patient.

Insight for me now
at another day's end:
Can that be enough to feel
therefore I am?
My schedule, my watch,
my palm pilot don't
hold my heart.

My heart holds
my head in
my hands.

What I give in visit
after visit after
visit all day long
I take home.
Ryan meets my son,
Mrs Yinder greets my
wife, Mr Sila calls
my dad across
the country.
With these people
at wit's end at home
I feel fulfilled.

Is this Tuesday?
Thursday?
It's day's end.

Meditation, Prayer and Spiritual Healing: The Evidence



Marilyn Schlitz, PhD

*Marilyn Schlitz, PhD, is the Vice President of Research at the Institute of Noetic Sciences and Senior Scientist at the Research Institute of the California Pacific Medical Center. She completed a bachelor of philosophy degree from Monteith College, Wayne State University, a master of arts in social and behavioral studies from the University of Texas, San Antonio, a PhD in social anthropology from the University of Texas in Austin, postdoctoral fellowship in cognitive sciences laboratory, Science Applications International Corporation, and a postdoctoral fellowship in psychology at Stanford University. She has published more than 200 articles in the area of consciousness studies and is the co-editor of *Consciousness and Healing, Integral Approaches to Mind-Body Medicine*, by Elsevier. She conducted research at Stanford University, Science Applications Internal Corporation, the Institute of Parapsychology, and the Mind Science Foundation. She has taught at Trinity University, Stanford University, and Harvard Medical School, and has lectured widely, including at the United Nations and at the Smithsonian Institution. She served as a Congressionally appointed advisory member for the National Institutes of Health Center for Complementary and Alternative Medicine and is on the board of trustees for the Esalen Institute and on the board of directors for the Institute of Noetic Sciences. She also serves on the scientific program committee for the Tucson Center for Consciousness Studies.*

Dr Schlitz: This is a remarkable time in human history—never before have so many world views, belief systems, and ways of engaging reality come into contact. On one hand are the remarkable successes of science and technology: an orbiting space station, cloned sheep and cats, and a computerized chess champion that has outsmarted even the best of the human chess champions. On the other hand, through the Internet, awareness of the world's wisdom and spiritual traditions has expanded: we now have access to practices that were once isolated in the Himalayas or deep in the Amazon and available only to a very small group of adepts. Today we are experiencing a convergence of these different ways of knowing, science

on one hand and diverse religious, spiritual and cultural traditions on the other. Nowhere is this more clear than in the case of medicine.

There are various ways of responding to the unprecedented convergence we now experience. One is conflict; we need only turn on our radios to see how widespread this response is at a global level. Another response is co-option, where one tradition—typically the Western technological, scientifically based rationalist model—overpowers indigenous wisdom, often in very covert ways. A third response takes the form of creativity: As differences come together, we have the opportunity to birth new ideas and new ways of being together as a collective humanity.

My focus this morning is on the research perspective that lies at the interface of science, spirituality, and medicine. How can science begin to offer insights into these wisdom and spiritual practices? And how are these wisdom practices influencing science and medicine in ways that may lead to a more integral approach to health and healing?

Primary Areas of Evidence

There are five primary areas of data or evidence: the crosscultural data, survey studies, public health research, basic science related to mind-body medicine, and clinical studies of distant healing.

Crosscultural Perspectives

Indigenous cultures hold no separation between healing and a connection to the sacred. If you examine various traditions, it is only within our own culture that we make this demarcation between what is the rationalist approach and what is our deep engagement with the mystery. From the survey studies, it is clear that people are hungry for a deeper sense of meaning and for a connection to their spirituality. Seventy-three percent of adults believe praying for someone else can help cure their illness; this is based on a CNN poll. Fifty percent of patients wanted physicians to pray with them. This says something about what people are calling for; how people will feel happier, more contented; how they feel satisfied in terms of the therapeutic encounter. A recent survey¹ published

by the National Institutes of Health looked at the ten most common complementary and alternative practices or modalities that are used by Americans today, and they found that of the top ten, three involved prayer: prayer for self, 43%; prayer for others, 24%; and prayer groups, a very common modality for people to engage in.

Public Health Studies

In terms of public health research, through the use of epidemiological methods and tools, we are beginning to understand the correlations between spiritual and religious practice and physical outcomes. Jeff Levin, a social epidemiologist, notes that more than 1600 studies have been conducted examining the correlation between religious and spiritual participation and health.² The evidence is overwhelming. Findings persist regardless of religious affiliation, diseases or health conditions, age, sex, race or ethnicity, or nationality of those studied. This finding is positively correlated with education. People who have a strong educational background believe that these kinds of practices and principles are important for health and well-being.

Basic Science on Mind-Body Medicine

So let's talk about the mind-body connection. From cross-cultural perspectives, it appears that people believe in and practice spirituality in the context of healing and, in fact, don't make a separation. Within the Hawaiian Kahuna tradition, healers and religious spiritual practitioners are one and the same. It's clear from the correlational studies within the epidemiology data that positive relationships exist between religious and spiritual practice and health outcomes on a variety of different conditions. We hear so much about the

placebo effect as a mind-body piece for example. In our new book, *Consciousness and Healing*,² we consider an integral approach to medicine in that healing and consciousness is not only a part of this mind-body connection but also is a part of our connection to our relationships—our interpersonal relationships, our relationship to the environment, and our relationship to the transpersonal or the spiritual. Harris Dienstfrey, contributor to *Consciousness and Healing*, writes, "The mind as a source of medicine is waiting to be explored."^{2p 60} It is very interesting to me as a researcher that the placebo effect is something that we tend to put aside. It's the control condition. And yet if we really wanted to understand the innate capacities of the body to heal, wouldn't we want to focus in there and look at the ways in which our body can take an inert substance and produce a physiological change? More so, this inert substance knows the whole cascade of responses that are necessary to lead to a particular kind of outcome. How does that happen? It is a profound mystery and one that needs to be explored more fully.

Wound-Healing Study

We received an NIH grant to look at the effects of prayer and spirituality on wound healing; research we are conducting at California Pacific Medical Center. This is a three-arm clinical trial with women, primarily breast cancer patients, who are undergoing reconstructive surgery after mastectomy. We have recruited healers from across the country to participate in this study—people who believe they can use their minds, their prayers, and their intentions to influence other people at a distance.

These healers include: Chi Gong masters, Johrei practitioners, Reiki

practitioners, Carmelite nuns, Buddhist monks, and Christian groups. All the healers in our research study keep a daily log that describes their practice and their experience. People report making use of techniques such as directing healing energy toward the distant person, using some kind of focusing tool, such as a photograph, to focus their attention on the distant person, or making use of petitionary prayer to call on divine help from supernatural forces.

The women who come into the surgery unit are randomized into two blinded arms: Either they receive distant healing or they don't. In the third arm of a distant healing or prayer and intention healing group, patients are called every day and are told that they are getting healing. The outcome in this study is the rate of wound healing by measuring collagen deposition in a little GORE-TEX® patch inserted in the groin area, a standardized location. We're also looking at a variety of psychosocial measures. This is an example of bringing spiritual and religious practices, what we call compassionate intention, into a laboratory setting and looking at the role of expectancy and placebo as it relates to the particular outcome measure. We are framing the possibility that our intention can actually influence the physical well-being of another person, even if that person is unaware of that intention.

Distant Healing Research

In the recent National Center of Complementary and Alternative Medicine (NCCAM) survey study I mentioned, a significantly high percentage of the population makes use of prayer for other people. Many people believe that if I pray for you, you will become better, or if you pray for me I'll become better, and yet

It's clear from the correlational studies within the epidemiology data that positive relationships exist between religious and spiritual practice and health outcomes on a variety of different conditions.

we know very little of the mechanism to explain how this might happen. So this is a frontier area for research. To date, more than 180 studies have been done in this area, with more than half of them producing significant results. In these experiments, one person through their intention tries to influence the physiology or the physical condition of a target system, such as cell cultures, animal models, and there are human studies. As of March 2004, there have been nine controlled clinical trials looking at intercessory prayer (compassionate intention at a distance). Six of these have produced statistically significant positive results. For a complete list of these studies, one can visit the distant healing research site at the Institute of Noetic Sciences Web site (www.noetic.org).

As an example, Dr Elizabeth Targ at California Pacific Medical Center did a series of trials looking at AIDS patients.³ She selected AIDS as a condition because, at the time of the study, it was very resistant to conventional allopathic medical intervention. Patients were randomized into standard care alone or they got standard care plus a booster, which was this intercessory prayer at a distance. This was a blinded study. In both a pilot study and a confirmation study, the prayer groups had statistically significant improvements in outcome, suggesting that the intervention has clinical relevance.

Compassionate Intention and Cancer Patients: The Love Study

Anyone who works with cancer as a condition knows that partners of cancer patients can feel very disempowered: There is very little to do to help your partner. The Love Study is another project that is relevant to the translation of basic science into clinically relevant out-

comes. Specifically, one of our goals was to promote psychological robustness in the partner of the cancer patient.

We trained the cancer patient partner in compassionate intention. When the training program was over, we conducted a distant healing experiment in our lab at the Institute of Noetic Sciences. We monitored the patient's physiology, looking at autonomic measures: skin conductance, respiration, heart rate, and EEGs. One person was situated in a 2000-pound electromagnetically shielded room to rule out any conventional explanations that might account for the results. We asked the couple to exchange meaningful items—a psychological activity that helps them stay connected. For example, a man gave his wife his boots and she gave him her doll, which they held while doing the experiment. The job of the partner of the cancer patient, at random times throughout a session, is to try to calm his partner's physiology. This is a "proof of principle" type study to show that physiological changes occur as a result of this kind of exchange. The man watched a closed-circuit television as his wife's image intermittently appeared on the screen. Neither he nor she knew when those viewing periods were going to occur. The experiment is based on a randomized double-blind-type protocol.

This study can be seen in light of other studies using this same testing paradigm. A study published in the *British Journal of Psychology*⁴ examined 35 studies that looked at whether the intention of one person can interact with and influence the physiology of another person. They found a statistically significant positive difference across the studies.

We feel we have established the

proof of principle that there is some kind of nonlocal or transpersonal exchange of information between two people. So, now the question for all practitioners is: How does that relate to our practice? How do we bring these ideas of spirituality and compassionate intention into our practice, and how do we begin to see whether or not it helps clinically?

Practical Application

In the introduction to *Consciousness and Healing*, Ken Wilber notes that the most important aspect of this integral approach to medicine is the transformation that happens in the healer.² Rather than thinking about this as something outside of ourselves, how do we really bring these principles into our own lives. Key to an integral approach is not the content of the medical bag, but the holder of the bag: one who has opened herself or himself to the multidimensional nature of healing, including body, mind, soul, spirit, culture, and nature.

Spiritual Education

Today, 101 medical schools incorporate patient spirituality in their curriculum, up from 17 in 1995. This fact suggests that these principles are being incorporated into medical education, albeit at an elective level. Some hospitals such as UCLA Medical Center encourage physicians to include spiritual histories in patients' charts. This acknowledges that in fact these kinds of principles are being incorporated into mainstream medicine. Harold G Koenig, MD, who works at Duke University, recommends that physicians ask every patient if they consider themselves spiritual or religious. Doctors should encourage prayer and religious participation if that is a source of comfort.⁵ Religion has the power to heal, and we

Many people believe that if I pray for you, you will become better, or if you pray for me I'll become better, and yet we know very little of the mechanism to explain how this might happen.

have an obligation to value that power alongside medicine.

Conclusion

By way of conclusion, each of us in some way represents both the hospice worker who is helping in a very loving, kind, gentle way to let the old paradigm die, to watch and release it from its own suffering, and at the same time, each of us acting as midwives for the birth of something new. As these different cultures and different world views converge,

we can begin to see the birthing of a creative solution to many of the problems we face today. ❖

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Fly!

You and I are made for goodness, for laughter, for joy.
We're made for transcendence. Fly!

— Archbishop Desmond Tutu, b 1931, South African cleric and activist

Meditation

Charles Elder, MD, received his BA, MD, and MPH degrees at Boston University and completed his internship and residency at the University of Michigan in 1990. He joined the Northwest Permanente Medical Group as a primary care internist in 1991. He has offered a natural medicine consultative group clinic for six years and established the KP Northwest Integrative Medicine Service last year. He organizes the Northwest Permanente Complementary and Alternative Medicine Journal Club, is cochair of the regional natural products committee, and is clinical lead for the interregional CAM domain. He is a clinical investigator at the Center for Health Research, is principal investigator for two NCCAM NIH-funded clinical trials, and has published several papers on the topics of integrative and Ayurvedic medicine.

Dr Elder: The glaring discrepancy between our patients' needs and what we are capable of offering them within the confines of allopathic care represents an underrecognized root cause of chronic dissatisfaction among adult primary care clinicians. Complementary and alternative medicine (CAM), including the spirituality, prayer, and spiritual healing discussion that we're having today, can offer us practical tools to help bridge this chasm. The following discussion focuses on meditation: the mechanics of meditation, the evidence base to support its use, and the practical recommendations we can offer to patients.

We can understand "science" as denoting any branch or department of systematized knowledge considered as a distinct field of investigation or object of study. That "science" connotes empiricism is not an a priori truth but rather a provincialism of our age. An authentic meditation technique, then, can be properly understood as a scientific pursuit, with the object of systematic study being consciousness or the self. Meditation does not represent a mood-making or counterculture phenomenon but instead a specific set of simple but sophisticated techniques having definable physiologic markers and clinical results. Mantra meditation represents one technique, where the meditator sits comfortably with eyes closed and focuses his or her attention on a specific mantra or sound. This procedure serves to guide the mind from active awareness to a more tranquil state rooted in pure consciousness. Once this restful state is achieved, however, thoughts may fre-

quently "bubble up," diverting attention back toward the external world. The meditator responds by gently returning focus to the mantra and so on, back and forth. The technique thus represents a simple yet specifically directed procedure.

The physiology of meditation has been exhaustively studied. When meditating, patients exhibit decreases in heart rate, respiratory rate, blood pressure, and cortisol levels, as well as increased serotonin availability and reduced free radical burden. In one classic study published by Keith Wallace, MD, in the journal *Science*,¹ subjects demonstrated reduced O₂ consumption, reduced respiratory rate, and increased galvanic skin resistance during meditation practice. In another paper published in *American Psychologist*,² meta-analysis data comparing meditation with simple eyes-closed rest suggested increased basal skin resistance, reduced respiratory rate, and reduction in plasma lactate in the meditating groups. Thus, the literature clearly describes distinct physiologic changes that occur during meditation.

Let's next consider some of the clinical trials data. A paper published about ten years ago in *Hypertension*³ compared patients with mild hypertension, randomized into three groups: an attention control group receiving standard patient education, a physical stress reduction group receiving training in the progressive relaxation technique, and a meditation group receiving instruction in Transcendental Meditation. At three months, this single-blinded study showed statistically and clinically significant reductions in systolic and diastolic blood pressure in the meditating group compared with control.

In another study published in the *American Journal of Cardiology*,⁴ 21 patients with documented coronary artery disease were tested at baseline by exercise tolerance testing and were assigned either to meditation instruction or to a wait-list control. After eight months, the meditation group had a 14.7% increase in exercise tolerance, an 11.7% increase in maximal workload, an 18% delay in onset of ST-segment depression, and significant reductions in rate-pressure product at three and six minutes and at maximal exercise compared with the control group.

In addition to cardiovascular disease, studies have suggested beneficial clinical effects for meditation in numerous other clinical conditions, including anxiety



Charles Elder, MD

disorders and substance abuse. For example, meta-analysis data have shown a significant effect size for meditation compared with other standard behavioral interventions in the context of both alcohol and tobacco abuse. Finally, numerous studies in the literature suggest that regular meditators use less health care. One study,⁵ for example, compared five years of medical insurance utilization statistics of approximately 2000 regular meditators with a normative database of approximately 600,000 members of the same insurance carrier, showing the meditating group to have lower medical utilization rates in all categories.

At a practical level, what can we offer our patients? Some KP Regions offer training in various stress management protocols through the Health Education Department, and most larger cities offer additional community resources. In Portland, I sometimes refer my patients to the Portland Transcendental Meditation Center for meditation instruction or to the Oregon College of Oriental Medicine for classes in Qigong.

In summary, meditation represents a sophisticated mental technique that is associated with a definable physi-

ology and can render significant positive clinical effects. Through the use of meditation and other evidence-based CAM modalities, as adjuncts to usual care, primary care clinicians may be able to affect a sizeable number of patients we might otherwise be unable to reach. ❖

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All The Answers

It is reasonable to expect the doctor to recognize that science may not have all the answers to problems of health and healing.

— Norman Cousins, 1915-1990, writer, editor, citizen-diplomat

Spiritual Moments

Naomi Newhouse, MS, CNM, completed her graduate study at the University of California San Francisco in 1995. She served as chair of the TPMG nurse midwifery peer group for six years and is a California Health Care Foundation Fellow. As a board member of the California Nurse Midwife Association, she has been actively involved in moving legislation to support midwifery statewide. She has personally delivered more than 3000 babies and practices clinical midwifery at three TPMG sites. She and her husband, David Newhouse, MD, are busy raising their two children, Daniel and Elizabeth.



**Naomi
Newhouse, MS, CNM**

Ms Newhouse: Growing up in a small rural community, I had the opportunity to watch the lives of many friends and community members unfold over time. I knew why Mrs Jones had horrible headaches and why her daughter was often sick. By watching, I learned that what is wrong with our lives soon becomes what is wrong with our bodies and our minds.

This realization drew me to midwifery and sculpted my practice. The care I provide is patient centered. I ask questions and listen hard. The expert is sitting in my office. Working with thousands of women over the years, I have come to appreciate that the patient is intimately acquainted with her circumstances and knows what will or will not be effective. She ultimately holds the responsibility for any choices made, and she will bear the consequences. This is all about her.

In a culture where we are conditioned to ignore our own voice, my greatest challenge is to create a "sacred space" or "safe space" where a woman can tune in and hear what her heart is trying to tell her. As I regard the value of her voice, she regards the value of the message and moves to make the necessary changes.

By its very nature, birth creates this space for you. New life is

emerging, the lights go down, and the sacred takes center stage. This is the woman's moment. Holding the space without bias or judgment and keeping her and her infant safe is the essence of the work I have come to love.

Each family brings their unique perspective to birth: a perspective affected by culture, religion, and personal experience. Last year, I had the pleasure of working with a family from Afghanistan. When I say family, I mean a family of 12. The entire family had immigrated the year before and took turns supporting the laboring couple. They

prayed continually but would stop as soon as a nurse or other clinician entered the room. When I assumed care, I mentioned how important prayer was in my life and encouraged them to feel comfortable praying in my presence and in the presence of our supportive staff. When the family began to feel more comfortable, I noticed that the mother relaxed considerably. I encouraged the family to become more involved with her direct care, showing them where they could

access supplies to keep her more comfortable and asking them how they felt about her progress. Soon they were sharing their experiences and their concerns. The young mother quickly progressed, and the female members of the family moved with us to the largest delivery room. They stayed with the laboring woman throughout the delivery, praying out loud continually and offering encouragement as the woman worked hard to deliver her first son. The only man present was the father of the baby. Standing off to the side and close to the wall, he smiled occasionally, comfortable with the support his wife received from family members. After I completed the delivery, I felt someone's hand in the back pocket of my scrubs. Quickly taking off my gloves, I turned to see the father of the baby remove his hand from my backside.

I was shocked to discover he'd placed two hundred-dollar bills in

my back pocket; and turning to the family, I knew immediately that they were expecting me to accept their gift graciously. The nurse and I exchanged a worried glance, and I began to tell them as carefully as I could that I could not accept their money. They

were completely offended and physically turned away from me. Hours spent making them comfortable had ended in failure. Thinking fast on my feet, I lifted my hands in

Birth bears witness to the creative power we all possess. It's a time of transformation, an opportunity to remind a woman how powerful she can be.

Special Feature

the air and exclaimed in a loud, plaintive voice that accepting money was against my religion! To my great relief, they quickly turned to face me and graciously nodded their acceptance and understanding.

Birth bears witness to the creative power we all possess. It's a time of transformation, an opportunity to remind a woman how powerful she can be. Many, many times, I have

whispered into the ear of a new mother that she should remember what she did here today. When it gets tough, she should remember how strong she is. Honoring her ability to self-create, to transform her life, plants the suggestion that she can mobilize and realize changes that will benefit her and her family. These women will track me down just to tell me they've fin-

ished their GED, started college, left an abusive partner. For those who will hear their own voice, who will value what is true for them above all else is the gift of vitality and the power that comes with it. What is right about her life will soon be what is right about her body, mind, and spirit. ❖

Nurturing Spiritual Growth

Although the act of nurturing another's spiritual growth has the effect of nurturing one's own, a major characteristic of genuine love is that the distinction between oneself and the other is always maintained and preserved.

— *M Scott Peck, b 1936, author, nationally recognized authority on the relation between religion and science*

Pastoral Spiritual Care

Kurt Smidt-Jernstrom lives in Canby, Oregon, with his wife and two children and enjoys work, cycling, fishing, boating and choral singing. He received his theological education at Fuller Theological Seminary in Pasadena and at the Graduate Theological Union at Berkeley, California. He took his chaplaincy training and internship at Stanford Medical Center, UCLA Medical Center, and Legacy Emanuel Hospital in Portland, Oregon. An ordained minister in the United Church of Christ, he has served as pastor of a local church, as interfaith chaplain at a care center, as pastoral counselor of Kaiser Permanente Hospice, and is a chaplain at Kaiser Sunnyside Hospital in Portland. He is a member of the KP Regional Ethics Committee; a board-certified chaplain through the Association of Professional Chaplains, and a doctoral candidate at the University of California, Berkeley.



Kurt Smidt-Jernstrom

Mr Smidt-Jernstrom: I am going to begin by listing my three main points: First, it is possible for healing to occur (healing in the broadest sense, meaning a reintegration of body, mind, emotion, and spirit that enables one to live life fully, with a sense of equanimity), whether or not physical symptoms actually improve. Second, supporting and fostering this healing process is something you can do in the clinic setting. Finally, to provide effective spiritual support, it is helpful to reflect on one's own spirituality.

At the outset, I would like to offer a couple of definitions that may be helpful as we discuss spirituality. I often make a distinction between spirituality and religion.

Spirituality is an aspect or condition of human being, concerning:

- relationships (involving love and intimacy)
- meaning and purpose for being
- letting go of the crippling past (forgiveness)
- openness to the future; hope.

Religion is:

- a system of beliefs and formal practices that are practiced individually or in community, usually as a focus for finding meaning in life, understanding death, and maintaining hope for the future.

As a hospital chaplain, I provide spiritual and emotional support (and occasionally religious support as a Protestant Christian clergyman) to patients, sometimes to families, and occasionally to hospital staff. One of the tools I use in providing this support is

active listening (listening to a person nonjudgmentally and compassionately) to try to understand that person and not necessarily to fix a problem. Another tool I use is a supportive presence; in other words, the nonverbal aspects of communicating interest and compassion when attending to another. Maintaining a supportive presence is important in any patient encounter but becomes especially important when working with someone who is struggling with cognitive impairment and who finds it difficult, if not impossible, to communicate verbally, not to mention engage in a reflective process. Prayer (and to a lesser extent, meditation) are other tools I use to provide spiritual support and to help enable a person to cope with illness or injury or sometimes dying. I work, as best I am able, within patients' belief systems, helping them to tap into their own spiritual resources.

Prayer and meditation are practices that can aid the ability to cope by enabling a person to modify the perception of a stressor. (I have a graphic image that shows the relation between prayer, meditation, and various coping behaviors.) For instance, some people have told me that in their struggles with chronic illness or pain, they have learned to "befriend" their illness or to "dance" with their pain. These metaphors seem to indicate a certain ability to cope with various stressors.

A woman I worked with recently had lymphoma. The cancer itself plus the side effects of various medical interventions left her, at times, physically, emotionally, and spiritually exhausted. Throughout her life, she had prided herself on her physical condition and appearance and so occasionally became distressed at the disfigurement that occurred as a result of the chemotherapy and the progression of the cancer. For all this, she refused to let her illness (and eventually her dying) keep her from participating in family and community life. Until quite near her death, she was attending family gatherings, grandchildren's school events, and church. She had a very deep faith that she drew upon continually for inner strength. A saying that she gave me shortly before her death is an indication of how she was able to modify the way she perceived some of the powerful stressors she experienced.

Special Feature

LIFE'S JOURNEY

Life is not a journey to the grave with the intention of arriving safely in a pretty-well-preserved body, but rather to skid in broadside, thoroughly used up, totally worn out and proclaiming:

WOW!

WHAT A RIDE!

This coping or healing can be fostered and supported in the clinic setting by using spiritual support tools, such as active listening—listening CARE-fully, sensitively and respectfully—and attending to spiritual concerns when they are mentioned. Occasionally, a patient will explicitly mention a religious preference, belief, or spiritual concern. In that case, it is helpful to follow-up. When I talk with patients, I always listen for openings that give me the opportunity to follow-up on spiritual issues or concerns.

Some people like to take a spiritual history using one of various spiritual assessment tools. One popular assessment that has been peer reviewed and listed in medical journals was developed by Christina Puchalski, MD.^{1,3} You might find this or other assess-

ments helpful in developing your mental template and your own way of broaching spiritual issues. Good opportunities to conduct a spiritual assessment might be when a person is admitted to the hospital, or perhaps during a new patient visit, or during a medical maintenance visit.

Sometimes the presentation of spiritual issues can be complicated, and one needs to tease them out. For instance, I worked with a young woman who had ovarian cancer and who was very angry. By listening carefully and by establishing a nonjudgmental presence, I offered her the opportunity to talk about and reflect upon her anger, which in turn, allowed her to begin to understand the effects that her anger had on others as well as herself. (Editor's note: Mr Smidt-Jernstrom wrote about this in a story to be published in a future issue of *TPJ*.)

Referrals are another way of offering spiritual support. When addressing spiritual concerns threatens to go beyond the time constraints of an office visit, it may be helpful to suggest a referral to a chaplain or social worker. In addition, in the KPNW, we have health consultants to whom patients can be referred, and those consultants can link people to various groups who are open to reflecting on spiritual concerns as they relate to the patient's own illness or condition.

Finally, to provide effective spiritual support, it is beneficial to reflect on one's own spirituality. Some may be novices at that, and so I have included a short list of questions to reflect upon that can serve as starters (Table 1). They prompt reflection on spirituality in general as well as on one's own spiritual journey. ❖

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Table 1. A short list of questions/discussion points for reflection
Discuss the following thoughts and questions about spirituality:
<ul style="list-style-type: none"> • What are some of the barriers to discussing spirituality/spiritual issues in general and/or with those you care for? • It is often helpful to distinguish between religion/religiosity and spirituality • Spirituality is elusive. It's not my mind or my feelings, although it's part of them. It's that part which holds together all the rest. Spirituality refers to an acknowledgment, belief, or conviction that there is more to life than the material ... People are looking for commonality—for common ground.
Various ways of describing spirituality:
<ul style="list-style-type: none"> • Journey—with metaphors such as traveling, destination, or crossing over^a • The business of living—the work one has to do, unfinished or unresolved business, pride in what has been accomplished^a • Relationships—with metaphors for healing, estrangement, and separation^a • Interpersonal—issues such as fear of suffering or questions of forgiveness, shame, and guilt^a • We all perceive life in our own way. Difficulty arises when we cling to a world of perception as though our own perception is the ultimate reality^b • We all ask such questions as: Why? Why me? Why now? Questions for which there are no answers. What's required is not a seminary education but sensitivity and ears that can hear and being comfortable with not knowing.^b

^a Brad DeFord remarks at National Hospice Organization's annual meeting in Salt Lake City, Utah; 1992.

^b Don Dinsmore remarks at Hospice Organization of Wisconsin annual meeting; 1993.

Spirituality in the Medical Encounter: The Grace of Presence

Elizabeth Sutherland is a naturopathic doctor. She received her bachelor's degree in biopsychology from Tufts University and her naturopathic medical degree from the National College of Naturopathic Medicine in Portland. She completed a two-year postgraduate fellowship through the Kaiser Permanente Center for Health Research and is currently a research associate with that organization. She is a clinical investigator on the NIH-funded study, Alternative Medicine Approaches for Women with TMD, and the principal investigator on two pilot studies that examine the experiences of chronic pain patients at the Kaiser Permanente Northwest Pain Clinic who received an energy healing intervention. Her research interest centers on developing methodologies to study the doctor-patient relationship and transformational change, and she has published in this field. In the past, she studied Classics at Cambridge University.

Dr Sutherland: It is easy to think of spirituality as a domain that is distinctly separate from the practice of medicine. If spirituality is considered to have a place in the medical setting at all, it is usually envisioned as a *discussion* between doctor and patient where the doctor gingerly approaches the topic of the patient's religious beliefs to better assess the patient's available social support. Sometimes, this discussion takes place when the doctor feels s/he has reached the limits of medical knowledge and doesn't know what else to do, as with a patient facing the diagnosis of a terminal disease or other life crisis. The goal of the discussion may then be to refer the patient to a chaplain or other religious expert.

While this type of discussion is vital and admirable, it is possible for the doctor-patient relationship itself to be a profoundly spiritual encounter, even if the topic of religious beliefs is never broached. I lived within a spiritual community for several years where meditation and

introspective work were built into a rigorous schedule. The real emphasis of the practice, however, was that spirituality is grounded in everyday life, not separate from it; that, by our nature, we are spiritual beings, and that *connection* is, in a sense, the fundamental unit of life. The practice involved becoming aware of this connection and consciously serving it. In the medical setting, spirituality can be defined as the practice of *cultivating awareness of a larger and larger context*. This may sound like a kind of "off-label" use of the term spirituality, but when we practice cultivating awareness of a larger context, in essence we take a step back and be-

gin to contemplate both ourselves and the patient, each as a whole person. Practicing medicine as a spiritual encounter is really a lifelong work of meditation and introspection, which can be expressed as three steps:

1. Cultivating awareness of wholeness within oneself
2. Seeing wholeness in another
3. Connecting from the sense of wholeness within oneself to the sense of wholeness one perceives within another.

The language may sound abstract, but if connection is a constant principle of life, then we are just acknowledging and consciously participating in that connection process. A way to step into practicing medicine as a spiritual encounter is to listen for the meaning of a patient's experience, instead of listening only for the reporting of symptoms. Think of this as our attention span, not how many minutes we can concentrate with our minds, but how far we can open our hearts and simply behold ourselves and another person in a given moment. This is deep listening, a facet of spirituality with concrete benefits.

Deeply listening is not just a nice



Elizabeth Sutherland, ND

Sidebar: The benefits of listening deeply

For the patient

- Improved medical outcomes through better diagnosis
- Improved satisfaction leading to greater adherence to treatment

For the doctor

- Greater job fulfillment
- Less stress-related illness and burnout
- Personal expansion and growth

thing to do. It is in itself an agent of healing and transformation. Deep listening is an internal orientation of you, the doctor, that becomes experience and then a state you transmit to the patient. (See Sidebar: The Benefits of Listening Deeply.) It may feel like doing nothing, but it can make all the difference in the world. Knowing one is truly heard and understood gives a sense of self-value and a greater ability to bear whatever is going on. The culture of medicine has become so fraught with time constraints, performance measures, and litigation that it loses sight of the two people who are in the room participating in an experience together. Medical training essentially trains doctors to take the *person* (that is, themselves and the patient) out of medicine. To help bring the *person* back into medicine, consider two concepts:

The First Law of Theo-Dynamics
Sometimes, the least is what you know; the most is who you are.

The Second Law of Theo-Dynamics
How much time you actually spend with the patient is less important than the quality of your presence.

I use *Theo* here to represent the spirit and creative power of wholeness or completeness that resides within each of us. Being present and deeply listening brings the person, the humanity, back to the medical

encounter and turns it into a therapeutic relationship. The practice of medicine is a spiritual encounter in which the doctor as person is an integral part of the medicine, acting as a catalyst in the therapeutic relationship to reconnect the patient with his/her inherent capacity to be whole. Spirituality in the medical context is about the doctor as expert human being rather than religious expert. This can take the form of holding for patients the vision of their wellness when they are unable to connect with it themselves. It can mean realizing that fear of giving the patient false hope may in fact be directing the patient toward false despair.

A way to step into practicing medicine as a spiritual encounter is to listen for the meaning of a patient's experience ...

How to Practice Medicine as a Spiritual Encounter

Begin every visit with a spiritual orientation toward your patients. This means wanting to know the meaning their experience has for them. (It may help to hold inside of yourself the thought: "I want to know who you are.") Begin with an invitation: "How can I help you?"

If a patient reports to you what is in his/her medical records, redirect: "I know all of that. I want to know what is going on for you." A patient may cry because this is the first time anyone has ever asked this. If the person cries, it is actually a good sign. You don't have to *do* anything. Just wait a few seconds. The patient will tell you what is really going on, making connections s/he has perhaps not understood until now.

In the presence of your deep listening, you have created the space for self-awareness. Stop talking. Listen. Listen beyond the mere reporting of symptoms. Remember, listening from your heart is a state of deep acknowledgment that you will transmit to your patients.

Even if you only have a few minutes, the patient will feel heard, hopeful, and understood because you have deeply listened. Get comfortable doing nothing. Get comfortable letting a patient leave without a prescription. Listening may be all the medicine your patient needs in that moment.

Conclusion

Spirituality is found in the human condition; it's in the connection between people. It takes a relatively small investment to connect. It's not the time spent; it's the quality of your presence. Connection is the human face of medicine; the human face of medicine is spiritual medicine. Listening beyond the reporting of symptoms will transform your practice and will transform you as a person. ❖

The time will come
 When, with elation,
 You will greet yourself arriving
 At your own door, in your own
 mirror,
 And each will smile at the other's
 welcome
 — From "Love after Love," by
 Derek Walcott^{1:p95}

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1. Housden R. Ten poems to change your life. New York: Harmony Books; 2001.

Spirituality Symposium: Panel Discussion

Dr Janisse: I want to thank our panel for their thoughtful, informative, and entertaining presentations. I would like to open this discussion up for questions.

Time

Audience member: I love connecting with my patients, and it's always the time issue. Once you start connecting with them, they really want to open up and let it all out as though you were from the behavioral science department. So what do we do with that? Do you have something specific that you stay with and focus on with the patient, and how do you stop them without invalidating them when they start to go on and on?

Dr Sutherland: Because I practice on the fringes of medical society, so to speak, I have the luxury of spending sometimes an hour, sometimes an hour and a half with patients, and maybe I'll ask two questions in that time. The first question I'll ask is, "How can I help you?" At which point they'll either tell me what's in their chart, for example, "I've just been diagnosed with ovarian cancer." I'll say that I already know that. What I'm interested in is what is your experience: I want to know your story. Or they'll cry, and that's when I know I'm really doing good work. They'll cry because no one has ever asked them, how can I help you. So, how can I help you? And then maybe I'll ask, "What else?"

What we're really talking about is the cultivation within you, the practitioner, of certain qualities. How you describe these qualities, I think, is whatever resonates with you. Dr Schlitz talked about compassionate intent. I talk about being fully present and deeply listening. So this is something, as I think all of the panelists have mentioned, that a practice we do all the time. Hopefully we're successful with it in that moment with a patient, but it's not something that we can turn into a technique. When you practice it all the time, you can step into it immediately because it's a state that is always there so you can connect with it.

When you have that demeanor, your patient is going to feel you've really spent a lot of time with them even if it's only seven minutes. You probably heard about a statistic recently that surgeons who don't get sued spend more time with patients than surgeons who do. Do

you know how much more time they spend with patients? It's not 90 minutes. Three minutes. Three minutes, but it was something about their demeanor. So in terms of how to redirect a patient when you're running out of time: One, is the fact that you have listened so deeply that patient is going to feel acknowledged so then whatever you say (because you will in that state allow the words to come to you rather than forcing words), they'll still feel acknowledged. You can say to them: I think what you're saying to me is so important that I really want to continue exploring this with you. We've run out of time, so I'd like you to make another appointment. This leads to you, the practitioner, getting comfortable doing nothing, because when you think you're doing nothing that's actually when the healing is happening. To send that patient away without a prescription, maybe the only thing you say to them is: In the coming week, in the coming month I'd like you to spend ten minutes on your own thinking about your experience right now and see what it brings up for you and then tell me about it when you come back.

Mr Smidt-Jernstrom: I would add to what Dr Sutherland has said, only that you can communicate compassion and understanding and it doesn't necessarily take a long time. I can appreciate that there are times that you feel this particular patient has just given you something you don't have time for, and that's when handoffs are good, like referrals, as a way of redirecting. You can say, "This is really important, and I'm wondering if you might be willing to talk with someone else about this."

As I mentioned about doing a spiritual history, I know of a physician, for instance, who asks his patients: "What are you doing for yourself besides taking your pills?"

Dr Elder: I think the presence of the clinician is, in itself, healing. What we can do that doesn't take a lot of time is just be ourselves and take care of ourselves. Then, when the patient comes in sick, s/he will pick up on that energy, and that is itself therapeutic. The other point is that it doesn't take a lot of time to make positive comments to the patient, because we forget how powerfully we communicate to the patient through

This leads to you, the practitioner, getting comfortable doing nothing, because when you think you're doing nothing that's actually when the healing is happening.

our body language and other nonverbal behavior. These reflect who we are and how happy we are in our own circumstance. We also communicate through what we say to the patient, like, “You’ll be better in two weeks,” or “You’re looking great.”

Dr Schlitz: There’s that expression: The doctor will see you now. Really seeing someone doesn’t take long.

Applying Meditation in Clinical Practice

Audience member: How do you think we could use meditation, and in what conditions and situations would this be particularly valuable?

Dr Elder: There’s a lot of data supporting the use of meditation in cardiovascular disease, that’s number one. Number two, in substance abuse. Number three, depression and anxiety. Learning these techniques isn’t inexpensive but is cost-effective in the long run when you consider that, for example, the average cost of being on a drug is about \$1500 a year per drug. So, if we can give patients alternatives to medication, we can go a long way in terms of being cost-effective.

Dr Schlitz: Also, just as a resource, on the Institute of Noetic Sciences Web site¹ is a meditation bibliography, called *The Psychological and Physiological Correlates of Meditation*. There are different illness categories and the research.

Mr Smidt-Jernstrom: Practically speaking, oftentimes I suggest a focus on breathing as a way for people to clear their mind and slow their breathing. Sometimes people find a certain phrase helpful, and they use it over and over. Sometimes music. A single parent I work with in the hospital focuses on her youngest child and uses that as a starting point for her meditation. It could be a walk in the woods.

Ms Newhouse: In the Diablo Service Area in Northern California, we have a trainer in a technique called mindful meditation, developed by Jon Kabat-Zinn. It’s non-sectarian. It’s available in a course for physicians and also for patients, for example those with chronic pain. Dr Kabat-Zinn initially worked with chronic pain patients in his clinic to discover their own power of healing and has had a lot of success through applying this technique.

Audience member: I was very interested in the cardiologist who says a prayer before he goes into the procedure. It reminded me of the JAHCO standard now to have a time-out in the OR before every case. It’s an

incredibly powerful thing that when the patient is draped, prepped and getting ready for the procedure, the surgeon has to quiet everybody down, tell a brief history of the patient, then the circulating nurse and the anesthesiologist give their important points about that patient. It’s a powerful moment.

Dr Schlitz: This moment also allows a renewal for the practitioner because it’s a two-way interaction. How they can find, and we can find, our centering so that it’s a more responsible engagement.

Mr Smidt-Jernstrom: Recently, I met a young woman who had surgery, and she had listened to some wonderful meditation tapes and read a book on meditation. She came up with a list of statements that she wanted her surgeon to read to her before she went under anesthesia. The list contained such things as “You will only have minimal blood loss during surgery” and “You will recover completely and quickly from this procedure.” There were six things, and the surgeon read them all.

Audience member: How long is the meditation that you would suggest patients do? For a lot of people with their busy lives, trying to start meditating would probably take some practice.

Dr Elder: Twenty or 30 minutes of practice, once or twice daily, has been generally recommended for the techniques that we have studied at our Center for Health Research (including Transcendental Meditation and Qigong). In our studies, patients have generally reported 80-90% compliance. Some patients have told us that they find the mind-body practice time efficient because they can get so much more done with the rest of their day.”

Dr Schlitz: In Jon Kabat-Zinn’s work, it’s ten minutes, and it’s just a simple centering exercise that’s distilled from a number of different practices, so it can be a deeper immersion in the practice or it can be something so simple as just connecting to your core self and relaxing.

Presence At Death

Audience member: Although I’m an endocrinologist, I still take hospital call, and I’m amazed in this day and age that I still have to declare people dead. When I enter the room, the family is there, and the patient’s dead. I’m entering that sacred space, if you will. That’s when I take my time-out—before I enter that room—because I don’t know this patient at all; never met them.

... if we can give patients alternatives to medication, we can go a long way in terms of being cost-effective.

I'm not their personal physician, I'm the hospitalist, and it still gives me goose bumps. I would do that until I stop practicing medicine. And when I entered medicine I never thought I would. I thought I would be afraid of death and would not honor it. We've talked today about birth, which is a beautiful thing, but the time of death is also when we can be present with the family. That is incredibly healing for the family. I just know that's true.

Dr Schlitz: Both birth and death are the transitional phases where the sacred comes and goes, so they're similar. They are so related, it's almost hard to divide them, and honoring that space doesn't take a lot of time. It's about your willingness to just center your spirit for a moment before you walk into that space, and the more aware you are of what is going on in your own heart and mind and being able to put that aside for a moment. When you're interfacing with critically ill patients or with patients who are very upset or in a state of crisis, holding that sacred space can be done in short fashion, and it begins with how in touch you are with your spirit. When they see you get centered, they get it right away. You can feel it, you can feel them zoom in on you.

Dr Sutherland: I wanted to give my talk today the title: "What is spirituality? Or what do you do when you think you have nothing to offer?" And we've been talking about profound experiences, people who are dead, patients who are facing death or birth. I'd just like to say again that spirituality is the human condition. It's something that's with us all the time and we can connect with it all the time. In the Tibetan tradition, they have mantras, which are like prayers, for everything. There is a mantra for going to the bathroom, and this is not making something sacred profane; it's saying that everything's sacred.

Negative Effects?

Audience member: I went to medical school at Columbia with a surgeon named Emmett Oz. Whatever happened to his work about giving suggestions during surgery?

Audience member: He is still out there. People now believe this is very valuable, but what are the side effects of these practices? If you believe it works, then it could actually have a negative effect. In Emmett's research, he said that when playing music in the operating room, some music would actually reduce blood

loss during surgery but that some music would actually increase blood loss during surgery.

Dr Schlitz: That is such a good point. That's why research in this whole area is so critical. We just don't know enough. It's a whole new sort of discipline. When you consider something as benign as prayer, we just don't know enough about in what conditions it is helpful and in what conditions it is harmful.

Dr Sutherland: Because of this, it's safer to keep yourself as the instrument, because if you're listening, if you're being fully present, I really don't think you're going to do any harm.

Mr Smidt-Jernstrom: I think it is important to remain patient-focused. I always work within the belief system of the patient to enable them to tap into their own spiritual resources.

Dr Elder: Your point emphasizes the importance of thinking good thoughts about our patients, because in the course of a busy day, when we're seeing two dozen patients, we can come to a point when we're not at our best and we start having thoughts that aren't entirely positive about our worklife and the people whom we serve. If we believe that thinking positive things about our patients can have a positive impact, then the reverse is probably true, and so we need to be very mindful of that.

Dr Sutherland: What we're doing when we're with a patient is inviting them; we're not demanding. We're not saying, you know, I'm loving you unconditionally, what's your problem? Because we can do that. We can think our intent is loving kindness and it's putting energy into another person that they may not want. So you have to hold within yourself that: I want to know who you are. Let everything you do be an invitation.

Dr Janisse: Well, thank you all for coming. And a special thanks to the panel for bringing knowledge, experience and wisdom to this relevant subject. ❖

Reference

1. The physical and psychological effects of meditation [monograph on the Internet]. Petaluma (CA): Institute of Noetic Sciences; 2004 [cited 2005 Jun 13]. Available from: www.noetic.org/research/medbiblio/ch_intro1.htm.

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