

The role of the spiritual dimension in medical decisions

Paolo Petralia[1,2], *Rosagemma Ciliberti*[3]

[1] University of Genoa, Italy; [2] General Direction Local Health Authority ASL4, Liguria, Italy; [3] Department of Health Sciences, University of Genoa, Genoa, Italy

Abstract. Spirituality and science, in medicine, belong to worlds that are only apparently distant and irreconcilable. Clinical practice constantly testifies how they, while maintaining their own identity, walk in parallel, influencing and supporting each other in defining a treatment path. The anthropological perspective of the concept of health also refers to recognizing the breadth and complexity of its dimension, as the result of an intricate set of biological, psychic, social, cultural and spiritual factors, in a continuous relationship with the environment in which the individual lives and interacts. This awareness calls for a peculiar consideration and attention towards this dimension, which also requires an adequate preparation of health personnel and clinicians to recognize and take charge of the spiritual needs of the patients. The cultural process that goes by the name of "humanization of care" constitutes the terrain that must be explored in order to attempt the reconciliation between science and spirituality.

Key words: Spirituality, spiritual resources, clinical care, modern medicine, religion, ethics

Introduction

The theme of spirituality, as a founding element of bioethics applied to the practice of medical care, is increasingly relevant and it reflects not only the need of the patients for empathy, listening, awareness, but also that of those responsible for the medical care itself, who are confronted with various decision-making problems revolving around what is good for the patient (1, 2).

The progress of medical science is probably one of the main factors that has made more and more necessary the search for ethical principles on which to base the decision-making (3). In order to give some examples of the context in which doctors operate today we can mention how the clinical criterion for ascertaining the state of death has changed, from cardiovascular to cerebral; how it is possible to prolong life by deciding whether to implant, operate, connect a person to a machine that guarantees his survival, postponing the death beyond natural limits; how the respect for the will of the person might require the doctor to stop the therapeutic activity even when it could be a life-saving treatment (4). All these elements call for the adoption of a matrix of principles to which those who work in the medical field can refer when they have to take difficult decisions, and at the same time capable of respecting the constitutive principles of the patient's identity and the values at stake (5, 6).

A second element that prompts a bioethical reflection around the theme of spirituality relates the new approach in the doctor - patient relationship, or, better, medical team - patient which provides for the possibility for the patient to exercise more and more explicitly his rights of awareness and informed choice on the recommended therapies, in a real therapeutic alliance.

A third aspect relates to the very structure of the present healthcare system, with the hospital at its centre: a place that "magically" solves health problems in everyone's deepest imagination, but at the same time, a place which, in the name of standardization for efficiency and quality, can easily be depersonalizing and anonymous, replacing the traditional relationship of domestic proximity that the doctor once had with his

own patient when, as a common practice, the treatment took place mainly at home in well a known and personalized environment.

Within the context defined by these assumptions, the preparation of a doctor in terms of empathy and conscious ethics becomes an extremely topical theme, all the more complex in a multicultural society which has enriched itself with a differentiated Weltanschaung, sometimes fragmented into a thousand of personal and less and less objective points of view.

Therefore, alongside the due technical and professional competence, there seems to be an increasingly urgent need to develop a code of values and meanings with which to give significance both to the disease and to one's work in relation to the ill person, paying attention to his spiritual dimension as a founding element of his very existence, all with the goal of making it possible to "transform each clinical case and the relative therapeutic choice into a human encounter" with the ill person. and not just with his own illness (7).

Man between corporeity and spirituality

The technical medical progress, the attention to the financial aspect, the tendency towards efficiency, and the search for the best result with the minimum economic expenditure, can easily determine a progressive depersonalization of the medical treatment, an increasingly massive use of the technical diagnostic instrument, a progressive focus on disease alone and on the diseased organ, with a consequent growing inattention to important human dimensions such as respect for dignity, understanding of pain, the value of communication, the feeling of the sacred, the religious and spiritual values characteristics of each person (8).

This diminished attention towards human relationships has determined both a climate of distrust of patient towards medicine and a model of defensive medicine, in which informed consent, instead of being an instrument of interrelationship, is, at least sometimes, used as a mere instrument of legal protection.

It is precisely to overcome the mentality of a purely technical medicine that it is necessary to return to focusing on the centrality of the person, favouring an integral and systemic vision of the patient (9).

Each person is the interweaving of different fundamental dimensions that ethical principles, in general terms and particularly in the clinical setting, are called to protect.

In the first place, the principle of charity (*beneficio*) i.e. the curing without harm, which aims not only to safeguard the psycho-physical integrity of the patient, but also to promote their development.

In the second place, the principle of autonomy, which favours the self-determination that the assisted, informed and responsible for his treatment path, can exercise within the limits of the law and of the proposed therapeutic alternatives (10). These choices must be made in the context of an open relationship in which both the health worker and the patient exercise, each within their own limits, autonomy and responsibility (11).

Once the centrality of the person is placed at the foundation of the health care, spirituality and medicine, science and faith no longer appear as opposing and irreconcilable worlds, but as elements that should dialogue and interact in the search for suitable proposals and solutions.

Spirituality is an existential dimension that guides the human being in his life choices, in the knowledge of himself and of the world, in the definition of values and morals, in giving meaning and purpose to life (12).

In the clinical setting, the ethical and religious dimension has very ancient roots.

In ancient times, and for a long time, the reasons for conditions of suffering and illness were connected to a fault or a sin against the divinity, an offense through the infringement of the ethical - behavioural precepts dictated by the very same divinity. For the Greeks plagues were the direct consequence of an offense to a God, for the Jews leprosy was the sign of the violation of the Law. Illness in this sense was an event that involved the whole community, which charged the priests or prophets with discovering its causes (Sophocles, Oedipus Rex, 95-98; Leviticus, 14.2 and following) and correcting them by resorting to purification through rites or other appropriate actions.

All the first medical experiences were characterized by an overwhelming preponderance of religious, magical and spiritual aspects over the technical as-

pects, also limited by the very scarce knowledge in the scientific field in those times (13).

It is only by the 19th century, with the advent of the industrial revolution and with the progress of technology, that health professionals began to develop knowledge, technical skills and professional practices with no direct relations to spiritual, magical or religious practices (14).

In the second half of the last century, however, the scientific world has once again shown interest in the effects of spirituality on health, disease prevention and healing processes, this happened in the face of growing moral complexity, of the presence of ethical polytheism, of non-concordant references for the evaluation of the world and of the living, from either a religious, philosophical or political point of view.

Furthermore, a new concept of health has recently been introduced and universally recognized, health being defined by a complex set of interactions between biological, psychic, social, cultural and spiritual factors, in continuous relationship with the environment in which the individual lives and interacts.

Several studies and researches have demonstrated how the valorisation of spirituality, expressed by meditation, or prayer, or by the desire for transcendence, regardless of the chosen religious creed, produces positive effects on the state of general health and can represent a valid adjuvant in medical treatment pathways, capable of significantly influencing both the outcome of treatments and the quality of life of the patients (15-16).

Very recent surveys confirm that most healthcare professionals consider the spiritual dimension a resource and a support, an element that can help improve the quality of life and health of patients (17, 18).

In times of pain and suffering, the patient frequently uses his spirituality as a resource to deal with the adversities caused by the lack of health; prayer promotes resilience and offers a valid emotional support capable of giving birth to an inner dialogue, of finding meaning in the experience of illness and death, of providing comfort and hope (19, 20).

The very ancient and close relationship between religion and medicine - also attested in all European languages by the common etymological root of the words "health" and "salvation" - seems therefore to refer to a knowledge in which both the health of the body and that of the spirit must be conceived as a whole, a continuum.

Christian anthropology, the experience of illness and the act of healing

In the Christian-Catholic religion the drama of illness is entirely traced back to the relationship that binds God to the individual and to the community.

While in the Old Testament illness was considered as a punishment for the committed sins, a sign of the breaking of the covenant between God and man, and which therefore called for the obligation to exclude the sick, the impure, from the community, in the New Testament the arrival of the Messiah freed the sick person from such isolation, reinstating him in the new Covenant. Indeed, the Messiah proposed a different interpretation of sickness and suffering: "And as Jesus passed by, he saw a man which was blind from his birth. And his disciples asked him, saying: Master, who did sin, this man, or his parents, that he was born blind? Jesus answered: Neither hath this man sinned, nor his parents: but that the works of God should be made manifest in him." (Jn 9:1-3).

In the Gospels we can observe the great attention of God who became a me towards the sick, attention which is manifested through the miracles of healing; Christ's attention is not to illness or its causes, but to the wholeness of the human being, body and spirit, to his fragility and vulnerability, both to the earthly dimension and to that of transcendence.

In Christian anthropology, therefore, medicine cannot limit itself to accompanying the sick by focusing only on the healing the body, but must recognize the importance of the inner dimension of the patient, even more so in those situations in which clinical healing is precluded and healing simply means relieve from suffering.

Therefore, in the practice of health care, it is necessary to learn what "whole person" or, as the French say, "total person" means. In this context, for the doctor it is not sufficient to rely solely on his scientific competence, it is also necessary his ability to be a person

alongside another person, capable of opening a profoundly empathetic dialogue with the patient.

Jeanne Garnier, Cicely Saunders, Elisabeth Kübler-Ross, Marie de Hennezel have traced the essential lines of this *humanitas*, or pietas, to be exercised towards patients (21-23). They affirm that the greatness and dignity of each person must constitute a request for responsibility and attention from the doctor and they recall how this responsibility must be charged with an even greater curative attention in respect to matters related to the end-of-life.

Lately, Eugenio Borgna has dedicated particular attention to human fragility, aiming both at denouncing the current individualistic drift, which would separate the fulfillment of each individual from significant relationships with other persons, in a dangerously narcissistic vision of the world, and at bringing out how fragility (uncertainty, doubt) is essentially the material human relationships are based on, and must therefore be considered as a fundamental value for life (24).

The fragility of the other, which has its epiphany in illness, demands above all that the doctor takes care of the person, that he feels this a duty towards him, not only personally, but as a social subjectivity (25).

If the relationship with the "fragile person" constitutes the touchstone of ethics and of the act of health care, then the doctor must take all of this into account in his work, trying to safeguard the physical and psychological integrity of the patient.

In particular, in Christian ethics, the accompaniment of the person towards a better quality of life cannot be separated from the recognition of the conscience of sick person as a fundamental instance of his choices, both in life and in the face of death. As the Second Vatican Council affirmed, in every person there is "the conscience" which — "is the sanctuary of man, the most secret and inviolable nucleus" (*Gaudium et spes* 16), which every individual is called to respect (26).

The concept of freedom is a conquest of Christianity. A deterministic vision of reality prevailed In the Greek world, according to which everything – including the Gods – was subordinated to a superior fate (Ananke, necessity) against which the will could do nothing. Among countless examples, the figures of Cassandra, Achilles and that of King Oedipus, none of whom was able to escape his destiny, are emblematic.

On the contrary, with the New Testament, the essence of man was refounded precisely on the concept of freedom (cf. Rom 7:6; Jn 8:36). But the freedom of which Christianity speaks is not realized primarily by knowing - as the Greeks believed - it is a completely new freedom, which is achieved by serving one's neighbour (cf. Jn 13:13-14).

The Christian is therefore a free man, master of his actions, of his acts; a man who disposes of himself "qui est causa sui"; "freedom - however - is not only the choice for this or that particular action, but it is also, within such a choice, a decision about oneself and a disposition of one's life for or against the Good, for or against the Truth, ultimately for or against God."

Freedom is therefore not just pure will, or the faculty to act or not to act, to do this or that, to choose good or evil but, in the end, it is the definitive permanence in good and, therefore, the choice between a good and another good, between the "ideal" good and the "possible" good.

All these considerations introduce a model of a doctor at the service of others, often described through reference to the parable of the good Samaritan (10.25-37), whose behavior describes well both the moments of the therapeutic gesture - getting close, overcoming indifference, bandaging the wounds, using the available medicines - and taking care of him: putting him on his own donkey, paying for his hospitalization.

As Pope Francis affirmed during the Audience with the National Federation of Orders of Surgeons and Dentists (20.09.2019), the doctor - like every health care professional - is asked to «possess, together with the due technical competence- professional, a code of values and meanings with which to give meaning to the disease and to one's work and to make every clinical case a human encounter» (27).

Conclusions

The doctor has always been and still is called to find a reasoned justification for his decisions.

The doctor's choices are based on criticism, experience, observation, the goal of treatment, healing or

improvement of the patient's clinical conditions, but, above all, they cannot disregard the respect for the dimension that constitutes his or her being a person.

In a truly human-centered medicine, the goal of medical activity is in fact, first of all, the realization of the patient's good, to be identified not only with reference to his physical health, but to the entirety of his dimension as a person.

As Carrasco states "the exercise of the medical profession cannot be separated from the reflection on what its purposes are and, above all, from an anthropological conception of what man is, because we only relate to the patient in relation to this" (28).

In the context of promoting the anthropological perspective as the foundation of the ethical dimension in daily medical practice, the contribution offered by the various religions to the valorisation of man in his biological, psychic and spiritual entirety can be significant.

Among them, also the principles of the Christian tradition certainly offer a possible unifying moment of thought and action for all men, also facilitating, after centuries of estrangement, the recovery of the shared foundation of every individual right: "Even when we have them recognized and assumed thanks to dialogue and consensus, we see that these basic values go beyond any consensus, we recognize them as values that transcend our contexts and are never negotiable" (29).

The health care profession is at the service of the sick person, but not only. Its exercise also constitutes an opportunity for the healthcare worker to grow in humanity. Religion and ethics keep alive not just principles and duties, but also the basic question of existence: "What kind of person do I want to be?"(30).

A disclosure / conflict of interest statement

None of the authors of this manuscript has a financial or personal relationship with other people or organizations that could inappropriately influence or bias the content of the paper.
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Corresponding author:
Paolo Petralia, University of Genoa, Italy, General Direction Local Health Authority ASL4, Liguria, Italy,
Email: paolo.petralia@edu.unige.it