ESSAY REVIEW

On the interface between science, medicine, faith and values in the individualization of clinical practice: a review and analysis of ‘Medicine of the Person’

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Introduction

What is ‘Medicine of the Person’? Is it simply a highly individualized approach to patient care, set within the context of a personal relationship between a doctor and his patient, or something a little more than this? If the spirituality of both doctor and patient is an integral component of ‘Medicine of the Person’, then how is it interpreted and received by people of different faiths and none? What is the role of the family and friends of the individual in his healing? If ‘Medicine of the Person’ is not a new or emerging specialism within medicine, but can be seen, rather, to have its roots in a time when medicine had a very different view of the world, can it be of relevance now, when medicine’s increasing scientistic reductionism and the technocratic, quasi-assembly line production mentality of Western health services seem inexorably to be transforming traditional notions of ‘best clinical practice’ into something that is at best suboptimal and at worst grossly deficient? These are some of the questions that John Cox, Alastair Campbell and Bill Fulford set out to answer within what is certainly, overall, an important and stimulating volume, recently published by Jessica Kingsley and made available to the reader at an entirely reasonable cost.

Structurally, Cox et al.’s volume is constituted by 14 chapters divided into three parts. The Foreword, by Baroness Julia Neuberger, and the Preface by Professor John Cox, are useful in orientating the reader, rapidly, to the essence of the volume and in Cox’s case, in outlining his own very personal encounter with this particular approach to clinical practice. His account of how ‘Medicine of the Person’ became transformative for him within the context of his own marriage and in the illness and recovery of his wife Karin, is at once moving and provides a key insight into Cox’s dedication to this field of study. Cox is clear that ‘Medicine of the Person’ is an encounter that requires a ‘constant holding together of body, mind and spirit’ and it is with these wise words, which close the Preface, that we move to the body of the text and to a detailed exposition of what most readers are likely to experience as an immediately interesting, sometimes surprising and controversial, but always deeply reflective and thoughtful account of a philosophy and approach to the care of patients that had almost been forgotten, but whose time has most certainly now returned [1].

At the heart of healing

Chapter 1 of the volume (pp. 17–29) is introductory in style and functions to acquaint the reader with the background against which
Medicine of the Person developed. Interestingly, the authors refer at the outset to the ‘scientific basis of health care’ and to ‘scientific medicine’, being careful never to equate medicine with science, an approach with which I entirely agree. Indeed, it appeared to me to illustrate the authors’ view that medicine is not a science, but rather a science-using practice, a view recently emphasized by Kathryn Montgomery in an important volume [2], in the Essay Review of her work published in the Journal of Evaluation in Clinical Practice by Miles [3], as well as in an address on the same subject by the latter author to La Sapienza University in Rome in late 2008 [4]. The authors recognize, and remind the reader, that the growth of scientific medicine during the twentieth century was associated with a progressive alienation of traditional notions of faith and healing, with a growing number of colleagues believing that medicine should be based increasingly on knowledge derived from the so-called objective sciences, a growing rejection of the subjective values and beliefs of the faith traditions and a decline in interest in the spiritual and psychosocial aspects of health care. There is no doubt in my own mind that such developments have greatly impoverished the practice of medicine with a concomitant disadvantaging of extensive numbers of patients over many decades.

I join with the authors, then, in celebrating the re-emergence of interest in the spiritual dimensions of health care [5–10], which are not, as they rightly point out, in any way opposed to the use of science in medicine, or in any way intended for paternalistic imposition on patients, but which aim to enhance the delivery of care through taking proper account of patients’ values, needs, wishes and expectations, as they themselves express them, in increasingly multicultural and multi-faith societies [11–14]. This is where Medicine of the Person is positioned – it focuses as much on the spiritual aspects of health care as it does on the scientific ones. For some readers this will be immediately controversial, for others perhaps less so, or indeed not at all. Importantly, this volume should be read with an open heart and not a closed mind.

Part One: Medicine of the Person: Paul Tournier’s vision

A biography of Paul Tournier, the man

Chapter 2 (pp. 33–45), which opens Part One of the volume, provides a detailed biographical account of Paul Tournier, a doctor and writer from Geneva, Switzerland, widely recognized for encouraging an increased study of the value of an integrative approach in medicine, whereby medical intervention takes place within a context of psychological understanding and pastoral counselling. Tournier then, is the founder of ‘Medecine de la Personne’: ‘Medicine of the Person’. Tournier’s vision cannot be understood outside of the context of his own personal and emotional experiences and it is these that Pfeifer and Cox (pp. 33–45) take great care to describe and analyse within their chapter. Notable, early on, is an insight into Tournier’s philosophy that is at once superficially simple, but at the same time essentially profound:

I believe people have an intuitive ability: they share with us what we are ready to receive. When I approached them intellectually, they only brought up intellectual questions. But if you have walked a deeper process in your soul, they open up and share their deeper problems which they have been hiding thus far [15].

Tournier became widely recognized for his belief in the need to integrate the ‘deposits’ of science and of faith and also the roles of medical doctor and spiritual counsellor so that a personal relationship between doctor and patient might prove genuinely therapeutic. Encouraged by the distinguished psychoanalysts Alphonse Maeder and Theo Bovet to pursue a synthesis of psychology, classical medicine and even religious belief, Tournier, determinedly unconstrained by any one specific doctrinal bias or prejudice, set out to ‘understand man as a whole’ [16]. This endeavour resulted in the publication in 1969 of a seminal text presenting, along with much else, the core concepts of Medicine of the Person [17]. Central to Tournier’s philosophy was not simply a concentration on the patient’s problems only, but also on those difficulties that confronted and affected their doctors and, when holding meetings at which practitioners were present, biblical texts would be utilized, less, it is said, for the purposes of theological exegesis, than for ‘existential explication’. It is reported that this very particular and personal dimension to Tournier’s ‘consultations’ with colleagues resulted in unforgettable experiences for those who had attended. Tournier’s published works are certainly extensive in nature and in addition to a large volume of individual papers, he authored more than 20 books (see [16,18–37]), each being translated into over 20 languages, selling millions of copies and finding extensive and international readership. Each, within its own aims and scope, emphasized the need for attention to be given to the whole person – to the biological, psychological, social and spiritual aspects of man, his diseases, his conditions. Note, for example, Tournier’s statement that:

I am not denying the usefulness or the interest of the effort to synthesize our scientific knowledge of man. But, however, successful, it will reveal only one side of man’s nature: that of his mechanisms. It will still be necessary to complete it with a personal knowledge, which is of a different order, the order of the person, not that of things. This knowledge is within the reach of every doctor, be he an ordinary general practitioner or a learned specialist [38].

It is unsurprising then, to learn that Tournier expressed an acute concern with the effects on clinical care of a ‘mechanical reductionist medical practice, devoid of ethics and without sustaining compassion’. For him, a reductionist approach to clinical practice restricted to biomedicine alone was a dangerous activity, lacking the integration of body, mind and spirit necessary for health and wholeness and overlooking the healing potential of the therapeutic relationship. What, then, would Tournier have made of the principles and practice of evidence-based medicine (EBM)? My impression is that he would have found its basic tenets shocking and would certainly have become a particularly vocal opponent. If by this point in the text (p. 44) the reader has sought a working definition of Medicine of the Person derived from the broader philosophical discussions that make up the vast literature, then one is supplied by Pfeifer and Cox at the end of Chapter 2. For these authors, Medicine of the Person can be defined as:

an integrative, person-centred medicine that considers psycho-spiritual as well as biosocial aspects of patient care and in particular recognises the healing potential of a caring relationship.
Going on to describe the aims of medicine of the whole person, Pfeifer and Cox describe its core objectives as:

to help patients find the meaning of their sickness and their life; to deal with the problem of death; to discover a specific ethical approach to their environment; to open sources of love for themselves and for their fellow men; to sense the meaning of suffering...to find strength through the community for a new responsibility towards themselves and their fellow men [39].

**Medicine of the disease versus medicine of the whole person**

With this working definition and these objectives delineated, we move to Chapter 3 (pp. 46–55). Here, Bernhard Ruedi, begins his contribution to the book with a clarification of terms. Medicine of the Person, he says, should be clearly distinguished from personalized medicine, the latter being defined as:

- the application of genomic and molecular data to better target the delivery of health care, facilitate the discovery and clinical testing of new products, and help determine a person’s predisposition to a particular disease or condition [40], and thus an approach to practice distinct from Tournier’s vision of whole person care. As Ruedi emphasizes, if the suffering patient is today very concerned indeed to access the best treatment and technologies, then he is also hoping that such technical excellence, where it is available, will be provided through a personal doctor–patient relationship. Ruedi is clear that there is no contradiction, essential or otherwise, between these approaches to care. Medicine, he insists, must succeed in providing each, with neither being excluded from the doctor’s duty of care to his patient. Thus, practising Medicine of the Person does not involve a relegation of scientific knowledge and medical technologies to a secondary position. Rather, it must lead the doctor to personalize care with reference to the biological characteristics of the disease or condition, while providing such personalized therapies within a personalized therapeutic relationship with the patient. Ruedi does well at this juncture to refer to Fierz’s thinking, where the latter author, in an important work, documents his observation that:

- the personal aspects of health care have been partly neglected in the current era of evidence-based scientific medicine. We now know that a “one size fits all” type of treatment has its limits. Medicine needs to be re-personalized...the challenge is to regain individualism on a scientific base.... [41].

Not much to disagree with there. I think. But in my view, Fierz underestimates the extent to which EBM-type approaches to care have diminished the essence of the doctor–patient relationship and Fierz’s own example of how to re-individualize medicine on a scientific base falls short, as Ruedi points out, of Tournier’s vision. Indeed, while science is at the heart of modern clinical practice, it does not equate to its essence and is rarely to be found at man’s ‘core’ – the place with which Tournier was famously preoccupied. Having observed as much, Ruedi’s departure into the role of medical informatics and the usefulness of particular approaches to undergraduate and postgraduate medical education, makes some interesting points. He is, for me, entirely correct when he notes how modern medical training is characterized solely by the teaching of scientific knowledge and little more, with all of the attendant limitations of this approach. Here, Ruedi refers specifically to the futility of burdening the student’s memory with vast quantities of information that are easily forgotten, when computers can provide an essentially immediate access to the same. Rather, Ruedi emphasizes the preferential need to teach the student the way in which to use intuition and the ability to ‘meet the person of the patient’ in order to share a real personal dialogue and not a computerizable communication. For him, if preferential emphasis were to be placed on teaching students only that knowledge to which they must have immediate access through memory (with the rest available via a computer), then effort could be directed to teaching students the great skill of gathering information about the patient from various sources and integrating it into the making of decisions as part of a personalized therapeutic process. Not that Ruedi, in extolling the value of medical informatics in assisting the development of a medicine of the whole person, is unaware of the dangers of the same tool. On the contrary, he is clear that if misused, informatics can lead directly to a depersonalized medicine ‘in which scores are used and guidelines and algorithms are applied without discrimination, for the benefit of the greater number, but with no consideration of the (individual) person’. In this sense, informatics represents a two-edged sword, emphasizing the need for teachers of students to ensure that this increasingly central tool in modern medicine is employed appropriately, but with the needs of patients kept firmly at the centre of the doctor’s mind.

Such considerations, for Ruedi, should begin at the very start of a student’s training, so that the imperative never to allow a relationship with the patient to be replaced with science can be observed. Moreover, the ideal that students should become masters of the compassionate use of science, rather than slaves in its technical application, should be definitively ensured. In the conclusion to Chapter 3, Ruedi sums up his philosophy with great eloquence, and so struck was I by his argumentation that I quote him here verbatim and at length:

**Retaining the person in medical science means achieving the capacity to include evidence-based individualized health care, apprehending the multiple facets of a sick individual and providing this in a personal relationship. Evidence-based knowledge is gathered through objective procedures, focused towards a ‘sick object’, which appears as the sum of the characteristics of a suffering person. But the core of the person, covered with altered biological functions, can only be reached and helped through a true person encounter, involving the whole person of the caregiver. This encounter is therapeutic and can also have true biological effects. Such a medical attitude cannot be taught in the same way as medical knowledge. It is not sufficient to repeat that encounter is important and worth the time it needs if the teacher does not show that he is behaving this way with his patients and with his students. He must not only exhibit a sparkling erudition, but also be true in his behaviour. This will be a difficult challenge, since medical activity involves more and more teamwork, bringing the student face to face with several intervening physicians, making it difficult to find among them a convincing identification model. The finality of the medicine of the person is not only to get rid of the diseases restraining life, but to promote health, with the assurance to be in life, which means to be in the movement of the life.**

In our Judaeo-Christian culture, the
discovery and the meeting of the Person of God may open a way for the doctor who feels the need to encounter the suffering person. It is what Paul Tournier has experienced, and the meaning of his testimony (p. 54).

**Medicine, the Bible and medicine of the whole person**

These words of no small wisdom lead us to Chapter 4 of the volume (pp. 56–69). It is here that John Clark enlightens the reader with an account of Paul Tournier’s theological thinking and how this underpinned and developed Tournier’s philosophy of Medicine of the Person. Tournier’s reading of the Bible we are told, was well-informed and thoughtful, being marked by the discernment of a scholar, which is to say that he eschewed literalism in favour of a search for an over-arching meaning. Tournier saw Christ as unique in history and outside the limits of psychology and inconceivable within the limits of classical psychological determinism, a source of growth and development more complete that can be conceived by psychology confined within the limits of nature. Christ’s call for detachment involves a surrender that Tournier viewed as evidence of the compatibility of Christianity and psychology (p. 60).

What, then, are we to make of Tournier’s theology in terms of its relevance to clinical practice? For Tournier, the value of the biblical perspective is that it radically changes our attitude towards the events of life. Here, an individual may fail at something or be successful at it, but what matters is not success or failure, but what that success or failure signifies in God’s purpose. For Tournier, an appreciation of this reality engenders strength and independence in the face of people and events, even when confronted by major failures in life. Moreover, he was convinced that illness raises two very different sorts of questions – scientific questions and spiritual ones. Indeed, for Tournier, the whole of medicine was summed up by its imperative to help men live and then to help them to die [18]. Can it be, then, that some patients, suffering from the most difficult diseases, conditions or situations can only, ultimately, find a solution in faith alone? For Tournier, the answer to this question is very much in the affirmative. Here, he is clear in insisting that:

- of the meaning of things, the meaning of sickness and cure, of life and death, of the world, man and history, science tells us nothing; here it is the Bible that speaks to us. For this reason the study of the Bible is as valuable to the doctor as the study of science . . . (so) that the doctor must learn to handle his Bible as he handles his pharmacopoeia [18].

What is certainly clear from Tournier’s writings is his belief that there are two things that contribute to the making of a good doctor: great scientific competence combined with a great heart [37]. As Clark records towards the end of his chapter, Tournier preferred not to speak of a specifically Christian medicine. His belief was that science provides knowledge of the mechanism of things, whereas the Bible speaks of their meaning. He realized that in every sick person there is not only a psychological perspective, but also a spiritual one and that there is a reciprocal relationship – as there is between body and soul – between the physical (the domain of classical medicine) and the propositions of religion [37]. So, in summary, Tournier was convinced that neither reason nor science nor the instincts are, on their own, adequate guides to life. For him, the answers lay in efforts to reconcile psychology and faith in a manner that prevented psychology from enabling a patient to become aware of his problems without developing an understanding of how those problems could be resolved. Indeed, Tournier was able to observe that modern psychology had demonstrated the impotence of the will when it is not supported by imagination – that is to say, by insight into the psychological meaning of faith [30] (p. 67). Tournier’s Medicine of the Person had two hands, therefore – the hand of scientific competence and the hand of personal communication. For him, these two hands required a joining in prayer in acknowledgement of a listening to God, an acknowledgement of His sovereignty and a seeking of His aid [35]. Thus, while showing the highest regard for medical science and for psychiatric skills, Tournier retained a firm conviction that it is through Christian faith that a doctor’s gifts reach their fruition.

**The value of values**

Martin Conway’s contribution to the volume, Chapter 5, entitled ‘The Value of Values – do they go deep enough?’ (pp. 70–80), brings to a temporary cessation the logical development of the volume up to that point. The title of Conway’s text promises the reader an exposition, perhaps, of the nature of values and their pivotal place in shared decision making between doctor and patient. In actuality, it most certainly does not result in any such thesis. Failing to appreciate a coherence of the content of this chapter with the content of the volume up to this point on first reading, I re-read the work twice and remained unable to modify my initial impression. Other readers may find differently but, with the chapter beginning on page 70, the reader has to wait until page 78 to experience any real stimulation and originality, only to discover at that point that the material of interest is not derived from Conway’s own thoughts, but from a document published by the British Council of Churches. This particular chapter, rambling, disconnected and disappointing in my view, concludes Part One of the Volume and leads us directly to Part Two (Faith Traditions and Medicine of the Person) and to its opening chapter by Robert Atwell and Bill Fulford.

**Part Two: Faith Traditions and Medicine of the Person**

**Spiritual direction, a theology of diversity and medicine of the person**

Atwell and Fulford commence their chapter (pp. 83–95) with a brief account of Tournier’s theological position, augmenting the consideration given in Chapter 4. Tournier, although having roots in the Calvinism of Geneva, was nevertheless ecumenical in outlook, with a profound respect for the wide diversity of individual values and beliefs that he encountered within the cultural and faith traditions that were the context of his clinical work. Although this is not the place to elaborate a further theological analysis of his thinking, Tournier was almost certainly a universalist [42]. From here, Atwell and Fulford continue with a contemporary case history – the story of Sarah, in order to discuss some of the key ideas from the tradition of spiritual direction. The example they employ is indeed illustrative.

**The case of Sarah**

Sarah, a woman in her mid 40s with three existing children, all in adolescence, discovers that she is pregnant with a fourth. As the
pregnancy progresses, she experiences major fluctuations in blood pressure that require two admissions to hospital. A termination of the pregnancy is recommended by her gynaecologist. Both Sarah and her husband believed abortion, as the destruction of human life, to be ethically wrong and in some distress they consult their (Anglican) priest. The case history reveals that the priest asked open-ended and non-judgemental questions, that he invited the consideration of options, that he enabled a discussion of feelings of guilt and that he declared his intention not to advise them of what to do, but that he would instead ‘travel with them’, supporting them in whatever decision they made. Following that decision, which was to submit to the abortion, Sarah subsequently experiences an episode of self-recrimination and guilt. The priest, having anticipated this reaction, gives the absolution for which Sarah had asked and administers the laying-on of hands, part of an ancient Christian ministry, with prayers for the healing of her memories.

What does this case history tell us? For Atwell and Fulford, the key points relate to the priest’s language that talks of journey and accompanying and his skill in building the quality and equality of their engagement as persons, so that discussions and decisions occurred as part of a process of discernment. Here, then, are illustrated key facets of Tournier’s Medicine of the Person: (i) Listening (seeking to understand the particular needs and circumstances of individuals and why they have come to see you); (ii) Staying with (rather than giving answers such as, ‘this is right’ or ‘that is wrong’, one works with the person to help him find a solution for himself); and (iii) Avoiding absolutes (whatever one’s own values, one starts with a maximum sensitivity to the individual and the situation in which he finds himself) (pp. 85–86).

Atwell and Fulford are correct in anticipating that a conservative Roman Catholic priest or a fundamentalist Protestant pastor may have responded differently to Sarah’s dilemma, tending, perhaps, to be more prescriptive in their counsel than the more ‘liberal’ Anglican cleric. But they are clear, and agree, that the fundamental skill of therapeutic use in this context is one of engagement of person with person, with an integral attempt to discern the spiritual state of the individual, all as part of the process of spiritual direction. Here, a strong commitment to the highest moral ideals, in association with the exercise of great sensitivity in dealing with the individual, are central components of the respect for the particular values and beliefs of the patient in the specific and very real circumstances in which the patient finds himself. I suspect that the authors would take issue with me in describing, as I have done above, the Anglican cleric’s approach as ‘liberal’ in his apparent ‘refusal’, as it were, to give more prescriptive advice to Sarah and her husband (although the case history presented is insufficiently detailed for the reader to be able to assess the nature of the discussion of options that took place between the cleric and his two people). Indeed, Atwell and Fulford dismiss as incorrect any suggestion that a complete openness and respect for differences of values could be interpreted as a ‘weak liberal compromise’. Different readers will have different positions on this, but suffice it is to say that it was a core feature of Tournier’s approach. Whether or not the basic approach of spiritual direction could be refined by closer reference to the many absolutes of established moral theological teaching or contemporary ethical thinking is a point worthy of reflection here, as some patients search for, invite and value such advice in contrast to others who consult a priest or other minister of religion to act as a soundboard for their own thoughts. Perhaps, then, the precise approach to be taken depends on an accurate discernment of the individual’s needs with the approach to be taken formulated in accordance with the result of this process. I suspect Tournier would agree.

It is at this juncture in Atwell and Fulford’s chapter that the authors divide their remaining text into eight distinct, but highly interrelated, sections that specifically and highly usefully map out the core components of spiritual direction in terms of the theoretical concepts that underpin the tradition itself and also in terms of their practical effectiveness in enhancing the quality of pastoral care. Beginning with friendship, the authors trace the practice of spiritual direction to early Christian monasticism, engaging in a brief overview of this historical association before proceeding to examine the place of friendship between doctor and patient within contemporary clinical practice. As the authors point out, friendship is an unlikely concept to find at the heart of pastoral and clinical care within modern medicine, given the degree of professional distance that has come to be required between doctor and patient. Citing Tournier’s close relationship with many of his patients, Atwell and Fulford recognize the potential pitfalls of too naïve a replication of this approach within contemporary clinical practice and step back from recommending it uncritically, instead acknowledging that ‘professional boundaries have to be carefully sustained according to the mores of the time and inappropriate forms of intimacy avoided’ (p. 87). These are wise words indeed. But the authors’ solution to the conflict between the need for professional distance and the pastoral benefits of closeness is for a form of friendship between doctor and patient that is based on a meeting of souls and they insist that there is an entirely appropriate sense in which if a pastoral encounter is to be fruitful — it has to be intimate. Disappointingly, the authors leave the practical questions that relate to how an entirely necessary but carefully ‘designed’ friendship between the human person of the doctor and the human person of the patient is to be achieved and sustained, unanswered. They need not have. They might, for example, have reflected upon how Tournier’s approach in this context and their own concerns of how its essential basis should remain comfortably applicable within modern medicine, could be reconciled by a medicine not of friends, neither of strangers, but by a medicine of neighbours. Indeed, in a seminal text cited at the beginning of this Essay Review, Kathryn Montgomery is convinced of the absolute necessity of a special relationship between doctor and patient, and devotes much thought to the form it must take [2,3]. For Montgomery, the idea of the doctor as ‘friend’, although giving the reassurance of the doctor as ‘trustworthy and solid’, seems a ‘bit too simple’. It is self-evident that the nature of friendship varies. So what, then, underpins the concept of the doctor as a friend? Some authors see friendship in this context as related to the medical virtue of compassion, so that a good doctor, like a friend, would always be compassionate, but will bring to the relationship a competence not required of friends [3,43]. Others develop the explanation further, describing ‘friendliness’ as the ‘key virtue in medicine’ and insist that the doctor–patient relationship requires a foundation of ‘loving friendship’ [3,44]. Friendship between the doctor and patient may also represent an ethical standard [45] of importance in assisting the process of ‘values clarification’ and ‘moral persuasion’ [46]. Certainly, ‘the secret to the care of the patient is to care for the patient’ [47], but for Montgomery, a ‘medicine of friends’ has the potential to be emotionally exhaust-
ing, even perilous, for the clinician [2]. Hence her conceptualization of a relationship between doctor and patient which preserves some fundamental notions of friendship, but which excludes incautious or hopeless intimacy and which bears many characteristics of a good neighbour.

Moving from considerations of friendship in the doctor–patient relationship, Atwell and Fulford begin their reflections on self-knowledge and its meaning in the context of Medicine of the Person. Citing a commentary by Gregory of Nyssa, an early fourth century theologian and bishop, on the Song of Songs, the authors remind the reader of the importance of self-knowledge as one of the four greatest protections that individuals have in this life. Because self-knowledge protects us against enslavement to delusion, its exercise means that we do not end up trying to defend or recognize a person who does not in reality exist. Self-scrutiny therefore should occupy a central place in living well. This was certainly the experience of Sarah and her husband, who were discussed earlier in terms of the case history the authors described.

The concepts of self-knowledge and friendship as part of Medicine of the Person are linked by the authors to the need for ‘a word’. Here, the importance attached by early Christians to the type of advice that could be sought from, for example, the Desert Fathers, is highlighted. The availability to the individual in need or distress of ‘a word’ is now far more associated with Protestant evangelism than, for example, with Catholic pastoral care. Certainly, and as the authors explain, it was rarely intended by the giver to function as a definitive answer to a living problem, neither was it a form of counselling as counselling is currently understood as part of the so-called ‘talking therapies’. Rather, the giving of a word, based by the ‘word giver’ on an intuitive understanding of the particular situation of the ‘word seeker’, was more associated with its ability to bring life and hope to the individual and has a deeper resonance within the context of healing, specifically healing through relationship. Atwell and Fulford go on to explain the connection between the particular meaning attached to ‘the word’ (as healing through relationship) with an additional feature of spiritual direction – the notion that ‘direction’ in ‘spiritual direction’ has little to do with paternalistic instruction of the patient in terms of what might be the ‘right’ thing to do, but, rather, everything to do with the enabling of self-discovery through relationship. Atwell and Fulford show how this thinking is well illustrated by the case history of Sarah; specifically, how the decision to proceed to the abortion of their child in utero was the result of their own decision making, which decision making was enabled through a process of self-discovery, taking into account the medical knowledge of their doctors and the discussions that had taken place with the cleric that had been consulted. For the authors, it was the essential independence of this decision from medical and clerical dogma, as it were, that allowed Sarah and her husband to take a decision that eventually resulted in a healing outcome and that if it had been interfered with by concerns external to the marriage may well have left a sore that could have proved impossible to heal. The nature of the integrity necessary of the cleric in these circumstances is well summarized by the authors’ citation of Anna Theodora, a fourth-century ascetic:

Such a teacher ought to be a stranger to the desire for domination, vain-glory and pride. One should not be able to fool him by flattery, nor blind him by gifts, nor conquer him by the stomach, nor dominate him by anger; but he should be patient, gentle and humble as far as possible; he should be tested and without partisanship, full of concern, and a lover of souls (p. 90).

Continuing with their study of the relevance of monastic writing to Medicine of the Person, Atwell and Fulford refer to the ‘gift of tears’ and ‘compunction of heart’ that were key terms in the vocabulary of early Christian spirituality and, although rarely heard or discussed in contemporary medicine and religion, are nevertheless integrally related to the exercise of compassion for people in crisis. The word compunction derives from the medical term employed by ancient Roman doctors (compunctum) in order to designate attacks of acute pain, but was later appropriated by Christian monks to refer to pain of the spirit. Often, such spiritual pain is directly symptomatic of an uneasiness of conscience or a remorse born of penitence and requires the attention needed to bring about its release and resolution. Often, grief and sorrow is well dealt with by that most foundationally human of emotional behaviours – crying, the liberation of tears, a painful process that frequently relieves pain. We learn that crying was the ultimate sign of healing in Sarah and her husband.

Moving through a consideration of the nature of human desires and how our desires are an expression of the deepest truth about ourselves and thus the ‘very agenda’ of spiritual direction, Atwell and Fulford end their chapter with concluding sections on discernment and on healing. Desires, in the tradition of spiritual direction, are to be recognized as key factors that shape our lives and our life choices, for good or ill. But how are we to evaluate the difference in ‘quality’ between these negative and positive effects of our desires? The authors answer this question by discussing a key concept at the heart of spiritual direction – the concept of diakrisi (discernment). Etymologically, the term derives from the Greek for ‘right judgement’ and is something on which St Ignatius of Loyola, the Founder of the Jesuits, had much to say within his Spiritual Exercises, a compendium of advice on spiritual direction and the ‘discerning of spirits’. Quite what does discernment mean in this context? Atwell and Fulford usefully draw to the reader’s attention here, the contemporary writings of Philip Sheldrake who has contributed significantly to the analysis of the Ignatian texts and, particularly, contextualized them in a manner in which they are more immediately accessible to the modern student. Quoting from Befriending our Desires, the authors review Sheldrake’s holistic view of life and his insistence that no individual should ever believe that a desire is irrelevant to the process of their spiritual growth. Specifically, practising discernment enables us to become aware of and to accept the whole range of desires that we experience and to begin to appreciate more clearly how, if we follow some through, they diminish or injure us and how, if we follow others through, they enrich us and enable harmony and growth [48]. Growing able to appreciate this is as important as a proper understanding of the fact that the health of the spirit is as important as the health of the body. With reference to the latter, antipathy to the body, as it is seen in early Christian thought, and as it has recurred since, was greatly fuelled by neo-Platonism in the ancient world and the understanding of what it is to be human, for the purposes of therapeutics, has developed greatly from twentieth century thinking onwards. As Atwell and Fulford are concerned to emphasize, there are no watertight compartments here – the physical, emotional, social and spiritual well-being of human
beings are closely interconnected such that, as St Irenaeus would have it: ‘The glory of God is a human being fully alive’.

**A theology of diversity: Medicine of the Person in Jewish, Islamic and Hindu contexts**

Having considered Medicine of the Person within its originally Christian context so far, Cox and his colleagues’ volume proceeds, through chapters 7–9 (pp. 96–138), to consider the validity, applicability and usefulness of Tournier’s care vision in the Jewish, Islamic and Hindu contexts.

**The Jewish context**

Opening Chapter 7, Claire Hilton and Michael Hilton are clear that given its strongly Christian formulation, Tournier’s Medicine of the Person cannot be translated directly into a Jewish context, but that many of Tournier’s concepts are amenable to interpretation through a Jewish perspective. Qualifying their statement they explain that, in the twenty-first century, the identity of a Jew is based on factors greater than religious experience alone, where personal identity within Jewish communities can be seen to be influenced by a plethora of other factors, including cultural, historical, social, psychological and spiritual considerations. Within a health care context, it is therefore not possible, the authors argue, to understand the needs of an individual Jew purely on the basis of a working knowledge of the Jewish religion alone and a broader analysis is therefore required.

The authors’ review of Jewish demographics, social behaviours, anti-Semitism, synagogue membership and conversions to Judaism (pp. 97–100) are certainly informative, but largely irrelevant to the core purpose of the chapter and the reader has to wait until page 99 for a tangential reference to Tournier’s emphasis on the need for time to be set aside for prayer, reflection, repentance and forgiveness, within an altogether brief discussion of how the spirituality of the High Holy days of Judaism might embrace part of Tournier’s vision. On page 101, the authors return to Tournier’s thinking, to a minor extent only, with explanations of the conflicts that may arise within the health care environment when, for example, a Jewish staff member might decline to reveal his or her Jewish identity to a Jewish patient in order to avoid the risk of being asked to prioritize the patient’s care or give them preferential treatment ‘because of their communal identity and responsibilities’. They go on to explain how the converse may also be true – where the Jewish patient may decline to reveal his or her Jewish identity to the care professional because of who else the professional may know in the Jewish community, as a result of a fear of a breach in confidentiality. The accompanying discussion here is brief and almost entirely uninformative and the excursion into the current regard for the profession of medicine within the Jewish community and its historical antecedents and the section on ‘Belief in God’ that follows, while being fully descriptive, are not evaluative and leave the (non-Jewish) reader confused and unenlightened by a chapter, the principal purpose of which is to deliver clarification on the applicability or otherwise of Tournier’s core philosophies in Judaism. If only the authors had drawn more extensively in their writing on the website of the Jewish Hospital Chaplaincy Services that they appear content simply to quote, such clarifications could have been made integral to the text, rather than requiring the reader to consult separate, decontextualized sources.

Hilton and Hilton devote the remaining pages of their chapter to the presentation of five case studies, interspersed with further sociological and historical information on Judaism, with the case studies presentationally disjointed from their paired learning points, these being clustered at the end of the chapter immediately before the References and Further Reading sections. Of these remaining sections, the case histories represent the more interesting, but fail to present clinical scenarios of sufficient complexity to provide convincing evidence or otherwise of the applicability of Tournier’s core concepts to Jewish patients in all their diversity. Are we to conclude, then, that Tournier’s philosophies are inapplicable within Judaism? Or are we to conclude that the authors have failed in their commission to provide a sufficiently detailed and well-researched answer to that central question? For this Essayist, it is the latter question that may be answered in the affirmative and not the former, so that the chapter appears to represent a substitute for the editors’ commission and not a satisfaction of it and the central questions relating to Tournier’s vision and Judaism remain open as a consequence.

**The Islamic context**

Many of the criticisms I have found it necessary to make of Hilton and Hilton’s chapter, I find it equally necessary to make of Chapter 8. While opening with a one-sentence reminder that the ‘Ancient Egyptians had healing temples where psyche and soma were one unity and patients were treated by both medication and healing through their mystical and spiritual beliefs’ and therefore capturing the reader’s imagination at the outset, Ahmed Okasha’s text (pp. 110–124) rapidly descends into a simple exposition of the current sociological, psychological and theological characteristics of Islam. It is notable that the chapter does not mention the name of Tournier even once and does not even tangentially address the central commission that the editors must surely have given to the author: ‘What is the relevance of Paul Tournier’s Medicine of the Person to Islamic peoples and Islamic culture?’ Simple and also detailed expositions of Islam’s general and specific characteristics are available in an extensive number of texts available elsewhere and a working knowledge of them is of course necessary in attempts to contextualize Tournier’s philosophies. But while the working knowledge is demonstrated here, its application to the ‘Tournier question’ is not. Reading and re-reading Okasha’s chapter some readers might conclude that the Islamic imperatives of determined paternalism and enforced dependence so starkly articulated and uncontested by Okasha, find themselves violently in conflict with Tournier’s more benign values of self-awareness and self-determination as foundational components of the compassionate care of the ill or distressed person. So, the question: ‘Is Paul Tournier’s Medicine of the Person applicable within Islam?’, can surely be answered only in the negative if we rely solely on Okasha’s chapter. When mechanisms of cultural control are preferred to strategies for health, the way is paved for derelictions of professional duty.

**The Hindu perspective**

Chapter 9 deals specifically with Tournier’s Medicine of the Person within the context of Hindu and Ayurvedic understandings. But,
writing this Essay as I am, following my second reading of Cox and colleagues’ text, I begin my review of Dinesh Bhugra’s chapter (pp. 125–138) with many of the same criticisms as I have found it necessary to levy against the preceding two works, Certainly for me, Bhugra’s chapter (which refers to Tournier only twice – and tangentially – in the body of the text and only once in the Reference section), like the preceding two chapters that I have discussed above, utterly fails to consider the central question of whether Paul Tournier’s core concepts are as applicable within the Hindu and Ayurvedic systems of thought as they are in Western life. Much of Bhugra’s chapter is devoted to the presentation and discussion of theoretical concepts in psychiatry and psychology (see, for example, the content of tables 1–4), which present information available elsewhere and which information is understood more readily by psychiatrists and psychologists than by the non-psychiatrist medical or non-medical reader. Indeed, there is a great deal in the text of what risks the description of ‘esotericism’ and which left unexplained (as it is), requires separate study if an attempt is to be made by the reader to make sense of the work. I will go further and suggest that the density of unfamiliar terminology within this chapter risks its (probably unfair) description of ‘psychobabble’ by many readers and the result of this abject failure to address the requirements of what I take to have been the original commission is, as with the preceding two chapters, which exhibit the same central deficiency, to render the resulting chapters of little use to those colleagues who might genuinely wish to understand whether Tournier’s core philosophies can, with the relevant interpretation and extrapolation, be of definitive use in transcultural medicine. Concluding my own analysis of these three chapters on ‘inter-faith’ considerations of Tournier’s broader relevance, I have to say that I am unconvinced of the immediate applicability of Tournier’s vision within Judaism, Islam and Hinduism and that further works devoted to such analysis should, with proper editorial insistence, address the relevant issues far more specifically and comprehensively than has been the case in Cox and colleagues’ volume.

**Medicine of the Person in contemporary practice**

We move from Part Two of the volume, which has been concerned with faith traditions and Medicine of the Person, to Part Three of the book, the ultimate part, devoted to Medicine of the Person in the context of contemporary clinical practice. Five chapters constitute this final section of Cox and colleagues’ volume. Certainly, as Medicine of the Person was very much a ‘child of its time’ during Tournier’s lifetime, the whole notion of whether it remains applicable to clinical practice in its original form or with given modifications, is a centrally important consideration and one that I shall consider in no small detail in the General Discussion of this Essay. But first let us complete our analysis of Cox and colleagues’ text by moving to a discussion of Peter Gilbert’s essay in Chapter 10 (pp. 141–155).

**Spirituality and mental health – proposals for action?**

Gilbert’s contribution is in part a narrative of the author’s own personal difficulties and experiences and his own perspective on the place of spirituality and mental health within the broader provisions of the UK National Health Service. Reflecting on the sheer impact in the world of the late sufferings and death of His Holiness John Paul II, he remembers the words of the current Pope, Benedict XVI, then Joseph Ratzinger and Dean of the College of Cardinals, on the desolation of modern spirituality and the ‘emptiness of souls no longer aware of their dignity or the goal of human life’. Of importance later in the text is the author’s presentation of Plato’s belief:

As you ought not to attempt to cure the eyes without the head or the head without the body, so neither ought you to attempt to cure the body without the soul . . . for the part can never be well unless the whole is well [49].

Gilbert completes a long and at times rambling chapter, with an understanding of spirituality as a clear facet of our individual humanity, linked to aspects of uniqueness, meaning, identity, purpose, relationships, a sense of the holy and the spirit that drives us (p. 153). His chapter does not progress the student’s understanding of Tournier’s Medicine of the Person very far, but it is an enjoyable read and it does challenge the reader to consider some very particular considerations that had not emerged within the volume until this juncture. I shall return to an analysis of some of these considerations later in this Essay.

**Justice, theology and general practice**

Continuing my search for a greater understanding of the modern relevance of Paul Tournier’s Medicine of the Person (and not having found it within the last four chapters of the volume), I turned to Chapter 11 (pp. 156–170) of Cox and associates’ text by Thierry Collaud. Collaud is clear at the outset that the image of the doctor as an ‘available person who is capable of extracting himself for a few days from daily preoccupations to devote himself to a patient’, has always fascinated and attracted him. But, he goes on, ‘although it attracted me as an ideal scenario, the situation always seemed to me completely unrealistic in the context of general medicine’.

Collaud refers here to the episode described within the last pages of Tournier’s seminal volume Medicine of the Person where Tournier suggests to a particular patient that they should spend three days away together in the mountains, in order to review some existential questions that were tormenting the patient. It is here that Collaud introduces a discussion of the tension between the responsibilities of the doctor to the individual and also to the community. Drawing on Michael Balint’s famous work *The Doctor, his Patient and the Illness* [50], Collaud believes that a notable omission in Balint’s focus on the healer-healed couple is what might be termed the communal third party. What, precisely, is meant by this? Does such a ‘third party’ have integral relevance within the consultation or is it some form of unwarranted and inappropriate intrusion? For Collaud, such questions have inescapable relevance at a time when the excluded third party reappears in economic guise, knocking, as it were, at the surgery door.

While Collaud is clear that the face-to-face doctor–patient relationship has played a major role in the history of medical practice, he clearly believes that there is a place for other ‘players’ within the consultation, the exclusion of which would be to risk a relationship that would beintroverted, rigid and sterile. Collaud usefully introduces Levinas’ thinking here, which is clear that we can never entirely take in the person we meet as we would do an impersonal object [51]. That is to say, there will always be some-
thing in the patient that opens out towards the infinite beyond, not least the world of other people and it is this ‘opening out’ that prevents the relationship from closing in on itself in a ‘complicity of privacy’ (pp. 158–159). Does this view compromise the one-to-one doctor–patient relationship? For Collaud, the answer is in the negative. Indeed, he feels that, on the contrary, it greatly enhances it and proceeds to explain why, although he personally, did not feel completely convinced by the nature of Collaud’s reasoning. It is easier to agree, however, with the author’s point that the doctor should never render himself inhuman by cutting himself off from the person he really is, becoming nothing but an ‘expert’ – a sort of ‘super-computer’ as Collaud puts it – who simply announces to the patient the choice between therapeutic alternatives. Collaud is right, I think, to warn of the danger that this is what the modern doctor might find himself doing; suppressing his personality, perhaps, in an effort simply to ‘do his job’ and nothing more. This impersonal and ‘minimalist’ approach, which we see developing within modern health services at a rapid and seemingly inexorable pace, is the antithesis of what it is to be a ‘good doctor’ and the polar opposite of Tournier’s vision when he talks of the need for the doctor to bring to the consultation his own personal history and all of the characters who people it, his beliefs and his values, his concepts of truth and falsity, right and wrong (p. 159).

Serving the community versus the individual

Collaud is of course correct when he makes clear that, in general terms, the doctor is present within the doctor–patient relationship not on his own initiative, but rather as a ‘representative’ of Society – the Society that has ‘trained him as a doctor and transmitted to him the knowledge which he possesses and applies, delegating to him Society’s caring function at the patient’s side’. It is this knowledge and the ability to apply it which Collaud rightly argues gives the doctor his technical and organizational superiority over the other health care professions. When it comes to caring and the exercise of compassion, such skills do not belong to medicine alone. It is the doctor’s recognition of his limits and the imperative to maintain the caring relationship that act to prevent the dangers of depersonalization within health care systems. For Collaud, and for this Essayist, the danger of depersonalization has become greater as technical progress has advanced, what the author vividly refers to as: ‘the dream of science where everything can be explained, foreseen, regimented; systems that know no limits . . . (so that) . . . in the excitement of this and of a handful of successes, doctor and patient alike dream of guaranteed cures and the total eradication of disease’. The Journal of Evaluation in Clinical Practice has long regarded the Evidence-based Medicine movement as being one of the principal culprits in stimulating such dreams, offering spurious forms of certainty where no certainty in reality exists and actively promoting a depersonalization and decontextualization of the clinical encounter as part of this process [52–68]. Collaud’s words have resonance when he says that from a viewpoint such as this, health is nothing but the application of science and technique and when health and disease are seen only from the viewpoint of scientific medicine and its remedies, we leave far behind the principle, which was so dear to Paul Tournier – that health must also be associated with a personal decision, linked often to a fundamental reorientation of one’s way of life (p. 161).

So what are the frank disadvantages of Collaud’s ‘communal third party’ thesis within the context of the consultation? Some aspects of this involvement are, for Collaud, ‘repulsive, forbidding and overwhelming, particularly in the matter of economic and administrative problems’. But there is also an anxiety caused by the medico-legal environment in which modern medicine is practised and by the regulatory frameworks that continue to interfere negatively with the exercise of clinical care and the delivery of medical services. The ‘good doctor’, then, will have to navigate carefully between ‘technical activism and burdensome bureaucracy’ and the need to be Society’s representative in charge of the patient and his open-hearted advocate in times of distress – but not one or the other.

Collaud develops his thinking in an interesting manner by turning to the subject of justice as a pursuit of what is good for the individual. From here, he discusses how Theology enriches secular notions of justice and from it he derives the concept of brotherhood as membership of the same family. As Collaud explains, this is a notion that recurs consistently in the Scriptures and within the theological tradition and represents, perhaps, a means of departing from the rigid polarity between patient and Society at large discussed earlier. Here, while preserving the notion of patient as brother, Collaud constructs the notion of the third party as brother, thereby offering a different vision of brotherhood, which can be seen as complimentary rather than conflicting in terms of the images employed and which leads the author to reflect on the utopian ideal, almost a dogma in psychiatry, that it is impossible to look after an individual patient without a wider care for the whole family system. By extension, if one considers the notion of a family community within the political body, then the claim may be made that it is impossible to look after an individual patient without a concern for the community at large. So for Collaud, if we accept Tournier’s vision for the prioritization of personal relations within the clinical encounter, then we must also, according to this particular philosophy, extend this relational emphasis to wider Society and thus always to consider the patient within his communal context.

The concluding pages of Collaud’s chapter return to the context of general medical practice, where the author seeks specifically to consider how clinical practice would be affected if the philosophies the author has discussed were implemented into the day-to-day routines of patient care. Collaud’s chapter represents, without question, an important contribution to this volume, but I ended my reading of it with a nagging doubt that the author had inadequately differentiated between the role of the family and the role of the community in terms of the appropriateness of their interest and involvement in the doctor’s care of the individual patient and I was left unconvinced by the author’s closing plea that we should go beyond a relation-centred perspective and favour a community-centred view (p. 169).

Spirituality and care: a public health perspective

Following the close of Collaud’s chapter, Tom Fryer initiates a discussion on spirituality and care from a public health perspective (pp. 171–188). Fryer’s writing is impressive and profound. Let us begin an analysis of his thinking with an extended quote, verbatim, from his Introduction:
I am assuming ‘spirituality’ to be concerned with components of human life and experience that are not material, nor tangible, but that are unarguably real in every person’s life, and give human value and deep satisfaction to that life. For me, these components are largely encompassed by love, joy, peace and faith. Though not essentially intellectual, they will be enhanced by clear and honest thought; though not primarily emotional, they are unlikely to be experienced without feeling. Anything material or social which threatens them prejudices the wholeness, or health, of the person. Anything which fosters them is promoting spiritual healing. They can be experienced in spite of physical or mental suffering (pain, sickness or disability), but they may enhance the body’s healing processes, which diminish physical and mental suffering. Thus body, mind and spirit are inextricably linked in the whole person.

As Fryers emphasizes, while these observations and factors are of central importance to Christian peoples, they are of equally substantial significance for non-Christians and to people who subscribe to no recognized belief system at all and he goes on to explain precisely why and how in the sections of his chapter that follow. See, for example, his thinking as articulated under the sections ‘Beyond the self’ and ‘The individual, others and community’.

**Givers and receivers of care**

Fryer’s writing on ‘givers and receivers’ of care presents a dilemma, which the author sees as more personally concerned with ‘inner life’ values of people who are in need of, and in receipt of ‘care’. As he says, care may represent a simple consultation with a doctor, or something a great deal more complex. The *Journal of Evaluation in Clinical Practice* sees care as being quintessentially represented by the latter and for this reason recently instituted the new Forum on Systems and Complexity in Medicine and Healthcare [69]. But in this section of his chapter, Fryers is more concerned to analyse the notion of the ‘dependence’ of the individual patient on the health care system, which he discusses in terms of two very different perspectives. Taking first those sources of care that are often termed ‘welfare systems’ (whether provided by the State, by a charitable agency or by an individual professional), Fryers reminds the reader how such systems are often perceived as actively fostering a dependence of the individual patient on ‘authority’ or on ‘agents of authority’. Certainly, these agents may include doctors and for the reasons Fryers reflects upon. Taking second (and in the same cultural context) the complaints from individual patients about their dependence, Fryers shows how this perception is common among, for example, disabled people with significant disadvantages in Society, but who have actively addressed their dependence with a view to limiting it.

From both of these perspectives, it can be seen how the avoidance of unnecessary dependence of individuals has become an overriding concern of health care systems and of preventive medicine more broadly and it is clear that ‘dependence’ has become a very negative word and concept (p. 176). But in general and not absolute terms. Indeed, as Fryers notes, while in general terms, the ‘ideal life’ in Western culture is seen as one of independence and autonomy, with individuals failing to fulfil this ideal risking misunderstanding and stigmatism, Society retains a near absolute respect for and understanding of those individuals who simply cannot care for themselves in any realistic sense. But Fryers warns, rightly, that there is a risk here, that individuals and agencies may be tempted to call anything ‘sickness’ if there is a perceived need to permit dependence without loss of self-esteem or to prevent the incurring of stigma. And while it has long been fashionable to castigate the medical profession for such tendencies and for its involvement in the so-called ‘medicalization’ of conditions and disorders, the reality is, perhaps, that doctors, patients and Society at large typically collude in the legitimization of dependence.

Fryer’s reflections on such matters lead him to a consideration of ‘interdependence and reciprocity’ and to an analysis of how, from a spiritual perspective, this problem can be considered and solutions to it sought. I agree wholeheartedly with Fryman (who is a doctor as well as a Christian) that human life needs to be conceived of not in terms of autonomy or dependence, but rather in terms of interdependence (and therefore involving cooperation). Surely, he is right to emphasize how ‘every individual needs both separate identity and close relationships, neither controlled by other people, or lost in another’s personality, nor set against everyone else in competition, but living in rich interdependence with others, and acknowledging the contribution, genetic, cultural and environmental, of human society to his or her assumptions, beliefs, expectations and experiences’. Fryers concludes his chapter with a detailed, highly insightful and inspiring consideration of six substantive areas of thinking on the relationship between carer and cared-for: (i) caring is sharing; (ii) caring acknowledges the whole person; (iii) receiving is also to be blessed; (iv) a ministry of reconciliation; (v) process and outcomes; and (vi) whole persons live in communities. I strongly recommend that the reader consults the original text in order to experience the ‘full force’, as it were, of Fryer’s wisdom and so I will here only briefly outline the essentials of his thinking.

‘Caring and sharing’? What does this mean? Fryers notes, in explanation, the long tradition in Western Medicine of the authoritarian doctor, ‘at worst unfeelingly paternalistic, at best paternalistic’, which has given way in more modern times to a non-directive tradition characterized principally by the patient’s making of his own decisions about treatment and other interventions, so that the role of the professional has mutated from authoritarian paternalism to one who now simply informs, guides and facilitates within the clinical encounter. Certainly, the doctor or care professional almost always occupies the ‘dominant’ position within the consultation, having, as Fryers acknowledges, a wider professional knowledge and experience than the patient or client so that, as he says, the professional has a considerable responsibility to ‘get the balance right between facilitating independent decisions and actions and being prescriptive and directive on the patient’s behalf’. Is this the place for the exercise of true wisdom in the professional relationship then? For Fryers, and for this Essayist, the answer is in the affirmative – whether this imperative is understood within the traditional consultation between patient and doctor concerning sickness, or in caring for an elderly person in a domestic setting (p. 180). And in acknowledging the same, we see the necessity for a ‘real sharing of yourself as well as your knowledge and time and, where appropriate, as much of your inner self as the patient can receive’ [16].

Such meditations, simple in concept, but complex in practice, lead us to Fryer’s second consideration, that *caring acknowledges*
the whole person. As Fryers points out, all wise clinicians know that many of the people consulting them have a much broader and deeper need than the reason they give for requesting the consultation in the first place. Fryers identifies here the spiritual needs concerning self-esteem, relationships with others and relationship with God. For Fryers, good doctors with an appreciation of the necessity of whole person care will, generally, recognize this and will therefore wish to engage with patients at a deeper level, although the practical considerations in doing so are formidable in nature, when one considers the fundamental constraints of time, economics, technologies and organizations. Given this, Fryers sets out five highly specific ‘qualities’ perhaps ‘competencies’, even, of the ‘good doctor’, which are, in the view of this Essayist, fundamentally sound and insightful.

Moving from this second consideration of caring acknowledges the whole person, we move to Fryer’s third: receiving is also to be blessed. Here, at the outset, Fryers compares and contrasts two of Christ’s principal teachings in terms of giving and receiving: ‘It is a more blessed thing to give, rather than to receive’ [70] and, in another context, ‘Let her alone. Why do you molest her? She hath wrought a good work upon me’ [71]. The juxtaposition of these teachings illustrates the interrelationship between giving and receiving in a beautifully simple and dualistic manner and Fryers draws upon further examples from Holy Scripture in emphasizing his central points [72,73].

Notwithstanding these core principles, it is common in Western societies, as Fryers points out, for individuals to resent being in a position of receiving without being able to pay back the benefits they have received in some sort of immediate and tangible way. As he accurately observes, it is typical in modern Western societies to focus on a type of commercial relationship in which reciprocity is immediate. But, as he says, in reality we ‘receive where and when we are in need’. Indeed, as Fryers properly reminds the reader, we all need to learn to accept gifts of love and joy and to go in peace (p. 183).

Moving to Fryer’s fourth area of analysis, we consider the ministry of reconciliation. Certainly, the author continues to show his fundamental understanding of the issues at hand: ‘if pride prevents people from accepting gifts, how much more does it prevent people from accepting and offering forgiveness?’ So, ‘love can be defined as staying in relationship, and forgiveness is an essential component of staying in relationship’ [74]. From this it follows that the inner life is disturbed whenever we are in conflict with others, so that for so many people presenting with depression, anxiety and psychosomatic disorders, disturbed relationships occupy a foundational place in the disturbances and incapacities of presentation. Indeed, disturbed relationships can affect people’s capacity to work and to live at peace with their neighbours (p. 183). As Fryers emphasizes, for people who are approaching death, reconciliation to those with whom they have passed their lives is a high priority if they are to have peace. I found deeply moving here, Fryer’s quote of Jewell [75]:

Older people will frequently confess that their deepest desire is to die at peace; with their fellows, with their God, and therefore with themselves. The damage and the hurts we inflict on one another as human beings cry out for resolution even though they may lie buried deep in the psyche. The unfinished business of human relationships from our earlier years becomes the pressing business of our later years.

Fryers is clear that in recognizing these things, we simultaneously recognize the demand of justice in our relationships, which can only be fulfilled in love. Here, in any care situation in which it is possible to enter into spiritual issues, the matter of reconciliation must be dealt with, and professionals dealing with it will inevitably be brought face to face with their own relationships and their own need for reconciliation (p. 184).

Moving to the fifth of the six of Fryer’s analyses, we arrive at the consideration of process and outcomes. While Fryers appears to accept the rhetorical tenets of evidence-based medicine, he is clear that there are so many areas of practice where the knowledge base is insufficient and where therefore formal evaluations of efficacy are not possible within the constraints of modern scientific reasoning. There is, as he says, a growing knowledge base demonstrating the beneficial effects of social support and expressed compassion through comforting, encouraging, calming and praying, but he is clear, and I applaud him for saying so, that interventions such as these should not always depend upon results as conventionally measured:

In personal encounters in which the whole person is fully recognised, love, compassion, giving and forgiving are called for in all cases. The application of love in caring relationships places process above outcomes, means above ends. This means that being is similarly placed above doing. For technological medicine the doctor needs to be as well trained and as technically competent as possible. But considering spiritual aspects of the relationship between doctor and patient, being a loving person is more important than anything he or she does (p. 185).

The sixth and final of Fryers analyses in its title reminds the reader that whole persons live in communities. As he points out, some people who present with medical problems, but who may well have deeper spiritual needs, may also have practical, economic, employment or housing issues that would need to be dealt with as part of their overall care. Fryers’ view is therefore that as people are ‘whole persons’ and given that their whole personhood is tied into relationships, cultures and communities, the needs of individual persons are thus inevitably broad and complex and it comes as no surprise to see that when relationships, cultural corrections and communities break down, individuals become seriously disturbed and begin to manifest deep personal need. When circumstances such as these arise and where their consequences become apparent, Fryers is convinced that our aims must include not only wholeness for persons, but also wholeness for communities. He concludes by reflecting on Archbishop Desmond Tutu’s words:

Our wholeness is intertwined with their hurt. Wholeness means healing the hurt, working with Christ to heal the hurt. Seeing and feeling the suffering of others, standing alongside them. . . . We yearn to experience wholeness in our innermost being. Our spirits cry out for the well-being of the whole human family [75].

The re-emergence of home health care: a holistic response to ageing and consumer empowerment

The penultimate chapter of the volume, by Mike Magee (pp. 189–206) is, in it’s style and profundity, in sharp contrast to the preceding work by Fryers and is written more in the manner of a
activities of daily living. Magee is concerned to discuss what he believes to be the necessary, indeed urgent, restructuring of disease prevention strategies and care delivery philosophies that are consequent upon the ‘scientific and social services race against the very real challenges of aging demographics’ and with reference to the rise of the increasingly educated and empowered patient. While he writes primarily in terms of the American context and perspective, much of what he has to say is of immediate relevance to British and European health care environments. Magee is convinced that while the USA has accomplished much over the last two decades, it has not yet successfully converted its health care system from one focussed on intervention to prevention, neither has it resolved the ‘issue’ of its large number of uninsured citizens and neither has it ‘fully leveraged’ its information systems and technology, with the aim of strengthening the patient–doctor relationship and of reinforcing ‘multigenerational’ health. Yet despite these observations, he believes that hidden within these ‘current converging mega-trends’ are ‘predictable tipping points’ that are set, imminently perhaps, to transform health care into a home-centric, holistic model, far more able to provide ‘health for the person’ than those systems currently in place. Moving through discussions of the challenges of ageing (p. 190), to considerations of the support necessary to maintain the activities of daily living (p. 191), Magee next provides brief reviews of current trends in long-term care (pp. 191–192) and of the realities and management of stressed caregivers (pp. 192–195), concluding with a discussion of the limited time and space in the doctor’s surgery for care (pp. 195–196), before beginning a developed narrative on the ‘management of two very personal events in his own life. These focus on two family deaths and Magee shares with the reader his reflections on what he terms the ‘four organisational stages of dying’: (i) engagement; (ii) release; (iii) testimony; and (iv) recovery (pp. 197–199).

Much of what Magee writes under these heading is interesting, eminently sensible and commendable. But I was made uneasy by his subsequent reference to the four stages discussed as posing ‘unique management challenges in (their) own right’ and that each ‘requires planning’, ‘demands decisions’, ‘causes fatigue’ and ‘requires team support’, and that they require ‘different missions’, ‘players’, ‘organisational interfaces’, ‘support staff’, ‘time pressures’ and ‘measures of success’. Is his use of such terms a matter of semantics and elegance of English usage or is there here a robotic managerialism and pragmatism redolent of the techno-centric and Taylorian approaches to health services management that have so damaged the quality of health discourse in recent times and that have promoted a sense of ‘coldness’ in the way in which organizational restructurings are designed and implemented? I accept, of course, that Magee is striving to formulate an operational approach(es) to what he believes, philosophically, to be the most prudent way forward in terms of service redesign. But there remain dangers in the use of some words within the context of health discourse given the rampant managerialism of our times [76].

Magee’s discussion of the ‘financial stakes’ that follows (pp. 200–201) and how such stakes ‘must evolve to include more rational approaches to public, private and family investment’, coupled with questions of ‘who will pay?’ and statements of how ‘the ability to live independently at home is less expensive than institutionalization’ and how ‘in 1999 it was roughly five times more expensive to be elderly and dependent in a nursing home versus independent in one’s own home’ compared with costs in 1992, seem to me to continue the theme of ruthless pragmatism versus what is best for the individual, so as to render such considerations anathema to Tournier’s core vision of care provided on the basis of compassion, discernment, understanding and spirituality as well as scientific progress and technological advancement. Magee’s discussions appear to be operating from the basis of a generous and supportable philosophy constrained and thus ipso facto altered by ‘modern’ managerialist ruminations. Consider this:

In the future, the home itself will look quite different – it will generally be more stable, productive and controlled. Technology, originally directed at seniors with cognitive decline, cancer and cardiovascular disease who wanted to age in place, will be advancing the health of all ages. The infrastructure for maintaining home-based wellness will include wireless sensors that track movement of people and objects in-home; intelligent software that will analyse data and provide appropriate behavioural clues and guidance; friendly, communicative interfaces through a wide range of devices such as wristwatches, telephones and televisions and Internet connectivity with the rest of the healthcare team.

And consider also Magee’s approbatory quoting of David Tennenhouse within Dishman [77]: ‘The real challenge for research now is to explore the implications and issues associated with having hundreds of networked computers per person. These networked computers will work together to learn our habits and patterns and be proactive in providing us with the information and services we need for a healthier, safer, more productive and enjoyable life . . . (they will) . . . adjust behaviour in physical fitness, nutrition, social activity and cognitive engagement’ and assist seniors with incontinence, in regular toileting and assure better adherence to medication regimens’.

Oh, what a brave new World that has such systems in it? I think not! Magee’s chapter is cold, robotic and frightening. Operating initially on a solid philosophical position of what might be best for the individual patient, the author’s vision appears quickly to dissolve into a technocratic consideration of how the ‘problem’ of ageing might be contained. For this Essayist, the finale of Magee’s chapter consists of nothing more than emotive rhetoric that risks the charge of intellectual bankruptcy [76]. Will the reader agree?

Consider this:

At the end of the day, caring will re-centre in the home where caring, compassion and personalization reside. Here, caring will integrate mind, body and spirit; bring together faith, values and science; focus on wellness and functionality; integrate and prioritize resources along the four or five generation family divide; and tailor care to the unique cultural, social and spiritual needs of family members. Homes will look to their communities for value grounding, integrated social systems and resources by exclusion if overwhelmed by complexity. Physicians and nurses will advocate for these changes because they make sense and are the only reasonable way to manage the cost and quality demands of global aging societies. I remain far from convinced, then, by Magee’s employment of ‘buzzwords’ and of the author’s attempt to construct a semblance

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of logical argument based on tenuous connections between disparate concepts. Am I convinced by Magee’s reasoning that ‘dumping’ older people at home improves the overall quality of their care as a generic principle? No I am not. Am I depressed that a ‘Senior Research Fellow in the Humanities to the World Health Organisation’ and a ‘Director of the Pfizer Medical Humanities Initiative’ could find it within his capabilities to write as a health services management automaton, rather that as an academic? Yes I am.

Neuroscience and belief: a Christian perspective

The final chapter (pp. 207–224) that closes Cox and colleagues’ volume, is contributed by Andrew Sims, a Christian psychiatrist and like Cox, a former President of The Royal College of Psychiatrists UK, who uses the findings of neuroscience in his work, but who also utilizes Christian belief within his medical practice. His chapter explores, then, the connection between faith and practice in the field of mental health and illness through an initial examination of the nature of neuroscience and then a subsequent relating of this examination to significant issues for belief such as cause and effect, free will and the effects of religion on health (p. 208).

Sim’s review of ‘what is neuroscience?’ is informative and reminds the reader of where modern understandings of neuroanatomy, neurodevelopment, neuroendocrinology, neurotransmitters and neuropathology, lies. Having set out such brief reminders for the reader, Sims continues by explaining how two other scientific disciplines are pivotal in understanding the functioning of the human brain. Here, he specifically considers psychoneuroimmunology and genetics, without forgetting the role of progress in experimental psychology and epidemiology in the promotion of the same broad understanding.

Neuroscience and religion – conflict or complementarity?

As Sims notes, there is a history of unproductive conflict between science and religious belief, with many academic scientists in the late nineteenth and the first two-thirds of the twentieth centuries aligning themselves with atheism. I thought particularly useful, the author’s division of science into its three guises; science as fact, science as hypothesis and science as dogma. Sims points out that much science teaching at school and undergraduate level is delivered as dogma and that those students who believe in God have a particular problem with the scientific dogma of randomness. He is clear that a refutation of randomness is needed for psychiatric practice, emphasizing that rational treatment in psychiatry is based upon a diagnostic formulation and for this, a descriptive psychopathology, including observation of the patient and emphatic understanding of the subjective state, is crucial (p. 211). He goes on to discuss how, if human behaviour or thought processes were seen to be random, then thinking itself and the speech that derives from it, become meaningless, representing only epiphenomena of the underlying clinical mechanisms. This dilemma over causes poses particular problems for those who hold the Christian faith, because a belief in randomness is, as Sims notes, incompatible with the omnipotence and omnipresence of God. Sims develops his thinking for the reader here, by presenting a useful and insightful section on ‘cause and effect’ as understood variously in science and religion (pp. 211–212), before expanding his reflections on notions of causality in the section, which then follows on determinism versus free will.

Sims does not provide an exhaustive discourse on this subject within this section, but rather considers the particular example of addiction in direct illustration of the ‘dilemma of causality’ when studying human behaviours in their ‘normal’ or pathological forms. The account he provides is a fascinating one, illuminating how insights from the Christian doctrines of sin and redemption can assist the understanding of the complexities he describes. Noting the notion of the ‘divided will’ (and quoting both St Paul [78] and St Augustine [79] in this context), Sims shows how the phenomenological experience of the addict is similar to the experience of anyone individual who has found himself subjectively drawn into engagement in behaviour that he believes to be morally wrong. The contribution that a Christian perspective can make in enhancing the understanding and potential treatment of this problem is then shown: the Christian believes that wrongdoing (sin) occurs and is universal, that it can enslave and become habitual, but that forgiveness, reconciliation and restitution are also possible by the individual who has failed to achieve his own standard and regrets it (sense of sin, confession, penance, absolution).

The effects of religion on health

In the section that follows, Sims addresses the question of whether religious belief per se can alter prognosis, citing the major review by Koenig and colleagues that constitutes their monograph handbook of Religion and Health published by Oxford University Press in 2001 [80]. The significance of this volume to the ‘evidence base’ on the effects of religious belief on health is summarized by Sims: 1200 research studies and 400 individual reviews spanning both physical as well as psychological health are evaluated in terms of their aims, scope and methodological quality, with religious belief being analysed using several different measures. The overall conclusion of this systematic study was positive in that correlations between religious belief and greater well-being can be found in, among others, physical as well as psychological health. The full section on ‘cause and effect’ as understood variously in science and religion (pp. 211–212), before expanding his reflections on notions of causality in the section, which then follows on determinism versus free will.

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Religion complementing science for mental health

The remaining section of Sim’s chapter, which closes the volume as a whole, is divided into four parts: ‘Relationship as a world view’; ‘God of love’; ‘Personal relationship with Jesus Christ’; and ‘Harmony: with God and in the world’. All four parts fit perfectly together. In the first, Sims, quoting Ward [81], reflects on the theme that in all aspects of His creation, God is concerned with
relationship. Thus, human beings are organisms of relationship, such that being human involves relating to other humans in a wide variety of ways. As Sims points out, we can only develop fully through relationships with others and all mental illnesses manifest a disturbance of relationship. While we relate more or less equally with one another in terms of giving and receiving, our relationship with God cannot be equal – He gives and we receive: ‘All things come of Thee and of Thine own do we give Thee’. But in living with other humans in peace, harmony and prayer, we please God and communicate with Him.

Sims asks: ‘What if neuroscience can localize prayer or what has been called transcendence? Does this invalidate prayer? Interestingly, he draws the reader’s attention to an investigation of the relationship between 5-HT (1A) receptor density and personality traits, which demonstrated that ligand binding potential was inversely correlated with scores for self-transcendence (a personality trait covering religious behaviour and attitudes). The study’s authors were able to conclude that the serotoninergic system may well serve as a biological marker for spiritual experiences [82]. Asking, then, whether it could be true that spiritual experiences merely represent activity of the brain at this location, Sims resists in the negative, because if this localization is indeed correct it indicates simply where it is mediated. As he says, neurosciences cannot explain why it is happening, or the individual’s relationship with God ‘any more than an analysis of the wood fibre explains away the meaning of the article in a newspaper’. Quite.

In the second of the four final subsections, Sims proceeds to explore the ‘positive and non-destructive relationship between God and humankind (that) is called love’ (pp. 218–219). Here, love is seen as the basis of positive relationships between people, with loving actions and relationships forming the ‘cement’ of human society, enabling Society to function successfully and harmoniously. Sims is clear that if we are to bring the concept of love into the practice of medicine, we must bring with it the notion of values. With reference to Fulford [83], Sims illustrates how medical values are different from moral or aesthetic values, but that when involving a spiritual component, medical, moral and aesthetic values all become relevant. This is an important point, with real implications. As Sims says, a doctor who regards himself as a pure scientist with limited sensitivity to and appreciation of patient values will be a very different doctor to the doctor who strives to put the value of love at the centre of his practice, the former perhaps appearing ‘callous’ and the latter appearing ‘caring’ (p. 219). Indeed, we have seen some colleagues risk the former appellation in the early days of the Evidence-based Medicine movement and, to a significant extent still today, where a failure to appreciate the limitations of science and a failure to learn the lessons and arts of traditional medical practice have resulted in incomplete forms of clinical practice that deny patients the benefits of the holistic approach in medicine that they incontrovertibly merit and deserve [2,3,52–68].

The third subsection that Sims presents sees the author discuss his views on a personal relationship with Jesus Christ. While the belief that Christ rose from the dead, is alive today and that He gives context, hope and salvation to mankind cannot be explained nor refuted in neuroscientific terms, Sims insists that notions of ‘being in Christ’, ‘with Christ’, ‘Christ in me’ and ‘Christ with me’, can be explored using the methods of phenomenological psychopathology [84]. Such statements, Sims explains, can be evaluated in two ways – through passivity experience or delusion of control that could be explained by specific disturbance of brain function [85] and by trance and possession disorder, a temporary loss of the individual’s identity and awareness of his surroundings. Neither of these states, however, fits the spiritual description by the believer, of an internal experience of God directly assisting him in making him be the person he truly wants to be. Indeed, the experience of ‘being within the Love of God’ becomes incorporated, as Sims describes, into the concept of self and self-image, such that we ‘find our personal God from a position of need – on our knees’ (p. 220).

The final subsection that closes Sim’s chapter and indeed the volume itself is concerned with the need of the individual to live in harmony with God and in the world. By way of introduction to the central, albeit brief, thesis in this subsection, Sims reminds the reader of the commonly accepted tenet within evolutionary theory, that natural selection produces a progressively improved human race – only to demonstrate how antithetical to Christian spirituality is the whole notion of an innate superiority of a stronger more perfected individual over a ‘lesser’ individual. The scriptural quotes employed by Sims here, are apposite [85–88]. Harmony with God then is, as Sims emphasizes, expressed in harmony with mankind. Central to it is the need for forgiveness – to be forgiven by God and to forgive and be forgiven by other people and thus to become reconciled to God and reconciled to people from whom one has become estranged. Thus, Christian spirituality enables the perfection of altruism, praises self-sacrifice and explicitly rejects notions such as ‘survival of the fittest’ and concepts such as ‘the selfish gene’ (p. 221) [89]. Unsurprisingly, then, the Church is seen for what it is – a supportive community and this, for Sims, and with reference to the large evidence base discussed earlier, is one of the major reasons for religious involvement leading to superior outcomes from a range of illnesses [80]. So, Sims is, in conclusion, convinced that neuroscience and belief far from being mutually exclusive or antagonistic can, in reality, work together and be mutually enhancing. He is similarly convinced that religion is a much neglected factor in studying prognosis and health outcomes and that Christian teaching on relationship, forgiveness, reconciliation and harmony provide valuable insights to inform the evaluation and development of modern medical practice.

**General Discussion**

The above, then, is an account of Cox and colleagues’ contribution to the study of Tournier’s Medicine of the Person as it is set out within their volume. But several questions could be posed at this point, which might afford the reader further insight into Tournier’s vision and how it has contributed directly to modern understandings of spirituality and religion in health care and how such concepts can be utilized within contemporary clinical practice. What is spirituality as distinct from religiousness/religiosity? Is spiritual and religious care a necessity for the optimization of clinical practice? What, precisely, is the evidence for the benefits of spiritual and religious care within a highly patient-centred doctor–patient relationship as Tournier recommended? What are the limitations of that knowledge base and the research studies that underpin it? Can we measure the benefits of such interventions? How is spiritual and religious care actually practised? What further research needs to be done? What are the political, ethical and professional issues that need to be considered in the provision of spiritual and religious care?
Interest in spiritual and religious care in Medicine

Historically, medicine and religion have been integrally linked, but more recently there have been tensions and these continue in one form or another. Freud, for example, equated religion with neurosis [90] and DSM-III employed concepts of religion and spirituality to illustrate psychopathology [91]. The revision of DSM-III, however, added a diagnostic category for religious and spiritual problems, so that DSM-IV recognized for the first time that religious/spiritual beliefs are not inherently pathological [92]. Controversies continue, however, and for Eckersley, materialism and individualism are two particularly powerful factors that militate against the development and understanding of spirituality in Western societies today [93–95]. Nevertheless, there is certainly, now, a rapidly growing interest in spirituality in medicine of which Paul Tournier would have been proud. In 1994, for example, only 17 of the then 126 accredited US medical schools offered courses on spirituality in medicine. Four years later, however, the number had increased to 39 and by 2004 to 84. By late 2008, over 100 schools in the US now engage in the teaching and debate of spirituality in medicine and this is a trend which is now being increasingly replicated elsewhere [96].

Until recently in medicine, considerations of the spiritual dimensions of clinical care have been almost entirely confined to the specialties of palliative medicine and to a lesser extent psychiatry [97]. But there are many new and emerging studies, which aim to apply traditional methods of enquiry in medicine to the assessment of spiritual needs in a broader clinical context. Take, for example, Katerndahl [98], who describes an empirical study of the impact of knowledge of spiritual symptoms on health care utilization, extreme use of services and life satisfaction among primary care patients through use of a self-report measure that included indices of ‘peacefulness’, ‘a sense of purpose’ and a ‘reason for living’. Consider also Anandarajah [99], who has recently presented several conceptual models which are of significant use in progressing medical understandings of the spiritual dimensions of clinical care and which necessarily, given the constitution of contemporary Society, discuss multicultural perspectives. Moreover, Curlin and associates [100] are clear that because religion and spirituality are important components of many clinical encounters, clinicians would benefit from increased professional training on religious/spiritual issues as well as an increased awareness of pastoral or theologically trained colleagues with whom they might consult when appropriate.

Definitions of spirituality and religiousness

One major source of ongoing confusion among health care practitioners is that while spirituality is a concept universally acknowledged in medicine, no meaningful consensus has yet been reached on how precisely it should be defined [101,102]. As a concept, spirituality is, perhaps, the single most important experience of meaning that, by its nature, transcends the individual’s personal circumstances, social situation and the material world. It is widely acknowledged to be able to sustain people through the disturbances and stresses of human life. Its values are in so many ways antithetical to the macrocultural factors of materialism and individualism of which Eckersley writes [93–95]. Indeed, these, in enticing the person into investing too much of the self into things that are transient, ephemeral, fragile and temporary, are often a recipe for successive disappointments, disillusionments and the experience of ‘emptiness’ and ‘quest for purpose and true meaning’ that spirituality or formal faith by their nature supply. Without these spiritual ‘resources’, a person will often ask questions, but will hear no voice in reply.

It has been said, rightly, that the nature of spirituality is mysterious and elusive, making it extraordinarily difficult if not impossible for science to define and measure with conventional techniques [93]. Indeed, the spirit exercises a crucial but still unacknowledged role in the promotion and well-being of the individual. As Tacey argues [103] and as Eckersley et al. agree [104], spirituality has the capacity to nurture and transform an individual in a way in which secular societies have yet to understand. But what is this ‘meaning’ in life that we speak of? Certainly, Man finds meaning at a variety of different levels [105]. Here, job/career, family, friends, goals and the satisfaction of personal desires in general are of clear importance, as is the position of the place of the person within their peer group, cultural setting and in the wider community. Crucially, there may also be an individual’s experience of faith in God, leading him to be able to describe a personal relationship with God, which contextualizes the core purpose of living.

Not that spirituality and faith are synonymous, although there is often a major degree of overlap between them as intuitively might be expected [106]. Yet many clinicians continue, wrongly, to equate spirituality with religion, unsurprisingly perhaps, as typical dictionary definitions of spirituality infer a definitive interrelationship. As a consequence, we find in the medical literature that religion and spirituality are frequently confused or conflated [107–109]. Usefully, Stoll [110] has described both vertical and horizontal components of spirituality. For this author, the vertical component involves an individual’s personal relationship with a higher power, typically the experience of God, whereas the horizontal component typically represents the relationship of the person with himself, with others and with the environment.

If such studies help conceptualize spirituality for clinical purposes, then Johnston and Mayers [111], on the basis of a structured review, have defined spirituality as:

the search for meaning and purpose in life, which may or may not be related to a belief in God or some form of higher power. For those with no conception of supernatural belief, spirituality may relate to the notion of a motivating life force which involves an integration of the dimensions of mind, body and spirit. This personal belief or faith also shapes an individual’s perspective on the world and is expressed in the way he/she lives life. Therefore, spirituality is experienced through connectedness to God’s higher being and/or by one’s relationship with self, others or nature. Tournier would, I think, have entirely agreed.

Doctor–patient relationships in spiritual and religious care

What form, then, might the doctor–patient relationship take if spiritual and religious care were to be extended within the consultation and in assessment and treatment pathways? Davidson,
for example, poses several key questions, which are of immediate relevance in this context [112]. At the definitional level, he asks, how can we objectively measure clinician sensitivity to the spiritual dimensions of the patient? How can we assess such qualities as ‘being present’ – ‘the type of sensitive attention conveyed by the clinician marked by physical proximity and intentionality’ [97]. As Tournier would have argued, the very presence of the doctor may represent a therapeutic intervention in its own right. How does the possession of these qualities by a clinician affect the patient? Are there changes in the patient beyond the subjective changes in well-being and perceived care? As Davidson [112] notes, the medical profession has become increasingly open to considering the importance of these issues for good medical care, a ‘hopeful sign of a more complete and open view of the complex interdependence between healthcare clinician and patient . . .’ Certainly, during the past decade there have been great advances in the scientific understanding of mind-brain relations and of the relationships between the brain and peripheral biological systems that are integrally linked to health and illness, such that science is increasingly able to analyse the complex mechanisms through which the brain influences peripheral biology, thus providing the basis for study of how the mind itself may influence the body and its systems. These observations, as Davidson emphasizes, make clear an urgent need to study and understand the ‘interpersonal environment’ and the whole nature of the doctor–patient relationship in terms of how this can affect the patient’s emotions, psychological state and general level of well-being [112].

Can the doctor, then, directly influence the patient’s brain and thus the patient’s peripheral biological systems that are important for health? Studies conducted to date certainly indicate that such influences can indeed be mediated by the doctor. Consider, for example, Davidson’s summary of the results of an earlier study demonstrating one simple example of the biological consequences of interpersonal relationships [113]:

In one recent study from my laboratory, we brought into the laboratory married couples who reported a highly satisfied married life. We then scanned the wife using functional magnetic resonance imaging of the brain while we induced anxiety through the threat of electric shock. In one condition, the wife held the hand of her partner, in another condition she held the hand of a stranger and in a third she was alone. We found that activation of the pain matrix in the brain (a well characterized circuit involving several interconnected structures including the anterior cingulate cortex, insula, prefrontal cortex and hypothalamus) was significantly diminished when she was holding the hand of her spouse. Further, the more intimate and close the relationship was reported to be, the greater was the attenuation in neural activation in several of these brain regions. This study illustrates how high quality social relationships can ‘get under the skin’ and affect brain function in specific, predictable and beneficial ways.

These effects, objectively demonstrable, cannot be ignored and their wider implications for the doctor–patient relationship requires detailed experimental investigation. Davidson refers his reader to the emerging discipline of contemplative neuroscience [114], a relatively new field of study focussed on changes in brain function and structure that result directly from contemplative practice, itself predicated on the substantial body of literature on neuroplasticity, which holds that the brain changes in response to experience and training. Data accumulated to date appear to indicate that practice is required to change the brain and that more practice leads to more pronounced transformation and certainly in those neural circuits that are associated with compassion and attention. Training in contemplation would therefore seem particularly appropriate for clinicians, in order that they can develop an acuteness of ‘sensitive attention, compassion and positive attention’ [114]. The examples quoted by Davidson, as they relate to how neural circuits transformed by meditation exercise a key role in the modulation of peripheral biological systems of importance in health and disease [115,116], are of considerable significance to this debate.

Adding a further dimension to this discussion, Puchalski [117] believes that doctors cannot deal effectively with the religious or spiritual needs of patients unless they have dealt effectively with their own [118]. D’Souza agrees [119] and has emphasized that clinicians’ own religious or spiritual practices or non-practices may affect their ability to function effectively in this area of practice, as caring for others requires one to draw on one’s own inner strengths. Certainly, relationships are in general terms integral to well-being, which depends upon and is enhanced by connection and engagement in a network of relationships and interests. Consider, for example, the increased psychological morbidity and mortality associated with social isolation versus relationship with family, friends and community [120]. Of relevance here is Tournier’s writing on the role of the family and of friends in the healing of the whole person.

What is the evidence for the effects of spirituality and religion on health and clinical outcomes?

As Eckersley points out [93], the complex nature of the relationship between religion, health and well-being lies behind a continuing debate among researchers about the effect of religion on health. What, then, constitutes the evidence base that argues for a fundamental place for spiritual and religious care within routine clinical practice? There is, certainly, an abundance of literature that demonstrates the benefits to well-being of social support, sense of purpose, moral code and existential meaning, all of which form part of what may be called spirituality [120–124] and, as it were, an integrated manner. Moreover, religion and spirituality can act as powerful modifiers of otherwise destructive behaviours, influencing diet, exercise, smoking, drinking, sexual behaviour and a variety of other factors [95].

The celebrated and seminal 2001 study by Koenig and associates [80] and upon which Sims draws in Chapter 10 of Cox et al.’s volume, was certainly a major milestone in the development within medicine of a greater understanding of the effects of spirituality and religion on health. But Sims omitted consideration of a great deal of the more recent research that would have significantly strengthened his conclusions. We can consider a representative, but by no means exhaustive, sample of such work here. A good starting point is, perhaps, the recent and concise review by Williams and Sternglanz [125] and also the article by Moreira-Almeida and associates who have demonstrated the protective effects of religion-associated variables on multiple mental health

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indices such as well-being, suicidal behaviour and substance misuse [126]. Moreover, Shreve-Neiger and Edelstein [127] report that religious attendance and intrinsic (internalized) religion tend to be associated with reduced anxiety, in contrast to extrinsic (utilitarian) religion, which tends to be positively associated with anxiety. Further evidence of an effect of religion on health is provided by Smith and co-workers [128] who, following a meta-analysis of 147 studies, were able to demonstrate an inverse association between religiousness and depressive symptoms. The therapeutic influence of religion in the treatment of depression has also been noted by other investigators [129,130]. Take also, studies of adolescent behaviour that have demonstrated an inverse relationship between higher levels of religious involvement and alcohol and drug use, smoking, sexual activity, depressive symptoms and suicide risk [131–134]. Other studies have similarly documented the ability of positive forms of religious coping to effect a lowering of depression, anxiety and distress scores, with negative forms of religious coping being associated with poorer psychological adjustment [135]. These studies are usefully considered alongside those that have documented an association between religious belief and coping in HIV-positive individuals [136], with their observations of an association of spirituality and religion with improved immune system function being of direct clinical importance.

Neither are these positive effects of religion and spirituality confined to psychology, psychiatry, HIV medicine and coping in terminal illness. Indeed, Townsend and colleagues [137] in a systematic review of randomized controlled trials, reported an association between religious prayer and improved health outcomes in patients with coronary syndromes and in children with leukaemia. Furthermore, explorations of the relationship between religiosity and health-related physiological processes were able to document positive effects on blood pressure and immune function, with practices such as Zen, yoga and meditation being correlated with lower levels of stress hormones, cholesterol and better overall health outcomes in clinical patient populations [138]. Of interest in this context also, is the well-documented inverse relationship between religious attendance and mortality. Hummer and colleagues [139], for example, in a study of 21 000 adults, were able to observe a strong, graded association between religious attendance and mortality. Here, individuals who had never attended services were reported to have a 19 times higher risk of death over an 8-year period than those individuals who attended services more than once a week, an association that existed for most causes of death. Interestingly, striking differences in life expectancy were also evident. For example, life expectancy at 20 years of age for those individuals who attended services more than once a week was, on average, 7.5 years longer than those who never attended. The investigators were able to observe this association as being even stronger in African Americans, where a 13.7-year difference was observed, with considerable variation being documented within observed populations in the nature, frequency, content and meaning of prayer so that understanding the relationship between prayer and health will require consideration of the conditions under which particular dimensions of prayer may be related to specific health outcomes [125]. They are equally clear that not all effects of religious attendance may be inherently spiritual or religious and that future research needs to differentiate between aspects of attendance that may be spiritual, from those that may be more social and cultural. Also, while a recent US national mortality study found a robust effect of religious attendance on health after adjusting for a broad range of potentially confounding and mediating behavioural, social and psychological variables, highlighting the imperative to explore the direct effects of religion on health [148], even the most sophisticated research has been unable to explain the relationship of religious attendance to mortality.

Williams [125,146] additionally highlights the need for prospective studies aimed at developing our understanding of the temporal ordering of the relationship between exposure to spirituality and the timing of health consequences and for studies designed to strengthen confidence in causal inferences [144,149]. An important methodological point is the duration over which studies are conducted. As Williams notes, some spiritual activities such as prayer, meditation and yoga produce relatively immediate results on physiological parameters such as blood pressure and heart rate, but others may have significant effects only in the longer term, with short follow-up periods and retrospective or cross-sectional studies likely to miss such effects.

Sloan and associates [150] have previously cautioned that confounding factors such as behavioural and genetic differences and stratification variables such as age, sex, education, ethnicity, socioeconomic status and health status all have an important role in the association between religion and health and that failure to control for these factors can lead to a biased estimation of this association. As they point out, multivariate methods allow estimation of the magnitude of the association between religious
variables and health while controlling for the effects of other variables, but use of these methods requires a complete presentation of the results and at the very least the coefficients and corresponding confidence intervals for all the variables in the statistical model, without which the given studies are incomplete and may well be misleading.

Measures and measurement of the effect of spiritual and religious care

Davidson [112] is surely correct to stress that, as we move forward, it is essential that future studies of spiritual care incorporate rigorous biological measures to determine the relation between caregiver characteristics and clinician–patient interaction and direct biological measures that are relevant to disease outcome. As he says, such mechanistic studies will help the wider biomedical community to understand and appreciate the importance of spiritual qualities in clinical care. Certainly, there are now multi-dimensional indicators of religion and spirituality with good psychometric properties [151,152], but more need to be developed and this is yet another area for urgent study.

These observations make clear therefore the need for more systematic research to address how a broader range of indicators of health practices, belief systems, role identity, the clergy, social support and other social and psychological resources may mediate the relationship between religious involvement and health [124,145]. There are also to be considered the biological effects of religion and spirituality, which go beyond the well-documented effects on and simple indices of blood pressure and involve more complex systems such as the central nervous system, metabolic parameters and the immune system [124,138]. Williams [146] equally feels that, while the effects of religion and spirituality in providing a sense of meaning and purpose in life are well recognized, they have not been systematically investigated and are worthy of significantly greater research attention. For Williams, a major challenge for the ongoing research agenda is in the definition and measurement of spirituality as distinct from religion [141]. This research is of central and clear importance. Shahabi and colleagues [153] for example, in a national survey in the USA, were able to observe a considerable overlap between the two concepts such that 52% of Americans surveyed rated themselves as religious and spiritual, 10% as spiritual only, 9% as religious only and 29% as neither religious nor spiritual.

Finally, Williams [146] argues for more diversity in terms of religious orientation and geography within the research agenda, noting that the greatest volume of research on spirituality and health has focused on US populations with strong Judeo-Christian religious affiliations. He argues that despite the challenges inherent in such research, there is a need to perform cross-cultural comparisons of the associations between religion, spirituality and health in order to test the generalizability of current findings [124,138,144,145]. Equally important will be studies investigating the association between religion, spirituality and health across different socioeconomic groups because population level analyses may mask significant heterogeneity within the population [154].

Assessments and interventions

Certainly, and as D’Souza [119] points out, in patients’ interactions with clinicians they do not cease to be human beings with deep and wide ranging needs and it is often in times of illness, crisis and transition that life, death and other spiritual matters loom all the more strongly in a patient’s consciousness. The recognition of the patient’s spiritual concerns could therefore, as D’Souza says, be seen as an essential component of the patient-centred medicine that is increasingly regarded to be foundational to high quality care [119,155].

So, how can spiritual and religious considerations inform clinical practice? Numerous authors have advanced particular methodological approaches, suggesting them useful. D’Souza [156], for example, suggests the taking of a spiritual history and a consensus panel of the American College of Physicians has, some 10 years ago, suggested the questions that might form the basis of the history taking: (i) Is faith (religion/spirituality) important to you? (ii) Has faith been important to you at other times in your life? (iii) Do you have someone to talk to about religious; and (iv) Would you like to explore religious, spiritual matters with someone? [157]. Other authors have indicated that the taking of a spiritual history may represent a powerful intervention in itself [158], not least because patients with strongly held religious and spiritual beliefs frequently appreciate a clinician’s sensitivity to their belief systems. As D’Souza [119] rightly says, by ensuring the inclusion of such considerations into the initial history taking and through the whole episode of care, doctors and clinicians can demonstrate to patients their concern with the whole person, a message that enhances the doctor–patient relationship and that may increase the therapeutic impact of an intervention and enhance positive well-being [159]. He is at the same time clear, however, that doctors and clinicians should not ‘prescribe’ religious beliefs or activities for health reasons. Neither should they, he maintains, impose their own religious or spiritual beliefs on patients or initiate prayer without knowledge of the patient’s religious background or without having established first whether the patient would appreciate such activity. Neither, again, he maintains, should doctors provide in-depth spiritual counselling to patients, a function that he sees as best exercised by trained and experienced clergy.

Puchalski [160] sees spirituality as ‘that which allows a person to experience transcendent meaning in life . . . often expressed as a relationship with God, but it can also be about nature, art, music, family or community – whatever beliefs give a person a sense of meaning and purpose in life’, providing a further definition of spirituality to those already discussed. In formally assessing patients’ needs, she notes that the typical questions in dealing with patients who hold these values will include: ‘What gives my life meaning?’; ‘Why is this thing happening to me?’; ‘How will I survive this loss?’; and ‘What will happen to me when life ends?’. For Puchalski [160], medicine – now led by science – has neglected a lot of the non-technical aspects of clinical practice. She is convinced that the spiritual assessment ‘reclaims or brings us back to those compassionate, care-giving roots of the patient–doctor relationship’. Doctors, she goes on, are so burdened by time constraints, stress and the enormous amount of technical knowledge that must be learned, that they leave medical school not very well trained to communicate with patients about such things as non-physical suffering or end-of-life decisions.

Evidence, mainly in the form of satisfaction surveys and qualitative interviews, indicates that patients are highly dissatisfied with not being able to form a warm and caring relationship with their doctors and that they are discontented with doctors who walk to
the bottom of the bed, focus on medications and vital signs and then leave. Puchalski [160] reports the spiritual assessment as being transformative of the doctor–patient relationship, observing its power to establish a certain level of intimacy in terms of being able to understand who the patient is at a much deeper level. That is to say, the superficial clinical association of the doctor and patient becomes a relationship between the person of the doctor and the person of the patient. Tournier would thoroughly have approved.

Differentiating between psychosocial assessments and spiritual assessments of the patient, Puchalski [160] compares and contrasts the typical elements of these quite separate types of consultations. Questions emblematic of the psychosocial assessment such as: ‘How are you coping with this illness?’; ‘What are the stresses in your life?’; ‘Are you fearful about dying?’; ‘Do you have any fears for the future?’; and ‘How do you think your family is coping with all of this?’ are either replaced or more commonly augmented with questions such as: ‘Do you have feelings of despair?’; ‘Are you searching for meaning and purpose?’; and ‘Do you believe in God and/or an afterlife?’. Patient need, Puchalski feels, ‘permission’ to talk about these things, so that without some sort of signal from the doctor, they may feel that to make their religious or spiritual needs clear is somehow not appropriate or welcome. Once a doctor starts engaging in these conversations with patients, Puchalski [160] asserts, he or she immediately becomes aware of that aspect inside him or herself, becoming a more open and compassionate doctor as a result. Patients, in turn, respond to this, becoming more open and trusting, with these conversations about purpose and meaning touching that part of the doctor that made him or her want to be a doctor in the first place. As Puchalski [160] says: ‘I think we need to get a little bit more analytical, even though I resist being analytical about spirituality because I think some things just can’t be measured, I really do . . . You can measure denomination, you can measure church/temple/mosque attendance, but certainly the intensity of a person’s own spirituality, I think, is very difficult to measure. I think that’s one of the things people are having trouble with’. Puchalski’s methodology for the taking of a spiritual history is well known and is in use today as well as having formed the basis of other techniques [161].

**The need for an integrative approach**

What do considerations of spirituality and religion in medicine indicate? Interestingly, the disintegration of mind, body and spirit by Western Medicine over the last 100 years or so into body/mind and soul/spirit is now increasingly challenged as clinicians rediscover their functional interrelationship, an interrelationship never disputed or modified by, for example, Eastern traditions [162]. This dichotomy can be seen also in the common conception of science as ‘cold and unfeeling’ and the humanities as ‘warm-hearted and well-intentioned’. But as D’Souza emphasizes, both science and humanities can be united in an approach that deepens our understanding of human health and well-being [119,159]. Drawing on Gordon’s writings [163], D’Souza is clear that an approach that integrates multiple perspectives – biomedical, spiritual, philosophical and sociological – can help clinicians develop insight into the relationship between patients, doctors and the health care system, thereby enhancing their capacity to cure, relieve and comfort patients. If we keep patients’ beliefs and spiritual/religious needs separate from their care, we may cure the disease but not heal the person, thereby antagonizing our intention from the start, which was to return the whole person to health wherever possible. Moreover, the treatment of the body in isolation from the mind and/or spirit may well interfere with healing, leaving the patient’s recovery incomplete and, potentially, predisposed to relapse or subsequent illness [119,159,164–166].

Also of considerable significance are the increasing numbers of studies, which indicate that taking religious belief and spirituality into account enhances the effectiveness of other therapies. See, for example, cognitive behavioural therapy (CBT) [166,167], such that spirituality augmented CBT applied in patients who rated spirituality as ‘important’ or ‘very important’, can prove more effective in terms of clinical outcome than non-spiritually augmented CBT, as shown by well-designed randomized controlled trials. Intuitively, one might hypothesize that similar effects might not be confined to psychiatry, but may well be present across a range of other conditions and diseases and, indeed, preliminary research certainly indicates that they may well be. Such observations indicate the need for urgent research. If, however, such benefits were to be convincingly demonstrated by well-conducted research, to be avoided would be the development of a school of thought in medicine, which would view religious/spiritual care as nothing more than as clinical intervention to be employed alongside pharmacotherapy or surgery, simply because it has been shown to ‘work’. This would be an almost cynical appropriation of religion and spirituality, degrading them into simple means to overall medical ends [168]. The life of the spirit is not so easily minimized.

This emphasis on religious faith and spirituality, which are often highly important values for patients and on which Medicine of the Person with its insistence on the uniqueness of the individual is founded, illustrates an immediate conflict with the empiricism, scientism and standardization implicit within ‘evidence-based medicine’. Recent utterances by the EBM community have admitted great difficulty in integrating patient values and preferences into clinical decisions, finding the matter ‘vexing’ [169–176] and illustrate the tensions, which continue to exist within debates on the most appropriate models of modern medical practice. Scheurich [177] has noted as much and agrees that medical practice has become a ‘fairly positivistic and soulless discipline overall’ in recent years and that it should neither exalt nor demean religious belief, but rather situate it among the countless values people may hold. He is clear that we are learning or perhaps more accurately re-learning what medicine has forgotten in a century of empiricism – that illness is closely bound to any number of significant values, which may or may not involve spirituality and/or religious faith.  

**Conclusion**

What, then, does this brief review of the literature on spirituality, religion and medicine tell us about the relevance of Paul Tournier’s Medicine of the Person for contemporary medical practice today? During Tournier’s lifetime, values and ethics contributed little to person-centred care, with the then nascent discipline of medical ethics being a rather paternalistic field of study preoccupied with codes of professional conduct and seemingly little else. Certainly, this is no longer the case and ethics now occupies a central place, along with other sources of knowledge and reasoning, in the develop-
opment and regulation of reflective practitioners, notwithstanding objections to ethicists’ often ‘over-intellectualist’ and ‘impersonal’ formulations [178]. These, as Cox and his colleagues point out, have perhaps diminished in recent years as enthusiasm for narrative ethics, virtue ethics and feminist ethics, for example, has grown rapidly, bringing to bear on clinical practice their much more developed emphasis on context, on character and on the importance of emotional as well as intellectual factors when dealing with the individual person who is ill [179]. Not that ethics alone have transformed the doctor–patient relationship. The establishment of health economics as a definitive academic subject and the rise of decision theory have had equally substantial effects in this context but are, as Cox and associates point out, essentially impersonal in nature and thus antithetical in approaches to care that make the patient and his doctor central to the healing process and in which value-based practice plays a pivotal role [14,180].

Making the patient’s values central to the doctor–patient encounter is foundational to Tournier’s Medicine of the Person, but for Cox and colleagues, developments in ethics and value theory, although entirely compatible with and complimentary to the faith traditions in Medicine, are no substitute for them. Tournier, of course, worked within a predominantly Christian context and his faith informed essentially everything he did. Modern health services are delivered within a multicultural, multi-faith context and this has led many colleagues to attempt to ‘collapse’ theology into psychological language and to ‘collapse’ spiritual guidance into so-called non-directive counselling as the volume discusses (p. 22). Such approaches are contrary to the philosophy of Medicine of the Person given the tenet that Theology has critical lessons to teach individuals, which lessons are of clear relevance to their care and cure. Consider here, for example, the distinction between the experience of guilt as a manifestation of a psychological pathology and guilt experienced by an individual as part of what it is to be human and thus morally aware [21]. Tournier’s respect for the richness and diversity of other cultures is well documented, but little in Cox et al.’s volume indicates how Medicine of the Person can be practised transculturally to powerful and enriching effect within the non-Christian traditions that populate our increasingly multicultural society. Medicine of the Person, then, is a tool, a resource, an approach to an almost absolute personalization of care that can be utilized if the patient desires it and reserved if he does not. Clearly, it cannot be employed ethically outside of such proper constraints. At no juncture do the editors of the volume or the individual chapter authors argue for any form of paternalistic imposition of what remains, largely, a philosophy of care, rather than an intervention that has been tested by multicentre studies employing a variety of methods of outcome characterization and measurement. Such observations argue for the need for formal evaluation of the power of this technique, much as have been performed, for example, for cognitive behavioural therapy.

Medicine of the Person does return us, though, to the debates on holistic approaches to care that acknowledge the complex in medicine and health care systems [69], versus those that continue to be content with more reductionist formulations. For this reason, many readers, and very particularly those colleagues who favour attempted simplifications of complex problems in medicine through appeal to reductionist concepts such as evidence-based medicine [52–69], may regard arguments for the central place of faith, spirituality and wholeness of persons as equally relevant as the science base in the making of clinical decisions, as either completely irrelevant to modern clinical practice or dangerously partisan. In my own view, Cox and his colleagues have, through placing Tournier’s historical and foundational philosophies within a contemporary health care context, demonstrated how absurd such contentions are. Indeed, a plethora of well-conducted studies that describe patients’ expectations of conventional health services as well as investigations that have shown an enormous increase in the popularity of Integrated(ive) Medicine and other systems for the introduction of holism in medicine, clearly demonstrate what it is that patients now seek from the clinical professions and it is not simply an assurance that their medications have been shown by certain methodologically limited epidemiological study designs to have an effect size statistically significantly greater than placebo. Patients desire personalized medical services delivered compassionately by a caring doctor with whom they have established a trusting, personal relationship through the mechanism of the consultation and which consultation takes full, not cursory, account of their personal values, which often includes their spirituality and religious faith, in the provision of advice and the making of decisions. When compared with this model of clinical practice, EBM-type approaches to medical care are revealed as deeply deficient and not just from an epistemological and ethical position, but very importantly, from a humanistic one also. The accomplished doctor will recognize this – and practise accordingly.

It would be a very significant mistake for any clinician to pay lip service to such notions in the mistaken view that it is a ‘politically correct’ imperative to acknowledge the role of such holism in modern approaches to care, while stepping back from implementing them within his own practice. Clinicians would similarly err if they engaged in attempts to accept these holistic philosophies in general terms, while marginalizing the value of them through suggestions that their place in medical care is limited to such specialties as Psychiatry, Palliative Medicine and Primary Care, for example, rather than acknowledging the case for a more universal applicability in the care of patients. While opinions on these matters will inevitably differ as a function of the ongoing debate on the adequacy of current health services, it is incontrovertible that a human individual is infinitely greater in complexity than the disease or condition that he has presented with. The patient must therefore be treated as such. Medicine, and the other clinical professions which have followed it in becoming seduced by ‘biomedicalism’, would do well to stop, reflect and reintegrate much of the ‘art’ into their practice that has become lost during the last 100 years or so over which medicine has seen a major development in its science base. We must remember that medicine is most categorically not a science. Rather, it is primarily a practice which employs science. It must employ art too and yoke science and art together, if it is to provide a medicine for the whole person [2–4].

As religious faith and practice diminish in some sections of Society, but increase in others, should clinicians respond to this time of change in beliefs and values by saying to their patients who request spiritual and religious care, in the manner of Alastair Campbell when questioned about British former Prime Minister Tony Blair’s faith: ‘we don’t do God’ [181] and relegate these functions to the nearest priest or chaplain in a rather formulaic and compartmentalized manner? I think not, although the role of the chaplain remains pivotal, especially in complex cases. The General
Medical Council of the UK, for example, explicitly recognizes the importance of a patient’s spiritual beliefs in helping him to cope with illness [182], whereas the UK Department of Health has warned that disciplinary action could be taken against any member of staff discussing prayer with patients if ‘non-religious people and those from other religions or beliefs could feel harassed and intimidated by this behaviour’ [183]. Certainly, vigorous debate on the role of the clinician in providing spiritual and religious care, continues. Puchalski [184], Post [185] and Karff [186], writing very recently in Virtual Mentor in October 2009, continue to insist on the importance of spiritual and religious care within the relationship-centred model of health care, but within ethical constraints and observing professional boundaries, having suggested previously in Post et al.’s case that ‘the lack of appropriate clinical spiritual referrals can constitute a form of negligence’ [187]. Other writers, notably Sloan [188] continue to insist that claims for the benefits and practice of spiritual and religious care are ‘substantially exaggerated’ because: (i) the evidence of a connection between religious devotion and better health is weak and difficult to interpret; (ii) there is too little time in clinical practice to take on religious matters; (iii) doctors are not trained to do so; and (iv) doing so raises significant, unresolved ethical issues, so that the best approach for doctors is to respectfully note patients’ interests, religions or otherwise, and move on’ [188]. Readers may be forgiven for finding Post and colleagues’ intimacy of negligence somewhat provocative and Sloan’s position both dismissive and nihilistic.

A note of common sense in the ongoing debate has been sounded, perhaps, by Hamish Meldrum, Chairman of Council of the British Medical Association, whose view is that it is perfectly acceptable to ask a patient if he would like access to a chaplain and then to deal with any issues that arise out of any conversation that might then develop [189]. However, a call to allow doctors to discuss spiritual matters with consenting patients was recently rejected by the 2009 Annual Representatives meeting of the British Medical Association [189]. This is, however, a debate that by its nature will not easily be extinguished. Questions relating to patient demands for spiritual and religious care and the freedom of clinicians to practise a holistic approach to care that therefore involves spiritual care, as well as questions that relate to the value and appropriateness of ministers of religion becoming an integral part of the multidisciplinary team and ward round, need to be squarely addressed and not suppressed, however, uncomfortable that discourse may prove to secular colleagues and secular institutions.

Before concluding, I have some general criticisms of Cox and colleagues’ volume. There is more than one example of repetition between chapters in the book, particularly where individual authors discuss Tournier’s character and behaviours. These repetitions do not distract the reader unduly, but they could easily have been excised by more rigorous editing. An approach to editing such as this could also have called upon Conway, the author of Chapter 5, to restructure his contribution in a way which would have facilitated a smooth passage of the reader from Chapter 4 to Chapter 6, rather than risking an interruption of flow. Also, the fourteen constituent chapters of Cox et al.’s volume are of variable quality, some referring directly to Tournier’s philosophies, some tangentially to them and some not referring to them directly at all in variance, perhaps, to the original editorial commission. This gives the reader the impression of a set of works trying to achieve cohesion into a unified whole, but in the final analysis failing, perhaps, to do so, with a sense of loose connection between individual works prevailing, rather than a sense of strong interrelationship.

These quibbles apart, Medicine of the Person by John Cox, Alastair Campbell and Bill Fulford is certainly to be recommended as essential reading for any clinician who wishes to develop and refine his practice on the basis of an understanding that the ‘whole is greater than the sum of its parts’. This is not a quote from Cox and his co-editors, but rather a central component of philosophy as taught by Aristotle and recognized as foundational relevant in medicine not least by Osler [190]. The time has come for well-grounded philosophies such as Medicine of the Person to contribute actively to the debate on what really does constitute optimal clinical practice in our modern times and for clinicians to give such philosophies the serious consideration that they incontrovertibly merit.

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Acknowledgements

The author thanks Mr Francesco Scordamaglia of the Professorial Unit for excellent administrative assistance in the preparation of this manuscript.

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