Editorial

Healing in modern medicine

Aparna Sajja[1], Christina Puchalski[2]

[1]The George Washington University School of Medicine and Health Sciences, Washington, DC, USA; [2]George Washington Institute for Spirituality and Health, The George Washington University School of Medicine and Health Sciences, Washington, DC, USA

Correspondence to: Christina Puchalski. Professor of Medicine and Health Science Director of The George Washington University's Institute for Spirituality and Health, The George Washington University School of Medicine and Health Sciences, Washington, DC. USA. Email: cpuchals@gwu.edu.

Submitted Jun 01, 2017. Accepted for publication Jun 05, 2017.
doi: 10.21037/apm.2017.06.18
View this article at: http://dx.doi.org/10.21037/apm.2017.06.18

The practice of modern medicine has followed the tradition of Cartesian reductionism, which clings to probabilities and material certainties, and invests in genes and molecules. This science treats the body as a biochemical machine and physicians as specialized technicians who can repair the machine (1). While there have certainly been monumental advances in the medical field as a result of this tradition, it comes at the cost of abandoning *healing* the ill patient, particularly when physical cure is not possible. In this era of "personalized" medicine, health care has increasingly become depersonalized. Why should we care? Per the 2012 CDC report, half of all adults (117 million people) had one or more chronic health conditions. One in four had two or more chronic health conditions. These numbers will continue to increase as the field of medicine progresses and our population ages. With more patients suffering longer with chronic illnesses, it will become more urgent to revive medicine's goals of healing and relief of suffering.

Undoubtedly there is confusion and skepticism regarding the role of healing in medicine. Medicine offers no definition for healing, nor does it attempt to, as it does so for science (2). Egnew noted that there is no single Medline search mesh heading for healing; the majority of papers are on physical and technical aspects of healing (3). Only recently there has been an increase in articles on spirituality and its role in healing within traditional medicine paradigms. Nonetheless, these still contain qualifiers related to psychology and alternative medicine. This seems to suggest that modern medicine considers healing beyond its domain, leaving the task of healing to alternative or shamanistic medicine (3).

What is interesting, however, is that for centuries spirituality and health have been closely linked as evidenced by the roles of healers such as priests and shamans. Hospitals in the United States were founded by religious orders and organizations in part to meet the diverse cultural and spiritual needs of immigrants in this country. These religious hospitals emphasized health and healing and called on clinicians to practice altruistic, compassionate care. However, in 1920 the Flexner report emphasized the need for medical education to have a greater foundation in a scientific and evidence based approach (4). Some say that in the 19th century people became disillusioned with religion as they still were ill and died. Hence the turn to science.

While this grounding in science was critical and resulted in tremendous advances in medicine, it resulted in a de-emphasis on spirituality and even humanistic approach to care. In the mid to late 20th century there was a greater outcry from the public for more holistic and religious approaches to care to be re-integrated into medicine. This has led to the development of research and an educational model and field in spirituality and health (5).

Today people still suffer from illness—and will continue to do so for the eternity of humanity. Science has not cured all illnesses and suffering. People are turning to a variety of healing practices—shamanistic healing rituals, prayer, and meditation (6). Perhaps this is reflective of society's desire for something deeper that can heal, provide meaning and coherence—even in the midst of suffering. National data shows that in 2007 about 38% of U.S. adults (about 2 in 5) used some form of alternative medicine. More astonishing is the number of annual visits to providers of alternative medicine exceeded the number of visits to all primary care physicians, even in the 1990s (7,8). These numbers can be interpreted as a growing discontent with the technologically-oriented health care system or a search

for care not provided by the contemporary clinician (9).

Within conventional medicine, Palliative Medicine gained special recognition in 2006 by the American Board of Medical Specialties. The principles of Palliative Medicine are rooted in the distinction between curing and healing. Curing refers to treating a physical illness, while healing refers to the inner sense of peace, coherence, and purpose the patient finds even in the midst of an incurable condition. Palliative Medicine includes spiritual, existential, and religious issues as required domains of care (10). Models and tools have been developed in which suffering or spiritual and psychosocial distress are identified and treated alongside physical pain (11). These models are based on the initial description of hospice and palliative medicine by Saunders as the care of the "total pain" of the patient—physical, psychosocial and spiritual—what is now referred to at the biopsychosocial and spiritual model of care (12,13). In 2004 Huber and her colleagues in Europe proposed a newer definition of health from the 1947 WHO definition: "health is the ability to adapt and to self-manage" (14). This recognizes an individual's ability to cope with chronic illness and be healthy even with the presence of ongoing chronic illness or conditions. Independent of Palliative Medicine, Huber and her colleagues also described the spiritual domain as an essential domain in this definition of health. This domain refers to the ability of people to achieve individual fulfillment, meaning, and purpose (14).

To heal means "to make sound or whole" and stems from the root, *baelan*, which refers to the condition or state of being *bal*, whole (3). According to Cassel, wholeness has to do with one's relationship to self, body, and amongst others. Illness threatens most notions of what it means to be oneself—and this generates suffering (15). Suffering can include pain but at its core is different from pain. Pain can be reducible to a neurophysiological phenomenon; however, suffering has to do with the patient's experience. Suffering comes from the awareness that one's familiar way of being in the world is now threatened, reflecting insecurities about one's integrity of person-hood, feelings of helplessness and alienation from society. While confronting, existential loneliness is an inevitable and inescapable part of human life (16), it is strange that in illness "we are brought home to a heightened awareness of the body, but it is a body in which we are *no longer home*" (17). What is interesting is although illness is an immensely isolating and disconcerting experience, the nature of the human suffering is not solitary—it is an often-forgotten universal experience.

Abraham Heschel, a Jewish philosopher and theologian, once said "to heal a person, one must first be a person" (18). If physicians are dedicated to the task of healing patients, they must at least *attempt* to understand how illness affects patients as spiritual individuals struggling with metaphysical questions. In order to do this, physicians themselves must truthfully contemplate these transcendent questions and reflect on what it means for medicine to be a spiritual practice (19). The fact that physicians are confronted with the existential dimension of illness and loneliness in every patient encounter—and tend to ignore it—makes it an even more pressing topic for discussion. Rather than flee from the expressions of lonely uncertainty and vulnerability in our patients and in ourselves, or better yet suppress these with medications, we should embrace them. Only when we acknowledge the loneliness of our shared existence, are we able to share our deepest humanity.

The healing relationship is thus characterized by reciprocity, in which both doctor and patient move each other to recognize what lies deep within each other. The role of a physician requires shifting from achiever to guider and expert fixer to companion (3). Authority becomes genuine caring, which makes way for relief of suffering and healing. This involves relinquishing the ego's need to control ("learning to fall") —something that is arguably difficult for physicians (20). Healing differs from curing in that it is nurtured by acceptance. This acceptance is not a passive submission, but an active appreciation of reality kindled by hope, the lantern of the human spirit. The roots of hope grow deeper than those of a mere wish, reflecting peace within reality and solace within personal meaning. Healing has been defined on many accounts as the transcendence of suffering (3,19,21), where suffering relates to the *meaning* patients ascribe to their illness experience. Incorporating the search for purpose and connection, it is conveyed as a personal narrative. When we analyze what healers do in traditional cultures, we see that they help people live with and formulate meaning from their experience of illness (3). According to Viktor Frankl, the fundamental human quest is not for prestige, fame, or fortune, but it is the *search for meaning* (22). He states that we find meaning in five domains: things created or accomplished, things left as a legacy, things believed in, things loved, and finally the experience of suffering itself. Frankl puts it very aptly, "suffering ceases to be suffering in the same way once it finds a meaning" (22). This makes sense when we observe that people suffer most when they

have stripped themselves of meaning in relation to the world.

Sharing suffering through narrative creates meaning. When given this space, patients can re-contextualize their life narratives with added purpose to accept, and in so transcend, suffering. Even though it is ultimately the patient's onus, the physician can help in this process by partaking in conversation regarding the nature of the patient's *dukkha* (that which is an untranslatable emptiness, suffering, by Sanskrit and Buddhist texts). Modern medicine does not train physicians as healers. We are taught to minimize storytelling in favor of eliciting the relevant HPI and often ruthlessly interrupting tangents to support efficiency. However, only when physicians have the narrative skills to recognize medicine's ideals can they serve up to their profession. Indispensable to the art of healing is narration—listening deeply and with care to the patient's story and accompanying the patient in discovering a new meaning in it. Engaging in a patient's narrative traverses unquantifiable truths: the heart-wrenching sense of loss of freedom among the elderly, the solitude of death, and the despondence of those with terminal illness—all of which the physician has a duty to acknowledge and alleviate. According to Broyard, what a sick man hopes most from people, "is not love but an appreciative critical grasp of his situation, what is known now in the literature of illness as 'empathetic witnessing'" (23). When this is neglected, as often seen in "evidence-based medicine," patients feel abandoned, holding tremendous repercussions for the integrity of our profession.

Most would agree that medicine is the most fragile form of applied science, but would hedge in calling it a spiritual practice (18). Within the essence of the word healing lies *hal*, which is the root of "holy," or "spiritually pure" (2). Spirituality may be defined as one's relationship with the transcendent, where transcendence refers to "extending or lying beyond the limits of ordinary experience" (23). Spirituality is expressed at three levels—to the self, to others, and to ultimate meaning (whether this be God, the nameless, and/or the cosmos). It is an inseparable aspect of healing and, truly, humanity. To be human is necessarily to be spiritual, whether an individual is religious or not. Regardless of who we are, our time on earth includes the experiences of illness and death; suffering is intrinsic to human experience. It is most often amidst illness that we yearn to comprehend the infiniteness and finiteness of life, and ask spiritual questions—does my life have meaning and purpose? Why am I suffering? How can I be hopeful?

There is a deep curiosity for the spiritual these days—as noted by Dr. Sulmasy, Bioethics scholar and expert, as evidenced by the growing interest in self-help books, yoga classes, and therapy. Why? Sulmasy sees it as a reaction to a sense of meaninglessness. Life has lost its purpose and direction. He also posits that perhaps it is a result of the growing uneasiness that we are sliding into a moral abyss, becoming culprits to our own scientific prowess—and, ultimately, our health care crisis is a spiritual problem (18). Care is becoming increasingly divorced from health; and medicine, once a healing profession, is slowly dissolving its art. Sadly, modern medicine has no well-efforted model for healing or what it means to be whole as a person. Inevitably when such a discussion arises, it is quickly deemed outside its realm—more fitting of "holistic" medicine, carrying undertones of pseudoscience or perhaps psychiatry if generous. However, healing is simply not conflatable to psychological well-being or mental health—it involves a sense of historical continuity and connection to the sacred.

Modern medicine is an object, fundamentally distant to the nature of humanity because it lends to the idea that the spiritual component may be at most complementary, certainly not legitimate healthcare. Medicine these days stakes legitimacy through its scientific approach.

Science has allowed physicians to intercede heroically in the course of disease. While medicine has mastered acute illness, it struggles with the growing burden of chronic disease—arthritis, cardiovascular ailments, cancer, diabetes, and neurological impairments. Physicians, trained as scientists, focus on diagnosis, treatment, and prevention. In doing so, cure and not care, has become the primary outcome. However, healing is a process with implications for search for meaning and purpose, not simply measurable outcomes. Egnew mentions a time when physicians had little to offer patients except the strength of their soul and personality (3). Not every patient can be cured and by learning to accompany them on their journey, the doctor can rediscover meaning in his or her own work. It is an invitation for physicians to reflect on their own ethos and personal development. In re-empowering the physician as healer, the doctor will inadvertently become a recipient of healing—coming to face with his or her own vulnerabilities and engaging in self-exploration.

With advances in medical science, values have given way to technology. This growing tide of consumerism and commoditization of healthcare has turned physicians

into providers, patients into customers, and medicine a byproduct (8). The result? Health care is like any other industry, where the principle virtue is no longer a virtue. We are removing compassion and empathy for efficiency. As Sulmasy so aptly points out, medicine has become a system where parts are interchangeable and any patient can see any physician about any problem in any place at any time (18). In this kind of industrial setting, where patient visits have been reduced to 10 minutes, it becomes impossible to formulate questions regarding meaning.

Medicine can no longer be an industrial practice that tells the story of our cells nor can it be replaced with a nomadic revivalism. Instead what we need is a paradigm that will reconcile both into a practice that is intrinsically a virtuous endeavor. Healing requires that we re-examine our values of human interdependence and compassion rather than buttress expressions of competition and self-interest. In the face of uncertainty, we often lose sight of what should be certain about—virtues like wisdom, patience, and truthfulness. Medicine must heal through our gentlest form of humanness laden with honesty, courage, and presence and not through a blind pursuit of attaining perfection. Many physicians may argue that investing in healing during an era focused on maximizing efficiency and tangible outcomes is a fool's task (24). Yet the calling to become pilgrims on this path of "foolishness"—accompanying our patients in the midst of their suffering—has never been stronger. We must hear it in order to preserve medicine's highest ideals and renew our humanity.

Acknowledgements

None.

Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

References

1. Scott JG, Scott RG, Miller WL, et al. Healing relationships and the existential philosophy of Martin Buber. Philosophy, Ethics, and Humanities in Medicine 2009;4:11.
2. Egnew TR. Suffering, meaning, and healing: challenges of contemporary medicine. Ann Fam Med 2009;7:170-5.
3. Egnew TR. The meaning of healing: transcending suffering. Ann Fam Med 2005;3:255-62.
4. Flexner A. Medical education in the United States and Canada. Bull World Health Organ 2002;80:594-602.
5. Puchalski CM, Blatt B, Kogan M, et al. Spirituality and health: the development of a field. Acad Med 2014;89:10-6.
6. Gallup G. Spiritual beliefs and the dying process: a report on a national survey. Conducted for the Nathan Cummings Foundation and the Fetzer Institute 1997.
7. Eisenberg DM, Kessler RC, Foster C, et al. Unconventional medicine in the United States--prevalence, costs, and patterns of use. N Engl J Med 1993;328:246-52.
8. Lown B. The commodification of health care. Chicago: Physicians for a National Health Program Newsletter, 2007.
9. Astin JA. Why patients use alternative medicine: results of a national study. JAMA 1998;279:1548-53.
10. World Health Organization. Strengthening of palliative care as a component of comprehensive care throughout the life course. World Health Organization, Geneva, Switzerland) 2014. Available online: http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R19-en.pdf
11. Puchalski C, Ferrell B, Virani R, et al. Improving the quality of spiritual care as a dimension of palliative care: the report of the consensus conference. J Palliat Med 2009;12:885-904.
12. Sulmasy DP. A biopsychosocial-spiritual model for the care of patients at the end of life. Gerontologist 2002;42:24-33.
13. Saunders C. Care of the dying-4. Control of pain in terminal cancer. Nurs Times 1976;72:1133-5.
14. Huber M, Knottnerus JA, Green L, et al. How should we define health? 2011;343:d4163.
15. Cassel EJ. The nature of suffering and the goals of medicine. N Engl J Med 1982;306:639-45.
16. Tillich P. The eternal now. McGraw-Hill, 1959.
17. Leder D. Illness and Exile: Sophocles' Philoctetes. Lit Med 1990;9:1-11.
18. Sulmasy DP. The rebirth of the clinic: an introduction to spirituality in health care. Washington, DC: Georgetown University Press, 2006.
19. Puchalski CM. A time for listening and caring: Spirituality and the care of the chronically ill and dying. USA: Oxford University Press, 2006.
20. Simmons P. Learning to fall: The blessings of an imperfect life. Bantam, 2003.
21. Puchalski CM. The role of spirituality in health care.

Proceedings (Baylor University.Medical Center) 2001;14:352.
22. Frankl VE. Man's search for meaning. Simon and Schuster, 1985.
23. Broyard A. Intoxicated by my illness: and other writings on life and death. 1992.
24. Ventres WB. Healing. Ann Fam Med 2016;14:76-8.

Cite this article as: Sajja A, Puchalski C. Healing in modern medicine. Ann Palliat Med 2017;6(3):206-210. doi: 10.21037/apm.2017.06.18

