CHAPTER 10

Spirituality and healthcare

Marius Swart

1. INTRODUCTION

Depending on the severity of the disease, a patient also has, apart from the physical discomfort, psychological and social challenges to deal with. In the holistic approach to patient care, the healthcare practitioner should be sensitive to the spiritual needs of the patient – and this sensitivity should involve taking the religious and faith needs of the sick person into consideration.

To treat only the body is to deny the person as a whole. In the Judeo-Christian faith the heart is the place where the body, soul and spirit connect as one (Nouwen, 2011:95). The Latin word for heart is indeed *cor,* which is the etymological origin of the more familiar word core or centre. However, these concepts of body, soul, spirit, and even mind, can be confusing. Waaijman (2002:132) attempts to clarify this by stating that the body is the place where the soul chooses to be spirit (*pneuma*) or flesh (*sarx*). One should not see this trichotomy of body, soul and spirit in an anatomical context, but should rather understand a human being as an embodiment of soul, or an ensoulment of body (Louw, 2005:16). Soul does not represent a part, but rather soul represents wholeness (Louw, 2012:2). Spirituality could thus be the religious dynamic of this ensoulment or embodiment. Spirituality, in a broad sense, means to find significance and direction in life, because spirituality is the point of interaction between the spirit of the human and the spirit of God (Schneiders, 2005:51). In particular spirituality refers to the meaning or even lack of meaning the patient may experience during illness (Truter & Kotze, 2005:974). However, this does not necessarily mean that spirituality is a pathway to "strange" religious experiences.

Spirituality is a way of life. The rabbinical word *halacha* refers to the way of the Torah. The follower of Buddhism sees spirituality as the way to Enlightenment. Even the root of the word Taoism (a Chinese philosophy) refers to "the way". The Christian is familiar with Jesus' claim of being the way (New Testament John 14:6). For the believer of Islam *shari'ah* is the road to travel (Waaijman, 2002:123-125). All of these religions have an eschatological emphasis that is important to the patient who, in his or her vulnerable state, may be thinking about what will happen after this life.

The term "spirituality" has its equivalents in many other languages: the French have *spiritualité*, derived from the Latin *spiritualis*, the Hebrew use the term *ruach* and the Greek *pneuma*. The term spirituality is also not bound to a specific religion; the Jewish *kaballa*, for example, means mysticism and inner life (Waaijman, 2002:360).

Spirituality is also not necessarily even associated with a religion. People may well be spiritual, but not religious. All people are spiritual to some degree, even though they may deny this (Hinshaw, 2005:271). To be human is to be spiritual (Pesut, Fowler, Taylor, Reimer-Kirkham & Sawatzky, 2008:2804). To accept the idea that all people are spiritual though not necessarily religious, one has to acknowledge a secular spirituality, or reverence. Such a spirituality can be defined as, for example, the amazement one can experience when spending time in nature; the enjoyment provided

by a piece of art or music; the feeling of being loved; or the warm feeling engendered by altruistic deeds (Ai, Wink & Shearer, 2011:535). To Waaijman (2002:427) a secular spirituality is inclusive. Secular spirituality may include a sense of awe associated with, for example, environmental matters, feminism and other non-theistic forms of spirituality. However, there should always be something sacred to spirituality, even if it is not in a religious context.

2. SPIRITUALITY IN HEALTHCARE

When it comes to healthcare matters, and in particular the investigation of spirituality as it relates to healthcare, it is important to distinguish between the concepts of religion and spirituality. Patients often do not realise this difference and even authors use these terms interchangeably, although they could mean or refer to the same human experience (Koenig, 2008:5).

Religion concerns the service and worship of (a) God. Religion is considered to be institutionalised and related to tradition. The members of a religious group are often accountable to some kind of authority. Certain aspects of religion can be measured and this is important in studies related to health. These aspects may be, for example, the regularity of attendance of religious meetings or the frequency of prayer, or of reading the Holy Scriptures. As a concrete example, the close association between religion and tradition or customs was strongly highlighted by the positive interreligious collaboration in West Africa during the Ebola crisis of 2014 (Marshall & Smit, 2015:5).

Spirituality is more personal, more inclusive and less formal than religion. Koenig (2007:S45) acknowledges that spirituality could also refer to psychological characteristics of people. This may well complicate the possibility of research which tries to find links between spirituality and (mental) health. When spirituality is investigated, the sacred or transcendent should be seen as part of spirituality (Koenig, 2007:S46; Lucchese & Koenig, 2013:105). The transcendent is that which lies outside the physical and perceptible reality. In that sense spirituality is very close to religion and to measure religion is to measure spirituality. In a practical sense spirituality in healthcare refers to everything about the patient that is not body (anatomy or physiology), but which belongs rather to the vulnerable inner space (Waaijman, 2002:436), and which is concerned about why me, why this, what if, what then. These are the typical existential questions people ask when confronted with disease.

For centuries, perhaps millennia, medicine and religion have gone hand in hand. The same person often performed religious and medical rituals. During and after the Enlightenment an epistemology of reason, objectivity and empirical data forced religion into the private lives of individuals (Pesut, Fowler, Taylor, Reimer-Kirkham & Sawatzky, 2008:2805). Science and religion separated and developed in different directions. However, today this is changing again, and a new era has dawned, or perhaps returned. The science-faith debate is very topical. The fields of science and

theology do not need to be in conflict with one another. Theology should take note of the findings of the hard sciences, re-interpret them and apply them in a religious tradition (Buitendag, 2004:65). Since the 2000s an explosion of research articles on spirituality and medicine has been observed (Lucchese & Koenig, 2013:105; Neely & Minford 2008:176; Van Erp, 2006:66). *Where Science and Spirituality Meet* becomes an appropriate subtitle for the book on health and religion by Harold Koenig (2008). The argument by Willis (2000:355) that healthcare should make some serious paradigm shifts, is thus relevant. These paradigm shifts can be summarised as a change in the way healthcare workers see patients; the way patients see themselves; and how God is perceived in suffering and healing.

3. WHAT IS THE EVIDENCE?

Religious people would rejoice if evidence could be produced to prove that spirituality, and in particular faith, contributes to curing. Of course, true believers don't need proof, and sceptics won't be persuaded by facts (Tarpley & Tarpley, 2002:644). There is, in fact, no lack of evidence for a positive link between spirituality on the one hand, and health and curing on the other. When the evidence is evaluated one should be attentive to the outcome of the investigation and the way that spiritualty has been applied. One should also be aware of underlying factors that may assist in explaining the association. Obviously, in such a debate one should be open to alternative standpoints.

Unfortunately, faith-linked controversies in healthcare are often closely related to culture, social factors and politics (Tomkins, Duff, Fitzgibbon, Karam, Mills, Munnings, Smith, Seshadri, Steinberg, Vitillo & Yugi, 2015:19). Family planning, child marriage, female genital mutilation, sexuality and end-of-life issues (suicide, euthanasia), to mention but a few, could all be faith/tradition related and have a decisive effect on health and well-being. Surgeons are familiar with the stance of the Jehovah's Witness religion pertaining the transfusion of homologous blood.

The positive relation between health and religion in general has been established. A meta-analysis of 42 articles and 126 000 patients who were followed up for a fixed period reveals a lower mortality rate among patients with active religious involvement – the odds ratio was 1:29 (McCullough, Hoyt, Larson, Koenig & Thoresen, 2000:211). People with religious affiliations were shown to have a better chance of being alive at follow-up. This finding was however criticised as a weak association, and it was pointed out that other psychosocial factors are or could be more important to health (Sloan & Bagiella, 2001:228). Sloan and Bagiella's (2002:19) own review of the literature a year later concluded that religion has no beneficial effects on health. However, the claim that religious attendance could have the same benefit in terms of additional life-years as using a statin or exercising regularly, is almost provocative (Hall, 2006:106) – yet no one will doubt

the importance of a statin and exercise in managing coronary artery disease. In a review article, physicians at the Mayo Clinic expressed the opinion that spirituality and religious activities have a direct positive relationship with health outcomes (Mueller, Plevak & Rummans, 2001:1232).

In the positivistic sciences it would make perfect sense to test faith by comparing a study group and a control group. This was done by Byrd (1988:826) in the late eighties and repeated ten years later by Harris, Gowda, Kolb, Strychacz, Vacek, Jones, Forker, O'Keefe, & McCallister (1999:2273), who tracked intercessory prayer, and concluded that intercession improves the outcome in the coronary care unit. In both of these studies, hard endpoints were used, such as antibiotic usage, ventilator dependence or coronary care scores. The consensus after a review of five randomised control studies was that intercessory prayer is useful. However, soon after this finding, the contrary was demonstrated by the Mayo Clinic, which presented findings of a methodologically very sound study (Aviles, Whelan, Hernke, Williams, Kenny, O'Fallon & Kopecky, 2001:1192). It was a randomised, double blind study to assess the effect of intercessory prayer on patients for 26 weeks after they had been discharged from the coronary care unit. The endpoints were also robust outcomes, but they found no difference between the two groups. In another study, intercessory prayer was applied to a surgical group (Benson, Dusek, Sherwood, Lam, Bethea, Carpenter, Levitsky, Hill, Clem, Jain, Drumel, Kopecky, Mueller, Marek, Rollins & Hibberd, 2006:934). Post-operative coronary artery bypass graft surgery patients were randomised into three groups. One group received prayers, though they were not aware of it. A second group received no prayers, but they did not realise it. The third group received prayers and they were conscious of it. Again, no difference was found between the first two groups, but surprisingly, the third group, which received prayers and were aware of it, had more postoperative complications. The measured outcome was the complications typically associated with major cardiac surgery. One possible explanation is that these patients experienced a religious struggle. The negative influence of religion has been investigated and confirmed (Ai, Pargament, Appel & Kronfel, 2010:1067; Ano & Vasconcelles, 2005:477). To add to this, links between the image of God, frequency of prayer and mental health have been established (Bradshaw, Ellison & Flannelly, 2008:654). Patients with a negative image of God (i.e. not-loving or remote) might experience more symptoms of psychopathology. This might even be in spite of a higher frequency of prayer, illustrating underlying stress. A good image of God shows an inverse association with mental health problems. To conclude on the possible correlation between intercessory prayer and curing, the authoritative Cochrane Library pronounced the futility of such "experiments" and concludes that such a positive correlation between intercessory prayer and no prayer as a way of curing patients does not exist (Roberts, Ahmed, Hall, Davison, 2009:2).

Prayer should be experienced as an end unto itself, and one should be careful of applying prayer as a means to reach some other endpoint, such as biomedical or physical curing (Pembroke, 2007:347). A point of criticism against studies involving study groups and control groups that are defined by

prayer or no prayer is the lack of a true control group, as patients themselves or their relatives may also pray. The dosage or duration of prayers cannot be defined. Someone who prays expects to experience change, especially after a petitionary prayer. This entails a change in the person who prays or in the outcome and thus a change in God and God's actions. Thomson (1996:534) asks whether it is possible that such experiments actually question the existence of God. When the patient relies on prayer for curing instead of believing in God, the emphasis is on prayer as a prescription, written on the treatment chart of the patient.

Ai, with several of her co-workers, investigated personal prayer extensively, together with its effect on alternative yet softer outcomes. After many years they confirmed the positive role of personal prayer in the post-operative recovery after, in particular, coronary artery bypass graft surgery (Ai, Ladd, Peterson, Cook, Shearer & Koenig, 2010:806). These investigators are of the opinion that patients' spiritual needs should be addressed by healthcare workers. They investigated, *inter alia,* the relationship between optimism and prayer and found that prayer predicted optimism, along with older age, better education and a healthier affect (Ai, Peterson, Boling & Koenig, 2002:77). Although the association is positive and in fact now generally accepted, the reason for the association is still unclear. Phrases such as, for example, a link, a relation or an association are often used to express the connection between spirituality and health. This does not necessarily imply a causal correlation. For the believer, however, such a connection is real and that should be respected. After all, how does one prove godly intervention, if that is what believers would like to believe? God does not need to be proven. God is supernatural. God is transcendent and experienced immanent. The only confirmation of God's existence is the fact that God is approached in confession, in glorification, in expressing gratitude or in petition.

Koenig (2008:2) lists six fields of medicine where this positive association is established, namely, mental health, the immune and endocrine systems, cardiovascular diseases, stress, death and physical disability. It is accepted that a spiritual or religious life is usually associated with healthier lifestyles, with positive support networks, with less sympathetic reactions and with strengthened immune systems (Koenig, 2001:1190; Mueller *et al.,* 2001:1229). Religious attendance could, for example, simply be a marker for active lifestyle, or a thriving social network (Bagiella, Hong & Sloan, 2005:451). It could perhaps even have been argued that religion is rather a demographic variable (Hall, 2006:107). This probably explains why Ai and her co-workers (2011:538) were able to find a positive correlation between secular reverence and healing after cardiac surgery. Does this mean there is no difference between a religious spirituality and a secular spirituality? Are they, in fact, the same experience? Certainly not. Both spiritualities could be acting through the same bio-physiological pathways (Ai *et al*., 2011:539). The positive result of both might be the same, but faith implies a relationship that is important to the believer and, in particular, the believing patient.

4. INSTRUMENTS TO MEASURE SPIRITUALITY

When the literature on spirituality in health and medicine experienced a revival, a number of tools were developed to measure religious practice. The scientist can now measure spirituality and quantify it, and these instruments can be applied to many religions. Organised religion (OR) is often determined by the frequency of the attendance of faith assemblies. Religious encounters comprise a multitude of spiritual experiences that may be beneficial for physical health (Idler, Boulifard, Labouvie, Chen, Krause & Contrada 2009:1). Non-organised religion (NOR) is expressed as the frequency of the believer's prayers, private meditations or readings from a holy book. Intrinsic religiosity (IR) refers to an individual's beliefs and how the believer perceives the world and decisions that need to be made (Cheever, Jubilan, Dailey, Ehrhardt, Blumenstein, Morin & Lewis, 2005:71). A spiritual well-being scale can be used to assess an individual's connection to God (Saguil, Fitzpatrick & Clark, 2011:281).

Reverence is assessed by questions about the specific religious conditions (private prayer or meditation) or secular reverence (being in nature, enjoying music or art, being loved or serving others) that make a person feel reverent (Ai *et al.* 2011:535). A complete set of religious items is available, and they can be adjusted according to a researcher's needs (Idler, Boulifard, Labouvie, Chen, Krause & Contrada, 2009:5).

5. THE PHYSICIAN-PATIENT RELATIONSHIP AS IT RELATES TO SPIRITUALITY

It would appear that a significant number of patients expect their physician to have an interest in their spirituality, particularly in the case of more critical medical conditions (MacLean, Susi, Phifer, Schultz, Bynum, Franco, Klioze, Monroe, Garrett & Cykert, 2003:40). Yet patients do not use the allocated consultation time to address spiritual matters, but prefer to concentrate on the primary medical problem. Patients interviewed at a surgical specialist clinic had higher expectations that the treating surgeon would have an interest in their spirituality than patients at a general outpatient department had (Taylor, Mulekar, Luterman, Meyer, Richards & Rodning, 2011:41). Though the group of orthopaedic and surgical patients at a specialist clinic had a comparable degree of religiosity, the surgical group had a deeper need of spiritual enquiry. Some patients appreciate it if the surgeon is open about his/her own spirituality (Taylor *et al.,* 2011:40). However, this expression of spirituality by the surgeon may have ethical implications if the treating physician is too explicit. Certain medical situations are more relevant to the patient's need for spiritual care: these conditions are serious and life-threatening medical illnesses, or if loved ones have been lost (McCord, Gilchrist, Grossman, King, McCormick, Oprandi, Schrop, Selius, Smucker, Weldy, Amorn, Carter, Deak, Hefzy & Srivastava, 2004:358, 359). Spiritual care during less serious

situations is not that important. Patients should know that believers are not exempt from disease and that spirituality as a mode of treatment cannot be applied like antibiotics or surgery. The reality is that patients have a certain expectation regarding spirituality during medical treatment. This is particularly important where end-of-life decisions are involved.

If the physician is to address the spiritual needs of the patient, the physician should be in touch with his/her own spirituality (Fosarelli, 2008:838; Hinshaw, 2005:264). Doctors are not exempted from existential questions. Physicians could, in the case of a negative medical result, reflect on themselves, or focus on the comorbidities of the patient and the patient's contribution. The believing physician would like to seek God's involvement in whatever outcome. The extent to which individuals ascribe the outcome of an event to personal doing, for example, a decision, an intervention or ability, is determined by a locus of control (LOC). Physicians with high internal LOC will look at themselves to find reasons for complications. A high external LOC will lead the physician to find the reason for the negative outcome elsewhere. This nature of LOC does not necessarily correlate with religiosity (Cheever *et al.,* 2005:67). In other words, doctors may be religious, but in the hospital they want to be in control. One would expect surgeons to have a higher internal LOC. At surgical mortality and morbidity meetings surgeons often feel the need to explain the reason for a complication (Barnard, 2011:135). However, Cheever *et al.* (2005:73), whose study group consisted only of surgeons, found that surgeons have a surprisingly moderate internal LOC. They did find that younger surgeons battle with a higher internal LOC. It should be noted that, in this study, the question related to LOC was answered by only 16% of the surgeons in the study group.

The more religious a physician is, the better the chance that he/she will have a positive attitude towards the patient in terms of respect for autonomy, altruism, empathy and a holistic approach to care (Pawlikowski, Sak & Marczewski, 2012:506). This study was done to investigate the doctor's ethical approach to patient care. These authors also found that, as far as religiosity is concerned, there is no difference between male and female physicians, yet there is a small but statistically significant difference between surgeons and specialist physicians. The authors (Pawlikowski, Sak & Marczewski, 2012:505) conclude that the work in surgical disciplines requires more factual thinking, with a direct effect on the patient. The therapeutic influence of pharmacological intervention on patients by non-surgeons is more indirect. In general, religion can also have a positive effect on the well-being of the medical doctor (Ayele, Mulligan, Gheorghiu & Reyes-Ortiz 1999:453; Pawlikowski, Sak & Marczewski, 2012:505).

6. HOW TO ADDRESS SPIRITUALITY IN PRACTICE

Surgeons, in particular, are not only poorly prepared to deal with their patients' spiritual needs, they are often unaware of these needs (Woll, Hinshaw & Pawlik, 2008:3048). Oncology surgeons at Johns Hopkins are advised to consider patients' faith as rational and to respect it with the necessary sensitivity (Woll *et al*., 2008:3056) – this advice is in accordance with the American College of Surgeons' Code of Professional Conduct. The College states that at the core of professionalism is the altruistic commitment to, *inter alia*, the spiritual needs of the patient (Gruen, Arya, Cosgrove, Cruess, Cruess, Eastman, Fabri, Friedman, Kirksey, Kodner, Lewis, Liscum, Organ, Rosenfeld, Russel, Sachdeva, Zook & Harken, 2003:606).

A basic spiritual enquiry permits the physician to establish the spiritual needs of the patient. The acronym FICA has been proposed for obtaining a spiritual history from the patient (Puchalski & Romer, 2000:131). A patient can be asked about his/her ***f****aith* or spirituality. How ***i****mportant* or what the **i**nfluence of this faith is? Is the patient part of a faith ***c****ommunity* and does it contribute to support the patient? How should these issues be ***a****ddressed*? These questions respect privacy, but present an opportunity to involve professional spiritual caretakers. CSI-MEMO is another approach, and it refers to the possible ***c****omfort* or ***s****tress* and ***i****nfluence* of beliefs. It enquires about ***mem****bership* of a faith community and whether the patient can be assisted in any ***o****ther* way (Taylor, Mulekar, Luterman, Meyer, Richards & Rodning, 2011:37). Such inquiries allow the doctor-patient relationship to be a source of kindness and optimism, especially in desperate situations.

Needless to say, training in spirituality for physicians should be as important as lectures in ethics and communication skills. Spirituality is indeed being taught more and more at medical schools in the USA and the UK (Neely & Minford, 2008:177), at both undergraduate and postgraduate levels (Saguil, Fitzpatrick & Clark, 2011:283).

7. A NEW PERSPECTIVE ON SPIRITUALITY IN HEALTH

In the past, medical doctors were taught to keep a distance between themselves and the patient. The familiar clerking of the patient, completing the clinical notes, and even the term registrar, all have the tone of an administrative connection which could create an emotional distance between patient and physician. It is therefore not surprising to find different interpretations of this relationship, which could, to a certain extent, also be considered a sacred relationship. It is also important to distinguish between disease and illness. Disease refers to the body, namely anatomy and physiology, whereas illness puts the accent on how the human being experiences this insult to the body (Frank, 1991:12). For instance, the doctor might see sickness as a purely biological phenomenon, while the patient might have serious existential questions. Hospitals should move away from a customer-driven attitude and rather see the patient as a guest (Willis, 2000:355).

Narrative medicine allows the healthcare worker to gain practical wisdom (Charon, 2006:vii) (see Chapter 2, paragraph 4). Within a specific surgical context and from a tradition of faith, interwoven narratives present the possibility of an interdisciplinary conversation between medical science and theology. Such practical wisdom was obtained from a narrative reflection on negative outcomes after coronary artery bypass graft surgery (Swart, 2015:376). Surgical outcomes the world over are similar. Mortality after surgery is related to co-morbidities as well as established risk factors. With a new hermeneutical approach to a personal surgical database it has become clear that patients have physiological limitations (Swart, Van Zyl & Van den Berg, 2015:128). Everybody has an innate power or energy to heal. In medieval times this was referred to as *vis medicatrix naturae*. The believer believes this "power" is from God and, as such, this is a dispensation of creation. The lifestyles of patients and the effects of other peoples' lifestyles on the patient contribute to disease. Lifestyle involves free choice and this too is part of creation (Hicks, 2012:6). God acts without violating natural laws or the free will of human beings (Brümmer, 2011:83). Yet the patient, especially the critically ill patient and his/her relatives, would like to see an intervention by God. Miracles are uncommon (Collins, 2007:44; Lewis, 1985:171). God does not necessarily intervene in an *ad hoc* way and thereby disrupt natural laws and free human choice. If this were the case, science would be impossible, and so would social structures.

The believing patient should see and experience the "hand" of God with a fresh outlook. The average patient expects physical or biomedical curing each and every time after petition by prayer. However, with a new perspective, each curing from disease, whether spontaneous or by medication, and every recovery after surgery can be experienced as a miracle. One should be amazed by even the simplest curing of the body. The limitation is the physiological capability of the human body. God has allowed human beings to develop medical science and move the physiological frontiers. An answer in response to prayer could even involve the strength to manage the disease; a reduction of anxiety before the operation; personal growth after a serious illness; the ability to change a detrimental lifestyle or the experience of peace amidst terminal disease. The support of a social network or faith community should be perceived as God in action. The patient may not necessarily experience a miracle, but may instead feel the love and support of caring others. Illness should also be an eschatological reminder of perfect health. These positive outcomes are all more than merely plain biomedical curing, but are the healing of the total person.

8. ETHICS

The application of spirituality to healthcare is bound by the same ethical rules that govern medical care in general. The set of rules that protect the patient is referred to as principlism. These principles are respect for autonomy, non-maleficence, beneficence and justice (Van Niekerk, 2011:37). Although the association between spirituality and positive health outcomes has been

established, spiritualty does not replace good medical care and treatment based on sound medical science. The physician has no right to proselytise the patient under care. The physician's inquiry into the spiritual needs of the patient should be important as far as it might influence diagnosis, treatment and well-being. The patient deserves respect for privacy regarding his/her religion, but not if, for example, spiritual struggle as a result of faith disappointments, or withholding treatment, stands to jeopardise the patient's recovery. The primary-health caretaker should be open to the spiritual needs of the patient and should know where and when to consult appropriately. It is also important to realise that spirituality is a personal matter, and that health workers do not necessarily have the know-how to deal with spirituality during health care. Few physicians are trained to guide patients spiritually – this guidance should be provided by people equipped to deal with the spiritual or religious needs of the patient.

9. FUTURE OF SPIRITUALITY IN HEALTHCARE

From a research point of view there are a number of limitations to the investigation of the role of spirituality in health. Mouch and Sonnega (2012:1051) point out a few:

- There is a need to measure spirituality more accurately.
- Though the concepts of spirituality and religion are defined separately, they are often applied randomly in studies.
- Studies in spirituality are likely to be qualitative studies, and that limits the study size. It is more convenient to interview fewer people.
- The association between spirituality, religion and health is strong, but causation is still not clear. Certain pathways have been suggested and were referred to in a previous paragraph. It has been suggested that in the future the accent should be on finding an explanation for this association (McCullough, Hoyt & Larson, 2001:229; Hummer, 2005:453). One should never forget that the field of faith and spirituality is, to a large extent, a mystery and research to unveil this might involve pitfalls and gaps.

The vast majority of related research has been conducted in the USA. The field of spirituality is still fallow land in other parts of the world. Other continents, countries and regions have their own versions of spirituality and the association with health should be confirmed under those circumstances. Faith leaders and health professionals all need to work together, perhaps by reinterpreting sacred texts and showing better understanding by moving out of their respective isolated disciplines, and starting to work together (Tomkins *et al.,* 2015:24).

10. CONCLUSION

Spirituality is a way of life and underlines the completeness of the patient.

Spirituality and the medical sciences, more and more, are sharing the same domain, and should no longer be separated.

The positive association between spirituality and health is well established, though the causality is still unclear. In certain communities, however, religion and related customs can also be detrimental.

Patients cherish certain expectations of spirituality and physicians have varying levels of spirituality. Easy ways exist to address the patient's need for spiritual care by asking a few simple questions. The shift from a power relationship to a complementary relationship is enhanced by this holistic interest in the patient's well-being.

The sicker the patient, the more vulnerable the patient becomes. The healthcare worker should respect the patient's sources of strength and allow him/her to draw from those.

The application of spirituality in healthcare is also bound by ethical rules.

REFERENCES

Ai, A.L., Ladd, K.L., Peterson, C., Cook, C.A., Shearer, M. & Koenig, H.G. 2010. Long-term adjustment after surviving open heart surgery: The effect of using prayer for coping replicated in a prospective design. *The Gerontologist,* 50(6):798-809.

Ai, A.L., Pargament, K.I., Appel, H.B. & Kronfel, Z. 2010. Depression following open-heart surgery: A path model involving interleukin-6, spiritual struggle, and hope under preoperative distress. *Journal of Clinical Psychology,* 66(10):1057-1075.

Ai, A.L., Peterson, C., Bolling, S.F. & Koenig, H.G. 2002. Private prayer and optimism in middle-aged and older patients awaiting cardiac surgery. *The Gerontologist,* 42(1):70-81.

Ai, A.L., Wink, P. & Shearer, M. 2011. Secular reverence predicts shorter hospital length of stay among middle-aged and older patients following open-heart surgery. *Journal of Medicine,* 34:532-541.

Ano, G.G. & Vasconcelles, E.B. 2005. Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of Clinical Psychology,* 61(4):461-480.

Aviles, J.M., Whelan, E., Hernke, D.A., Williams, B.A., Kenny, K.E., O'Fallon, W.M. & Kopecky, S.L. 2001. Intercessory prayer and cardiovascular disease progression in a coronary care unit population: A randomized controlled trial. *Mayo Clinic Proceedings,* 76(12):1192-1198.

Ayele, H., Mulligan, T., Gheorghiu, S. & Reyes-Ortiz, C. 1999. Religious activity improves life satisfaction for some physicians and older patients. *Journal of the American Geriatrics Society,* 47(4):453-456.

Bagiella, E., Hong, V. & Sloan, R.P. 2005. Religious attendance as a predictor of survival in the EPESE cohorts. *International Journal of Epidemiology,* 34:443-451.

Barnard, M. 2011. *Defining moments.* Cape Town: Zebra Press.

Benson, H., Dusek, J.A., Sherwood, J.B., Lam, P., Bethea, C.F., Carpenter, W., Levitsky, S., Hill, P.C., Clem, D.W., Jain, M.K., Drumel, D., Kopecky, S.L., Mueller, P.S., Marek, D., Rollins, S. & Hibberd, P.L. 2006. Study of the therapeutic effects of intercessory prayer (STEP) in cardiac bypass patients: A multicentre randomized trial of uncertainty and certainty of receiving intercessory prayer. *American Heart Journal,* 151:934-942.

Bradshaw, M., Ellison, C.G. & Flannelly, K.J. 2008. Prayer, god imagery, and symptoms of psychology. *Journal for the Scientific Study of Religion,* 47(4):644-659.

Brümmer, V. 2011. *Wat doen ons wanneer ons bid? Oor die aard van gebed en geloof*. Wellington: Bybel-Media.

Buitendag, J. 2004 ."Genes Я us" – of juis nie? Oor determinisme en voluntarisme by die mens met verwysing na homoseksualiteit. *Hervormde Teologiese Studies,* 60(1-2):61-81.

Byrd, R.C. 1988. Positive therapeutic effects of intercessory prayer in a coronary care unit population. *Southern Medical Journal,* 81(7):826-829.

Charon, R. 2006. *Narrative Medicine*. *Honoring the Stories of Illness*. New York: Oxford University Press.

Cheever, K.H., Jubilan, B., Dailey, T., Ehrhardt, K., Blumenstein, R., Morin, C.J. & Lewis, C. 2005. Surgeons and the spirit: A study on the relationship of religiosity to clinical practice. *Journal of Religion and Health,* 44(1):67-80.

Collins, F.S. 2007. *The language of God. A scientist presents evidence for belief.* London: Pocket Books.

Curlin, F.A., Lantos, J.D., Roach, C.J., Sellergren, S.A. & Chin, M.H. 2005. Religious characteristics of U.S. physicians. *Journal of General Internal Medicine,* 20:629-634.

Fosarelli, P. 2008. Medicine, spirituality, and patient care. *Journal of the American Medical Association,* 300(7):836-838.

Frank, A.W., 1991. *At the will of the body: Reflection on illness*. Boston: Houghton Mifflin Company.

Gruen, R.L., Arya, J., Cosgrove, E.M., Cruess, R.L., Cruess, S.R., Eastman, A.B., Fabri, P.J., Friedman, P., Kirksey, T.D., Kodner, I.J., Lewis, F.R., Liscum, K.R., Organ, C.H., Rosenfeld, J.C., Russel, T.R, Sachdeva, A.K., Zook, E.G. & Harken, A.H. 2003. Professionalism in surgery. *The American College of Surgeons,* 197(4):605-608.

Hall, D.E. 2006. Religious attendance: More cost-effective than Lipitor? *Journal of the American Board of Family Medicine,* 19:103-109.

Harris, W.S., Gowda, M., Kolb, J.W., Strychacz, C.P., Vacek, J.L., Jones, P.G., Forker, A., O'Keefe, J.H. & McCallister, B.D. 1999. A randomized, controlled trial of the effects of remote, intercessory prayer on outcomes in patients admitted to the coronary care unit. *Archives of Internal Medicine,* 159(19):2273-

2278.

Hicks, J.M. 2012. Classic arminianism and open theism: A substantial difference in their theologies of providence. *Trinity Journal,* 33NS:3-18.

Hinshaw, D.B. 2005. Spiritual issues in surgical palliative care. *Surgical Clinics of North America,* 85:257-272.

Idler, E.L., Boulifard, D.A., Labouvie, E., Chen, Y.Y., Krause, T.J. & Contrada, R.J. 2009. Looking inside the black box of "attendance at services": New measures for exploring an old dimension in religion and health research. *The International Journal for the Psychology of Religion,* 19:1-20.

Koenig, H.G. 2001. Religion, spirituality, and medicine: How are they related and what does it mean? *Mayo Clinical Proceedings,* 76(12):1189-1191.

Koenig, H.G. 2007. Religion, spirituality, and medicine in Australia. Research and clinical practice. *Medical Journal of Australia,* 186(10 Supplement):S45-S46.

Koenig, H.G. 2008. *Medicine, Religion, and Health*. West Conshohocken, Pennsylvania: Templeton Foundation Press.

Lewis, C.S. 1985. *Miracles.* 10th Impression. Glasgow: William Collins Sons & Co.

Louw, D.J. 2005. Do I have a soul? Soulfulness in life. In Louw, D.J. (ed.) *Mechanics of the Soul.* Stellenbosch: Sun Press.

Louw, D.J. 2012. A theological model for pastoral anthropology within the dynamics of interculturality: *Cura animarum* and the quest for *wholeness* in a *colo*-spirtuality. *In die Skriflig /In Luce Verbi* 46(2), Art.#57, 9 pages. http://dx.doi.org/10.4102/ids.v46i2.57.

Lucchese, F.A. & Koenig, H.G. 2013. Religion, spirituality and cardiovascular disease: research, clinical implications, and opportunities in Brazil. *Revista Brasileira de Cirurgia Cardiovascular,* 28(1):103-128.

MacLean, C.D., Susi, B., Phifer, N., Schultz, L., Bynum, D., Franco, M., Klioze, A., Monroe, M., Garrett, J. & Cykert, S. 2003. Patient preference for physician discussion and practice of spirituality. *Journal of General Internal Medicine,* 18:38-43.

Marshall, K. & Smith, S. 2015:5 Religion and Ebola: learning from experience. *The Lancet.* http://dx.doi.org/10.1016/S0140-6736(15)61082-0.

McCord, G., Gilchrist, V.J., Grossman, S.D., King, B.D., McCormick, K.F., Oprandi, A.M., Schrop, S.S., Selius, B.A., Smucker, W.D., Weldy, D.L., Amorn, M., Carter, M.A., Deak, A.J., Hefzy, H. & Srivastava, M. 2004. Discussing spirituality with patients: A rational and ethical approach. *Annals of Family Medicine,* 2(4):356-361.

McCullough, M.E., Hoyt, W.T., Larson, D.B., Koenig, H.G. & Thoresen, C. 2000. Religious involvement and mortality: A meta-analytic review. *Health Psychology,* 19(3):211-222.

Mouch, C.A. & Sonnega, A.J. 2012. Spirituality and recovery from cardiac surgery: A review. *Journal of*

Religion and Health, 51:1042-1060.

Mueller, P.S., Plevak, D.J. & Rummans, T.A. 2001. Religious involvement, spirituality, and medicine: Implications for clinical practice. *Mayo Clinic Proceedings,* 76:1225-1235.

Neely, D. & Minford, E.J. 2008. Current status of teaching on spirituality in UK medical schools. *Medical Education,* 42:176-182.

Nouwen, H.J.M. 2011. *Spiritual formation. Following the Movements of the Spirit*. Great Britain: Ashford Colour Press.

Pawlikowski, J., Sak, J.J. & Marczewski, K. 2012. Physicians' religiosity and attitudes towards patients. *Annals of Agricultural and Environmental Medicine,* 19(3):503-507.

Pembroke, N. 2007. Spiritual care by physicians: Maintaining the integrity of religion and finding an appropiate form. In Gräb, W. & Charbonnier, L. (eds) *Secularization theories, religious identity and practical theology.* Berlin: Lit Verlag.

Pesut, B., Fowler, M., Taylor, E.J., Reimer-Kirkham, S. & Sawatzky, R. 2008. Conceptualising spirituality and religion for healthcare. *Journal of Clinical Nursing,* 17:2803-2810.

Puchalski, C. & Romer, A.L. 2000. Taking a spiritual history allows clinicians to understand patients more fully. *Journal of Palliative Medicine,* 3(1):129-137.

Roberts, L., Ahmed, I., Hall, S. & Davison, A. 2009. Intercessory prayer for the alleviation of ill health. *Cochrane Database of Systematic Reviews,* Issue 2. Art. No.: CD000368. DOI: 10.1002/ 14651858. CD000368.pub3.

Saguil, A., Fitzpatrick, A.L. & Clark, G. 2011. Are residents willing to discuss spirituality with patients? *Journal of Religion and Health,* 50:279-288.

Schneiders, S.M. 2005. A hermeneutical approach to the study of Christian spirituality. In Dreyer, E.A. & Burrows, M.S. (eds) *Minding the Spirit. The Study of Christian Spirituality*. Baltimore: The Johns Hopkins University Press.

Sloan, R.P. & Bagiella, E. 2001. Religion and health. *Health Psychology,* 20(3):228.

Sloan, R.P. & Bagiella, E. 2002. Claims about religious involvement and health outcomes. *Annals of Behavioral Medicine,* 24(1):14-21.

Swart, M.J. 2015. The spiritual experience of a surgeon. *Annals of Thoracic Surgery,* 1:376.

Swart, M.J., Van Zyl, G.J. & Van den Berg, J.A. 2015. 'n Narratiewe teologiese verkenning van negatiewe koronêre vatomleidingsoperasie-uitkomste: 'n Chirurgiese hermeneutiek. *Acta Theologica,* 35(2):120-141.

Tarpley, J.L. & Tarpley, M.J. 2002. Spirituality in surgical practice. *Journal of the American College of Surgeons,* 194(5):642-647.

Taylor, D., Mulekar, M.S., Luterman, A., Meyer, F.N., Richards, W.O. & Rodning, C.B. 2011. Spirituality within the patient-surgeon relationship. *Journal of Surgical Education,* 68(1):36-43.

Thomson, K.S. 1996. The revival of experiments on prayer. *American Scientists,* 84:532-534.

Tomkins, A., Duff, J., Fitzgibbon, A., Karam, A., Mills, E.J., Munnings, K., Smith, S., Seshadri, S.R., Steinberg, A., Vitillo, R. & Yugi, P. 2015. Controversies in faith and health care. *The Lancet*. http://dx.doi.org/10.1016/S0140-6736(15)60252-5.

Truter, C.J. & Kotze, D.J. 2005. Spirituality and health: A narrative-pastoral approach. *HTS,* 61(3):973-984.

Van Erp, S.A.J. 2006. Diagnosing hidden religion in medicine: Health, illness, and the politics of hope. In Twohig, P. & Kalitzkus, V. (eds) *Making sense of health, illness and disease*. Amsterdam: Rodopi.

Van Niekerk, A.A. 2011. Ethics theories and the principlist approach in bioethics. In Moodley, K. (ed.) *Medical Ethics, Law and Human Rights.* Pretoria: Van Schaik Publishers.

Waaijman, K. 2002. *Spirituality. Forms, Foundations, Methods*. Leuven: Peters.

Willis, R.W. 2000. Positive paradigm shifts in health care. *Journal of Religion and Health,* 39(4):355-365.

Woll, M.L., Hinshaw, D.B. & Pawlik, T.M. 2008. Spirituality and religion in the care of surgical oncology patients with life-threatening or advanced illnesses. *Annals of Surgical Oncology,* 15(11):3048-3057.