Galway-Mayo Institute of Technology
Department of Humanities

The Alleviation of Pain and Suffering: Moving Beyond the Medical Model

Maura Mhic Iomhair

A Dissertation Submitted to the Department of Humanities
For a Master's Degree in Humanities

Supervisor: Rev. Eugene Duffy, D.D.
Western Theological Institute, Galway.

2005

Abbreviations:

CAM	Complementary and Alternative Medicine
EBM	Evidence Based Medicine
ECG	Electrocardiographs
EFIC	European Federation of IASP members
IHF	Irish Hospice Foundation
ICC	Integrated Cancer Care
ICS	Irish Cancer Society
IASP	International Association for the Study of Pain
MRI	Magnetic Resonance Imaging
OHE	Optimal Healing Environment
ORA	Organizational Religions Activity
SAHD	Schedule of Attitudes Towards Hastened Death
SUPPORT	The Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment
WHO	World Health Organization

Acknowledgements

I would like to thank the following for their encouragement and support in the preparation of this thesis: Ms Mary Mac Cague, Head of the Department of Humanities at the Galway-Mayo Institute of Technology, Ms. Pauline Logue-Collins, Dept. of Humanities, Dr. Fidelma Dunne, Department of Medicine, NUIG, Fr. E. Duffy, Western Theological Institute, thesis supervisor, and my husband Sean Mac Iomhair.

Table of Contents

Introduction 1

CHAPTER ONE: PAIN AND SUFFERING IN THE CONTEXT OF THE CURRENT DOMINANT MEDICAL MODEL

1.1	Introduction	13
1.2	A brief history of pain in the context of health care	16
1.3	What is pain? The medical approach	18
1.4	Pain and suffering: definitions and descriptions	25
1.5	The subjective-objective divide	31
1.6	How technology constitutes medical knowledge	34
1.7	The limitations of the scientific method	38
1.8	Evidence based medicine	44
1.9	Conclusions	47

CHAPTER TWO. SCIENTIFIC RESEARCH REGARDING SPIRITUALITY AND HEALING: A HOLISTIC APPROACH

2.1	Introduction	51
2.2	Holistic care	53
2.3	Spirituality and illness	60
2.4	Spirituality and healing	65
2.5	Spirituality illness and hope	71
2.6	Spirituality, clinical practice and scientific studies	78
2.7	Patient-oriented medicine	80
2.8	Challenges to the positive benefits of spirituality in the practice of medicine	85
2.9	Conclusions	90

CHAPTER THREE: THE ALLEVIATION OF PAIN AND SUFFERING: THE HOLISTIC APPROACHES OF SHEILA CASSIDY AND MICHAEL KEARNEY

3.1 Introduction 93
3.2 Sheila Cassidy: a brief biography 99
3.3 Fear and companionship 101
3.4 Pain relief / holistic medicine 103
3.5 An ideal approach to patient care 108
3.6 Encounter with a new patient: establishing a therapeutic relationship 113
3.7 The wounded healer 115
3.8 Michael Kearney: a brief biography 118
3.9 Myth 121
3.10 Story 123
3.11 The hospice movement 126
3.12 Encounters with patients 128
3.13 Guided imagery 130
3.14 Paradigm shift 132
3.15 The medical model 135
3.16 A critique of the works of Cassidy and Kearney 138
3.17 Conclusions 140

CHAPTER FOUR: HOLISTIC MEDICAL PRACTICE IN THE LIGHT OF BUBER'S PHILOSOPHY OF DIALOGUE: THE CLINICAL PRACTICE OF SHEILA CASSIDY AND MICHAEL KEARNEY.

4.1 Introduction 144
4.2 Martin Buber: A brief biography 145
4.3 Martin Buber: A Philosophy of Dialogue, I-Thou, I-It 148
4.4 The narrow ridge and the 'between' 152
4.5 Communication in a life of authentic dialogue 154
4.6 Directness and wholeness, will and grace, and the presence of mutuality 157
4.7 The Eternal Thou 160
4.8 Cassidy's holistic clinical practice, in the light of Martin Buber's philosophy of dialogue 165
4.9 Kearney's work in the light of Martin Buber's philosophy of dialogue 169
4.10 Conclusions 175

CHAPTER FIVE: A THEOLOGICAL FOUNDATION FOR A MODEL OF HOLISTIC MEDICAL CARE, EXPLORING THE CONTRIBUTION OF JOHN PAUL II.

5.1 Introduction 179
5.2 The problems of science are the problems of man 185
5.3 The meaning of suffering 189
5.4 Suffering in the context of salvation and redemption 195
5.5 A Christocentric theology of suffering 200
5.6 Contemporary challenges in healthcare 204
5.7 Developments of biomedical research: a Christian vision 210
5.8 Social responsibility in the context of healthcare 213
5.9 Care of the sick and suffering: the dignity of the human person 218
5.10 Relationships and the civilization of love 222
5.11 Healthcare and society: deliberations and proposals 225
5.12 Conclusions 229

CHAPTER SIX: FINAL CONCLUSIONS 234

Bibliography 245

Abstract

This study arose from a concern for the needs of patients who experience pain and suffering in hospitals or community settings. In this thesis, in attempting to move beyond the current medical model I propose a holistic medical model. The model I suggest compliments, balances and improves upon the current scientific medical approach. I seek to advance the best that scientific and technological advances offer together with a whole-person, patient-oriented emphasis on medical care and healing, particularly in relation to the treatment of pain and suffering. I examine in depth the holistic medical care of two clinical practitioners, Sheila Cassidy and Michael Kearney with a view to locating models of holistic medical care that can be applied across the medical field. I then also provide a philosophical underpinning, for this work in the exploration of the work of Martin Buber, which emphasizes the interpersonal dimensions of holistic medical care. His insights into the interpersonal relationships and dialogue have shown to be of value in the development of a therapeutic relationship between patient and doctor. Through an in-depth examination of the work of John Paul II it became evident that he provides a theological underpinning for an approach to holistic medical care, and a human anthropology which emphasizes the dignity and equality of all human beings at all stages of human life. He also includes a vision for Catholic healthcare rooted in the theological virtues of faith, hope and love. The provision of holistic care for all patients has implications for medical education, expansion of the health services, development of general practice, and the provision of community care for the sick, the elderly, the disabled and the mentally ill.

INTRODUCTION

In this thesis, in attempting to move beyond the current medical model, I propose a holistic medical model. The model I suggest compliments, balances, and improves upon the current scientific medical approach. While attempts to move beyond the dominant medical model are not altogether new, the originality of this work is in the provision of a philosophical and theological foundation for the model proposed. The holistic medical model of care, which I advance, is not an alternative to, but is inclusive of the best theory and practice associated with the current dominant model. I seek to advance the best that scientific and technological advances offer, together with a whole person, patient-oriented emphasis on medical care and healing, particularly in relation to the treatment of pain and suffering. Therefore I seek to identify key elements of a holistic medical model and highlight appropriate recommendations for the way forward.

This study arose from a concern for the needs of patients who experience pain and suffering in hospitals or community settings. This concern has also been voiced by different groups i.e. Irish Hospice Foundation, (IHF) and the Irish Cancer Society (ICS), as well as consultants in palliative care and medical oncology.[1] In a large-scale survey, undertaken by the World Health Organization, on 26,000 patients in five continents 22% of those surveyed, reported suffering persistent pain over the course of the previous year.[2] Irish results from a European survey has shown that more than half a million people in Ireland suffer from chronic pain with serious consequences for society as a whole: absenteeism from work, jobs lost, increasing disability and loss

[1] Health Supplement, *The Irish Times*, 22-07-04, p.1-2
[2] Ibid.

of independent living. This indicates serious deficiencies in the dominant medical model, evidence based medicine (EBM), with respect to the treatment and relief of pain and suffering. A more holistic model, taking into account the needs of the whole patient, may be more beneficial.[3]

My aim in this thesis is to go beyond the current dominant medical model, to provide a more holistic approach, to the treatment of pain and suffering, which would encompass the current medical model and in addition to it, therapies and treatments that would take into account the whole person, social, psychological, and spiritual as well as the physical. In essence I propose a bio-psychosocial approach. Furthermore I propose to examine in depth the holistic medical care of two clinical practitioners, Sheila Cassidy and Michael Kearney with a view to locating models of holistic medical care that can be applied across the medical field. I then also provide a philosophical underpinning for this work, in an exploration of the work of Martin Buber, which emphasizes the interpersonal dimension of holistic medical care. Taking this vision further I will also provide a theological foundation, for same by drawing on the theology of John Paul II. His vision of health care, which transcends the Christian faith is concerned with the universal human experience. His approach to the human person emphasizes the dignity and respect owed to each human being. His compassion for the sick and suffering is evident from his annual letters addressed to them, and he has been outspoken in his criticism of healthcare systems, which do not provide adequate alleviation from pain and suffering. This philosophical and theological underpinning of my vision of a holistic medical model of care is an original dimension.

---

[3] Ibid.

Evidence based medicine (EBM) as a concept has a positivist, biomedical perspective. This is the current dominant medical model. Its focus is on offering clinicians the best available evidence, from randomized clinical trials of groups of patients with the same clinical condition, for the provision of the most adequate treatment in a cognitive-rational manner.[4] An integral part of evidence-based medicine depends on the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice.[5] Through the expertise of clinicians and the availability of up-to-date evidence from research the doctor has at his disposal evidence, which enables him, to arrive at a diagnosis with accuracy and precision. It is clear that doctors need to understand their patients through a scientific knowledge of how the body works and to appreciate of how scientific research can help them to make decisions about the best treatment for their patients.[6] Nevertheless this scientific approach needs to be modified in the clinical situation when dealing with the individual patient. My vision of a holistic medical model concurs very much with MacNaughton's view concerning the importance of a "humane" doctor with the insight, interpretive ability, and ethical sensitivity, to apply scientific evidence and clinical skills, to the individual patient, which might be of benefit to this patient with this particular problem at this point in his/her life.[7] Where the patient is experiencing pain and suffering, the holistic medical model, which I am proposing in this thesis, benefits from a bio-psychosocial approach, which, is appropriate in order to alleviate the distress of pain and suffering.

---

[4] J. Bensing, "Bridging the gap. The separate worlds of evidence-based medicine and patient centred medicine." *Patient Education and Counselling*, 39 (2000) 17-25

[5] D.L. Sackett, "Evidence-based medicine: what it is and what it isin't," *BMJ* , 312 (1996) 71-72.

[6] J. MacNaughton, "The humanities in medical education: context, outcomes and structures" *Journal of Medical Ethics*, 26 (2000) 23-30.

[7] Ibid.

I agree with Cassell when he makes the point that suffering is experienced by persons, not merely by bodies, and has its source in challenges that threaten the intactness of the person as a complex social and psychological entity.[8] Suffering can include physical pain but is by no means limited to it, and the relief of suffering and the cure of disease, must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick. Suffering is personal and medicine is a personal profession, all care rests on that relationship. My belief is that the patient-doctor relationship is pivotal, especially where the alleviation of pain and suffering are concerned. A patient centered style would encompass a genuine dialogue, taking into account the patient's subjective experience, not just a history to establish signs and symptoms of disease, but also to gain an understanding of the patients hopes, fears and expectations, to address a wider psychosocial dimension, in other words to gain and understanding of the patient as a fellow human being, and provide a framework within which an effective consultation can take place.

Observations on the application of the current medical model suggests that the therapeutic power of the doctor-patient relationship is largely untapped, undervalued, or neglected, resulting in the impoverishment of medical care. It is not uncommon for a patient to be undergoing a series of tests, treatments, or cared for by a team of sub-specialists with no physician clearly responsible for the whole problem. Patients find themselves making decisions concerning high technology matters that doctors even have difficulty with. This disregard and derogation of the patient-doctor relationship can be distressing for the patient. Cassell believes that one of the most basic errors of

---

[8] E. J. Cassell, *The nature of suffering and the goals of medicine* (New York: Oxford University Press, 2004) 29-45. See also R.G. Evans, "Patient centred medicine: reason, emotion, and human spirit?" Some philosophical reflections on being with patients," *J Medical Ethics: Medical Humanities* 29 (2003) 8-15.

the modern medicine is to believe that patients cured of their disease are also healed or are whole again.[9] This is not necessarily so, however through an effective doctor-patient relationship, together with insight into the patient's problem and the acceptance of moral responsibility, it is possible to heal the sick, to make whole the cured, and to relieve suffering[10].

Hippocrates's rational approach to the practice of medicine can be seen as the beginnings of the medical model and evidence-based medicine. Hippocratic medicine treats pain and lessens suffering by intervening from without. The effectiveness of Hippocratic medicine is evident in its ability to diagnose and successfully treat pain. This approach can also lessen the distress caused by a patient's suffering, build trust between carer and patient, and help to create a secure space within an experience of chaos. By controlling or containing the pain, Hippocratic medicine helps to restore the status quo, returning the patient to the old order, to life as it was before. It describes how one with knowledge, expertise, and power intervenes to help another. Hippocratic medicine draws on objective evidence. 'Evidence-based medicine' is a contemporary example. The 'evidence' here refers to objective, tangible, and reproducible data and relates to the patient. Hippocratic medicine calls for clinical objectivity and works as an *opus contra naturam*, it also acts on the assumption that pain is only a problem to be solved, neutralized, controlled, or overcome, it measures it's success by how effectively it takes patients out of pain.[11]

---

[9] E. J. Cassell, op.cit.
[10] Ibid.
[11] M. Kearney, *A Place of Healing*, 37.

Hippocratic medicine acts as a link, a bridge and symbol for the need to combine both the experience of traditional, Eastern medicine and the trends of modern, Western medicine. According to Marketos, Hippocratic medicine is one vital pathway to the proper study of the evolution of the medical art.[12] Not only is it the beginning of the art and science of medicine, but modern medicine can still learn from the Hellenic medicine of ancient Greece. Hippocratic medicine is both an antidote to an over-concentration and over emphasis on medical technology and a stimulus to more humane technical achievements. Hippocratic bedside examination has not died, but is pushed aside temporarily by modern technology. The fact that ancient Hellenic medicine was based on the co-existence of both Asclepian (traditional) and Hippocratic (rational) medicine symbolises the necessary co-existence and cooperation of both systems, a synthesis of their concepts being essential to solve the problems threatening the future of humankind. Hellenic medicine serves to highlight that the parallels between Asclepian and Hippocratic medicine are closer than medical historians usually realise, and that alternative medicine may function in a complementary way to conventional primary medical care.[13] This Hippocratic approach, which holds a delicate balance between scientific and holistic approaches to medical care, provides an inspiration for my own thesis.

Ancient people readily understood sickness as a disturbance in relationships.[14] Because these people had a keen sense of the relationship between human beings and between the sick person and the cosmos, the task of the Shaman was to heal by

---

[12] J. MacNaughton, "The humanities in medical education: context, outcomes and structures" *Journal of Medical Ethics*, 26 (2000) 23-30. See also B.G. Charlton, "Holistic medicine or the humane doctor" *British Journal of General Practise* 43 (1993) 475-477.
[13] Ibid.
[14] M. A. Fatula, *Suffering*, in: The New Dictionary of Theology (Dublin: Gill and Macmillan, 1992) 990-992

restoration of right relationship between the sick person and the cosmos, thus healing was a religious act. It consisted in the restoration of right relationships between people and their gods. Where suffering has been described as the disruption of inner harmony,[15] healing in its most basic sense, means the restoration of right relationships, and holistic healthcare means a system of care that attends to all of the disturbed relationships of the ill person as a whole, restoring what can be restored.[16] A holistic approach to healing means the correction of the physiological disturbances the mileau interior, is only the beginning of the task. Holistic healing requires attention to the psychological, social, and spiritual disturbances as well. In 1960 Theilhard de Chardin stated that besides the mileau interior, there is also a milieu divin.[17] This means that at the end-of-life, when the milieu can no longer be restored, spirituality may be heightened, and healing is still possible, and the healing professions still have a role. Spirituality is struggling to find a place in main stream medicine, and contemporary medicine still stands accused of having failed to address the needs of the whole person preferring to limit its attention to the finitude of human bodies.[18] A more comprehensive model of care and research that takes account of the patient in the fullest possible understanding of their wholeness, as grappling with their ultimate finitude, is needed. This may be referred to as a bio-psychosocial-spiritual model of care. To hold together in one and the same medical act both the reductivist scientific truths that are so beneficial and also larger truths about the patient as a human person is the enormous challenge facing healthcare today, and lies at the very heart of my proposed way beyond the current medical model.

---

[15] Ibid.

[16] D.P. Sulmacy, "A biopsychosocial spiritual model for the care of patients at the end-of- life. *The Gerontologist* 42(2002) 24-33.

In the first chapter I will address the question of pain and suffering in the context of the current medical model. A brief history of pain in the context of healthcare will be followed by an exploration of what pain is from a medical approach. I will then define and describe pain and suffering. Next I will show how the objective approach of EBM leaves out the subjective feelings of the patient and how this leads to a subjective-objective divide. Then I will discuss how technology constitutes medical knowledge, and point out the limitations of the scientific approach, and its expression in the current dominant model. I end with an argument in favor of a more holistic medical model in the practice of medicine, which is central to my thesis goal.

Issues of spirituality and health are part of each person's search for truth about self, and the meaning and purpose of life, and now, the scientific world of medicine is beginning to take the spiritual world of faith seriously. In chapter two I provide and in depth account of scientific research regarding spirituality and healing. I explain the necessity to move beyond the medical model in order to meet the needs of patients in the face of pain and suffering. I will be proposing a holistic medical model of care where the current medical model EBM is supplemented by therapies and methods of care, which take account of the whole person. I will be recommending especially a spiritual component, which has been shown by medical research to complement EBM. I propose to demonstrate how medicine and spirituality find common ground for healing and wholeness of life. I will review the association found between religious involvement, spirituality and health related quality of life, ability to endure pain and suffering and enhance healing. Overall I will be promoting a patient oriented, holistic medical model, which will emphasize a viewing of the patient as a

whole person, not as a disease. I will point out the positive relationship found between spirituality and healing and in keeping with the goal of this thesis I hope to present substantial evidence of how the inclusion of a spiritual component in a holistic medical model in the practice of medicine, can be of benefit to patient in coping with illness, pain and suffering. Challenges facing new technology and treatments will also be discussed.

Clinical practitioner Sheila Cassidy did not hold with the idea that nothing more could be done for a patient, when the medical model failed to cure their cancer. She believed that there was always something to be done, be it a fine tuning of drug dosages, the help of local anaesthesia to ease a particular pain or oxygen to ease breathing difficulties. In the third chapter I explore a number of themes in her published works. The first theme I will be dealing with is fear. I propose to examine the fear, which strikes patients when they learn that they have a terminal illness, their need of companionship at the end of their lives, as well as their need for spiritual care as part of a holistic medical model of care. I will deal with Cassidy's vision of hospice, pain relief and her ideal approach to patient care. I will mention her felt need to be a voice for those in pain, of their needs which includes: empathy as well as competence, a good doctor-patient relationship, and how she prepares carefully for a first encounter with a new patient. She speaks of the importance of attentive listening as the patient is given the opportunity to narrate their story, in the setting up of a therapeutic relationship. She also speaks of the concept of a wounded healer, and her compassion for her patients having experienced torture and pain as a young doctor, all of which has significance for my proposed model of holistic care.

In common with Cassidy in the third chapter I will deal with Michael Kearney's view of the hospice movement and encounters with his terminally ill patients as a clinical practitioner. I will show how patients vary in their response to the fact of their imminent death and how some react with fear, dread, and denial and their unwillingness to accept it. Some patients have unfinished business. Next I will deal the importance of story, myth and imagery used by Kearney as therapeutic tools to lessen the psychological fear of his patients, reduce anxiety, and bring them to a place of healing and a peaceful death. I will explore Kearney's methods of treatment for those for whom the medical model failed and of the many therapies and treatments he used to compliment it. Kearney also speaks of the rationale behind the use of the science based medical model used by Hippocrates and how this links with the current medical model EBM, and how it was deemed insufficient for the treatment of pain and suffering and required the addition of a healing model. I will finish with a critique of the works of Cassidy and Kearney in an attempt to advance a model of holistic care that is not an *exclusive* application to the hospice movement.

In chapter four I will be using Martin Buber's philosophy of dialogue to provide a philosophical underpinning for my model of holistic care with special reference to the works of Cassidy and Kearney. Buber believed that the inability to carry on authentic dialogue with one another was an acute symptom of the pathology of our time and that meaningful communication is necessary to the survival of individuals. His main concern was with relationships. His concepts of relationship and dialogue can provide insights into the doctor-patient relationship. He views existence in two different kinds of relationships, I-Thou and I-It. The I-it relationship belongs to the normal everyday relation towards the things about them, the medical model

belongs to this realm of order, and the I-Thou relationship is where a human person enters into dialogue with another. I will point out his standpoint as operating on a narrow ridge where the meaning is not found in one or the other person but rather in the "between" where they live together. Directness and wholeness, will and grace and the presence of mutuality describe the behavioral characteristics of participants. Buber's insight sees relationships with each other as a reflection of relationships with God. It is hoped that his insights will provide a widening process to further illuminate key aspects of the doctor-patient relationships. Knowing how human relations are continually interwoven between the personal and impersonal provides a clearer view and better understanding of a successful patient-doctor relationship, where a patient is addressed as a whole human being, social, emotional, and spiritual. It also clarifies the doctors response, and how it moves from the interpersonal (I-Thou) of history taking, to the physical examination (I-It) where the patients illness is diagnosed and treatment is discussed and negotiated. This is where the holistic medical model which I am proposing, is applied to the patient.

Following a philosophical underpinning for a holistic medical model, in chapter five I propose to offer a theological underpinning of same, using the theology of John Paul II. The discipline of theology provides a profound reflection on the human condition including the meaning of human suffering which is a central aspect of this thesis. Theologies of salvation and redemption, theodicies of evil, together with reflections on healing the sick are interwoven and linked together in the prolific work of John Paul II. A number of themes will be dealt with in this thesis such as: the meaning of suffering, suffering in the context of salvation and redemption, developments in biomedical research, social responsibility in the context of

healthcare, and care of the sick and suffering with reference to the dignity of the human person and human rights, relationships and solidarity, as well as deliberations and proposals concerning healthcare and society. These themes will be explored by means of an analysis of the work of John Paul II, in order to further advance my own model of holistic care, as complimentary to the current medical model.

CHAPTER ONE: PAIN AND SUFFERING IN THE CONTEXT OF THE CURRENT MEDICAL MODEL

1.1 INTRODUCTION

Chronic uncontrolled pain may be the greatest health care crisis facing many continents today.[19] It is a worldwide problem with significant physical, psychological and social impacts.[20] It is the most common symptom for which people look for medical advice and is the second leading cause of medically related work absenteeism. Chronic pain problems also affect the elderly, and these conditions are expected to rise as the population ages.[21] According to the World Health Organization (WHO), in a survey carried out in 1998, on nearly 26,000 primary care patients in five continents, 22% of those surveyed, reported that, over the previous year they had suffered persistent pain.[22] Inadequate pain relief has also been reported among patients suffering from cancer.

It is estimated by WHO that 5 million people are currently suffering from cancer pain with or without satisfactory treatment.[23] The prevalence of pain increases with disease progression and varies according to the primary site. There may also be

---

[19] Peter S. Staats, "Pain management and beyond: evolving concepts and treatments involving cyclooxygenase inhibition." *J Pain & Symptom Management*, 24 (2002) S4-S9.

[20] J. Breen, "Transitions in the concept of chronic pain." *Adv Nurs Sci*, 24 (2002), 48-59.

[21] S.D. Lande, The problem of pain in managed care, http://www.ampainsoc.org, viewed 06-10-05, p. 1-2. See also, American Pain Societyhttp://www.ampainsoc.org/advocacy/opioids.htm, viewed 06-10-05, p. 1-4

[22] O. Gureje, M. Von Koriff, G. Simon, R. Gater, "Persistent pain and well being. A World Health Organization study in primary care." *JAMA* 280 (1998), 147-151.

[23]American Cancer Society, Cancer Medicine e5 (Canada: B.C. Decker Inc., 2000), Section 40. *Complications of cancer and its treatment* A.C. Carver, K. M. Foley, 140. *Management of cancer pain, scope of the problem*, p. 1-4. See also, T. Meuser, C. Pietruck, L. Radbruch, P. Stute, K.A. Lehmann, S. Grond, "Symptoms during cancer pain treatment following WHO-guidelines: a longitudal follow-up study of symptom prevalence, severity and etiology." *Pain*, 93 (2001) 247-257.

more than one kind of pain. In one study 81% of patients reported two or more distinct pain complaints and 34% of these patients reported more than three types. Patient's fear of cancer is directly related to their fear of severe pain and suffering. 69% of cancer patients surveyed reported that severe pain from cancer might lead them to commit suicide and 57% perceive death from cancer as painful.[24] Although the publication of numerous national and international guidelines on how to manage cancer pain effectively, under treatment of pain and suffering remains a significant problem.[25] Despite it's widespread occurrence and cost it is not well understood. Pain continues to be a major concern for patients who report inadequate pain relief and comfort while in hospital or other community setting.[26] The extent and prevalence of pain, and the degree to which it remains unrelieved has prompted me to undertake this thesis in search of a holistic medical model, which would alleviate pain and suffering.

Presenting the Irish results from a European survey on chronic pain, at the launch of the European Week Against Pain, Declan O'Keeffe stated that more than half a million people in Ireland are in chronic pain, which represents one in eight of the population.[27] One in five chronic pain sufferers have said that the pain was so bad they wished to die, and one in six reported having lost their job as a result of chronic pain. The most common causes of pain reported by chronic pain sufferers were arthritis/osteo-arthritis 35%, traumatic injury 22%, and herniated/deteriorating discs 18%. In relation to treatment many of the current available therapies are either

---

[24] Ibid.
[25] The SUPPORT Principle Investigators, " A controlled trial to improve care for seriously ill hospitalised patients. The study to understand prognoses and preferences for outcomes and risks of treatments" (SUPPORT) *JAMA*, 274 (1995) 1591-1598. See also, C. Ripamonti, E. Zecca, C. Brunelli, L. Groff, R. Boffi et al. "Pain experienced by patients hospitalized at the National Cancer Institute of Milan: research project towards a pain-free hospital." *Tumori*, 86 (2000) 412-418.
[26] M. G. Carson, G. J. Mitchell, "The experience of living with persistent pain." *J Adv Nurs Sci* 28 (1998), 1242-1248.
[27] D. O'Keefe, "Medical school training needed in pain management," *Medicine Weekly*, Oct. (2003) 18-18.

inadequate or cause uncomfortable to incapacitating side effects. Chronic pain results not just from a physical insult but also from a combination of physical, emotional, psychological and social abnormalities.[28] Because many pains persist after an insult is healed, the ongoing pain rather than the injury underlies the patients disability.[29] Untreated pain may become self-perpetuating because pain has immunosuppressive effects that leave patients susceptible to subsequent diseases.[30] However effective pain control can enable patients to regain normal functioning. For advanced stages of chronic pain multidisciplinary interventions are usually required and the key to successful treatment is to understand the mechanisms that generate and maintain chronic pain and suffering.[31] The medical model used today is evidence based and doctors apply their knowledge to patients in a logical way.[32] This is an objective approach, which values hard data and does not include the subjective feelings of the patient. This results in a subjective-objective divide.[33] This division has been the subject of much debate and a bio-scientific approach to alleviating pain has been challenged. This predicament prompted me to explore the rationale used in the science of medicine,[34] and its application in dealing with pain and suffering.

---

[28] M.A. Ashburn, P.S. Staats, "Management of chronic pain." *The Lancet* 353 (1999) 1865-1869

[29] T.S. Jensen, H. Gottrup, L. Nikolajsen, A.J. Terkelsen, N. Witting, "Has basic research contributed to chronic pain treatment?" *Acta Anaesthesiol* 45 (2001) 1128-1135.

[30] C.L. Stucky, M.S. Gold, Xu Zang, "Mechanisms of pain," *Proc Natl Acad Sci*, 98 (2001) 11845-11846.

[31] J.C. Wells, J.B.Miles, "Pain clinics and pain clinic treatment," *Br Med Bull*, 47 (1991) 762-785. See also, J. Bullington, R. Nordemar, K. Nordemar, C. Sjostrom-Flanagan, "Meaning out of caos: a way to understand chronic pain," *Scandanavian Journal of Caring Sciences*, 17 (2003) 325-331.

[32] Gambrill E. "Evidence-based clinical behavior analysis, evidence-based medicine and the Cochrane collaboration," *J Behav Ther Exp Psychiatry* 30 (1999) 1-14. See also M.R. Tonnelli, " The philosophical limits of evidence-based medicine," *Academic Med* 75(2000) 1184-1185.

[33] A. Beveridge, "Time to abandon the subject-objective divide?" *Psychiatric Bulletin* 26 (2002) 101-103.

[34] A. Warsop, "Art, science, and the existential focus of clinical medicine." *Med Humanities*, 28 (2002) 74-77.

This chapter in addressing the question of pain and suffering, in the context of current dominant model, examines the following: the history of pain from the medical perspective, the relationship between pain and suffering, an exploration of the current dominant model evidence-based medicine (EBM), with respect to the subjective-objective divide, the role of technology[35] and the limitations of the scientific method.[36] I end with an argument in favor of a holistic medical model, which is central to my thesis goals.

1.2 A BRIEF HISTORY OF PAIN IN THE CONTEXT OF HEALTHCARE

Ancient civilizations recorded on stone tablets accounts of pain and the treatments used: pressure, heat, water, and sun.[37] Relief of pain was the responsibility of shamans, priests, and priestesses, who used herbs, rites and ceremonies as their treatments. The Greeks and Romans were the first to advance a theory of sensation, the idea that the brain and nervous system have a role in producing the perception of pain. But it was not until the Middle Ages and well into the Renaissance-the 1400s and 1500s-that evidence began to accumulate in support of these theories. Leonardo da Vinci and his contemporaries came to believe that the brain was the central organ responsible for sensation. Da Vinci also developed the idea that the spinal cord transmits sensations to the brain.[38]

[35] B. Jennett, Medical technology, social and healthcare issues in: R. Gillon ed. *Principles of health care ethics* (New York: John Wiley &Sons, 1994) 872.
[36] J. Green, "Qualitative research and evidence based medicine," *BMJ*, 316 (1998) 1230-1232.
[37] NINDS, "Pain, hope through research, a brief history of pain," NIH pub. Dec. 2001, No. 01-2406 http://www.ninds.nih.gov/disorders/chronic_pain/detail_chronic_pain.htm, viewed 07-11-03, p.1-1
[38] Ibid.

In the 17th and 18th centuries, the study of the body-and the senses continued to be a source of wonder to the world's philosophers. In 1664, the French Philosopher Rene Descartes described what is now termed a "pain pathway."[39] Descartes illustrated how particles of fire, in contact with the foot, travel to the brain and he compared this to the ringing of a bell. In the 19th century, pain came to dwell in the domain of science paving the way for advances in pain therapy. Physician-scientists discovered that opium, morphine, codeine, and cocaine could be used to treat pain. These drugs led to the development of aspirin, to this day the most commonly used pain reliever. Before long, anesthesia both general and regional was refined and applied during surgery.[40] Five different doctors claimed to be the first to discover how to alleviate pain during surgery.[41] When John Collins Warren, surgeon, operated on his patient and removed a facial tumor, his patient slept through it all. This began a new era in surgery. The People's Journal of London carried the headline "We have conquered pain." [42] The struggle to understand pain and seek new ways to alleviate it, has been part of the history of medicine since its inception.

Although surgery no longer causes pain, it continues to be a blight on countless lives. In its many guises: migraine, arthritis, back pain, it causes more disability than cancer and heart disease combined. The psychological effects can be devastating, ranging from depression to anxiety and sleeplessness. And the annual

---

[39] What is pain? Descartes scientific theory, http://www.medserv.com.au/mundipharma/pain/history.htm. viewed 11-28-04. See also, A Benini, A. Joyce. "Rene Descartes, physiology of pain," *Spine* 24 (1999) 2115.

[40] NINDS "Pain, hope through research." The National Institute of Neurological Disorders and Strokes, http://www.ninds.nih.gov/health_and_medical/pubs/pain.htm viewed, 07-11-03, p.1

[41] C. W. Long, H. Wells, W. T. Mortan, C. Jackson. "Conquering surgical pain: four men stake their claim." http://neurosurgery.mgh.harvard.edu/history/ether3.htm. viewed 03-12-2004, p.1

[42] W. Morton, "Medicine's greatest gift, we have conquered pain." People's Journal of London, Oct. 1846. http://neurosurgery.mgh.harvard.edu/History/gift.htm. viewed 05-06-05, p.1

cost, for example in the US now hovers around 100 billion dollars.[43] Patients are demanding that pain be seen as a condition unto itself, not just a by-product of illness or injury. Congress recently declared this the *"Decade of Pain Control and Research."* Furthermore 11th October 2004, was announced as a *Global Day Against Pain,* jointly by the International Association for the Study of Pain (IASP) and the European Federation of IASP-Chapters (EFIC) who wished to raise global awareness to a fundamental truth that "*the relief of pain should be a human right*."[44] But what precisely is meant by pain in the medical context? The more we understand the mechanisms of pain, the closer we will become to the appropriate means of its alleviation.

1.3 WHAT IS PAIN? THE MEDICAL APPROACH

Pain has been described as a universal disorder.[45] It becomes immediately apparent. It may be the fiery sensation of a burn moments after you touch a stove, or a sudden sharp piercing pain in the back after lifting a heavy load, or a dull ache above your brow after a day of stress and tension. This describes acute pain, which for the most part, results from disease, inflammation or injury. This type of pain comes on suddenly, for example after trauma or surgery and may be accompanied by anxiety or emotional distress. The cause of acute pain can usually be diagnosed and treated, or it goes away when the injury heals or the stimulus is removed. The pain is usually self-limiting, that is it is confined to a given period of time and severity. In some instances it can become chronic. Pain in its most benign form warns us that something is wrong and we should take medicine or see a doctor. At its worst it robs us of productivity, our well-being and for many suffering from extended illness, our

---

[43]C.L.Stucky, M.S. Gold, Xu Zhang, "Mechanisms of pain. Persistent pain is a major Public Health problem today" *Proc Natl Acad Sci*, 98 (2001) 11845-11846

[44] IASP, EFIC, "The relief of pain should be a human right, Global Day Against Pain," 2004 http://www.iasp-pain.orgGlobal%20Day.html, viewed 02-12-04, p.1

[45]NINDS, "Pain, hope through research, A brief history of pain," NIH pub. Dec. 2001, No. 01-2406 http://www.ninds.nih.gov/disorders/chronic_pain/detail_chronic_pain.htm, viewed 07-11-03, p.1

very lives. In 1931 the French medical missionary Dr. Albert Schweitzer wrote "Pain is a more terrible Lord of mankind than even death itself."[46]

Scientific accounts of pain suggests that pain starts a sequence of events, when special nerve fibers in the body detect that something is wrong in the affected body tissue.[47] Once these fibers are stimulated, they release chemical pain messengers, called neurotransmitters. These neurotransmitters include, potassium and prostaglandin. For sharp pain, the neurotransmitters rush to the spinal cord through fast nerve channels. Dull ache type pains travel along much slower channels. Once the neurotransmitters reach the spinal cord they build up, until a "gate pain" opens and releases them into the brain. Pain is not actually felt until the message reaches the brain. The brain can also send chemical messengers to close this "gate." These messengers include adrenaline, serotonin, and most importantly, endorphins, which are similar compounds to opium. As these are receptors for endorphins throughout the nervous system, opium based drugs like morphine are the most powerful painkillers.[48]

Pain has both a reactive, or emotional, and a sensory component. It is not just a sensation because it involves a degree of perception.[49] The perception is real in that you feel the pain whether or not the message that damage has occurred is still relevant. This perception develops based on cognitive elements, which are linked to the behavioral and emotional response to pain. Pain is often accompanied by feelings

[46]Ibid.
[47] C. Kelb, "Taking a new look at pain," Newsweek, May 19, 2003. http://stacks.msnbc.com/news911585.asp, viewed 07-15-03, p. 2-7
[48] Ibid.
[49] What is pain? Assist Pain Relief.com, http://www.assistpainrelief.com/info/pain/ Viewed 11-27-03, 2002, p. 1-2

of anxiety and distress. It is because it is a complicated psychological phenomenon that pain is hard to categorize. The perception of pain and our response to it are determined by four distinct processes: The first is transduction, this is when damage occurs to tissue, affecting the peripheral sensory nerve endings and triggering the initial electrical impulse. Secondly, transduction involving the spinothalamic tract occurs. This incorporates the subsequent neurol events, that transport the impulse through the nervous system. The third part of the process is called modulation. Pain transmission neurons that originate from the peripheral and central nervous system are controlled by neural activity modulation. The final part of the process is perception. This is how pain feels to someone rather than pain as a physiological process. Perception encompasses complex behavioral, psychological, and emotional factors.[50] The provision of a holistic medical model, which I am promoting in this thesis, would encompass all the needs of patients, emotional, psychological, and spiritual as well as physical.

Gender differences in relation to pain are also in evidence. It is now widely believed that pain affects men and women differently.[51] While the sex hormones estrogen and testosterone certainly play a role in this phenomenon, psychology and culture too may account at least in part for differences in how men and women receive pain signals. Experts now agree that women recover more quickly from pain, seek help more quickly for their pain and are less likely to allow pain to control their lives. They are more likely to marshal a variety of resources and coping skills, support, and distraction with which to deal with their pain. Investigators know that

---

[50] Ibid.

[51] IASP, B. Fillingham, (ed.) Sex, gender and pain, progress in pain research and management, IASP Press, volume 17, (2000) 1-146.

both men and women have strong pain-killing systems but these systems operate differently. Research has shown that kappa-opiods work best with short-term pain, and provide pain relief for women. Why this does not work for men is not known and more research is needed.[52]

Aging also plays a significant role. Mitchell has stated that the aging process can bring with it an increased incidence of conditions which give rise to chronic pain.[53] Persistent musculoskelatol and/or neuropathic pain due to conditions such as back pain, rheumatoid arthritis, osteoporosis and diabetes in elderly patients can lead to a marked deterioration in their quality of life. Pain assessment can be complicated by concomitant disorientation, confusion and communication deficits, leading to an under-treatment of pain in this group. Pain management can be difficult due to the existence of multiple medical problems and the increased side effects related to the treatment.[54] Scudds and Iosbye studied the extent of pain and pain disability in 5,703 Canadians 70 years of age or older.[55] Results showed that 59.3% of women and 48.4% of men reported having pain in the 4 weeks prior to the interview. Of those who reported pain a greater proportion of women compared to men reported that pain at least moderately interfered with physical functioning (moving about, normal tasks, recreational activities and sleep), as well as psychological functioning (mood, enjoyment of life). The intensity of pain and chronic disease combinations were also shown to be significantly associated with pain related interference with physical and psychological functioning. A large proportion of older Canadians report pain and

[52] J.S. "The genetic mediation of individual differences in sensitivity to pain and its inhibition," *Proc Natl Acad Sci*, 96 (1999) 7744-7751.

[53] C. Mitchell, "Assessment and management of pain in elderly people." *Br J Nursing* 10 (2001) 296-304.

[54] Ibid.

[55] R.J. Scudds, R.J. Iosbye, "Pain and pain related interference with function in older Canadians: The Canadian Study of Health and Aging." *Disabil Rehabil* 23 (2001) 654-664.

pain related disability. Thorough pain assessment and management should be incorporated into the health programmes aimed at maximizing physical and psychological functioning in the older population.[56] A holistic medical model, which I am proposing in this thesis, would take care of the patient as a whole person, psychological, social and spiritual, as well as physical. And since the number of elderly now outnumber the young in many societies, increases in pain and disability will seriously challenge existing healthcare systems, this means that the provision of adequate pain relief requires urgent attention.

According to Carson and Mitchell living with persistent pain changes ones quality of life.[57] Ferrell goes further and suggests that pain influences all dimensions of quality of life.[58] Watching loved ones suffer as they bear witness to the anguish of relenting pain intensifies the torment for many people and often prompts those living with pain to withdraw into a private world. In Bowman's study the findings indicated that for persons with chronic pain having to alter their daily activities related to work or pleasure was a major concern.[59] Individuals came to realize that the pain they experienced had to be endured, and some patients described ways they found to live with pain, such as dreaming or praying. The spiritual component of a holistic medical model would be of benefit here.

---

[56] Ibid.

[57] H.G. Carson, G. J. Mitchell, "The experience of living with persistent pain" *J. Adv Nurs*, 28 (1998) 1365-2648. See also R.K. Porteroy, "Pain and quality of life: clinical issues and implications for research" *Oncology* 4 (1990) 172-178.

[58] B.R.Ferrell, "The impact of pain on the quality of life, a decade of research." *Nursing Clinics of North America* 30 (1995) 609-624

[59] J.M. Bowman, "The meaning of chronic low-back pain" *AAOHN*, 39 (1991) 381-383.

The treatment of pain is central to healthcare provision. Chronic pain is a condition for which patients seek care from various health-care providers.[60] This type of pain causes much suffering and disability and is frequently mistreated or under-treated. Patients who present for evaluation for chronic pain need a careful assessment before therapy. People with chronic pain commonly experience symptoms such as depression, sleep disturbance, fatigue, and decreased overall physical and mental functioning. They frequently need an interdisciplinary model of care to allow caregivers to address the multiple components of the patient's pain experience. According to Ashburn and Staats, the core team could include a pain management physician, a psychologist, a nurse specialist, a physical therapist, a vocation counselor and a pharmacist.[61] After a comprehensive assessment, a treatment plan is tailored according to the individual needs of the patient, with a focus on measurable treatment goals. The plan must fit the patient's abilities and expectations. For some individuals, education and medical management suffice whereas for others care may need to include an intensive rehabilitation programme that requires the patient to remain at the treatment centre 8 hours a day, 5 days per week, for 3-4 weeks.[62]

The treatment of cancer pain is a case in point. It is very complex.[63] Ideally palliative care is tailored to the individual needs of each patient, and supported by a multidisciplinary team.[64] The aim would be to provide holistic treatment, which

---

[60] M.A. Ashburn, P.S. Staats, "Management of chronic pain," *Lancet* 353 (1999) 1865-1869.
[61] Ibid.
[62] Ibid.
[63] P. Esper, "Pain management in patients with advanced malignancies," *Home Health Care Consultant* 7 (2000) 11-18.
[64] J. Morse, "Towards a praxis theory of suffering. Advances in nursing science," *Nursing Science* 24 (2001) 47-59, see also American Cancer Society, *Suffering in the patient, family and physician*, in

would take into account the psychological as well as the physical, the social and spiritual welfare of each patient, which corresponds with the holistic medical model, which I am promoting in this thesis. The overall goal would be to control pain and treat symptoms, to provide support as the disease progresses, and address any complications, which occur.[65] Continuous review of patient's condition would be required. WHO research guidelines for cancer pain relief over a 10-year period in an anesthesiology-based pain service associated with a palliative care programme, provides significant information and helpful guidelines.[66]

In this study the course of treatment of 2118 patients was assessed prospectively over a period of 140,478 treatment days.[67] Non-opioid analgesics (WHO step 1) were used on 11%, weak opioids (WHO step II) on 31% and strong opioids (WHO step III) on 49% of treatment days. Administration was via the enternal route on 82% and parenterally on 9% of treatment days. On the remaining days, either spinally applied opioids 2%, or other treatments 6% were utilized. Fifty-six of the patients were treated with morphine. Morphine dose escalation was observed in about one-half of the patients being cared for until death, whereas the other half had stable or decreasing doses over the course of treatment. Co-analgesics were administered on 37% of days, most often antidepressants 15%, anticonvulsants 13%, and corticosteroids 13%. Adjuvants to treat symptoms other than pain were prescribed on 79% of days, most commonly laxatives 42%, histamine-2-receptor antagonists 39%, and antiemetics 35%. In addition, palliative antineoplastic treatment

---

Cancer Medicine 5, Section 22. Principles of Multidisciplinary Management, Palliative care, 73 (2000) p.1-2

[65] SUPPORT, Principle investigators "A controlled trial to improve care for seriously ill hospitalized patients," *JAMA* 274 (1995) 1591-1598

[66] D.F. Zech, S. Grond, J.Lynch, D. Hertel, K.A. Lehmann, "Validation of World Health Organisation Guidelines for cancer pain relief: a 10 year prospective study," *Pain* 63 (1995) 65-76.

[67] Ibid.

was performed in 42%, nerve blocks in 8%, physiotherapy in 5%, psychotherapy in 3%, and TENS in 3% of patients. A highly significant pain reduction was achieved within the first week of treatment ($p<0.001$). Over the whole treatment period, good pain relief was reported in 76%, satisfactory efficacy in 12%, and inadequate efficacy in 12% of patients. In the final days of life, 84% rated their pain as moderate of less, while 10% were unable to give a rating...... Results emphasize the marked efficacy and low rate of complications associated with oral and parenteral analgesic therapy as the mainstay of pain treatment in palliative care of patients with advanced cancer. Wide dissemination of WHO guidelines among doctors and healthcare workers is thus necessary to effect a clear improvement in treatment of the many patients suffering from cancer pain in the clinical and home setting.[68] Having examined the complexity of pain, in itself, I will now examine the relationship between pain and suffering, and its alleviation, since this distinction is central to the holistic approach which I later propose in this chapter and throughout the thesis.

1.4 PAIN AND SUFFERING, DEFINITIONS AND DESCRIPTIONS

The word pain comes from Middle English (in the sense 'suffering inflicted as punishment for an offence'): from Old French *peine*, from Latin *poena* penalty and later pain. This differs from suffering which means to undergo, experience, or be subject to: pain, loss, grief, defeat and change. It can also mean to, put up with or tolerate pain.[69] Pain has been defined by the International Association for the Study of Pain (IASP) as an unpleasant sensory and emotional experience associated with

---

[68] Ibid.

[69] R.E.Allen (ed.) Pain, *The Concise Oxford Dictionary*, (Oxford: Clarendon Press, 1992) p. 856

actual or potential tissue damage, or described in terms of such damage.[70] Pain, however, is more than a sensation or the physical awareness of pain, it also include perception, and the subjective interpretation of the discomfort. Furthermore, perception gives information concerning the location, intensity and also an indication of its nature. Both the conscious and unconscious responses together with sensation and perception, including the emotional response, add further definition to the overall concept of pain.[71] Pain, in its most benign form, warns us that something is wrong and we should take medicine or see a doctor. At its worst it robs us of productivity, our well-being, and for many suffering from extended illness, our very lives.[72] The multidimensional character of pain and suffering attest to its complexity and shows how it challenges the whole human person. Nevertheless as our understanding of it increases the closer we come to satisfactory measures to combat it.

The *Gale Encyclopedia of Medicine* in it's definition of pain informs us that pain is more than an unpleasant feeling that is conveyed to the brain.[73] The discomfort signals actual or potential injury to the body. Pain is also more than a sensation, or the physical awareness of pain; it also includes perception, the subjective interpretation of the discomfort. Perception gives information on the pain's location, intensity and something about its nature. The various conscious and unconscious responses to both sensation and perception including the emotional response adds further definition to the overall concept of pain.[74] Pain has been described by Chapman and Gavin as a complex multidimensional perception with affective as well

---

[70] International Association for the Study of Pain, IASP, *Pain* http://www.iasp-pain.org/terms-p.html viewed 01-12-04, p.1
[71] Ibid.
[72] National Institute of Neurological Disorders and Stroke, NINDS, Pain and Hope through research. http://www.ninds.nih.gov/health_and_medical/pubs/pain.htm.available Viewed 11-08-03, 1-20
[73] Pain, *The Gale Encyclopedia of Medicine*, volume 4 (London: Gale) p. 2141
[74] Ibid.

as sensory features. In part, it is a somatically focused negative emotion resembling perceived threat.[75] The word suffering means to undergo, experience, or be subject to: pain, loss, grief, defeat and change. It can also mean to, put up with or tolerate pain. Suffering responds as a perceived threat to the integrity of the self, helplessness in the face of that threat and the exhaustion of psychosocial and personal resources for coping. The concepts of pain and suffering therefore share negative emotion as a common ground. Examination of the central physiological mechanisms underlying pain, negative emotional arousal, and stress help to clarify the physiological basis of suffering and the causal influences of persistent and other stressors.[76]

Cassell agrees that suffering is experienced by persons, not merely by bodies and has as its source challenges that threaten the intactness of the person as a complex social and psychological entity.[77] Suffering can include physical pain but it is by no means limited to it. Thus, the relief of suffering, and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick. Despite the apparent connection however, between suffering and pain, the two are not necessarily linked. The question arises as to whether the relief of patient's pain and relief from suffering are the same? In an attempt to clarify the patient's perspective concerning pain and suffering Terry and Olsen studied 100 patients who were terminally ill.[78] On admittance to a hospice the patient's diagnosis, their pain scores and the reasons for admission were recorded by the treating physicians. The mean ages of the patients was 68 years, (range 28-93 years) 92 had advanced

---

[75] C.R. Chapman, J. Gavrin, "Suffering and its relation to pain." *J. Palliative Care* 9, (1993) 5-13
[76] Ibid.
[77] E.J. Cassell, *The nature of suffering and the goals of medicine.* (New York: Oxford University Press, 1991) p. 29-44.
[78] W. Terry, L.G. Olson, "Unobvious wounds: the suffering of hospice patients." *Intern Med J,* 34 (2004) 604-607

malignant disease, and 51 of these patients were women. Answers to the question 'In what way are you suffering?' were recorded verbatim at interview. The 100 consecutive answers collected were independently reviewed by the investigators and classified. Four groups of answers were identified: 1) those which highlighted primarily physical suffering, 2) subdivided into pain and other (breathlessness or nausea) symptoms, 3) those who highlighted primarily emotional suffering, and 4) those in which physical and emotional suffering appeared to be comparably important. At the same time as patients answers concerning their suffering were recorded, their underlying disease was also recorded such as: malignant tumour, or brain tumours; the reason given for admission or the criteria adopted by the admitting clinician were as follows: pain control, other symptom control, emotional distress, or family respite. The results showed that twenty-four patients were unable to state the reason for their admission, but none had any uncertainty in identifying the nature of their own suffering. Thirty-five patients identified their suffering as physical symptoms other than pain. Twenty-eight patients identified their suffering as entirely emotional in origin, and seven patients identified their suffering as mixed somatic and emotional in origin. The results showed that there was a weak correlation between the patient's view of their suffering and the reason for admission. The identification of pain as the cause of suffering was weekly correlated with pain scores. Some patients with pain scores of 8-10/10 did not mention pain as a cause of suffering, and others with scores of 0/10 did identify pain as the cause of suffering.[79] In conclusion it appears that a single open-ended way can expose a different dimension of distress, and the views of the 100 patients of this study support the statement that relief of pain

[79] Ibid.

and relief of suffering are not the same.[80] So what precisely is the relationship between pain and suffering, in the medical context?

The concepts of pain and suffering are frequently mixed, however they are distinct phenomena. Dantz points out that suffering is a subjective experience that is unpredictable and difficult to communicate even in the competent person, and is more inscrutable in a delirious or unconscious patient.[81] Despite the apparent connection between them, he re-iterates the opinion of Terry and Olsen,[82] that pain and suffering are not necessarily linked. Cassells in his explanation of suffering, begins by saying that reductionist scientific methods are not useful for the understanding of the whole person, and all aspects of persons are subject to injury and loss, and that if injury is sufficient the person suffers.[83] Furthermore, if suffering continues and there is a threat to the integrity of the person, then suffering will continue until the person is made whole again. Even persons who recover physically, may not return to normal function. If the goals of medicine are to be reset towards relieving suffering, the need for this is clear. Chapman and Gavrin point out that some patients' suffering from unrelieved pain, suffer because pain changes who they are.[84] Breen believes that suffering is closely related to chronic pain, and the terms pain and suffering are often used together.[85] Furthermore, she states that the amount of suffering is related to the duration of the pain and the number of physical, emotional, and social consequences.

---

[80] Ibid.

[81] B. Dantz, "Who defines suffering?" A short commentary, *J Pain and Symptom Management*, 17 (1999) 302.

[82] W. Terry, L.G. Olson, "Unobvious wounds: the suffering of hospice patients." *Intern Med* J 34 (2004) 604-607

[83] E.J. Cassells, *The nature of suffering and the goals of medicine* (New York: Oxford University Press, 2004) 29-45.

[84] C.R. Chapman, J. Gavrin, "Suffering: the contributions of persistent pain," *The Lancet*, 353 (1999) 2233-2237.

[85] J. Breen, "Transitions in the concept of chronic pain," *Adv Nurs Sci* 24 (2002) 48-59.

The amount of suffering she believes has physical, psychological, social and cultural correlates.[86] It is now recognized that multiple interventions are needed including the use of complimentary or supplementary therapies to manage pain and suffering with the increased recognition that the biological, psychological and social aspects of chronic pain are inseparable. This has direct relevance for my thesis since I believe, in common with Cassells,[87] that the current medical model is insufficient in the face of suffering, and that additional therapies need to be applied in conjunction with the current medical model, and multidisciplinary support, for whole person care including the successful alleviation of pain and suffering. This is what I will be recommending in proposing a holistic medical model in this thesis.

Suffering is a broader state that encompasses more dimensions than pain and has potential causes, of which pain is only one. Not all pain causes suffering and not all suffering expressed as pain or, coexisting with pain, stems from pain. In lay terms suffering connotes enduring something unpleasant and inconvenient, sustaining loss or damage, or experiencing a disability. Thomas undertook a phenomenologic study of chronic pain and during in-depth interviews she listened to patients experiences who described it as "unremitting torment by a force that cannot be tamed.[88] The body was altered and recalcitrant, the life world was shrunken and the pain set up a barrier that separated them from other people. Time seemed to stop, and the future was unfathomable.[89] This summed up the devastating effect which unrelieved pain can have on some individuals.

---

[86] Ibid.
[87] Op. cit.
[88] S.P. Thomas, "A phenomenologic study of chronic pain," *West J Nurs Res* 22 (2000) 683-699, discussion 699-705.
[89] Ibid.

Pain is a perceived threat or damage to one's biological integrity. Suffering is the perception of serious threat or damage to the self, and it emerges when a discrepancy develops between what one expects of one's self and what one does or is.[90] Some patients who experience sustained unrelieved pain suffer because pain changes who they are. At a physiological level, chronic pain promotes an extended and destructive stress response characterized by neuroendocrine dysregulation, fatigue, dysphoria, myalgia, and impaired mental and physical performance. This constellation of discomforts and functional limitations can foster negative thinking and create a vicious cycle of stress and disability. The idea that ones pain is uncontrollable in itself leads to stress. Patients suffer when this cycle renders them incapable of sustaining productive work, a normal family life, and supportive social interactions. Although patients suffer for many reasons the physician can contribute substantially to the prevention or relief of suffering by controlling pain.[91]

1.5 THE SUBJECTIVE-OBJECTIVE DIVIDE

The objective approach views the patient as an object, a faulty biological mechanism that relies on the detached gaze of the clinician to determine where the fault lies.[92] The objective approach values hard data and is concerned with measurement of bodily fluids such as blood, urine, cerebrospinal fluid, even brain scans; if it cannot be measured, it is not considered important. This is a reductive view, which may have value in simplifying complex clinical data. An impersonal,

---

[90] C. R. Chapman, J. Gavin, "Suffering: the contributions of persistent pain." *The Lancet* 353 (1999) p. 2233-2237

[91] Ibid.

[92] A. Beveridge, "Time to abandon the subjective-objective divide?" *Psychiatric Bulletin* 26 (2002) 101-103

objective character is deemed essential to the practice of medicine. As doctors accumulate knowledge, they share it with their peers, through conferences, meetings, and published work. It is within this community of the discipline of medicine that this pool of knowledge establishes the objectivity of science. Science as applied to medicine, in its methodology and thinking should be insulated from all psychological, sociological, political and moral ideologies, which can influence thought in life and society. The objective knowledge of truth is deemed essential to the practice of modern medicine. Problems arise however if the doctor is unable to see the patient as anything other than an object, if the doctor looses sight of the patient as a human being.[93]

Psychiatry, too, has become involved in the subjective-objective divide.[94] The methods used by psychiatrists, to ascertain the mental status of patients has puzzled me for some time. The standard method used in the assessment of patients is to contrast the patient's supposedly 'subjective' account with the doctors 'objective' description. In other words, the doctor establishes his subjective opinion of the patient's state of mind, and contrasts it with the subjective feelings of the patient. Adopting a privileged position, the doctor's approach is considered neutral, scientific and representing the truth, ignoring the preconceptions and prejudices that the clinicians brings to the interview. It ignores the effect the interview has on how the doctor perceives the patient, and how the patient responds. The patient's subjective report is regarded as distorted and potentially false. To me, this is an absurd situation. The core of the problem has been stated by Laing:

---

[93] Ibid.
[94] Ibid.

> " Psychiatry tries to be as scientific, impersonal and objective as possible towards what is most personal and subjective. The disordered suffering treated by psychiatrists has to do with what are our most personal and private thoughts and desires. No other branch of medicine has to contend with this domain so much. Nothing whatsoever in western medical training exists to adapt students and young doctors to integrating the personal aspect into clinical theory and practice.[95]

Furthermore, according to Laing, the psychiatrist who approaches his 'subject' from an 'objective' perspective fails to understand his/her own involvement of relationship with the 'who' under investigation.[96] This mode of depersonalization, or objectification, Laing suggests although conducted in the name of science, yields false knowledge. In neglecting to see the uniquely human relationship between doctor and patient, between an I and a Thou[97] the traditional models can only view a person's behavior as 'signs' of a 'disease' and, more important, forgo the possibility of seeing such behavior, as expressive of his existence. Laing explains further, concerning the role of the medical model, it is not the medical model approach itself, which is mistaken but our use of it trying to understand the psychological landscape of suffering persons fails to bring us closer to an understanding of their world. This, Laing believes is simply a narrow approach, which fails to view persons '*qua* persons' and degrades them to the status of 'objects,' such an understanding of a 'mentally disordered' person precludes a deeper understanding and appreciation of a world in conflict.[98] Increasing criticism of the medical model on scientific grounds has prompted renewed evaluation of Laing's work.

---

[95] R.D. Laing, *Wisdom, Madness and Folly*, (London, Macmillan, 1985)

[96] V. Barbetti, *Classification and the treatment of the patient*, Colloquia on the Politics of Diagnosis http://laingsociety.org/colloquia/polofdiagnosis/barbettipoldx.htm. p.1-14.Viewed 06-12-05, p.11, 31.

[97] Refers to Buber's Philosophy of Dialogue, *I and Thou*. Martin Buber *I and Thou*, trans. R.G. Smith (London: T&T Clarke, 2003) Part One, p.21

[98] R.D. Laing, op. cit.

Saunders has attacked the view that the practice of medicine is the application of a scientific, value-neutral truth; clinical reality he claims is different.[99] Practice varies widely between different medical communities, and neither evidence from randomly controlled trials nor observational methods can dictate action in particular, individual circumstances. He states that evidence-based decision models may be very powerful, but are like computer-generated symphonies, in the style of Mozart – correct but lifeless. The art of caring for patients, then, should flourish in the recognition that what is black and white in the abstract becomes grey in practice. If general medicine has misgivings about the bio-scientific approach to human suffering, then there is all the more reason for psychiatry to recognize the limitations of such an approach, dealing as it does with intangibles of mind and body relations. Undoubtedly the impact of technology on the scientific medical model is enormous.[100] I argue that technology assists in the constitution of medical knowledge, which is beneficial to our further understanding of the process of medicine, but which nevertheless at present contributes to the subjective-objective divide, and neglects the person as a whole human being. A holistic medical model would take into account, the whole person, emotional, social, psychological as well as physical.

1. 6 HOW TECHNOLOGY CONSTITUTES MEDICAL KNOWLEDGE

Technology constitutes the concept of disease in three ways. Firstly, technology provides the physiological, biochemical and bio-molecular entities that are applied in defining diseases. Secondly, it establishes the way we try to gain

---

[99] John Saunders, "The practice of clinical medicine as an art and a science," *Journal of Medical Ethics*, 26 (2000) p. 21,18-22.
[100] Ibid.

knowledge of disease and the way we recognize disease in practice. Technology also constitutes the signs, markers and end-points that define disease entities and it strongly influences the explanatory models of disease as well as medical classification of disease. Altogether this constitutes technological influence on the concept of disease and therefore is considered as a technological invention of disease.[101] Technology also provides a complexity if devices, methods, and organization applied in purposeful activity. Technology today is integrated in modern medicine. For example a defibrillator, used to restart the heart, is much more than a device with wires, electrodes and electronic components. It is a defibrillator because it is a method of medical resuscitation applied in an organization of health care. This definition of technology stresses the significance of technology for different levels of healthcare and accordingly the term 'technological' medicine highlights the constitutive role of technology in modern medicine.[102]Undoubtedly, technology also plays an important role in the development of medical theory as well as clinical practice. Technology is also the driving force of medical development. It has changed medical knowledge as well as its practice. For example: the discovery of bacteria, the development of penicillin and the expansion of diagnostic and therapeutic devices such as electrocardiographs (ECG), x-rays, magnetic resonance imaging (MRI) endoscopies together with genetic and pharmaceutical products have contributed to the evolutionary role in medicine over the last two centuries.

Technology has also influenced healthcare and the concept of disease. The vast literature associated with these topics, attests to their importance. Technology

---

[101] Bjorn Hofmann, "The technological invention of disease." *Journal of Medical Ethics, Medical Humanities,* 27 (2001) 10-19.
[102]Ibid.

has eradicated many diseases, reduced the incidence of others and has contributed to the overall improvement of health. Technology has the potential to reduce disability and improve the quality of life. In other words, technology alters the occurrence of disease.[103]It has also been argued that technological development alters the physical and social environment of humanity, creating new diseases. This is evident where modern urban societies have contributed to the development of new diseases. Modern medicine has now largely become dependent on and altered by the explosion in new technologies and has contributed to knowledge both in theory and practice.[104] Technology provides the devices and events that are applied in defining diseases both in diagnostics and in treatment, in clinical practice and in research. The pathological morphology, chemical substances, biochemical agents and bio-molecular sequences studied in research, detected in diagnosis and applied in therapy are grounded in medical technology. More specifically, it is the x-rays, laboratory studies, and pathology reports that constitute the central phenomenon of disease[105]. In other words technology provides the basic entities for defining disease. In practical terms, light microscopy, for example establishes basic structures, such as the cell, whereas stains and cultures constitute viral and bacterial agents, and electron microscopy defines a range of diseases. It appears that technology moves in hierarchical stages, from the most basic structure to the specific component of disease[106]

---

103 B. Jennett, Medical technology, social and healthcare issues. in: R. Gillon (ed.) *Principles of healthcare ethics* (New York: John Wiley & Sons, 1994) 872.

104 H. Fabrega, "Scientific usefulness of illness." *Perspectives in Biology and Medicine*, 22 (1990) 557.

105 S.K. Toombs, "The temporality of illness: four levels of experience." *Theoretical Medicine*, 11 (1990) 227-241.

106 A.S. Evans, "Causation and disease: effect of technology on postulates of causation". *The Yale Journal of Biology and Medicine,* 64 (1991) 513-528

While acknowledging the potential of modern technology to establish the entities of disease, and assist in the diagnosis and decision-making regarding the appropriate treatment, technology is not the final answer when it comes to the alleviation of pain associated with disease, more is needed. In the treatment of low-back pain for instance the focus must be broadened to include the major concerns of the patients and providers.[107] Greater emphasis must be given to finding predictors and risk factors for lower-back pain, chronicity, improving self-care strategies and stimulating self-reliance[108]. Technology constitutes medical knowledge in several ways: it establishes the signs, markers and endpoints that define the disease entities. Definition of sign in medicine is an objective piece of evidence of disease i.e. such evidence as is likely to be determined by an examining doctor and which is opposed to the subjective sensations of thee patient. A para-clinical sign is objective evidence of disease provided by instrumentation. The term indicator is considered synonymous with sign and 'patho-genomic indicators/signs' have been applied as clinical signs. Para-clinical signs that define disease might be abnormalities of morphology, physiological aberrations, biochemical defects or genetic abnormalities. Such para-clinical signs can be reproduced and in this manner, technology grounds the para-clinical signs that define disease. For example, the electrocardiograph began to serve as the objective graphic method for establishing the clinical diagnosis of coronary heart disease.[109] In many cases the signs that define diseases are not accessible especially in the early development of disease. Genetic markers however, can be used

[107] J. M. Borkan, D.C. Clerkin. "An agenda for primary care research on low-back pain". *Spine*, 15 (1996) 2880-2884.
[108] J. M. Borkan, D.C. Clerkin. "A report from the Second International Forum for Primary Care Research on Low-back Pain, re-examining priorities." *Spine*, 23 (1998) 1992-1996
[109] G.E. Burch, "Developments in clinical electrocardiography since Einthoven." *American Heart Journal,* 61 (1961) 324, see also, N. J. Mehta, I.A. Khan, "Cardiology's 10 Greatest discoveries of the 20th Century" *Tex Heart Inst J* 29 (2002) 164-171, and K.M. Flegel, "From Delirium Cordis to Atrial Fibrillation, historical development of a disease concept," *Ann Intern Med* 122 (1995) 867-873.

to identify them. For instance, changes in DNA are markers or risk factors for Alzheimer's disease (on chromosomes 1, 14, 19, 21). Such genetic markers might indicate a disposition towards the disease. Advances in technology facilitate the identification of new markers[110].

The signs and markers of disease also represent the measure of what is to be altered in order to restore the patient's health. The belief in basic phenomena such as: ST-segment displacement and markers like trisomy 21, causes physicians to try to influence and manipulate them. They become endpoints of medical treatment. For example, the endpoint of the treatment of hypertension and cholesterol-anaemia is the blood pressure and level of cholesterol in the blood. Overall biomarkers are important tools in understanding the underlying mechanisms of causation, progression, and treatment effects for example in Parkinson's disease.[111] Scientific method and the use of technology in medical care make significant contributions to the treatment of pain and illness. Nevertheless, they do not provide care for the patient as a whole person, accordingly there are significant limitations to such an approach.

1.7 THE LIMITATIONS OF THE SCIENTIFIC METHOD

Many people assume that science is unlimited and can correctly answer any question or problem in nature. Sometimes scientists themselves are at fault for perpetuating the idea that science is all knowing and powerful. While the process of scientific inquiry can explain a lot of phenomena in the natural world, like all human

[110] M. Whittle, "Ultrasonographic soft markers of fetal chromosomal defects. Detecting them may do more harm than good." *BMJ,* 314 (1997) 918-919.
[111] K. M. Biglan, R.G. Holloway, "Surrogate endpoints in Parkinson's disease research," *Curr Neurol Neurosci Rep*, 3 (2003) 314-320.

strivings it has its limitations. Science can be defined as knowledge derived from observation, study, and experimentation.[112] This definition outlines the limits of science. Science is limited to what can be observed, measured, experimented with and reproduced. If anything interferes with the gathering of reliable data, then the likelihood of correctly evaluating a hypothesis diminishes. Amongst the things, which can interfere with the correct implication of the scientific method, are: inaccurate observations, not enough experimentation, lack of reliable measurements or data, lack of controls and human biases[113]

Shanner points out however, that although science is one of our better forms of gaining knowledge, the scientific method contains a distinctive flaw: 'it is inductive rather than deductive'.[114] The hypothesis testing method 'intuits' conclusions after observing several cases rather than deducing specific conclusions from known truths. These inductive conclusions then, become assumptions that ground future hypotheses and study designs. Accordingly, the scientific method can make mistakes by failing to observe enough cases of sufficient diversity before drawing conclusions: by hypothesizing from assumptions that turn out not to be true, or simply by choosing the wrong conclusion from several that might explain the data. The limitations of the scientific method open the door to frequent revision of what we claim to know.[115]

---

[112] Resource for students of Biology and Philosophy, Ethics / Biology Link, the limitations of the scientific method, http://www.coc.cc.ca.us/departments/Philosophy/ermmlimitsofSCI.html, viewed on 23-10-2003, p. 1-3

[113] Ibid.

[114] Laura Shanner, "Alternative knowledge's, alternative healing: What justifies the label standard?" *Health Ethics Today*, 11(2000) 1-3. See also T. Caulfield, " Physicians, alternative medicine and the duty of informed consent," *Health Ethics Today* 11 (2000) 1-4.

[115] Ibid.

Even without constant upgrading the scientific method faces some important limitations that challenge the difference between 'standard' or science based treatments and 'complementary' non-scientific approaches. Science can only answer the question that is asked. An absence of scientific information does not constitute proof or disproof, but merely a gap in an enquiry. These limits and gaps take many forms, creating openings for 'non-standard' approaches to fill. Women's health for example (except for Obstetrics) has traditionally been understudied, leading to a lack of information about alcohol metabolism, cardiovascular disease, and other processes that were assumed to be identical to those of male bodies.

Outcome measures as observed by Howard Brody sometimes makes the measurable drives out the important.[116] The question arises as to how important is the patient's perception of feeling better, worse, or 'not quite right' especially if no objective data confirms the status of the patients health? To an 'alternative' practitioner the self report often opens other avenues for relief even if a more specific cause is not further understood. The patient's perception of feeling better even without objectively measured improvement of metabolism or function is also deemed more important in 'alternative' approaches. All healing approaches seek similar outcomes: to relieve suffering, to improve function and where possible to cure illness or disability. We now have a better understanding of bodies and healing in which the lines between 'standard' and 'alternative' approaches will shift. The possibility of a paradigm shift will make us reconsider many taken-for-granted 'truths' in search of greater genuine knowledge.[117]

---

[116]Howard Brody, Philosophic Approaches, in: Miller & Crabtree (eds.) *Using Qualitative Methods.* http://www.phen.ab.ca/materials/het/het 11-03a.html accessed on 23-10-2003. See also Howard Brody, *Stories of sickness* (Oxford: Oxford University Press, 2002) 1-312.
[117] Ibid. See also, A. Sen, "Health: perception versus observation," Editorial, *BMJ*, 324 (2002) 860-861

Psychology has also taken issue with the notion of the subjective-objective divide: between humanistic and behavioral schools of thought. Behaviorism has been too dismissive of the mind and has attended only to outward behavior. Psychology, as the behaviorist views it, is a purely objective, experimental branch of natural science, which needs introspection as little as do the sciences of chemistry and physics. At variance with this view, there arose the humanist movement in psychology, which was influenced by existentialism and its view that individual experience was paramount. Man could not be seen as some kind of biological automaton, passively controlled by the forces of the physical world. Thinkers (such as Dilthey, Brentano and Husserl) argue that since human beings are different in kind from objects in the physical world, they require different methods.

This controversy is particularly incisive in the arguments concerning the mind-body problem. The neuro-scientific discoveries may eliminate the last remnants of the mental as all aspects of the mind may be explained in terms of neurobiology. At variance with these suggestions are those who argue that human consciousness and subjectivity are more than merely the secondary off shoots of brain activity. Mental life cannot be reduced to matter. Important aspects of being human, such as the need for meaning and value, and the notion of free will, cannot be accounted for by a purely materialist philosophy. While some may agree with Horgan when he concludes that the mind-body problem is a mystery beyond our capacity to solve, these findings are not just of scholarly interest; they influence clinical practice and affect how doctors view patients.[118] A physicialist doctor will see his patients as

[118] J. Horgan, "The undiscovered mind: how the brain defies replication, medication and explanation"

dysfunctional and prescribe physical interventions such as: drugs, ECT, or psychosurgery. A doctor at the other end who holds that human experience cannot so easily reduced to brain biology, may be more likely to emphasize talking. However Havens in his discussion of the different models used in psychiatry contrasts the objective-descriptive mode with the existential approach. In the objective-descriptive model the doctor is trying to obtain signs and symptoms in order to make a diagnosis whereas in the existential approach the focus is on how the patient feels.[119]

There is evidence now that intensive, multidisciplinary and bio-psychosocial rehabilitation with functional restoration reduces pain and improves function in patients with low-back pain. Using this strategy for pain relief the doctor can become a more effective healer and counselor for the patient. Modern distractions such as technology, litigation, and disability compensation have interfered with the ability of doctors to meet their patient's needs. If doctors are to be more effective managers of problems such as low-back pain they must rediscover their ability to help their patients cope with illness and suffering.[120] The importance of the patient's views are now recognized. The influence of existential thought can be traced to the present day with the rise of narrative based medicine, which suggests that the patient's history should be seen as a story unique to the individual. By telling his or her story the patient attains meaning and understanding of personal misfortune. The current revival of interest in the humanities also stresses the limitations of the traditional disease model and hopes to demonstrate that the arts can help clinicians to come to a deeper understanding of their patients and lead to 'whole -person understanding',

---

Am J Psychiatry 159 (2002) 333-334.

[119] Ibid.

[120] J Guzman, R., Esmail, K. Malmivaara, E. Ervin, C. Bombardier. "Multidisciplinary rehabilitation for chronic low-back pain: systematic review". *BMJ,* 322 (2001) 1511-1516.

rather than seeing them as signs and symptoms.[121] The humanities, as expressed in art, literature, drama and music, are expressions of human creativity; they reflect human joy and sorrow, and human celebration and reflection. Part of what it means to be a complete human being is to participate in some form of artistic activity, either as a spectator, reader, or viewer. Understanding this will help doctors to remember the purpose of their own art: to enable people to participate fully in life unhampered as far as possible by illness and disability.[122]To over emphasize the application of science to medicine at the expense of the world of values as represented by the humanities would be in error, and represent a devalued practice of medicine. Greenhalg aspired to the reconciliation of the narrative approach with the biomedical one. Similarly, Eisenberg referring to the notion that psychiatry had a tendency towards the mindless and brainless has quite rightly argued that a balanced view should be adopted by integrating the neurobiological with the social and psychological. If this can be achieved then the objective-subject divide could be abandoned.[123]

Having reviewed the scientific basis for the practice of medicine, I now propose to explore the medical model, evidence based-medicine (EBM) as applied to patients at the present time. I will argue that EBM in itself is insufficient when it comes to the relief of pain and suffering. More is needed. I will further argue that a more holistic approach to the treatment of pain and suffering will consider the biological, psychological, and social aspects of pain and suffering, as well as the existential and spiritual aspects. This can lead to whole person care.

---

[121] M. Evans, D. Greaves, "Exploring the medical humanities" *BMJ*, 319 (1999) 1216-1216
[122] R. Gillon, "Welcome to Medical Humanities, and why," Editorial, *J Med Ethics* 26 (2000) 155-156.
[123] T. Greenhalg, Narrative based medicine in an evidence-based world. in *Narrative-based Medicine (*eds.)T. Greenhalg and B. Hurwitz (London: BMJ Publishing Group, 1998) 247-265. See also L. Eisenberg, " Is psychiatry more mindful or brainier than it was a decade ago?" *British Journal of Psychiatry*,176 (2000) 1-5.

1.8 EVIDENCE BASED MEDICINE

Sackett et al. give a detailed description of evidence-based medicine (EBM) as practiced today. It is achieved by integrating individual clinical expertise with the best available external clinical evidence from systematic research.[124] An integral part of EBM depends on the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Through the expertise of clinicians and the availability of up-to-date evidence especially from patient centered research the doctor has at his disposal evidence, which enables him, to arrive at a diagnosis with greater accuracy and precision than before. The range of tests available to him include clinical examination, the power of prognostic markers and the efficacy and safety of therapeutic, rehabilitate and preventive regimes. Previous accepted diagnostic tests and treatments may be invalidated and replaced by new more powerful, more accurate and more efficacious tests. The authors conclude by stressing the importance of using both individual clinical expertise and the best available external evidence, neither alone is enough.[125]

Yet, there exists a gap between empirical evidence and clinical practice. Tonelli points out one aspect of this gap: that is the part that requires the consideration of values, in arriving at medical decisions.[126] There is another gap due to the fact that the empirical evidence is not directly applicable to individual patients and the knowledge gained from clinical research does not directly answer the primary clinical

---

[124]D.L. Sackett, "Evidence based medicine; what it is and what it is isn't." *BMJ,* 312 (1996) 71-72.
[125]Ibid.
[126]M. R. Tonelli, "The limits of evidence based medicine," *Respir Care*, 46 (2001) 1440-1441

question: what is best for the patient? To overcome the intrinsic gap clinicians need to incorporate knowledge from five distinctive areas in each medical decision: 1) empirical evidence, 2) experiential evidence, 3) physiological principles, 4) patient and professional values, 5) system features. The relative weight given to each of these areas is not predetermined, but varies from case to case.[127] Bensing agrees with Tonelli concerning the limits of EBM. He points out that this approach neglects the uniqueness of patients, their individual needs and preferences, as well as their emotional status as relevant factors in decision making.[128] The idea of patient-centered medicine has also been overlooked. This phenomenon is basically a humanistic, bio-psychosocial perspective, combining ethical values 'on the ideal physician with psychotherapeutic theories on facilitating patient's disclosure of real worries and negotiations theories on decision making. It's focus is on patient participation in clinical decision making by taking into account the patient's perspective, and turning medical care to the patient's needs and preferences. This approach has an ideological base and is more developed here than its evidence base. Modern medicine today needs both the ideological and evidential based knowledge and the hope is that both of these paradigms would be brought together, exchanging ideas and principles from which eventually, will emerge the best possible medical care.[129] A holistic medical model, which I am promoting in this thesis would encompass the needs of the patient as a whole person, emotional, social, spiritual and physical. EBM would be an integral part, together with other therapies and skills, distinguished by an existential focus directed to and caring for the patients' lived

---

[127] Ibid.
[128] J. Bensing, "Bridging the gap, the separate worlds of evidence-based medicine and patient-centred medicine." *Patient Educ Couns* 42 (2000) 295-296.
[129] Ibid.

experience in such a way that science can be applied therapeutically.[130] Rather than medicine's art being a part of a culture of medical science, science can only play its part if doctors are competent practitioners of the art of medicine.

The case against the use of evidence-based medicine has been stated by several authors. Hampton is unhappy because he believes that a doctor needs to have the freedom to treat an individual patient in the way he believes best.[131] Furthermore, in the real world of individual patients with multiple diseases being treated with different drugs, the application of EBM here is extremely difficult. He reiterates his belief that good practice still requires clinical freedom for doctors.[132] Williams and Garner are concerned with EBM as an approach to psychiatry. Hampton agrees with others doctors who are now critical of the emphasis on "the evidence" leading to constrained critical practice. According to Williams and Garner sources of evidence are limited and the psychosocial aspects of medicine are neglected in this process. Furthermore, too great an emphasis on EBM oversimplifies the complex and interpersonal nature of clinical care.[133] Harari is at one with Williams and Garner and also has reservations concerning the inadequacy of empiricism as a scientific foundation for evidence-based approaches to psychiatry.[134] A failure to recognize both the limitations of empiricism in science and the conceptual richness of alternate formulations that accord more closely with the complexity of psychiatry's domain will result in a naïve model of science and inadequate understanding of the limitations

---

[130] A. Wrsop, "Art, science, and the existential focus of clinical medicine." *J Med Ethics: Medical Humanities* 28 (2002) 74-77.
[131] J. R. Hampton, "Evidence-based medicine, opinion-based medicine, and real world medicine." *Perspect Biol Med* 45 (2002) 549-568.
[132] Ibid.
[133] D. D. Williams, J. Garner, "The case against "the evidence": a different perspective on evidence-based medicine." *Br J Psychiatry* 180 (2002) 8-12.
[134] E. Harari, " Whose evidence? Lessons from the philosophy of science and the epistemology of medicine" *AUST NZ J Psychiatry* 36 (2002) 724-730.

of 'evidence' that guide the training, clinical practice and research in the profession of medicine. The consequences will be the intellectual, clinical, and ethical impoverishment of Psychiatry.[135]

1.9 CONCLUSIONS

Chronic uncontrolled pain is a worldwide problem and pain and suffering is prevalent in society today. Historically, by the 19th century pain relief became the domain of science and physician scientists discovered that opium, morphine, codeine and cocaine could be used to treat pain. These discoveries led to the development of aspirin, which remains in use as a painkiller today. Pain has been described as and unpleasant sensory and emotional experience, but it is more than that, it includes perception and subjective interpretation of the discomfort. Both conscious and unconscious responses together with sensation and perception, including emotional response add further to the concept of pain. When it was discovered in the 1980's that pain repressed the immune system and could indirectly promote tumor growth, the stark phrase, *pain can kill*, was used to describe it.

Suffering means to undergo, experience, or be subject to loss, pain, grief, defeat, and change. Suffering responds as a perceived threat to the integrity of the self, helplessness in the face of that threat and exhaustion of psychosocial and personal resources for coping. Suffering threatens the intactness of the person as a complex social and psychological entity. Patients who experience sustained unrelieved pain suffer because pain changes who they are. At a physiological level,

---

[135] Ibid.

chronic pain promotes an extended and destructive stress response characterized by neuroendochrine dysregulation, fatique, dysphoria, myalgia and impaired mental and physical performance. This constellation of discomforts and functional limitations can foster negative thinking and create a vicious cycle of stress and disability. Patients suffer when this cycle renders them incapable of sustaining productive work, a normal family life and supportive social interactions.

An objective view of patient care which characterizes the current dominant medical model is problematic because it causes a subjective/objective divide. This objective view values hard data and problems arise when the doctor looses sight of the patient as a human being. The presumption, in this medical model is that the practice of medicine is the application of a scientific value neutral truth is being challenged. Moreover practices vary widely between different medical communities and, neither evidence from randomly controlled trials nor observational methods can dictate action in particular individual circumstances, hence the limitation of this approach.

Technology provides the physiological, biochemical, and bi-molecular entities that are applied in defining disease. Technology constitutes the signs, markers and endpoints that define disease, and provides a complexity of devices, methods and organization applied in purposeful activity. Technology today is integrated into modern medicine, it influences healthcare and the concept of disease, and it has the ability to reduce disability and improve quality of life, despite its limitations. It's potential is considerable. However, with ever-increasing technological interventions, the possibility of objectifying the patient increases, and the provision of holistic care

for the patient as a whole human being, may be bypassed, especially where pain and suffering is concerned.

Pain and suffering is prevalent in our society today despite the current available therapies. A brief history of pain outlines the discovery that the brain is the central organ involved and that the spinal cored facilitates the transmission of pain to the brain. This knowledge in turn precipitated the search for pain relief, which would reduce suffering. Many plant extracts were used and the most potent of these, opium, came from the poppy flower. Endorphins, which are similar compounds to opium have receptors throughout the nervous system and opium based drugs like morphine form much of the basis for the drugs used to treat pain and alleviate suffering, today. This knowledge in turn led to the development of aspirin and developments in anesthesia led to pain free surgery. Further studies have outlined the chain of events leading to pain and the impact it has on the individual, the sick and the elderly. The differences between pain and suffering have been explored showing that suffering can include pain but it is by no means limited to it. Suffering is a broader state that encompasses more dimensions than pain and has potential causes of which pain is only one. Not all pain causes suffering and not all suffering is expressed as pain. This distinction needs attention.

Evidence-based medicine (EBM) provides the clinician with the best available external clinical evidence from systematic research. The combination of EBM with clinical experience means that the clinician has at his disposal a range of tests, prognostic markers and preventive and rehabilitative regimes. This means that the doctor can diagnose his patient's condition and reach a decision concerning the

appropriate treatment with greater accuracy than before. Reservations have been voiced against the exclusive use of EBM. It has been suggested that there are gaps between empirical evidence and clinical practice where the consideration of values is concerned. There is also a shift away from the care of the individual patient to the care of populations. Furthermore the complexity of clinical judgment is no longer appreciated. Further reservations have been cited concerning the uniqueness of the individual patient and the neglect of the patient-doctor relationship. This means that medical decision making no longer takes account of the patient's needs and preferences. Some patients may have more than one illness, and already are treated with several different drugs. Concern has also been expressed about the exclusive use of the EBM approach in the field of psychiatry. This can lead to the neglect of the psychosocial aspects of medicine and the complexity of psychiatry's domain. In the light of these expressed concerns regarding the current medical model that in order to treat patient's pain and alleviate suffering, it is necessary to go beyond the medical model to a more holistic model of care. This would take into account the limitations of the scientific method and the benefits of whole person care dealing as it does with the intangibles of mind-body relations. Moreover a holistic medical model is strongly patient oriented. It attends to the whole person, body, mind and spirit. In the following chapter I argue, by means of scientific research studies, the overall positive relationship between spirituality and healing, with a view to providing a scientific basis for my argument in favor of a holistic medical model.

CHAPTER TWO. SCIENTIFIC RESEARCH REGARDING SPIRITUALITY AND HEALING: A HOLISTIC APPROACH

2. 1 INTRODUCTION

Issues of spirituality and health are part of each persons search for the truth about self, and the meaning and purpose of life. Finding meaning, purpose and hope has the capacity to nurture individuals in their suffering. All patients have a right to spiritual care and healing regardless of their belief systems, culture or creed within the context of spirituality.[136] The scientific world of medicine is now beginning to take the spiritual world of faith seriously, while science does not seek to determine what faith is. It accepts faith as a given. After releasing the findings of extensive research into the relationship between faith and a healthy immune system, Harold Koeing stated "We are not trying to prove that there is a higher power. But maybe believing in that higher power could be an important key to people's health."[137] What scientists are beginning to study is the power of the very act of believing in itself. Making an act of faith in God, or in God as you conceive God, or in a 'higher power' is now seen as being beneficial for the whole immune system.[138]

In this chapter I will explain the necessity of moving beyond the current medical model in order to meet the needs of patients in the face of pain and suffering. I will be proposing a holistic medical model of care, where the current medical model

---

[136] C.J. Smucher, "Nursing, healing and spirituality." *Complement Ther Nurs, Midrifery*, 4 (1998) 95-97. According to Smucker nurses are healers primarily through the caring relationships they form with the patients. In response to the patients unique experience, compassion, care, and other humanistic qualities of the medical staff help to create a healing environment

[137] H.G. Koeing, *The healing power of faith: science explores medicine's last great frontier* (New York: Simon and Shuster, 1999) 222.

[138] J. McManus, *Healing in the spirit* (Spain: Redemptorist Publications, 2003) 6-7

is supplemented by methods of care, which take account of the whole person. In the holistic medical model I will be recommending especially a spiritual component, which has been shown by medical research, to complement the current medical model. I propose to demonstrate how medicine and spirituality find common ground for the healing and wholeness of life. I will describe what holistic care means and show how patients can be helped to mobilize vast resources within themselves, encompassing their hopes, dreams and will to live, together with other coping strategies which enhances their conventional treatment in dealing with their illness, pain and suffering.

Incorporating spirituality in medical practice has been shown through biomedical research to enhance medical treatment from many perspectives: relationship with God; the provision of meaning and a reason for existence; the benefits of having faith, hope, love and forgiveness; the powerful effects of compassionate care and interaction with supportive others; appreciating wholeness through healing; the benefits of a healing environment; the provision of an interpretive framework; enhanced health outcomes and quality of life. In this chapter therefore I provide a review of research studies, which demonstrate the significant relationship between spirituality and illness. I will first define the term 'spirituality' and show how the transcendent can be experienced in and through the practice of medicine and personal relationships. I will show how self-transcendence gives integrity and meaning to life and the value of elements such as faith, hope and compassion to the healing process. Next, I will discuss spirituality and healing. I will demonstrate how the conventional medical model, with its focus on disease, does not take account of self-healing and wholeness, and that this limitation prompted the rise

of complementary therapies. I will show how a holistic medical model can be beneficial to the restoration of healing and wholeness to the sick.

The importance of hope for the terminally ill will be pointed our in this discussion I will mention interventions, which can assist the distressed: such as listening, empathy, and religious practices. I will stress the importance of patient-oriented holistic care to address the totality of the patients' relational existence. I will point out the relationship between depression, hopelessness and desire for hastened death. I will show how faith in God sustains the distressed. Finally I will show the sequence of events, which follows an individual sense of worthlessness, and incapability. There is a need to counteract suffering in these vulnerable people.
In light of current research findings while I acknowledge some conflicting evidence, I will be promoting a patient oriented, holistic medical model, which emphasizes a viewing of the patient as a whole person, not as a disease, and a patient-centered style of communication, where the patients' narration of events (the personal history) is central in coming to terms with their illness. Ultimately I conclude that the main body of research provides substantial evidence for the benefits of spirituality in the practice of medicine.

2.2 HOLISTIC CARE

Holistic care is based on the premises that there is a balance between body, mind and spirit, is important for well-being, each of these is interconnected and that each effects the others. Human spirit is considered the essence of being and is what

motivates and guides us to live a meaningful existence[139] Holistic medicine is broadly defined as those healing practices and beliefs lying outside the practice of scientific western biomedicine. Holistic medicine is understood as providing complementary and traditional medical practices. Holistic medicine in addition to its role in dealing with illness is also dedicated to the achievement of good health through preventative measures. A holistic method views the diverse causal agents in disease and the interaction of physical, mental, emotional, spiritual, environmental and social factors. A multidimensional approach is used, and illness is understood as a disturbance of the unified functioning of the whole and not just an isolated cause or effect whilst health is the sound functioning of the whole. The reasons for the resurgence of popularity in the Western world includes: the limitations of the conventional scientific medicine in treating illness, the increasing dissatisfaction with conventional medical care, the increased responsibility and control individuals are taking in disease prevention, health and well-being, health education and greater interest and belief in the connection between mind and body, as well as personal preference.[140]

In whole person care the aim of the doctor is to empower and support patients and their illness in order to help them maximize their health and deal with the psychological, emotional, social and spiritual aspects of their illness. This whole-person healthcare for Sheldon arose as a result of his early experience as a General Practitioner when he discovered that he had to deal with real people: their relationships, anxieties and fears. He found himself spending little time evaluating disease because he was so busy trying to deal with the actual person. He had to learn

[139] A. Narayanasamy, P. Clisset, L. Parumal, D. Thomson, S. Annasamy, R. Edge, "Responses to the spiritual needs of older people" *J Adv Nurs*, 48 (2004) 6-16.
[140] A. Williams, "Therapeutic landscapes in holistic medicine," *Soc Sci Med*, 46 (1998) 1193-1203.

some sociology and psychology on the job as well as how to counsel and listen to his patients and care for them. He wondered if he was trained to be a GP, and felt he needed more training. However he persisted, and went on to develop whole person care.[141]

The holistic medical model, which I will be promoting includes the current medical model, evidence-based medicine (EBM), which has been described as integrating individual clinical expertise with the best available external clinical evidence from systematic research. An integral part of EBM depends on the expertise and judgment that individual clinicians bring to it through clinical experience and clinical practice.[142] Through the expertise of clinicians together with the availability of up-to-date evidence, the doctor is enabled to arrive at a diagnosis with greater accuracy and precision than before. The range of tests available to him include: clinical examination, the power of prognostic markers, and the efficiency and safety of therapeutic, rehabilitative and preventive regimes. Previously accepted diagnostic tests and treatments may be invalidated and replaced by new more powerful, more accurate and more efficient tests. The authors stress the importance of combining both individual clinical expertise and the best available medicine, neither alone is enough.[143] Yet, there exists a gap between empirical evidence and clinical practice. Tonelli points out that one aspect of this gap: that is the part, which requires the considerations of values, both patient and professional prior to arriving at medical decisions. There is a gap due to the fact that the empirical evidence is not directly applicable to individual patients and the knowledge gained from clinical research does

[141] M. Sheldon, "Whole Person Medicine," *Nucleus*, (2004) 18-25.
[142] D. L. Sackett, "Evidence-based medicine, what it is, and what it is'nt." *BMJ*, 312 (1996) 71-72.
[143] Ibid

not directly answer the question: what is best for the patient? To overcome the intrinsic gap clinicians need to incorporate knowledge from five distinct areas: empirical evidence, experiential evidence, physiologic principles, and patient and professional values.[144] Bensing agrees with Tonelli concerning the limits of EBM.[145] He points out this approach neglects the uniqueness of patients, their individual needs and preferences, as well as their emotional status as relevant factors in decision-making. It also denies the patient the therapeutic effect of being included in negotiation and decision-making. The idea of patient-centered medicine is being overlooked in this instance and the needs of the patient as a whole are being bypassed. This situation is untenable. A more humane holistic model is needed.[146] Existential holistic group therapy keeps a positive perspective. It addresses the state of the person's wholeness; including, philosophy of life, love, purpose in life and a spiritual dimension.[147] It also attends to the emotional, and psycho-sexuality. The entities in existential holistic therapy hold that everybody has the potential to heal themselves, to become loving, joyful, attractive, strong and gifted, which is encouraging for many people. It can lead to equally positive emotional experiences, which in turn has the capacity to transform lives.[148] Furthermore, an existential holistic group can bond together leading to a cohesive whole. They become linked in their totality and solidarity with each other. Being in a group setting where all participants stand together and support each other, can lead to healing.[149]

---

[144] M. R. Tonelli, " The limits of evidence based medicine." *Respir Care*, 46 (2001) 1440-1441.
[145] J. Bensing, "Bridging the gap. The separate worlds of evidence based medicine and patient centred medicine," *Patient Educ Couns* 39 (2000) 17-25.
[146] Ibid.
[147]S. Ventegodt, N.J. Anderson, J. Merrick, " Principles of existential holistic therapy and the holistic process of healing in a group setting." *Science World Journal* 3 (2003) 1388-4000.
[148]Ibid.
[149] Ibid.

The setting up of a community of caring can foster holistic healing through bringing a spiritual dimension into the lives of those who endure pain and suffering. This can be set up in a hospital or rehabilitation unit.[150] Given a space for meeting, this community can come together, and share their deepest feelings, thoughts and concerns, and learn new ways of coping. Furthermore the community of care can motivate patients into overcoming negative feelings of inadequacy and low self-esteem. They also encourage self-acceptance despite physical trauma and loss. Spirituality can be fostered in the sacredness of the time spent together using the facilities of physical therapy, rehabilitation and recuperation. In this way relationships can be deepened within oneself, others and God. For those who are experiencing pain and suffering, time spent together in a group can mobilize their inner resources and help them to take responsibility for their healing and recovery.[151]

Ventegot et al. go further.[152] They point out that not only do we need holistic medicine, we need it to be spiritual as well in order to involve the depths of human existence, encompassing the whole human being. In a study by a group of researchers from Denmark, Norway, and Israel, conceptual frameworks in quality of life (QOL) were explored. From the groups viewpoint QOL represents an influence on health beyond both genetic and traumatic factors, which are in common usage in the current medical model. What the researchers are trying to specify are interventions to enable clinicians to motivate patients to help themselves. They hope to achieve this by mobilizing the vast resources within the patients themselves incorporating their hopes, dreams, and will to live.

---

[150] M.B. Durkin, "Pain and suffering: a spiritual dimension and holistic healing" *Health Progress* 73 (1992) 48-53, 70.
[151] Ibid.
[152] Op. cit.

This holistic approach to medicine according to Ventegodt et al. needs to be further expanded to include human consciousness, scientifically as well as philosophically.[153] In the light of this evidence concerning the patients potential for self-healing, which we hardly know how to mobilize, our healthcare systems need to be updated to provide a form of holistic care which could provide a vastly improved quality of life.[154] Ventegodt and his co-researchers also recommend existential group therapy to address emotional aspects of the mind.[155] It concerns issues related to death, freedom, isolation and meaninglessness. In contrast to psychotherapy existential holistic group therapy addresses the state of the persons wholeness. Entities such as philosophy of life, love, purpose of life and a spiritual dimension. Furthermore it attends to the emotional, psychological and the sexual. To this extent it covers a wider base than conventional psychotherapy. A further difference between the two methods of group therapy is that while psychotherapy is somewhat depressing, dealing as it does with the "fundamental human condition" on the other hand existential holistic therapy sees life as basically good. The message from holistic existential therapy is that everyone has the potential to heal themselves, to become loving, joyful, strong and gifted, which is very encouraging for most patients.

Numerous diseases worldwide cause pain and suffering. Cancer is one such disease. It is a painful debilitating progressive disease. It is also multidimensional and often changes its course. New mutations of the disease challenge current treatments. Some infections occur which are resistant to most antibiotics and these 'superbugs' prolong the patients' illness. It becomes evident that a more holistic

---

[153] S Ventegodt, N. J. Anderson, J. Merrick, " Holistic medicine: scientific challenges." *Scientific World Journal,* 13 (2003) 1108-1116.
[154] Ibid.
[155] S. Ventegodt, N.J. Anderson, J. Merrick, " Principles of existential holistic therapy and the holistic process of healing in a group setting." *Science World Journal* 3 (2003) 1388-4000.

form of treatment is necessary. Slowman et al. state that conventional cancer treatment may be insufficient to maintain a pain-free quality of life.[156] What these researchers propose is to incorporate relaxation techniques: involving deep breathing, muscle relaxation and imagery into a more holistic care of the patient. These recommendations have been made in the light of a study carried out on 67 randomly assigned, cancer patients with advanced disease. The adjuvant treatment was carried out twice weekly over a three-week period. The test of efficacy was monitored using the McGill Pain Questionnaire as well as the Visual Analogue Scale for Pain. These measurements were made pre and post treatments. The results showed that there was sufficient reduction in subjective pain as well as significant reduction in analgesic intake showing a reduced incidence of breakthrough pain. Relaxation exercises in addition to conventional treatment, clearly helped to provide comfort and pain relief for cancer patients.[157] In addition to conventional treatment Cunningham and Edmonds propose group psychological therapies for these cancer patients.[158] It is a four-step program, which can be provided at a treatment centre. The proposal describes adjuvant therapy in the form of psychological help in order to improve quality of life (QOL). This adjuvant therapy, which is essentially holistic, would include: providing information; emotional support; behavioural training in coping skills, psychotherapy of various kinds as well as spiritual existential therapy. This raises the relationship between spirituality and illness. In the next section I will define the term spirituality and illness and show how the transcendent can be an experience in and through the practice of medicine and personal relationships. I will

---

[156]R. Sloman, P. Brown, E. Aldana, E. Chee, "The use of relaxation for the promotion of comfort and pain relief in persons with advanced cancer." *Contemp Nurse* 3 (1994) 6-12.
[157] Ibid.
[158]A. J. Cunningham, C.V. Edmonds, " Group psychological therapy for cancer patients: a point of view, and discussion of the hierarchy of options." *Int J Psychiatry Med* 26 (1996) 51-82.

show how self-transcendence gives integrity and meaning to life and the value of elements such as faith, hope, and compassion to the healing process

2. 3 SPIRITUALITY AND ILLNESS

From the perspective of spirituality, illness has been defined as a holistic complex state, incorporating the physical, social, emotional and spiritual component, which effects the patient as a whole, thus the person as a whole is affected because, man is unique and his nature is a unity not a dualistic composition of physical body and spiritual soul, but an entity in which both find expression in the whole.[159] Spirituality may or not be rooted in religious beliefs and practices; which are common worldwide. When illness strikes spirituality can become important for coping. The term spirituality means different things to different people. The question then arises as to what does the term spirituality mean? and what role does it play in coping with stress including the stress of pain and suffering in the context of illness?[160] Spirituality and medicine have a long history in common. For much of that history and for many persons and cultures today, the rupture between medicine and spirituality that characterizes Western medicine at the brink of the 21st century is a distinct anomaly. For Sulmacy, spirituality is defined by a person's relationship with the transcendent.[161] Therefore, genuine holistic care must address the totality of the patients' relational experience: physical, social, psychological and spiritual. Only

---

[159]K.I. Pargament. "Religious coping reconcidered: an integrated approach," *Journal of Psychology and Theology* 26 (1998) 260-275, see also H.G. Koening, L. K. George, P. Titus. "Religion, spirituality and health in medically ill older patients," *J Am Geriatr Soc* 52 (2004) 554-562. See also K.I. Pargament, H.G. Koenig, N. Tarakeshwar et al., "Religious struggle as a predictor of mortality among medically ill elderly patients: a two year longtitudinal study," *Arch Intern Med* 161 (2001) 1881-1885.

[160] Ibid.

[161]D.P. Sulmacy, " Is medicine a spiritual practice"? *Acad Med* 74 (1999) 1002-1005.

persons are capable of such relationships. The transcendent can be experienced in and through the practice of medicine, which essentially involves personal relationships with patients and always raises transcendent questions for patients and practitioners.

Spirituality is to be distinguished from religion which is an organized system of beliefs, practices, and symbols designed to facilitate closeness to a higher power and includes the understanding of ones relationship with and responsibility to others. According to Astrow et al. religion is a set of beliefs, practices, and language that characterizes a community that is searching for transcendent meaning in a particular way usually in the basis of believing in a deity.[162] Thus, although not everyone has a religion, everyone who searches for ultimate or transcendent meaning can be said to be spiritual. Spirituality is the quest for understanding life's ultimate questions and the meaning and purpose of living which often leads to the development of ritual and a shared religious community, but not necessarily. Many people may not be formally affiliated with a religious tradition or even believe in God, yet still be involved in a spiritual quest, seeking meaning in something outside their own personal ego's.[163]

Meeting the spiritual needs of patients is part of holistic care. Difficulties arise however in the assessment of these spiritual needs due to inadequate definitions and conceptual frameworks. For example, it should not be assumed that spirituality is synonymous with religion. Adopting this view would lead to difficulties in providing individualized care. Reflection on recent literature reveals that the self, others, and

---

[162] A.B. Astrow, C.M. Puchalski, D.P. Sulmacy, "Religion, spirituality and healthcare: social, ethical, and practical considerations. *Am J Med* 110 (2001) 283-287.
[163] Ibid.

God provide the key elements within a definition of spirituality, and that other emerging themes namely meaning, hope, relatedness /connectedness, beliefs, belief systems and expressions of spirituality, can be articulated in the context of these three key elements. In particular, it is proposed that the nature of God may take many forms, and, essentially, is whatever an individual takes to be of highest value in his/her life. It is suggested that the themes emerging from the literature can be utilized as a framework to give practitioners and researchers a direction for future exploration of the concept of spirituality.[164]

According to some scholars spirituality is an elusive concept, especially when nursing theorists attempt to define it.[165] This problem is further compounded by the common misperception that the word is necessarily equated with institutional religions such as Christianity and Judaism.[166] Narayanasamy provides a working definition : spirituality is rooted in an awareness which is part of the biological makeup of the human species.[167] Spirituality is potentially present in all individuals and it may manifest as inner peace and strength derived from a perceived relationship with a transcendent God/an ultimate reality, or whatever an individual values as supreme. The spiritual dimension evokes feelings, which demonstrate the existence of love, faith, hope, trust, awe, and inspirations; therein providing meaning and a reason for existence. It comes into focus particularly when an individual faces emotional stress, physical illness or death. The term spirituality refers to both a lived experience

---

[164] Ibid.

[165] A.Oldnall, "On the absence of spirituality in nursing theories and models." *J Adv Nurse* 21(1995) 417-418, see also A. Narayanasamy, J. Ownes," A critical incident study of nurses responses to the spiritual needs of their patients, *J Adv Nurs* 33 (2001) 446-455

[166] E. Tayler, M. Amenta, M. Highfield. " Spiritual care practices of oncology nurses." *Oncology Nursing Forum*, 22 (1995) 31-39.

[167] A. Narayanasamy, "A review of spirituality as applied to nursing" *J Adv Nurs* 36 (1999) 117-125. See also A. Narayanasamy, P. Clisset, L. Parumal, D. Thomson, S. Annasamy, R. Edge, "Responses to the spiritual needs of older people" *J Adv Nurs* 48 (2004) 6-16.

and an academic discipline. For Christians (R.C.), it means ones entire life as understood, felt, imagined, and decided upon in relationship to God, in Christ Jesus, empowered by the Spirit. It also indicates the interdisciplinary study of this religious experience, including the attempt to promote its mature development. From a theological perspective the word spirituality as it refers to experience, has an interesting history. Originally a Christian term, from Paul's letters, it was an exclusive a Roman Catholic term until the late 19th century. It retained its original reference to life according to the Holy Spirit, yet gradually came to mean that life as the special concern of "souls seeking perfection" rather than as the common experience of all Christians.[168]

While striving to avoid Christian exclusiveness and denominational narrowness, virtually everyone discussing spirituality today is talking about self-transcendence, which gives integrity and meaning to life by situating the person within the horizon of ultimacy. In a philosophical sense, all humans are essentially spiritual and actualize that dimension of selfhood through the establishment of human relationships. The religious meaning of spirituality is based on the conception of what constitutes the proper and highest actualization of the human capacity for transcendence in personal relationships, namely, relationship with God. Spirituality then in its religious sense refers to the relationship between the individual and God pursued in the life of faith, hope and love. The Christian meaning is a specification of religious meaning, indicating actualization of the capacity for self-transcendence that

[168] Ibid.

is constituted by the gift of the Holy Spirit, which gives a relationship to God in Christ within the believing community.[169]

Patients and physicians have begun to realise the value of theological elements such as faith, hope and compassion in the healing process. Until recently a world health organisation (WHO) report has stated that the health professions have largely followed a medical model which seeks to treat patients by focussing on medicine and surgery, and give less importance to beliefs and to faith, hope and compassion in the healing process. In one study 93% of patients with cancer said that religion helped sustain their hopes.[170] Such figures deserve our attention. Hermann studied nineteen hospice patients, using a semi-structured interview.[171] The patients were asked what meaning they gave to spirituality and what were their perceived needs? Initially, participants defined spirituality as relating to God or religion; however as the interviews progressed it became apparent that their spirituality was indeed part of their whole existence. Furthermore, twenty-nine unique spiritual needs were identified and grouped into six themes: need for religion, need for companionship, need for involvement and control, need to finish business, need to experience nature, and need for a positive outlook. Participants perceived spirituality as a broad concept, that may or may not involve religion. Spiritual needs were likewise broad in scope and were linked closely to purpose and meaning in life.[172] Baldacchino and Draper point out that spiritual coping strategies involving relationships with self, others and God (ultimate other) or nature were found to help individuals to cope with their

---

[169] Ibid.
[170] L. Culliford, "Spirituality and clinical care." *BMJ*, 325 (2002) 1434-1435.
[171] C.P. Hermann, "Spiritual needs of dying patients: a qualitative study." *Oncol Nurse Forum* 28 (2001) 67-72.
[172] Ibid.

illness and suffering.[173] This could be because of finding meaning, purpose, and hope, which may nurture individuals in their suffering. This implies that holistic care incorporates facilitation of various coping strategies to safeguard the wholeness and integrity of the patients.[174]

Next I will discuss spirituality and healing. I will show how the conventional medical model with its focus on disease, bypasses issues of self-healing and wholeness, which prompted the rise of complementary therapies. I will demonstrate that the addition of these therapies to orthodox treatment can be beneficial to the restoration of healing and wholeness to the sick.

2.4 SPIRITUALITY AND HEALING

In recent decades orthodox medicine's successful focus on specific disease interventions has meant relative neglect of self-healing and holism, and from this shadow complementary medicine has emerged, with its counterbalancing biases. The gap between them is, however, narrowing with the emerging view, backed by the study of placebo and psycho neuro-immunology, that to ignore whole person factors is unscientific and less successful.[175] Almost twenty years ago doctor's interest in complementary medicine surfaced, suggesting major changes in Western medicine that seemed unimaginable at the time.[176] Indeed complementary medicine may have been largely driven by medicine's main omission, the failure of holism. After training

[173]D. Baldacchino, P. Draper, "Spiritual coping strategies: a review of the nursing literature." *J Adv Nurs,* 34 (2001) 833-841.

[174] Ibid.

[175] J.K. Kiecolt-Glaser, R. Glaser, " Psychoneuroimmunology: can psychological interventions modulate immunity"? *J Consult Clin Psychol* 60 (1992) 569-575

[176] D.T. Reilly, " Young doctors' views on alternative medicine." *BMJ* 287 (1983) 337-339

in complementary medicine, to supplement his knowledge as a general practitioner, Reilly stated that his interest in medicine had been rekindled, and that he could now see the patient as a whole person and not a biochemical puzzle to be solved.[177]

The question then arose as to how primary care could deliver its whole person perspective and honour a bio-psychosocial perspective in too short consultations with rushed doctors whose human contribution, in some cases, is so undervalued it is excluded from treatment protocols?[178] The back up is a pressured secondary care system designed around a mind-body split. A delivery of holism by complementary medicine might help but would not cure the system failure. The present evidence based treatment guidelines echo the focus on technical treatments for specific diseases, ignoring the critical impacts of whole person factors in these diseases. For example, in heart disease, we now know that hopelessness accelerates the disease and increases mortality. This fact is ignored in guidelines.[179] In developing and assessing care we cannot ignore that human caring and interaction is a powerful, creative activity with impact, which tools can serve but should not lead. Complementary medicine has its own blind spots, and needs to defend its specific interventions, undervalues what it has to teach about holism and healing. It has been shown that a homeopathic consultation alone has a healing impact before any additional effect from subsequent medicine.

---

[177] D.T. Reilly, M. A. Taylor, "Review of the postgraduate education experiment, developing integrated medicine: report of the RCCM research fellowship in complementary medicine," *Complement Ther Med* 1 (suppl. 1) 1993, 29-31.
[178]G.L. Engel, "The need for a new medical model: a challenge for biomedicine." *Science 196* (1977) 129-135.
[179]S.A. Everson, G.A. Kaplan, D.E. Goldberg, R. Salenon, T. Jukka, "Hopelessness and a four year progression of carotid atherosclerosis: the Kupuio ischemic heart disease risk factor study." *Arteriorscler Thromb Biol* 17 (1997) 1490-1495.

If the greater emphasis on human care and holism encouraged by complementary medicine can result in better outcomes, long-term cost effectiveness, and reduced drug use, iatrogenesis, and spirals of secondary care, the question then arises as to "how will orthodoxy change to get similar results"?[180] One way to improve orthodox medicine would be to explore how therapeutic engagement and qualities like compassion, empathy, trust, and positive motivation can improve outcomes directly in addition to any other intervention used. The next question is "can the creation of therapeutic relationship, or a healing encounter, be taught?" Or, does medical care need to balance short term analytic quick fix, and technical thinking with holistic processing? All of these questions have implications for a holistic model of care, and further exploration is required.

Exploration of the human healing process would ask, on multiple levels, "what facilitates or disrupts recovery processes in individuals, and with what potentials and limits"? Based on clinical care, it would gather knowledge from other places: placebo effects, hypnotherapy, psycho-neuro-immunology, psychology, psychosocial studies, spiritual practices, art, and complementary medicine, not as ends in themselves but as a gateway to common ground in creative change. It needs to be practical, for example if fear affects physiology, in say, bronchospasm, what help can we offer other than drugs?[181]In future the question to ask routinely maybe "what is the problem, is there a specific treatment, and how do we increase self healing responses?" Next question is "show me your evidence?" this requires evidence of effective human care and

[180] G. Lewith, D. Reilly. *Integrating the complementary.* NHS yearbook, 1999 (London: Medical Information Systems, 1999), 46-48.

[181] S.A.Eisenberg, P.M. Lehrer, S. Hochron, "The effects of suggestion and emotional arousal on pulmonary function in asthma: a review and a hypothesis regarding vagal mediation." *Psychosom Med* 54 (1992) 192-216.

facilitation of healing and not just data.[182] At this point a definition/description of healing is required.

Numerous researchers have explored the area of healing. Wendler defines healing as an "experiential, energy requiring process in which space is created through a caring relationship, expanding consciousness which can lead to a sense of wholeness, integration, balance and transformation."[183] Cowling also sees healing as appreciating wholeness : the realisation, knowledge, and appreciation of the wholeness in life that leads to better understanding and opportunities for action.[184]He further believes that in the participation of one's own healing means simultaneously healing oneself emotionally, psychologically, physical and spiritually. The process needs to include the examination of ones attitudes, memories and beliefs, with the intention of releasing all negativity that prevents full emotional and spiritual recovery. Thorpe and Barsky agree that self-healing requires a process of awareness and critical analysis leading to a new perspective, and acknowledging the need for change so that healing can begin.[185] All of this requires a paradigm shift beyond the dominant medical model.

Most people have an intrinsic spirituality and for many this spirituality becomes heightened when illness strikes. Spiritual factors can have a considerable impact on the process of healing either positively or negatively. A strong sense of spirituality can play a role in prevention, improved outcomes, and in coping skills. A negative spirituality can hinder the process of healing. An appropriate response is to

---

[182] David Reilly, "Enhancing human healing: directly studying human healing could help to create a unifying focus in medicine." *BMJ* 322 (2001) 120-121

[183] M.C. Wendler, "Understanding healing: a conceptual analysis" *J AdV Nurs*, 24 (1996) 836-842

[184] W.R. Cowling, "Healing as appreciating wholeness," Adv Nurs Sci, 22 (2000) 16-32.

[185]Karen Thorpe, Jeanette Barsky, "Healing through self reflection." *J Adv Nurs,* 35(2001) 760-768.

find a model of care where physicians treat the patient as a whole person, addressing not only the physical, but also the social, emotional, and spiritual issues.[186] Nurses have a particular role in this model.[187]

Marshall et al. have proposed a novel concept of optimal healing environment (OHE). Aspects of care such as the quality of the doctor-patient relationship and the care of the whole patient, mind/body/spirit and healing versus curing are considered as well as the psychosocial factors which may have had an impact on the ill patient, are taken into account.[188] Research results indicate the possibility of an OHE, to renew the healing mission in medicine, reveal new approaches to the patients' health problems and establish the importance of mind/body connection. Finding and maintaining balance according to Geffen, is one of the challenges involved in creating an optimal healing environment for cancer care. This new addition to the medical model promotes awareness, healing, and transformation at the deepest levels of the body/mind/spirit for patients and their families and commitment to developing the health well-being, awareness and communication skills of medical and other staff members. This challenge in creating and directing the optimal healing environment with a scientifically based, compassionate approach to healing has provided insights for dealing sensitively with cancer patients and their loved ones.[189]

---

[186]Stephen Kliewer, " Allowing spirituality into the healing process." *The Journal of Family Practice,* 53 (2004) 616-624.
[187]C.J. Smucher, "Nursing, healing and spirituality." *Complement Ther Nurs Midrifery,* 4 (1998) 95-97. According to Smucker nurses are healers primarily through the caring relationships they form with the patients. In response to the patients unique experience, compassion, care, and other humanistic qualities of the medical staff help to create a healing environment
[188] D.A. Marshall, "Optimal healing environments for chronic cardiovascular disease." *J Altern Complement* Med, 10 Suppl 1(2004) S147-155.
[189] J.R. Geffen, "Creating optimal healing environments for patients with cancer and their families: insights, challenges, and lessons learned from a decade of experience." *J Altern Complement Med* 10 Suppl 1 (2004) S93-S102

Another enhanced medical model to provide integrated cancer care (ICC) has been described by Block et al.[190] This treatment is given to patients under physician supervision, with conventional treatments in a healing context and is based on insights from research on nutrition, biochemistry, exercise and psycho-oncology. It uses evidence based as well as complementary and alternative medicine (CAM) It also involves strategies for enhancing treatment as well as side-effect management, and methods to reduce treatment resistance. The overall assessment and treatment plan is based on wholeness, and it is patient-oriented to cater for individual needs.[191] This enhanced treatment plan aligns itself well with the optimal healing environment (OHE). Within the healing environment patient well-being is fostered, and self-care practices are frequently used as therapeutic tools. Development of a healing presence among staff and patients are emphasised, as well as health promotion practices are standard. Integration of complementary and alternative medicine (CAM) in the practice is typical. This integrated cancer care (ICC) goes beyond the conventional medical model, deals with wholeness and delivers best medical care possible at the present time.[192] In the light of the above research I now propose to demonstrate how spirituality has clinical relevance and can have an impact on how people cope with suffering and illness.

---

[190] K.I. Block, P. Block, C. Gyllenhaal, " The role of optimal healing environments in patients undergoing cancer treatment: clinical research protocal guidelines." *J Altern Complement Med,* 10 Suppl 1 (2004) S157-S170.
[191] Ibid.
[192] Ibid

2.5 SPIRITUALITY, ILLNESS AND HOPE

Researchers in Norway, have documented the phenomenon of hope in seriously ill and dying patients.[193] These authors also acknowledge the importance of dealing with uncertainty, which can be seen as a perquisite for hope. A scheme involving three kinds of hope was introduced. a) hope on a daily basis; b) hope concerning a possible eternity; c) hope based on unrealistic premises. The difficulty lay in assessing how to communicate to patients the best way of expressing hope, and how best the physician could help the patient in expressing and reinforcing the patient's hope. Within palliative medicine, treatment involves many aspects of the patient's life. It is directed at treating the physical aspects of the disease, as well as the psychological, social, spiritual and existential dimensions of life. There are two fundamental questions patients with terminal cancer almost always ask: "will the disease eventually cause my death"? And "am I going to experience great pain and suffering"? These questions are marked with hope, the hope that there will be little pain, which may not only relate to physical pain but to psychological and social pain as well.[194]

The focus on hope is a good example of new emerging data. Hope can be seen as a form of trust in the future, and is often part of a religious/cultural matrix. A study carried out at the University of Michigan used a self-administered questionnaire with 108 women at various stages of gynaecologic cancer in order to understand their perspectives on how they handled the disease; 85% of the patients identified

---

[193] S Kaasa, LJ Materstvedt, *Hope. Tidsskrift for Den Norske Laegeforening*, (English trans.) 119 (1999) 1313-1315

[194] Ibid.

themselves as having some connection with organized religion, 76% indicated that religion had a serious place in their lives, 49% felt that they had become more religious since having cancer, and 93% indicated that their religious lives helped them sustain their hopes.[195] Because of its importance to patients, the authors think that the support of hope should be part of the clinician's expertise. In times of severe disabling illness, hope may be mediated through ritual, meditation, music, prayer, traditional sacred narratives, or other inspirational readings. Spiritual care in hospice skilfully redirects hope towards caring relationships and higher meaning. The hospice tradition provides an example of a health care team approach that integrates pain relief, emotional and relational well-being, and broadly defined spiritual care. The authors recommend that routine inquiry about patient spirituality can be included in the initial history and physical examination, and requests for pastoral care could be implemented. A study was carried out by Benzein, Norberg and Saveman, to examine the meaning of the lived experience of hope in patients with cancer in palliative home care.[196] Interviews with 11 patients revealed a tension between hoping for something, that is a hope of getting cured, and living in hope, that is reconciliation and comfort, with life and death. The patients told of their hope of living as normally as possible and of their experience of 'confirmative' relationships, as dimensions of their lived experience of hope. These findings show that hope is a dynamic experience, important to both a meaningful life and a dignified death, for those patients suffering from incurable cancer.[197]

---

[195] S. G. Post, Christina M. Puchalski, D. B. Larson, "Physicians and patients spirituality: professional boundaries, competency, and Ethics". *Annals of Internal Medicine*, 132 (2000), 578-583.
[196] E. Benzein, A. Norberg, B.I. Saveman, "The meaning of the lived experience of hope in patients with cancer in palliative home care." *Palliative Medicine*, 15 (2001) 117-126.
[197] Ibid.

Religious beliefs and spirituality are important for seriously ill patients, because it provides support and comfort which enables patients to cope with and endure their pain, suffering and disability. Multidisciplinary research papers now attest to the health benefits of those who have spirituality and religious beliefs as part of their lives. Koenig et al. examined the effect of religion and spirituality on factors such as: social support, fewer depressive symptoms, better cognitive function and greater co-operativeness ($p<0.1$ to $p<0.0001$). Relationships with physical health were weaker.[198] Organizational religions activity (ORA) predicted better physical functioning, and observer-related religiousness (ORR) and observer-related spirituality (ORS) with less-severe illness and less medical comorbidity, all at ($p< 0.05$) Patients who categorized themselves as neither spiritual or religious tended to have worse self-rated and observer-rated health and had greater medical comorbidity. Participants consisted of 838 consecutively admitted patients, over 50 yrs of age, to a general medical service. This is the largest and most detailed study reported thus far on the religious and spiritual characteristics of medically ill hospitalized patients and their relationship to social, psychological and physical health factors. They are among the sickest patients that medical practitioners treat and the ones most likely to have their coping abilities challenged by illness and disability.[199]

What is required therefore, is patient-oriented, holistic care. Sulmacy proposes a model for research and practice, which expands the bio psychosocial model to include the spiritual concerns of patients.[200] Patients want to be treated as

---

[198] H. G. Koenig, Linda K. George, Patricia Titus, "Religion, spirituality, and health in medically ill older patients." *J Am Geriatr Soc* 52 (2004) 554-562.
[199] Ibid.
[200] Daniel P. Sulmacy, "A biopsychosocial-spiritual model for the care of patients at the end of life." *The Gerontologist,* 42 (2002) 24-33.

whole persons and in his view the healing professions should meet their needs as whole persons. Persons can be considered as beings-in-relationship, and illness can be considered as a disruption in biological relationships that in turn effects all the other relational aspects of a person. Spirituality concerns a person's relationship with transcendence. Therefore, genuine holistic health care must address the totality of the patient's relational existence, physical, psychological, social and spiritual. Koeing agrees with Sulmacy that the spiritual needs of patients must be included in the holistic care of patients as whole persons and not as diseases.[201] A whole person is someone whose being has physical, emotional, and spiritual dimensions. Ignoring any of these aspects of humanity leaves the patient feeling incomplete and may even interfere with healing. For many patients, spirituality is an important part of wholeness, and when addressing psychosocial aspects in medicine, that part of their personhood cannot be ignored.

Physical illness is often accompanied by both mental and emotional suffering, which is not given due attention in conventional medical practice. A qualitative assessment was undertaken by McClain to determine the relation between spiritual well-being, depression and end-of-life despair.[202] One hundred and sixty hospice patients were interviewed, using standardized instruments including: the functional assessment of chronic illness therapy / spiritual well-being scale. The Hamilton depression rating scale, the Beck hopelessness scale, and the schedule of attitudes towards hastened death. Suicidal ideation was based on the results of the Hamilton

---

[201]Harold G. Koeing, "Religion, spirituality, and medicine: application to clinical practice." *JAMA*, 284 (2000) 1708-1708.
[202]Colleen S. McClain, B. Rosenfeld, W. Breitbart, "Effect of spiritual well being on end-of-life care," *The Lancet* 361 (2003) 1603-1607

depression rating scale. Results indicated significant correlations between spiritual well-being, and desire for hastened death (r=0.51), hopelessness (r=0.68), and suicidal ideation (0.41). Results of multiple regression analysis showed that spiritual well-being was the strongest predictor of each outcome variable and provided a unique significant contribution beyond that of depression and relevant covariates. Additionally, depression was highly correlated with desire for hastened death in participants low in spiritual well-being (0.40, p<0.0001). These results indicate that spirituality is an important part of wholeness and spiritual well-being offers some protection against end-of-life despair.

End-of-life despair is not uncommon in patients, diagnosed with advanced lung cancer. One hundred such patients were studied by Wenrich et al.[203] At interview patients ranked faith in God just beneath their oncologists recommendations as the most important factors in their decision about treatment. Another cross-sectional study administered to Indiana outpatients with advanced cancer found that spiritual well being was correlated with quality of life measures. Similarly, 200 of 3212 potentially eligible patients who were interviewed in a New York palliative care hospital were more likely to report end-of-life despair if they also reported unmet spiritual needs, including 40% wanting help finding meaning in life, 51% with overcoming their fears and 42% with finding hope.[204]

---

[203]M. D. Wenrich, J.R. Curtis, D. Ambrozy, J.D. Caraline, S. E. Shannon, P. Ramsey, "Dying patients need for emotional support and personalized care. Perspectives of patients with terminal illness, families and health-care providers." *J Pain and Sympton Management* 25 (2003) 236-246
[204]Ibid.

A further study was undertaken by Breitbart et al, who assessed the incidence of depression, hopelessness and desire for hastened death in ninety two terminally ill cancer patients.[205] The main outcome measures were scored on the Schedule of Attitudes towards Hastened Death (SAHD), a self-report measure assessing desire for hastened death. Scores indicated that 17% of patients were classified as having a desire for hastened death based on SAHD and 16% of 89 patients met the criteria for a current major depressive episode. Desire for hastened death was significantly associated with a diagnosis of depression ($p<0.001$) and hopelessness ($p<0.001$). In multivariate analysis, depression ($p<0.003$) and hopelessness ($p<0.001$) provided independent and unique contributions to the prediction of desire for hastened death while social support ($p< 0.05$) and physical functioning ($p< 0.02$) added significant but smaller contributions. Results show that desire for hastened death among terminally ill cancer patients is not uncommon and depression and hopelessness are the strongest predictors of desire for hastened death. Interventions addressing depression, hopelessness and social support appear to be important aspects of palliative care for these cancer patients.[206]

Wenrich et. al. also studied the emotional needs of dying patients and whether physicians helped or hindered these needs.[207]Twenty focus groups were held with 137 individuals comprising: patients with chronic or terminal illnesses, family members, health care workers and physicians. Content analysis was performed based on

---

[205]W. Breitbart, B. Rosenfield, H. Pessin, M. Kamin, J. Funesti-Esch, M. Gallietta, C.J. Nelson, R.Brescia, "Depression, hopelessnsss, and desire for hastened death in terminally ill patients with cancer." *JAMA* 132 (2000) 578-583.
[206]Ibid.
[207]M. D. Wenrich, J. Randall Curtis, D. Ambrozy, J. D. Caraline, S. E. Shannon and Paul G. Ramsey. "Dying patients need for emotional support and personalized care. Perspectives of patients with terminal illness, Families, and health care providers." *J Pain and Symptom Management*, 25 (2003), 236-246.

grounded theory. Emotional support and personalization were 2 of 12 domains identified as important in end-of-life care. Components of emotional support were: compassion, responsiveness to emotional needs, maintaining hope and a positive attitude, and providing comfort through touch. Components of personalization were: treating the whole person, and not just the disease, making the patient feel unique and special, and considering the patients social situation. The results indicate that although the levels of emotional support and personalization varied, there was a minimal level, defined by: compassion, and treating the whole person not just the disease, that physicians should strive to meet in caring for all dying patients.[208]

The impact of illness on the patients self image is also an area of importance to a patient-orientated approach to medicine. Stradmark has studied different dimensions of ill health based on individual experiences.[209] Twenty five individuals were given an in-depth interview using a philosophical / phenomenological method. The findings showed that the essence of ill-health is powerlessness, which comes from a self-image of worthlessness, a sense of being imprisoned in one's life situation, as well as emotional suffering. This individual views himself/herself as worthless, based on societal norms, attitudes and human models. A sense of incapability and worthlessness cause the individual to distrust her/himself and others. He/she is imprisoned in her own life situation due to limited choices and ability. Such a situation gives rise to apathy. Destructive feelings of alienation, anguish, shame and guilt take over, and the individual's autonomy and existence are threatened. As a

[208] Ibid.

[209]M. Strandmark, "Ill health is powerlessness, limitations and suffering." *Scand J Caring Sci* 18 (2004) 135-144.

consequence stigmatisation ensues and the patient suffers.[210] These vulnerable patients have unmet needs. They need human support and increased awareness, to live in the present, in a society, which takes heed of disability. These interventions are required to counteract the apathy and suffering of these patients. What is required is a paradigm shift, to a patient-orientated holistic medical model, which includes a spiritual component, which I am promoting in this thesis.

2.6 SPIRITUALITY, CLINICAL PRACTICE AND SCIENTIFIC STUDIES

Spirituality, which pertains to ultimate meaning and purpose in life, has clinical relevance. Patients are especially concerned with spirituality in situations of pain, suffering, debilitation, and dying. For some patients, these concerns may be taken up entirely within the context of human relations, values and purpose.[211] For others their resolution involves faith in a higher being in the universe, one that is a source of reassurance and hope. A recently developed and clinically tested spiritual well-being scales delineates the term spirituality in broad categories, including such phenomena as belief in a power greater than oneself; purpose in life; faith; trust in providence; prayer; meditation' group worship; ability to forgive; ability to find meaning in pain and suffering; and gratitude for life, which is perceived as a gift. The key to emotional coping with serious illness, pain and suffering are frequently found within the matrix of patient spirituality. Studies indicate that this matrix has clinical significance because it provides an interpretative framework for many patients coping

---

[210] Ibid.

[211] R.A. Emmons. "Religion in the psychology of personality" Journal of Personality 67 (1999) 874-888

with the stress of illness, pain, and suffering. For this reason, the physicians duty of beneficience requires respect for patients spirituality[212]

According to Pulchalski, caring for critically ill patients requires that physicians and other health care professionals recognize the potential importance of spirituality in the lives of patients, their families, loved ones and their own lives.[213] Patients and loved ones undergo tremendous stress and suffering in facing critical illness. Spirituality offers people a way to understand suffering and illness. Spiritual beliefs can also have an impact on how people cope with illness. By addressing the spiritual issues of patients, we can create holistic and compassionate systems of care. Mueller et al. reviewed studies examining the association between religious involvement and spirituality and physical health, mental health, and health related quality of life and other health outcomes.[214] They also reviewed articles that provided suggestions on how clinicians might assess and support the clinical needs of patients. Most studies showed that religious involvement and spirituality are associated with better health outcomes, including greater longevity, coping skills, and health related quality of life, and less anxiety, depression and suicide. Both Pulchalski and Meuller et al. agree that supporting the spiritual needs of patients may assist them in coping with suffering and can possibly enhance recovery from illness. Chaplains are available in most hospitals to support the spiritual needs of these patients. A holistic medical model, which I am proposing in this thesis, places the patients needs at the centre of clinical care and practice, and takes into account the whole needs of the

---

[212] Ibid.

[213] C. Pulchalski, "Spirituality in health: the role of spirituality in critical care." *Crit Care Clinic* 20 (2001) 487-504.

[214] P. S. Meuller, D. J. Plevak, T.A. Rumman, "Religious involvement, spirituality and medicine." *Mayo Clin Proc* 76 (2001) 1225-1235.

patient, physical, emotional, social and spiritual, in other words patient-oriented holistic care.

2.7 PATIENT-ORIENTED MEDICINE

Donnolly points out that although the relief of pain and suffering is commonly cited as a principal goal of clinical medicine, yet suffering gets very little attention in medical case histories except for symptoms or dysfunction which can be useful for diagnostic purposes.[215] This situation, however, according to Donnelly, is changing. The setting up of a patient-oriented record incorporating the patients perspective is now included in the medical record. This perspective includes a history of present illness, describing the patients sickness and disability, from two different perspectives, that of disease and of sickness. Sickness describes the patients' personal situation, sufferings, hopes and fears. To provide a holistic history doctors need to be mindful of the goals of medicine and the nature of suffering. Although no published studies have yet examined the benefits of taking a spiritual history, there is some indirect evidence in support of this practice. Keonig suggests that, first, religious practice is one of the most common ways that patients cope with medical illness, and it predicts both successful coping and faster remission from depression in medical settings.[216] Second, religious beliefs have been found to influence medical decisions that patients with serious medical illness make. Third, the faith community is a primary source of support for many medically ill patients, and social support has been associated with better adherence to therapy and medical outcomes. Fourth, based on a survey of 1,732,562 patients representing 33% of all hospitals in the United States, it

---

[215]W.J. Donnelly, "Taking suffering seriously: a new role for the medical case history." *Acad Med* 71 (1996) 730-737

[216]H.G. Koenig, "Taking a spiritual history" *JAMA* 291 (2004) 2881-2881

was shown that patient satisfaction with the emotional and spiritual aspects of care had one of the lowest ratings among all clinical care indicators and was one of the highest areas in need of quality improvement. Finally, unmet spiritual needs indicated by religious struggles (ie. feeling punished or deserted by God) are a predictor of increased mortality among medical patients following hospital discharge.[217]

There are many barriers to obtaining a spiritual history, including lack of time, lack of training, worries about imposing religious beliefs on patients, or lack of awareness. It is probably most appropriate to obtain a spiritual history when the physician is collecting comprehensive information, such as when taking complete history of a new patient. Those with terminal or chronic, disabling medical illness with whom the physician has an ongoing relationship are ideal candidates. The purpose of the spiritual history is to learn how patients cope with their illnesses, the kinds of support systems available to them in the community, and any strongly held beliefs that might influence medical care. The question of empathy, inevitably arises in a patient-oriented approach to medical care. In a recent letter Anfossi and Numico describe the relevance, in a doctor-patient relationship, of approaching the patient with the aim of understanding his innermost personal experience of cancer.[218] They also show how important it is to take time to delve deeper into the patient's life, and sharing an episode of her/his life not in direct connection with the clinical course of the disease. This way of caring is called empathy. As human science and study emphasize, empathy is a necessary dimension of the work of the caregiver (physician,

---

[217] Ibid.
[218] M. Anfossi, G. Numinico, "Empathy in the doctor-patient relationship," *Journal of Clinical Oncology*, 22 (2004), 2258-2259.

psychotherapist, psychologist, nurse or carer) who wants to facilitate a good outcome. The effect of an empathic relationship are positive both for the patient and for the doctor. It can increase satisfaction, trust, coping skills, and compliance with therapy, while also enriching the patient-doctor experience. Furthermore if empathy is combined with competence in an appropriate setting, it can protect caregivers from burn-out and support their therapeutic power.[219]

The issue here is one of communication, between the doctor and the patient. A holistic approach to communication considers that the patient, is a human person with social, emotional, physical and spiritual entities. Ignoring any of these aspects of personhood leaves the patient feeling uneasy and may even interfere with healing. Moreover the patient is a human-being-in-relationship: social, biological and transcendent. When illness strikes, it disrupts all aspects of relationships. Koenig makes the point that patients want to be seen and treated as whole persons, not as diseases.[220] For many patients, spirituality is an important part of wholeness, and when addressing psychosocial aspects in medicine, that part of their personhood cannot be ignored. Only a bio-psychosocial spiritual model can provide a foundation for holistic care.

Medical science has made progress in the diagnosis and treatment of human disease. However, the emphasis on the medical model has created a generation of doctors who have communication difficulties in relating to their patients about their suffering. The changing pace in the practice of medicine with the emphasis on treating and discharging the patient as quickly as possible has placed time constraints

[219] Ibid.

[220] H.G. Koenig, " Religion, spirituality and medicine." *JAMA*, 284 (2000) 1708-1708

on medical staff due to economic pressures. This disrupts the development of good doctor-patient relationships. In order to counterbalance the rational stance of the current medical model the inclusion of the emotional, and existentialist concerns of the patient must be taken into account. The problem with the current medical model, evidence-based medicine (EBM) is that it restricts itself to the physical evidence only or places evidence alone at the top of a hierarchy and devaluing any evidence further down.[221] This method is no longer tenable, a more holistic way of treating patients is called for, a widening process that would include philosophical and spiritual issues and perspective. Without this component, difficulties arise where issues of human suffering are concerned. Communication is an important component of patient-care. For a successful consultation the doctor needs to be satisfied that the patients concerns had been understood and dealt with. To be effective the doctor must gain an understanding of the patients' perspective on his/her illness. Patients concerns can be wide ranging from fear of death, disability, concern for loss of wholeness, grief or pain and suffering. Patients' values and cultural preferences need to be explored. The patient may benefit from raising his/her concerns in an optimal healing environment with a caring doctor who listens to their story. Readiness to share quality information, promotes a good patient-doctor relationship, and a good outcome from holistic patient care. There is strong evidence linking a number of health benefits including good emotional health, having symptoms under control, accurate physiological measurements and pain control.[222] When the doctor gives clear

---

[221] M.A. Stewart, " Effective physician-patient communication and health outcomes: A review." *CMAG* 152 (1995) 1423-1433.

[222] P. A. Barrier, J.T. Li, N.M. Jensen, " Two words to improve physician-patient communication: what else?" *Mayo Clin Proc*, 78 (2003) 211-14.

information, together with emotional support, physiological distress is reduced, pain is reduced and mood and anxiety improve.[223]

The patients accounts of illness have shown that the narration is an important way in which patients make sense of their illness, it restores there sense of personhood, establishes connectedness and reclaims their illness experience from the meta-narrative of medicine. That witnessing and assistance of patients with their illness narratives can be a caring practice with significant healing potential. Giving priority to the patients' voice, listening for meaning, rather than facts, provides a relationship enabling the patients' story to evolve. According to Sakalys, the patients' accounts of their own illness can be very important for both the doctor and the patient.[224] In the patients story a detailed account of their illness is given including the disruption caused to the patients self and life. The narration is also an important way for the patient to make sense of an illness, and to restore connectedness. Priority must be given to the patients' account of illness, as well as listening for meaning, can provide a relationship, which facilitates the telling of the patient's story. Patients want to talk about their worries and concerns, but surveys indicate that this is not happening. Spiritual issues may become a central concern for seriously ill patients and addressing their concerns can be a key to relieving suffering.[225]

There is a need to move on from a compartmentalized view that places problems of emotional, spiritual or existential kind outside the medical model. The medical model needs to be humanised, and be part of patient-oriented holistic care. It

---

[223] D. Roter, "The enduring and evolving nature of the patient-physician relationship" 39 (2000) 5-15
[224] J. A. Sakalys, "Restoring the patients voice. The therapeutics of illness narratives." *J. Holistic Nurse*, 21 (2003) 228-41.
[225] S. E. Shannon, P. Tatum, " Spirituality and end-of-life care." *Mo Med*, 99 (2002) 571-576.

follows that a holistic medical model of care needs a broader base for dialogue even to a spiritually informed philosophical viewpoint . According to Hauerwas ways of being in the presence of suffering seem to stretch the limits of dialogue in the medical literature.[226] A more inclusive form of dialogue is needed, beyond the language of medical science, models and skills.

Patient-centred medicine is basically humanistic, with a bio-psychosocial perspective combining the ethical values of the ideal physician, with psycho-therapeutic views on encouraging patients to give an account of their real worries and to share in the decision making. The patients' perspective, ought to be taken into account and medical care arranged to suit the patients' needs and preferences.[227]

2.8 CHALLENGES TO THE POSITIVE BENEFITS OF SPIRITUALITY IN THE PRACTICE OF MEDICINE

Having presented a strong case in favour of spirituality as an important component of a holistic medical model, it has to be acknowledged that, at the present time, there is some speculation as to whether it would be feasible to integrate a holistic model of care encompassing a spiritual dimension, into mainstream medicine. Conflicting reports concerning religion and physical health have also shown that while longtitudal epidemiological studies show that religious involvement is shown to have a protective effect on health, conversely cross-sectional results show high levels of religiosity associated with poorer, not better health since people in crisis sometimes

---

[226]S. Hauerwas, *Naming the silences: God, Medicine and the problems of suffering* (Edinburgh: T. and T. Clarke, 1990) 106.
[227] Jozien Bensing, " Bridging the gap. The separate worlds of evidence based medicine and patient-centred medicine." *Patient Education Counselling* 39 (2000) 17-25.

turn to God for comfort and support.[228] King also reported that patients with a religious and/or spiritual life view, and expressed strong beliefs were likely to fare less well clinically.[229] Powell also reported conflicting results. In healthy participants there is a strong, consistent, prospective and often graded reduction in risk of mortality in church/service attendees. This reduction is approx 25%.[230] Religion and/or spirituality protects against cardiovascular disease, largely due to a healthy lifestyle. However evidence fails to support a link between depth of religiousness and physical health. Furthermore, in patients there are consistent failures to support the hypothesis that religion or spirituality slows the progression of cancer or improves recovery from acute illness. The author concludes that attendance at church/service protects healthy people against death.[231]

Thorenson believes that a healthy skepticism is in order if we are looking for associations between religious/spiritual factors and health outcomes.[232] One needs empirical research and evidence based on well-controlled studies to support these claims. Sloan too is sceptical concerning the evidence linking religion/spirituality and health.[233] He believes that even in the best studies evidence is weak and inconsistent. Therefore he believes that it is premature to promote faith and religion as adjuvant medical treatments. The question of whether spiritual care and spiritual assessment is important for those who care for the sick remains unanswered for some. Draper and Mc Sherry argue that the suggestion that life has a spiritual dimension may be based

---

[228] E. L. Idler, " Religion, health, and non-physical senses of self." *Social Forces*, 74 (1995) 683-704.
[229] M. King, P. Speck, Angela Thomas, " Spiritual and religious beliefs in acute illness, is this a feasible area to study?" *Social Science and Medicine*, 38 (1994) 631-636.
[230] L. H. Powell, L. Shababi, C. E. Thorenson, "Religion and spirituality. Linkages to physical health." *Am Psychol* 58 (2003) 36-52.
[231] Ibid.
[232] C. E. Thorenson, A.H. Harris, "Spirituality and health: what's the evidence and what's needed?" *Ann Behav Med*, 24 (2002) 3-13.
[233] R. P. Sloan, " Religion, spirituality, and medicine," *Lancet*, 353 (1999) 664-67.

on a false presumption.[234] They point out that many people do not know precisely what spirituality means, or may disagree that their lives have a spiritual dimension. which suggests that spirituality has significant health benefits and the integration of Leatherbarrow he quotes Illich's landmark work on *Medical Nemesis* where awe inspiring medical technology gave the impression that contemporary medicine was highly effective.[235] Not so, according to Illich, rather medicine as practiced destroys the potential of people to deal with their own human weakness, vulnerability and uniqueness in a personal or self-directed way. Behaving in a self directive way can be detrimental to some patients if, for example, they disagree with the doctors recommendations and refuse to comply for religious reasons. According to Curlin et al. this form of conflict may occur in three ways, firstly where there is direct conflict between religion and medical recommendation, secondly where conflict is extensive and reflects what occurs in the broader society and thirdly where there is medical uncertainty where patients choose religion over medicine.[236] One solution for this dilemma is where the doctor remains open-minded and flexible while advising what is best for the patient. Thus medicine and religion integrate and the moral responsibility belongs to the doctor and his medical recommendations.

Scheurich, also suggests a negative correlation between spirituality and medical care.[237] He cautions against placing values on religious / spiritual views in medicine, since it runs the risk of offending non-believers and those who belong to minority faiths. He believes that a more neutral position as regards

[234] P. Draper, W. Mc Sherry, "A critical view of spirituality and spiritual assessment." *J Adv Nurse*, 39 (2002) 1-2.
[235] Martin Leather Barrow, "Limits to Medicine. Medical Nemesis," *BMJ*, 324 (2002) 923-923
[236] F.A. Curlin, C. J. Roach, B. R. Gorawara, J. D. Lantos, M. H. Chin, "When patients choose faith over medicine: physician perspectives on religiously related conflict in the medical encounter," *Arch Intern Med*, 165 (2003) 88-91.
[237] N. Scheurich, " Reconsidering spirituality and medicine." *Academic Medicine*, 78 (2003) 356-360.

religion/spirituality and medicine would be more acceptable, and suggests that a philosophical value theory could open up the enquiry and would not offend either secular or non secular views.

While acknowledging the reservations expressed by the above researchers there is an overwhelming body of evidence to suggest a positive correlation between spirituality and healthcare. Seeman takes a positive viewpoint, suggesting that evidence supports the hypothesis that links religiosity/spirituality to physiological processes.[238] This is early evidence from cross sectional studies. More recent research with more representative samples and multivariate analysis provides stronger evidence linking Judeo-Christian religious practices to blood pressure levels and immune function. The strongest evidence comes from randomized trials reporting the beneficial physiological impact of meditation. Overall religiosity /spirituality is linked to health-related physiological processes including cardiovascular, neuro-endochrine, and immune function.

Ellison has looked at the positive influences of religious certainty on well-being and finds that it is direct and substantial.[239] He also reports that individuals with strong religious faith have higher levels of life satisfaction, greater personal happiness and fewer negative psychosocial consequences after traumatic life events. The positive influence of existential certainty is especially important for older persons. Silvestri et al. looked at the ranking of priorities by patients and care-

---

[238] T.E. Seeman, L.F.Dubin, M. Seeman, "Religiosity/spirituality and health. A critical review of the evidence for biological pathways." *Am J Psychol* 58 (2003) 53-63.
[239] C.G. Ellison, "Religious involvement and subjective well-being." *J Health Social Behavior* 32 (1991) 80-99.

givers.[240] They ranked faith in God second, whereas doctors placed it last ($p<0.001$). Patients and caregivers agree on factors that are important when deciding about patient, treatment, for example lung cancer, but differ substantially from doctors. All agree that the oncologists recommendation is the most important. For some, faith is an important factor in making decisions about treatment. Koeing agrees, spiritual beliefs influence medical decisions that affect health care, it may conflict with medical advice and can influence the doctor-patient relationship either positively or negatively.[241] Support from the patients faith community can help patients' to cope better with life stresses. It may improve earlier detection of disease and can assist patients in their compliance with medical treatment. Although these findings are important for all patients, they are particularly important for women, the elderly, the chronically ill the disabled and certain ethnic groups. Larimore et al. suggest that doctors should not deprive their patients of the spiritual support and comfort on which their hope, health, and well-being may depend.[242]

While acknowledging the current debate in scientific research regarding the healing benefits of spirituality, the overwhelming thrust of research, is in the direction of the benefits of a patient-oriented holistic approach incorporating a spiritual component in conjunction with the current medical model, in other words, a holistic medical model.

---

[240] G. A. Silvestri, S. Knittig, J. S. Zoller, P. J. Nietert. "Importance of faith on moral decisions regarding cancer care." *J Clin Oncol* 21 (2003) 1379-1382.
[241] H.G. Koenig, "Spirituality, wellness, and quality of life" *Sexuality, Reproduction, and Menopause*, 2 (2004) 76-82.
[242] W.L. Larrimore, M Parker, M. Crowther, "Should clinicians incorporate positive spirituality into their practices?" *Ann Behav Med* 24 (2002) 69-73.

2.9 CONCLUSIONS

The current medical model EBM has limitations and neglects the uniqueness of patients and their needs as whole persons in dealing with illness, pain and suffering. A holistic medical model would include additional therapies to supplement the conventional medical model, such as belonging to a group linked in their totality and solidarity; belonging to a community of caring, in hospital or rehabilitation centre which fosters new ways of coping with illness in the face of trauma or loss. Existential therapy would deal with philosophy of life, love, meaning, and purpose in life, providing both emotional and psychological support. A holistic medical model would include a spiritual component, shown to be of benefit to patients, fostering their potential for self-healing. A patient-oriented holistic medical model would be particularly beneficial to patients who experience pain and suffering due to terminal disease like cancer. Additional therapies would include relaxation techniques and imagery in conjunction with, in this instance, palliative care, which also fosters holistic care of the entire person. Spirituality is potentially present in all people and may manifest itself as inner peace and strength derived from a transcendent God. For some it is essentially whatever the individual rates to be of highest value in their lives. A Spiritual dimension evokes feelings, which demonstrate love, faith, hope, trust, awe and inspiration, providing meaning and a reason for existence. It comes into focus in the face of serious illness or impending death when all relationships are interrupted. A holistic medical model would address the totality of the patients' relational experience, which includes the transcendent. Patients and doctors are now becoming aware of the value of theological elements such as faith, hope, and compassion in the healing process. In one study 93% of patients said that religion helped to sustain their hopes. Hospice patients defined their understanding of spirituality as relating to God

or religion as well as other needs: needs for companionship, for involvement, to finish business, to experience nature; and have a positive outlook, in other words, needs closely linked to purpose and meaning in life. A holistic medical model would incorporate coping strategies to safeguard the wholeness and integrity of the patients. The current medical model would also be part of this holistic medical model.

A holistic medical model with greater emphasis on human care and holism can result in better health outcomes and long-term cost-effectiveness. It would incorporate qualities like compassion, empathy, and trust, which can promote healing. Appreciating wholeness and promotion of self-healing can lead to new perspectives , acknowledging the need for change, which means that healing can begin at four levels: spiritual, mental, emotional and physical, each level requiring development. All of this requires a paradigm shift beyond the dominant medical model. A patient-oriented holistic medical model in a healing environment promotes awareness, healing and transformation at the level of mind/body/ and spirit for the sick and suffering. This holistic medical model would combine the current scientifically proven medical model with a compassionate approach to healing as well as insights from research on nutrition, biochemistry and exercise and for cancer patients, psycho-oncology. This holistic medical model goes beyond the current medical model, deals with wholeness and delivers the best possible medical care at the present time.

Research has shown that spirituality has clinical relevance for patients in situations of pain, suffering, debilitation and dying. For some patients these concerns are taken up in the context of human relationships, values, and purpose, for others faith in God or a Higher Power, is a source of reassurance and hope. Clinical studies

acknowledge the value of well-being scales where spirituality expresses itself in phenomena such as: purpose in life, faith, trust in providence, prayer, ability to forgive, find meaning in suffering and express gratitude for life. Emotional coping can also be found within the matrix of spirituality. Recent medical literature reports that clinicians looking after critically ill patients now recognize that spirituality offers patients a way of understanding illness, pain and suffering. It also shows that religious/spirituality involvement is associated with better health outcomes, greater longevity and health related quality of life, as well as less anxiety, depression and suicide. In conjunction with the current medical model the holistic medical model that I will be promoting will support the spiritual needs of the patients and place them at the centre of clinical care and practice, this corresponds with patient-oriented holistic care.

In the face of serious illness, pain and suffering, the quality of the patient-doctor relationship is vital for a good outcome for the patient. Research has shown that it can lead to better emotional health, symptom and pain-control. When the doctor gives clear information, together with emotional support, physiological stress is reduced and mood and anxiety improve. For the patient, having an opportunity to narrate their account of illness helps them to make sense of that illness: expressing their values and cultural preferences, voicing their fears, fear of death, fear of disability, loss of wholeness, and grief, pain and suffering. For the doctor, giving priority to the patient's voice, and listening for meaning can be a caring healing practice. Other dimensions of care include empathy, especially when combined with clinical competence can be enriching for both the patient and the doctor. Taking a spiritual history has been shown to be of benefit to patients. It would record the

patient's personal situation, how they are coping with their illness, what support systems are available to them and any strong beliefs held that might influence their decision making with respect to their medical care. Other benefits to patients include better coping skills, which can promote faster remission from depression in a medical setting. Spiritual support has been shown to lead to better adherence to therapy and medical outcomes. Unmet spiritual needs are a predictor of increased mortality among medical patients, following hospital discharge.

The current medical model is based on scientific rationalism and is doctor centered. The doctor extracts information from the patient, applies the biomedical model and instigates treatment. It does not concern itself with healing. It may or may not refer an immobilized patient to a rehabilitation centre. This model is insufficient. It fails to recognize the patient as a human person with social, emotional, physical and spiritual entities. Moreover the patient is a being-in-relationship: social, biological and transcendent. Ignoring these entities impedes healing and difficulties arise where issues of pain and suffering are concerned. There are many reasons why this form of hospital care is inadequate. The rapid turnover of patients in acute hospitals hinders the development of the doctor-patient relationship, and communication may be compromised. Patients may not get an opportunity to express their fears or say how their illness impinges on their lives. This has consequences for the critically ill patient, in the treatment of pain and suffering. What is missing is a bond of trust between the patient and the doctor, failure to recognize the patient as a whole human being, and failure to address their emotional, social, spiritual and existential concerns their grief, pain and unrelieved suffering. A mechanistic way of treating patients is dehumanizing and unethical. The current medical model needs to be humanized, in

other words to become part of a patient-oriented holistic medical model. A holistic medical model would provide a broader base for dialogue to encompass a spiritually formed philosophical viewpoint and deal with ways of being in the presence of suffering. An ideal mode of care would be holistic, respecting the dignity of the person, shared negotiation and decision making, to suit the patients needs and preference, in other words, a patient-oriented holistic medical model, especially in the face of pain and suffering.

In the next chapter I examine two models of medical practice, which are holistic in nature. While both are strictly applicable to the context of palliative care certain elements of both practices examined can provide for a holistic model of care which might be applicable across the broad medical field.

CHAPTER THREE: THE ALLEVIATION OF PAIN AND SUFFERING: THE CLINICAL PRACTICE OF SHEILA CASSIDY AND MICHAEL KEARNEY AS MODELS OF HOLISTIC CARE

3.1 INTRODUCTION

Having established the problem of pain and suffering and the unmet needs of patients treated by the medical model and the advantages of a more holistic way of alleviating pain and suffering, in chapter one; and having analyzed in depth scientific studies on the relation between religion/spirituality and well-being in the second chapter; in this chapter, I will be dealing with the holistic approach within clinical practice of two medical specialists, in the field of palliative care, namely Sheila Cassidy and Michael Kearney, taking a thematic approach to their work, I believe that lessons can be learned from an analysis their approach, which will be useful for the holistic medical model I am proposing. These are two contrasting models of clinical practice, within the hospice movement. Cassidy's contribution to palliative care, comes from her unique insight into pain and suffering, firstly as a result of her personal experience of torture in Chile, and secondly, through her active listening to the terminally ill, and unrelenting efforts in treating and alleviating pain and suffering in those facing imminent death. Kearney goes further, in addition to providing palliative care he also provides psychological therapy and image-work for distressed patients who have difficulties facing imminent death. Both Cassidy and Kearney exercise their expertise within the provision of palliative care for terminally ill cancer patients. What I hope for is that some of the expertise, therapies, and methodologies, as well as insights, which are successful in alleviating pain and suffering in this

context could be transferable to the wider medical field and used to treat other patients who suffer from unrelieved pain and suffering in hospitals, nursing homes or in their homes.

Palliative care is essentially patient-centered, holistic and treats the whole patient, emotional, social, spiritual as well as physical. What I am proposing in this thesis, is the development of a patient-oriented holistic medical model, to alleviate pain and suffering across a wide spectrum of medical cases and in the treatment other progressive diseases, as well as patient's traumatized through injury, and many inherited debilitating diseases. The expansion of palliative care could lead to the development of pain teams in hospitals, and the setting up of outpatient pain clinics could assist in the treatment of much chronic pain. The provision of these services could become adjuvant therapy to the current medical model and deal with the unmet needs of patients both in hospitals and in the community who continue to suffer from unrelieved pain, caused by mental, social, emotional, spiritual or physical distress or a combination of these.

I will begin with the life and works of Sheila Cassidy, which are relevant to the practice of a holistic medical model. After a brief biography I propose to mention a number of themes, which emerge during the course of her work, as a doctor, with the terminally ill. The first theme I will be dealing with is patient fear. I propose to examine the fear, which strikes patients when they learn that they have a terminal illness and that death is imminent. The next theme I will be dealing with is companionship. I will describe the terminally ill and suggest that they have begun their journey towards the end of their lives, where companionship is crucial. In this

context I propose to deal with religion and /or spirituality which of necessity is part of the holistic care of the patient, and also includes transcendence and their struggle for wholeness, and meaning in their lives.

One of the most important elements of palliative care is pain control. I will introduce Cecily Saunders, who is recognized as the pioneer who introduced the concept of "total pain," and describe how she conducted her research to arrive at talking about cancer pain in terms of "total pain." Next I will discuss hospice and/or holistic care for the terminally ill, how pain impinges on all aspects of a patients' life, emotional, physical, psychosocial, and spiritual and state why palliative care requires the support of a multidisciplinary team for its implementation. I will follow this with an exploration of Cassidy's views on an ideal approach to the terminally ill followed by an examination of their needs. Significantly she is describing her own philosophy of terminal care, which includes empathy and listening skills, and of crucial importance, the necessity of establishing a good doctor-patient relationship, which I regard as central elements in the provision of a holistic medical model of care.

Since I ultimately seek to provide a theological underpinning towards a vision of a holistic medical model I provide here an account of the God Cassidy meets during the course of "Sharing the Darkness" with the dying.[243] She reflects on the concept of the wounded healer and her own participation in that role. Cassidy finally deals with the possibility of transcending life and how that compares with the spiritual distress, which some patients endure as alienation and disconnection, and how

---

[243] Sheila Cassidy, *Sharing the Darkness* (London: Darton, Longman and Todd, 1988)

spiritual care can alleviate such distress. I do this with a view to highlighting the essential components of a holistic medical model of care.

Having completed an exploration of the clinical practice of Sheila Cassidy I will then deal with the work of another clinical practitioner Michael Kearney. After a brief biography I will introduce myth, it's meaning, uses and it's language. This is necessary in order to grasp the essence of Kearney's work dealing with the psychological difficulties of his terminally ill patients. In the next section I will deal with a number of themes, which Kearney uses to illustrate his work, as with Cassidy, I select themes, which I deem to be relevant to my own research interests. The first of these is "story" which enables the patients to narrate their life experiences within their unique context. Another theme on "the listening healer," emphasize how important it is to gain an understanding of others through attentive listening. In the next section, as in my examination of Cassidy's clinical practice I will mention fear and the effect it can have on the lives of the terminally ill.

I will also deal with guided imagery, a method used by Kearney to assist patients in their suffering. This is a method of treating patients who have particular difficulties in dealing with their terminal state, it can also link in with the medical model. In my view it can be adapted for use throughout wider clinical practice. I also give examples of Kearney's treatment of patients.' I examine how Kearney outlines the usefulness of a paradigm shift using the Greek myth of Chiron, which can assist the patient to arrive at a place of healing. I also give examples of the treatment of patients for whom the medical model fails and comments on the many ways explored to compliment it. Kearney outlines in some detail the rational medical model used by

Hippocrates and how this links with the current medical model, evidence based medicine (EBM). This provides significant insight into the enduring nature of the basic medical model, which, historically was deemed insufficient for the treatment of pain and suffering, and required the addition of a healing element.

3.2 SHEILA CASSIDY: A BRIEF BIOGRAPHY

Sheila Cassidy was born in 1937 in Lincolnshire, England, daughter of Air Vice Marshall John Reginald Cassidy, who played a central role in Great Britain telecommunications industry during the war. Determined from an early age to become a doctor she entered medical school at Somerville College, Oxford in 1956 and graduated in 1963. After two years residency, she decided to become a plastic surgeon. At this time she befriended Consuelo, a young Chilean doctor and it was from her that Cassidy first came to know Chile. In the early 1970's Cassidy decided to go to Chile to gain further experience in order to further her career in medicine. While there Cassidy worked in different institutions. Her friend Consuelo was her constant companion. She introduced her to English literature, classical music and poetry. It was through Consuelo that she became aware of the existence of injustice and inequality and the poverty, which existed side by side with the affluent, in her country. In 1973 there was a military coup led by General Augusto Pinochet. The Chileans were regularly captured, arrested and taken prisoner. It was during her second visit to Chile that Cassidy was asked to treat a fugitive called Nelson Gutierrez, which she did. She learned later that he was second in command of the left wing forces. A week later she was arrested, and spent 59 days in prison. During this time she was tortured with electric shocks, placed in solitary confinement and finally

deported. This experience changed her life forever. After her release she traveled the world as a human rights lecturer; she addressed American bishops, a Finnish tribunal, and the Swedish parliament.

In the years after her ill treatment Cassidy suffered a hidden life of insomnia, depression, exhaustion and fear. In 1978 on her return to England she felt called by God to dedicate her life to him. She felt drawn to the monastic way of life and spent 18 months in the periphery of the Abbey of Ampleforth. There she attended lectures in Scripture, theology, and monastic spirituality. After experimenting with various forms of religious life, during which her health deteriorated further, she resumed her work as a doctor, which she felt was her true calling, and decided to dedicate her life to the care of the terminally ill. She was devout and sincere although she frequently experienced failure. Nevertheless despite all her flaws she attained a deep level of spirituality. This is apparent in her writings, which are interspersed with theology. She has written extensively on suffering; as, for example in her works *Sharing the Darkness, and Good Friday people.*[244] Her faith in God is strong, she believes in a God who is both transcendent and immanent, close at hand. She is convinced that once you have encountered Him (as she did during her torture, and solitary confinement where she celebrated the Eucharist with plain bread) you cannot question

---

[244] Sheila Cassidy, *Audacity to Believe* (London: Darton, Longman and Todd, 1977) *Sharing the Darkness* (London: Darton, Longman and Todd, 1988) *Good Friday People* (London: Darton, Longman and Todd, 1991). See also Kenneth Noble*: Doctor to the Dying.* http://www.forachange.co.uk/aug94/cassidy.htm viewed 05-08-03, p. 1-3. *Together in the Darkness,* The Tablet, 1997. http://www.thetablet.co.uk/cgi-bin/archivedb.cgi?tablet-00136 Viewed 05-08-03 p. 1-3. *Should I Laugh or Cry?* The Tablet, 1998 http://www.thetablet.co.uk/cgibin/archive_db.cgi?tablet-00224 , viewed 03-15-04. p.1-2. *God Does Not Choose the Perfect.* Insights, The 3rd National Ecumenical Aged Care Chaplains Conference, 1999. http://insights.uca.org.au/1999/november/chaplains.htmViewed, 05-08-03. *Human Being* http://www.cb1.com/~john/religion/Human_Being/Cassidy1.html , 2002, viewed,12-01-03, p.1-4.

the suffering he allows to befall on you. She deals with this topic in *Light from the Dark Valley*.[245]

Cassidy warns against trying to find meaning in suffering, or glorying in it. She believes that she fell into this trap, denied the awfulness of it, and only later when suffering from post-traumatic distress, was she able to acknowledge it, and admit how hurt and wounded she was. She frequently suffers from burn-out, and relies on family, friends, psychotherapy and prayer to sustain her. She prays and listens to God every day and tries to become aware of where she is wanted, where her gifts are needed. She is happiest when she is writing or being creative, making things. Her coping strategies have to do with personal space and creativity.

3.3 FEAR AND COMPANIONSHIP

In *Good Friday People*, Cassidy brings to our notice the element of fear, which accompanies those who suffer when death is imminent.[246] Fear and terror frequently follows a diagnosis of AIDS. Cassidy presents the dying, including people with a terminal illness, as essentially people on a journey. They are uprooted people, dispossessed, marginalized, traveling fearfully into the unknown. What they want more than anything else is to be cured, made better or whole. But since this cannot be they need someone to be with them to face the unknown with them. They need a companion, a friend:

So the spirituality of those who care for the dying must be the spirituality of

---

[245] Sheila Cassidy, *Light From the Dark Valley* (London: Darton, Longman, and Todd, 1994).
[246] Op. cit.

> the companion, of the friend who walks alongside, helping, sharing and sometimes just sitting, empty handed, when we would rather run away. It is a spirituality of presence, of being alongside, watchful, available, of being there. Companions to the dying must go further. They must enter into the darkness go with them at least part way along their lonely and frightening road. This is the true meaning of compassion: to enter into the suffering of another, to share in some small way in their pain, confusion and desolation.[247]

This task is daunting for most people but there are others who seemed to be called to this work, and they do it very well. At the psychological level these carers must have certain qualities: the first 'an intensely down to earth practicality that does not flinch from the impact of the disintegration of human bodies and minds; the second is an oversized sense of humor; the third quality, a very special sort of sensitivity: a vulnerability to the pain of others, sometimes as a result of the personal experience of suffering.' At a religious level the most important gift is a sort of Paschal overview, the ability to hold in the same focus the harsh reality of suffering and the truth of the resurrection, of life after death.[248] This is a good example of holistic / whole person care, psychological, social, spiritual and physical. Issues arising here include, fear of death/unknown, need for companionship, spiritual support, and the alleviation of pain and suffering. These are elements, which could be included in the formulation of a holistic medical model which I am promoting in this thesis.

Attention to the spiritual dimension of a person is one of the essential elements in a holistic approach to hospice care. Although other hospice team members may be involved in matters of faith with patients, chaplains are the primary professionals concerned with the transcendent nature of life and the integrative role that spirituality plays in the care of the dying. Understanding spirituality in a person's living and

[247] Sheila Cassidy, *Sharing the Darkness*, 5.
[248] Ibid. 6

dying requires an understanding of religion and theology. Religion connects us to a caring community and a sense of tradition. Theology is a search for meaning, and spirituality, it is the life principle that pervades a person's entire being and generates a capacity for transcendent values. The body cannot be touched without the spirit's being affected, and vice versa. Efforts to help patients towards wholeness necessitate helping them accept freely their whole lives. Listening is one of the greatest spiritual gifts a chaplain can give. Being a companion is often all the chaplain can do. His concerns are for the well-being of the whole person, and the whole family.[249]

3.4 PAIN RELIEF / HOLISTIC MEDICINE

Part of the holistic care of a hospice includes pain relief. Pain frightens many terminally ill patients, it saps their energy, crowds their consciousness and then, they become overwhelmed and may wish to die. Cassidy refers to the concept of *total pain* as spoken of by Dame Cicely Saunders,[250] pioneer of the modern hospice movement.[251] She says that, the physical agony of the individual may be compounded by fear of death, loss of independence, conflict of loved ones and a state of spiritual

---

[249] S. Burns, "The spirituality of dying. Pastoral care's holistic approach is crucial in hospice." *Health Prog*, 72 (1991), 48-52.

[250] Cicely Saunders, "Dying with cancer,"*St. Thomas Hospital Gazette*, 56 (1958) 37-47. For pain control see, "Care of the dying 3. Control of pain in terminal cancer" *Nursing Times*, Oct. 23 (1959b), 1031-1032. For a study on mental pain see, "Care of the dying 4, Mental distress in the dying," *Nursing Times*, Oct. 30 (1959c), 1067-1069. For articles on fear, see "Uncertainty and fear", *District Nursing*, Dec. (1962b),2002. See also in: Uncertainty and fear, Proc. Conference on "Long term illness and its implications" *Queen's Institute of District Nursing*, London (1962), 7-9.
On intractable pain see "The treatment of intractable pain in terminal cancer," *Proceedings of the Royal Society of Medicine* 56 (1963), 195-197. And "The care of the terminal stages of cancer," *Annals of the Royal College of Surgeons* 41, Suppl. (1967), 162-169. Finally, typescript of a talk, *I was sick and you visited me*, given at *St. Mary's Hospital, London,* May 30, 1961; Cicely Saunders' archive, St. Christopher's Hospice, Sydenham. Although a substantial draft of her MD thesis on this subject was prepared, it was never submitted.

[251]Cicely Saunders, *Living with Dying: a guide to palliative care*. (New York: Oxford University Press, 1995).

anguish in which faith is stretched to breaking-point.[252] Here Saunders explores the elements, which contribute to the fear of patients, and her insight into these matters, is transferable to all patient's who are experiencing fear in approaching imminent death. In order to understand better Cassidy's approach to her work it is necessary to review briefly the work of Dame Saunders.

Pain first emerged as an area of clinical specialization in the 1950's, but more recently has attracted wider interest from social scientists and clinicians who wish to expand its understanding to incorporate ideas about meaning, embodiment and culture. At present there have been few empirical studies, which focus on how ideas and practices about pain are changing in modern healthcare. David Clark has now addressed these issues through a specific case study of the early writings of Cicely Saunders in the period 1958-1967. From a talk given at St. Mary's Hospital in London we can deduce the reason why Cicely Saunders became involved in terminal care and particularly pain in terminal illness, in the decade after 1958. In an excerpt from this talk Saunders said:

> I am fortunate, above all, in being a doctor who isn't in a hurry, so that I have time to know and enjoy my patients, and I very often take a portable tape-recorder round with me, which of course, they all know about. It is a very great help, both to get permanent records of them talking about their pain and its relief, but also about their attitudes towards their illness; what they know about it, and what they find particularly hard, and it is very revealing, both for them, and about myself too when I play it back.[253]

This is an unusual practice for any doctor of the period and is perhaps matched only by the parallel work of Elizabeth Kubler-Ross who at Montefiore Hospital, New

[252] Sheila Cassidy, *Light From the Dark Valley*, 84

[253] Cicely Saunders, typescript of a talk, *I was sick and you visited me*, given at St. Mary's Hospital, London, 30th May, 1961: Cicely Saunders archive, St. Christopher's Hospice, Sydenham.

York, in the early 1960's, sat on beds, held hands and talked for hours, and learned that there was not a single dying human being who did not yearn for love, touch or communication. Both doctors thus began to develop a certain method of talking with and listening to patients, which was to transform those patients into active subjects. In each case also the method they employed was to develop into a theory: for Kubler-Ross the 'stages of dying,'[254] and for Cicely Saunders the concept of 'total pain.'[255] These issues add further insight into the needs of the dying, and highlight the importance of empathy and communication skills of both listening and dialogue, which is central to patient-oriented care, an important element in holistic care of the patient, and is applicable to all patients, across the medical spectrum, which I will be recommending in my proposal for a holistic medical model.

Since no one person can meet all of the patient's needs, Hospice care is supported by multidisciplinary teams: doctors, nurses, social workers, chaplains, each contributing a particular expertise, trying to weave a seamless garment of loving care. According to Cassidy cancer has no respect for internal boundaries:

> The physical and the psychological become inextricably mixed up, fear exacerbating pain and pain making people terribly afraid. Spiritual issues are likewise inseparable from physical and psychological ones, for a depressive illness can induce a pathological sense of guilt and the resultant sense of unworthiness can make the person feel that they are beyond the reach of God's love and mercy.[256]

This phenomenon of 'total pain' in the dying demands of carers not only that they work in teams, each respecting the other's contribution, but that they be 'total

---

[254] E. Kubler Ross, *On Death and Dying*, (London: Tavistock, 1970)
[255] D. Clarke, "Total pain, disciplinary power and the body in the work of Cicely Saunders," 1958-1967," *Soc Sci Med.* 49 (1999), 727-36.
[256] Sheila Cassidy, *Light From the Dark Valley* (London: D.L.T., 1994) 85.

physicians', 'total nurses', and 'whole person chaplains.' When a patient is admitted to a hospice environment the concept of total pain is discussed together with the need for a multidimensional assessment of pain to enable effective management to be accomplished. A multi-professional approach to care along with inclusion of patient and spouse in decision making achieve the best quality possible quality of life for both. This is achieved by providing relief from pain and other distressing symptoms, including psychological, spiritual and social aspects of care, together with patient and relative autonomy. This study exemplifies contemporary palliative care in action.[257] It is another example of holistic care, with multidisciplinary support, which, treats the patient as a whole human being, is patient-orientated, involves the patient in decision making, and is concerned with quality of life. These entities are transferable to patients who suffer from a wide spectrum of diseases and disability, which would ideally be part of a holistic approach to care which I am advocating in this thesis, and from which I will be formulating a holistic medical model.

Recognizing the unmet needs of dying patients in hospital, Dame Cicely Saunders established the hospice, and with others, conceived of a comprehensive approach to dealing with the variety of symptoms and suffering often experienced by patients with progressive debilitating disease. Careful observation of the use and effects of morphine and similar drugs also originated at the hospice. When palliative medicine was accorded specialist standing in the United Kingdom, in 1987, the agreed definition was 'the study and management of patients with active, progressive, far-advanced disease, for whom the prognosis is limited and the focus of care is the quality of life.' Physical aspects of pain cannot be treated in isolation from other

[257] W. Greenstreet "The concept of total pain: a focused patient study," *Br J Nurs*, 10 (2001) 1248-1255

aspects, nor can patients' anxieties be effectively addressed when patients are suffering physically. The various components must be *addressed simultaneously.* There is an important lesson here for all who care for the sick and are involved in the alleviation of pain and suffering, irrespective of the nature of the illness. It is becoming obvious that palliative care is synonymous with patient-oriented holistic care. The alleviation of the patients' pain and suffering, taking into account of the whole person, psychological, social, spiritual as well as physical is part of a holistic medical model I am promoting in this thesis.

Cassidy adds further comments and insights into the provision of palliative care. Palliative care:

* Affirms life and regards dying as a normal process
* Neither hastens nor postpones death
* Provides relief from pain and other distressing symptoms
* Integrates the psychological and spiritual aspects of care
* Offers a support system to help patients live as actively as possible until death
* Offers a support system to help patients' families cope during the patient's Illness[258]

A seven step approach for physicians who provide *end-of-life care*, has been devised by von Gunten et. al.[259] In their opinion physicians should prepare for discussions by (1) confirming medical facts and (2) establishing an appropriate environment; (3) establish what the patient (and family) knows; (4) determining how information is going to be handled at the beginning of the patient-physician relationship; (5) delivering the information in a sensitive but straightforward manner; (6) responding to emotions of the patients, parents, and families; (7) establishing goals for care and treatment priorities when possible; and establish an overall plan.

---

[258] Ibid. 801.

[259] C.F. von Gunten, F.D. Ferris, L.L. Emanuel, "The patient-physician relationship. Ensuring competency in end-of-life care communication and relational skills," *JAMA*, 285 (2000) 3051-3057.

This pattern of palliative/holistic care and dialogue is ideal for an appropriate response to caring for patients dying from a terminal illness. It can compliment Cassidy's insights. What is new here is the setting of an appropriate environment, prioritising goals for treatment, strategic planning of how information is to be related to the patient and his/her family and how to deal with their emotions as it becomes clear that the patient cannot be cured of their illness. This can be applied to any dying patients and their relatives and lessons can be learned. In the light of these facts, next, I propose to explore Cassidy's ideal approach to care which she relates in considerable detail in her writings. She emphasizes that her recommendations refer to an ideal situation.

3.5 AN IDEAL APPROACH TO PATIENT CARE

According to Cassidy, doctors are learning slowly that a wielding of hi-tech medicine is not to be equated with 'doing everything possible' for the patient. In an ideal world, a different approach might consist of:

> A treating of the whole person, a negotiation and consultation and a tailoring of treatment to the individual. It involves making ourselves available to answer people's questions, sitting by the bedside, drawing diagrams, talking to relatives and above all admitting that we do not have the power to cure we are not God.

It also means learning new skills, how to handle old drugs effectively, how to improve our communication skills, discover the usefulness of meditation, relaxation

and psychotherapy. We must learn to become whole person doctors because patients are whole people, and we must learn humility.[260]

Cassidy's views exemplify lessons, which can be learned concerning the treatment of patients with terminal illnesses and which can be applied to other patients. Here she mentions the role additional treatments and therapy can play in the provision of a good quality of life for her patients. This coincides with my ideas concerning the formulation of a holistic medical model. I will be suggesting, not the replacement of the current medical model but rather its retention, and suggesting that other therapies and treatments are added to it.

Cassidy also expresses her concern for her patients in personal matters. In Cassidy's view, what really upsets many patients is the depersonalizing treatment of being stripped of their clothes and put into hospital dressing gowns before they see the doctor. A patient dresses in a particular way to see her doctor; she dresses as she wishes to be seen. Clothes in this way can be seen as the body language, which declares who they are, individual patients with their particular tastes and ideas. In asking patients to remove these clothes we are asking them to put aside some of their armour, which, the patient feels they need for perhaps a first difficult interview. In this way they are depersonalised and treated as objects. They will be less able to communicate effectively because they are nervous or embarrassed. The presence of a third person, a nurse, can inhibit patients from speaking freely, thus compromising the doctor-patient relationship. The second thing that doctors are unaware of is the

[260] Sheila Cassidy, *Sharing the Darkness*, 16

emotional discomfort of their patients. A third reason for patients' distress has to do with doctors and how they 'distance' themselves from their patients.[261]

Distancing themselves from their sick patients is the way in which doctors cope with constant daily contact with suffering in general medicine. Cassidy explains how she personally copes with her terminally ill patients. When she feels strong, she sees patients alone, without her white coat, and asks them how they are feeling, not just physically but emotionally. She asks if they are sad, angry or afraid, and inquires about home circumstances. In this way she meets some of the needs of her patients. It takes a lot of her emotional energy and she would be unable to give this attention to everyone and so gives it to patients who need it most. On days when she is not feeling strong, she sees patients in a more formal way, with a nurse, she checks symptoms, the progress of the disease, orders tests and prescribes treatments. This is the reality of caring.

Cassidy wished to be voice for the voiceless, and articulate their needs. She feels that it is part of her duty to be a spokesperson for those who are looked after in hospice care, and further believes that mainstream medicine could benefit from the hospice way of caring. She outlines in great detail the needs of the terminally ill:

> We listen to the cries of the people and try to speak out for them. We relate that they want to be treated as normal responsible people. They want to have their illness explained to them in words they can understand and be consulted about its treatment. They want to retain their dignity as individuals and keep some control over their lives. They want to participate in their care and share in the decision-making. They want doctors to be honest with them, warm and humble. More than anything else, they want us to combine our competence with compassion and when our hands are empty, to stay our ground and share the frightening darkness with them. More than anything they need our love.[262]

---

[261] Sheila Cassidy, *Sharing the Darkness*, 17-18

At times Cassidy tries to understand at an intellectual level why hospice care works. Hospitals have similar facilities but the staff-patient relationships are different. This is because their philosophy is different. The philosophy of hospice care is built on the conviction that all people, however far gone, are infinitely precious and their treatment must be tailored to their individual needs. Each patient is an individual, not just a case with cancer, but also for instance a woman called Mary, with a husband and child. Cassidy feels that this is *the heart of the matter*: the dying are individuals, complex human beings whose needs are legion: physical, intellectual, emotional, spiritual, and social. Hospitals also provide high quality diagnosis, and treat and try and cure disease. They provide for the physical needs as resources permit. They treat their patients with patience and kindness given the shortage of personnel and pressure of work. They try to help distressed families. What they dare not do is to enquire or treat their patients fear and anguish. Personnel are trained to surpress their feelings, and wear a protective uniform that keeps their patient's at a distance, and meet as professionals and client. It is possible that hospital patients are denied the one gift that they long for, that is, *human warmth*.[263] For Cassidy, this is an issue, which 'burns within her heart' the fear and embarrassment, which prevents us from giving those facing death the help they so desperately need.[264] More than anything they need empathy. What Cassidy tries to argue for is not more hospices but rather:

> a set of attitudes, developing a degree of insight into the patients' world, what the psychologists call empathy. With that insight goes a heightened sensitivity to the patients' distress and a searching for ways to relieve it... At heart professional loving is about competence, empathy and communication. It is about becoming sensitive to the pain of others, and therefore terribly vulnerable. For me, as for many, it is a way of caring which I aspire to, but

---

[262] Ibid.18-20.
[263] Ibid. 22
[264] Shelia Cassidy, *On Death: being together in the darkness*. The Tablet, 29-11-97 http://www.thetablet.co.uk/ogi-bin/archivedb.ogi viewed 05-08-03, p. 1-2.

achieve only some of the time. It is a costly loving for which I am repaid a hundredfold[265].

Patients are often referred to a hospice when there is nothing more to do, Cassidy does not agree, she claims that there is always something to be done perhaps a fine-tuning of pain control, local anaesthesia, or other physical ways of easing their pain. A certain number of patients could benefit from counselling or psychotherapy. The terminally ill patients however are different from others in terms of the short life–span, and the enormity of their loss. They may need physical comforting, human warmth and can benefit from honest communication about painful truths, that in no way dependant on the length of the relationship. Marchant agrees with Cassidy that a lot can be done to assist a person who is facing the end of his/her life on earth. In caring for dying persons and their loved ones, spiritual caregivers help them look at the past, cherish what has meaning and set right what is unfinished or in need of reconciliation. In listening to the life stories voiced, spiritual caregivers assist in the clarification of values and beliefs, the claiming of joys and pains, successes and failures, hopes and dreams. By non-judgmental presence in the search for meaning, spiritual care-givers foster inner spiritual growth, enabling patients and family members to find within themselves strength and integrity.[266] The emphasis on spiritual care is part of the holistic care of patients.' At times Cassidy is asked to see a hospital patient in the surgical ward, who may have difficulty coming to terms with a diagnosis, or who might benefit from being moved to a hospice. Meeting a new patient for the first time is an important encounter, for which she prepares herself.

---

[265] Sheila Cassidy, *Sharing the Darkness*, 25.

[266] Jean Marchant, *Ministering to persons who are dying.* http://www.rcab.org/healthcare/notesministering%2to%20dying.htm Viewed 04-07-03, p. 1-5

3. 6 ENCOUNTER WITH A NEW PATIENT: ESTABLISHING A THERAPEUTIC RELATIONSHIP

Cassidy believes that the setting up of a therapeutic relationship with her patient's is of the utmost importance for successful treatment, as their disease progresses and their pain increases. A good doctor-patient relationship is crucial, and must be instigated during the first interview. If Cassidy is tired, she postpones her visit until she is well rested, unless the case is urgent. Being rested helps her to work with sensitivity, and being well informed, as to what the patients fear and hope for, is also important. Conscious of the lack of privacy in hospital, she arranges to meet her patient in a side room where she can speak privately. Having a third party present she feels compromises the doctor patient relationship and inhibits patients from speaking freely. Then, she invites her new patient to 'tell her story.' This is not to inform her, but out of a wish to establish a good rapport, and to unearth some of the sadness and anger. Cassidy emphasises that it is in the telling of the story that she meets her patients, and in her listening to them they meet her.[267]

> This first meeting is a pivotal one in establishing a therapeutic relationship, and it may take up to an hour - sometimes longer. But it is to me well spent for in that hour one can establish bonds of trust and confidence, which are the practical tools for later work. Everything depends on the quality of my listening: The patients must understand clearly from my verbal and non-verbal cues that I am interested in them as persons as well as their physical problems.[268]

As the story unfolds and questions of clarification have been answered, the patients are asked how they feel about having cancer, with a view to establishing a supportive

[267] Sheila Cassidy, *Sharing the Darkness*, 28. This encounter between Cassidy and her patient, corresponds precisely to Buber's dialogical relationship in an *I-Thou* realm of being, furthermore it properly locates the happening in the realm of "the between."
[268] Ibid.

relationship. How the doctor breaks bad news to the patient is important, giving the patient some information, monitoring the response and stopping if the patient has enough to absorb at that time. Cassidy reiterates once more, two essential components of good caring: competence and compassion.[269]

For the effective practice of medicine, and good patient-physician relationship, Charon believes that the physician must have the ability to acknowledge, absorb, interpret and act on the stories and plights of others. Medicine practised with narrative competence, called narrative medicine, is proposed as a model for humane medical practice. With narrative competence, physicians can reach and join their patients in illness, recognize their own personal journeys through medicine, acknowledge kinship with and duties toward other healthcare professionals and inaugurate dialogue with the public about healthcare. By bridging the gap that separates physicians from patients, themselves, colleagues, and society, narrative medicine offers fresh opportunities for respectful, empathic, and nourishing medical care.[270] Twycross makes the point that palliative care is patient-centred rather than disease-focused, and while acknowledging the inevitability of death, simultaneously provides life-affirming holistic care. It also stresses the importance of appropriate treatment and the need for doctors not to subscribe to a lingering death. Even though there is no chance of a cure, there is much scope for psychosocial and spiritual healing.[271] Bollwinkel agrees with Twycross that spirituality plays an integral role in the care of the terminally ill patient. Hospice philosophy does indeed promote patient-oriented care that is palliative, holistic and interdisciplinary. In spiritual care

---

[269] Ibid. 28-29.
[270] R. Charon, "The patient-physician relationship. Narrative medicine: a model for empathy, reflection, profession and trust" *JAMA*, 286 (2001), 1897-1902
[271] R.G. Twycross, "The challenge of palliative care," *Int J Clin Oncol.* 7 (2002), 271-278

giving and in the context of the patient-doctor relationship guidelines for caregivers include self-knowledge of one's own spiritual needs, authenticity and honesty and respect for the beliefs and practices of the patient and family.[272]

In the last chapter of *Sharing the Darkness*, Cassidy writes an account of the God whom she meets in her life of 'sharing the darkness', and of how she personally has made sense of the world in which she lives. Some years ago she would have thought that a carer's God concept was his/her own private business, but the longer she works in the field of caring, the more important it is not to get hung up on false gods however comforting. She gives three reasons for this. Firstly, she believes that damage can be done to those we care for if we are promoting a theology in which illness is seen as a punishment for sin, or that physical healing is declared freely available to those with sufficient faith. Secondly, we ourselves will come unstuck if we search for facile explanations of the mystery of suffering instead of bowing down in baffled awe before the one, holy, unknowable God. Thirdly, as adult human beings, we have no business clinging to childhood beliefs when we should be letting go in faith to follow the truth.[273]

3. 7 THE WOUNDED HEALER

Cassidy believes that her experience in prison helped to prepare her for her work with the dying. Any major experience of powerlessness gives one insight, however limited, into the feelings of those facing death. The question arises as to

---

[272] E.M. Bollwinkel, "Role of spirituality in hospice care," *Ann Acad Med Singapore*, 23 (1994), 261-263.

[273] Sheila Cassidy, *Sharing the Darkness*, 86

what the prisoner of conscience has in common with the cancer patient? Her strongest memory is of fear, the fear of pain, of helplessness, of brutality, of humiliation and of death. It was fear, which possessed her like a demon, present day and night, lurking like an animal in the shadows. It invaded her very being. It attacked her knees and she could barely walk. It attacked her mind, paralysing thought, clouded her vision like the blindfold so that all landmarks disappeared and she was disorientated and alone. It was a fear that made her want to scream like an animal, but she did not. She was hurt, vulnerable, it was hard but she never lost hope. She was sustained by her strong faith in God, and her sense of transcendence.[274]

To transcend is to go beyond the limits of lived human experience, and hospice workers accompany people who are travelling beyond the limits. Zerwekh has written about thirty-two hospice work experts working with people nearing death. Spirituality was described as the essence of personhood, the longing for meaning in existence, experience of God, experience of ultimate values, and trust in the transcendent. Its ultimate end is union or connection with a reality more enduring than the individual self.

In contrast, spiritual distress is manifested as alienation and disconnection. The reality of the dying process involves a progressive series of disconnections from life, which requires the process of letting go. Thus, transcending life involves both the need to detach and separate from life as it has been lived. One home visiting hospice nurse has described dying as a spiritual process of both reflecting and detaching. Three goals of caring spiritually include: fostering personal integrity;

---

[274] Ibid. 87.

promoting interpersonal connection; and supporting personal search for meaning. This hospice spiritual care is promoted through the practice of presence, compassion, hopefulness and the affirmation of life as fruitful.[275]

The World Health Organisation has defined palliative care as: the active total care of the patient whose disease is not responsive to curative treatment.[276] A holistic medical model includes control of pain and other symptoms, of a psychological, social or spiritual nature in order to achieve the best quality of life for patients and their families. When palliative medicine was given specialist standing in Britain it was agreed that physical aspects of pain could not be treated in isolation from aspects, nor could patient's anxieties be effectively addressed when patients are suffering physically, various components of pain must be *addressed simultaneously*. This was the state of knowledge concerning alleviation of pain, suffering and the care of the terminally ill and dying when Cassidy became involved in hospice care. Cassidy while benefiting from Saunders concept of total pain nevertheless sought to add to this knowledge, her basic philosophy being that the *dictum* of mainline medicine that nothing more could be done for terminally ill patients, was untrue. In her experience there was always something more that could be done for a distressed patient. It could be a fine tuning of medication, treating localised pain with anaesthetic, or providing oxygen when a patient was short of breath. A meticulous attention to detail was Cassidy's *forte*.

---

[275] J. Zerwekh, "Transcending life: the practice wisdom of nursing hospice experts." *Am J Hosp Palliat Care*, 10 (1993), 26-31.
[276] Op. cit.

Having completed the exploration of the clinical practice of Sheila Cassidy with her terminally ill patients I will now deal with the work of a second clinical practitioner Michael Kearney. Kearney goes beyond conventional palliative care in order to address the psychological suffering, which causes distress for patients who have not become reconciled to the idea of death. Kearney is a specialist in this area, and makes use of guided imagery, psychological work and psychotherapy to assist this group of patients to find healing and accept that their lives in this world, are coming to an end. Kearney is eminently qualified to do this work. I will now proceed with a brief biography

3. 8 MICHAEL KEARNEY: A BRIEF BIOGRAPHY

Michael Kearney was born in 1953 and graduated from University College Cork Medical School in 1977. He was the first Irish medical graduate to qualify as a specialist in Palliative Medicine, at St. Christopher's Hospice, London. In 1989 he was appointed consultant in palliative medicine and medical director of Our Lady's Hospice in Dublin. Kearney has many years experience in psychological and spiritual aspects of healthcare. Trained in psychotherapy (London Institute of Psycho synthesis) and spiritual direction (Heythrop College, London) with many years experience of Jungian analysis and clinical supervision, he has also completed a two year postgraduate training in dream work at Pacifica Graduate Institute, California. He has gained international recognition for his contribution to promoting a model of integrated, whole-person palliative care, which is relevant throughout healthcare. Amongst his referees he cites Dame Cicely Saunders, Chairman, St. Christopher's Hospice, London. He was a frequent keynote speaker at major conferences throughout

the world on all aspects palliative care, with particular emphasis on psychological and spiritual issues. Work with psycho-spiritual suffering in patients with advanced and terminal illness has been featured in a television documentary on Irish television (Radio Telefis Eireann, 1996). He taught a number of courses with an emphasis on healing in healthcare. In the academic years of 2002-2003 he worked with Professor Balfour Mount at McGill Medical School Montreal to introduce an educational initiative on "Healing in Medicine" into the undergraduate medical curriculum. This involved working with all years of the undergraduate program and with an ongoing group of medical faculty, which was established to examine in depth the question of "Healing in medicine" and to consider how these issues might relate to ongoing medical education and clinical practice. This initiative has, in part, been responsible for a number of significant recommended changes in the Mc Gill Medical Curriculum. Other published work attests to his broad experience and expertise. [277]

When Kearney initially finished his medical studies, he had already become disillusioned with clinical medicine, as he saw it practiced on the wards of the teaching hospitals and was considering leaving medical school to pursue his interests in English literature and film. An older man, whose advise he was seeking, suggested

---

[277] Michael Kearney, *A Place of Healing: working with suffering in living and dying* (Oxford: Oxford University Press, 2000). See also selection: *Hospice Medicine*, in *Changing Health Care*. eds. A. Cribb and D. Seedhouse, (John & Sons) 1989. M.K. Kearney, B. Mount, *Spiritual Care of the Dying Patient*, in Psychiatric dimensions of palliative medicine, eds. H. Chockinov and W. Brietbart (Oxford University Press) 2000. B. Mount, M. Kearney, "Healing and palliative care: charting our way forward." Editorial in, Palliative Medicine, 17 (2003) 657-658. M.K. Kearney, "Spiritual pain" *The Way* (1990) 47-54. M.K.Kearney, " Pallaitive Medicine- just another specialty?" *Palliative Medicine* 6 (1992) 39-46. M.K. Kearney, "Imagework in a case of intractable pain," *Palliative Medicine* 6 (1992) 152-157.D. Waldron, C. A. O'Boyle, M. Kearney, M. Moriarty, D. Carney. "Quality of life measurement in advanced cancer: assessing the individual," *Journal of Clinical Oncology*, 17 (1999) 3603-3611.

that before he did that, he should visit St. Christopher's Hospice in London, which he described as 'a place of healing.' He did this and there he encountered patients who, despite the fact that their bodies were frail and dying, seemed to be among the most real and complete human beings he had ever met. He too felt more alive in their presence and left with his faith restored in the power of the human spirit and medical care. As he struggled afterwards to understand what had happened there, he found himself remembering his friend's words. A place of healing accurately described what he experienced during his visit, which had also rekindled an enthusiasm to continue with his medical training.

That experience in many ways, became the genesis of an exploration, both professional and personal, into the nature of healing and its place within healthcare. By 'healing' he meant the process of becoming psychologically and spiritually more integrated and whole, a phenomenon which enables persons to become more completely themselves and more fully alive. We may feel that 'healing in healthcare' is what it is all about, but this is far from the truth. Western healthcare has become good at 'curing' as in 'fixing' or 'making better,' on restoring the patient to the status quo of how life was before. Contemporary healthcare is not really concerned with the question of healing. If healing happens it is considered a bonus rather than a desired outcome. A significant advance in healthcare in the latter part of the twentieth century has been the development of the hospice movement and the specialty of palliative care. From within this specialty a body of expertise has been established that can do

much to control the pain and lessen the suffering of patients and their families who are living with far advanced and terminal illness.[278]

3.9 MYTH

In order to appreciate fully the essence of Michael Kearney's work in *Mortally Wounded,* and *A Place of Healing* a brief introduction to myth seems appropriate. The word myth has two basic meanings. It may mean an ancient story about superhuman beings, gods and heroes, or it may refer to something illusory, fictitious or difficult to prove. In the past myths were used to explain unknown phenomena, like the cycle of nature, or natural disasters and to justify the existing order like the hierarchical structure of societies. They also reflected common virtues or vices or epitomised numerous wishes and desires: eternal youth, unconditional love, undying devotion, or true justice. Throughout the ages, artists and authors have found mythical themes a vast source of inspiration.[279]

Myth is also the symbolic language of human experience, of story and ritual, of dreams and tradition. Myth links us together, providing crucial context and illumination for understanding the mysteries of existence. Myths are the eternal truths hidden within the heart of the stories we hear, read and see. Their wisdom guides us to meaning, mental health and even conflict resolution. Today, however people seem cut off from their traditional sources of meaning. A deeper meaning in life can be reached through delving into myths, archetypes, stories and cultural history. It was Jung who saw the importance of mythology for the human psyche and who came to

---

[278] Michael Kearney, *A Place of Healing: working with suffering in living and dying* (New York, Oxford University Press, 2000) vii.
[279] British Council. The power of myth, http://elt.britcoun.org.pl/m_power.htm 2004. Viewed 24-03-04.

understand the symbolic and metaphoric language as a form of collective dreaming. By making the connection between the unconscious material of our own dreams and the symbols and metaphors that make up the mythological world, Jung has allowed us to see the connections between our own individual psyche and the collective psyche.[280]

In *Mortally wounded* Kearney explores the nature of soul pain in those close to death, by sharing and reflecting on the stories of a number of individual patients, with advanced illness in the light of two models, one mythological, and the other psychological. Some of these stories illustrate a particular way of working with the deep inner aspects of a dying person's experience and shows that the work is essentially a co-operative adventure with the healing forces of the person's own psyche. Kearney believes that this inner or depth work is the essential complement to the outer care of the individual, and may enable that person to find his or her own way through the prison of soul pain to a place of greater wholeness, a new depth of living.[281] From the outset, in his writings, it becomes clear that Kearney emphasizes the crucial role of communication in the doctor-patient encounter. Because the patients' he treats, have particular difficulty in coming to terms with imminent death, Kearney needs access to their subconscious, if his psychological work and image work are to be of therapeutic value for his patient's.

[280] C. J. Jung, *The structure and dynamics of the psyche,* Collected works vol. 7, Bollingen series, XX (New York: Pantheon, 1953, 190-193. See also, Elizabeth D. E., Papathanassoglou, Elizabeth I. Patiraki, "Transformations of self: a phenomenonological investigation into the lived experience of survivors of critical illness," *Nursing in Critical Care*, 8 (2003) 13.
[281] Michael Kearney, *Mortally Wounded*, 57, 60-66

3.10 STORY

In our hurried and high-tech society, patients hope that those who care for them are interested in the depth and uniqueness of their lives. According to Nagai-Jacobson & Burkhardt [282]viewing persons as stories enables the understanding that events and experiences in life occur within a unique context for each individual. Story involves an interpretation of events and experiences and may reveal more truth about the patient than extracted data from traditional history taking. Patient's accounts of illness can reveal the disruption in selfhood that accompanies illness, and the narration is a way to make sense of that illness. According to Sakalys, the witnessing of illness narratives can be seen as a part of a caring nursing practice with considerable healing potential. What is important for the nurse or carer is the quality of the listening, especially listening for meaning, rather than gathering facts, and providing a relationship, enabling the ongoing story of the patient to be told as it unfolds.[283] Roche believes that allowing the patient to narrate the story of his/her life is therapeutic. Each person's story has the potential to provide the key to healing. Sensitive listening and dialogue can help the dying person discover connections between their own story and possibly those of the Scriptures. Even dreams can provide a method of unlocking the unconscious. As Jesus used images from nature and symbols from everyday life, so too care givers use analogies to get to the heart of the matter.[284]

---

[282]M.G. Nagai-Jacobson, M.A. Burkhardt. "Viewing persons as stories: a perspective for holistic care." *Altern Ther Health Med.* 2 (1960) 54-58.
[283]J.A. Sakalys, "Restoring the patient's voice, the therapeutics of illness narratives." *J Holist Nurs.* 21 (2003) 228-241
[284]J Roche, "The story: a primary spiritual tool: stories can be a healing power in the dying process." *Health Prog* 75 (1994) 60-63

Over the centuries, listening has been a crucial aspect of the various endeavors undertaken by healers in the interest of acquiring information from, achieving understanding of, and bringing about healing effects for suffers. Yet it has been vision rather than hearing that has been emphasized in knowing and understanding, and looking rather than listening that has been emphasized in healing endeavors. Jackson believes that it was only around the turn of the twentieth century that there emerged, the focused study of care in listening, of listening beyond the words themselves, and of the significance of the interested listener as a soothing, empathic force. The place of listening in depth and with empathy is a crucial element in healing. While the emphasis on looking remains significant in the gathering and appraisal of data, at times it threatens to overwhelm the need for an attentive and concerned listener. There appears to be a natural tension between the two modes that has, in modern time, been translated into a tension between a scientific mode of gaining information and a humanistic mode of knowing sufferers. Telling our stories is at the core of human communication. While we have developed many forms of communication, which carry our messages across vast reaches of space and time, "Story," in the oral tradition, still transports us into the essential realms of imagination as no other form can. There is a tremendous difference between news and story. The news media informs the mind in important ways but storytelling allows for transformation. According to Hechest, story draws from wellspring deep human symbols, archetypes and story exalts what we can be, what we can become, and our potential to transform. Whenever and wherever stories are told a cord is plucked within the understanding of the listeners. Often the story is heard by the ear, but listened to by the sub-conscious mind where its deeper meaning resides. Stories, myths, or fables, seep into the listeners inner resources and awaken the

imagination.[285] There is convincing evidence that the patients' narration of their story, is beneficial not only in providing information for the doctor but it is beneficial also for the patient. Good patient-doctor communication is a crucial component of palliative care, and for the provision of a holistic medical model of care to treat pain and alleviate suffering which I am promoting in this thesis

Adam Blatner writes about 'Re-story-ing the soul.' The idea of re-story-ing is not just having a story, or even telling the story, but actually re-creating and re-working the story, bringing the power of spontaneity and the knowledge of circumstances in the here-and-now to the cultural conserves of the past. As far as re-story-ing affecting the soul is concerned, this involves weaving in some elements of what might be called myth- making. This helps people not only to realize and re-create their stories but also to connect these to some deeper dimensions of the psyche, those associated with the idea of "soul." In so doing, people are helped to develop that ego-soul connection, which is an important element in spiritual development and psychological healing and resiliency. Helping people to tell their stories, is itself, healing. Helping them to re-tell their stories, to re-construct them in a more positive fashion, a story that then can lead one towards thinking more hopefully about oneself and life, this is even more healing.[286] The potential capacity of patients to become involved in a healing process may be restricted, by the level of fear experienced at the thought of imminent death. Kearney suggests that we all share primal fear, an instinctive fear of the dark. This existential and primal fear of the unknown causes a particular form of human suffering he calls 'soul pain'. He explains this pain in

[285] M. Hechest, interviewed by Kari Berger. "The truth in story," *The Ecology of Media* 23 (1989) 58
[286] Adam Blatner, " Re-story-ing the soul: transformational power of the healing arts," Available http://www.blatner.com/adam/level2/restorsoul.htm. Viewed 02-11-04.

psychological terms. The prime mover, he feels is that a particular part of the mind known as the 'ego' which is happiest when in control of a world, that is familiar and predictable, but when threatened by the approach of death, it sees chaos and the ultimate unknown. In an effort to survive, the ego may project its fear of death on to the unconscious aspects of the mind, which Kearney terms 'soul' seeing in it unpredictable depths a "microcosm of death itself." This unraveling of existential and primal fear by Kearney, explains where this fear comes from, and how, it can be accessed through the medium of story.

In order to survive the ego 'flees from the soul' and alienates itself from all in our depths leaving us feeling isolated and terrified in a wasteland of meaninglessness and hopelessness, that is soul pain. For those patients who are having a difficult time in their dying and seem impossible to comfort, Kearney is convinced that if he could lead these vulnerable individuals to a place where they could find a creative way of responding to the challenge of soul pain, that it might open up a path to the very heart of living, even in the shadow of death.[287] Kearney, in his work with distressed patient's, adds his particular expertise to the field of palliative care, and it could also be part of a holistic model of care

3. 11 THE HOSPICE MOVEMENT

Michael Kearney has the experience of working as a consultant within the Hospice Movement. He is familiar with the impact the holistic approach and

[287] Michael Kearney, *Mortally Wounded*, 13-15.

compassionate attention to the whole person, can make for the terminally ill. Dame Cicely Saunders, founder of Hospice provides their mission statement:

> You matter because you are you,
> You matter to the last moment of your life,
> And we will do all we can
> Not only to help you die peacefully
> But also to live until you die

This makes the process of dying easier by expertly controlling the individual's pain and other physical symptoms while fostering 'open and honest communication with them and their families.' This can transform what may have been a frightening and miserable existence into a time of 'continuing personal growth and completion.' The hospice movement which, has done so much to allay the fears and distress associated with the dying process, has origins, which can be traced back to the caring impulse, at the heart of all professions. Kearney believes that this caring impulse has evolved in the twenty-first century as a redress to the imbalance created by increasingly scientific, and technological medical systems. In the past twenty-five years the principles of treatment and care which were developed within this movement have begun to be integrated into mainstream western medicine and has led to the international dissemination of this new, yet old, healthcare specialty known now as palliative care.[288] While the stories of terminally ill patients, which, Kearney uses in this text show what pioneer hospice worker Cicely Saunders calls this 'effective loving care' of the dying, the stories also reveal that sometimes, the suffering persists, and more is necessary in responding to soul pain.

[288]Michael Kearney, *Mortally wounded*, 15, J Cameron Muir, Robert M. Arnold, "Palliative care and the hospitalist: an opportunity for cross fertilization," *The American Journal of Medicine* 111 (2001) 10-14.

This suggests that a quest for inner wholeness, understood more in terms of commitment to a process than achievement of a goal, might inform the direction of our response. And if the theory is correct that the root of this problem is a personal and cultural disconnection from and a devaluing of all that is soul, then the initial direction we must take in this quest is inward. Kearney acknowledges the pivotal role that honest and open communication plays in the life of each person. This perception of ones existence as a whole, however, is opposed in our time by everything that is commonly understood as specifically modern.[289] A holistic medical model of care, would treat the patient as a whole human being, psychologically, social, spiritual and physical. Achieving wholeness, renewed strength and acceptance is one of the goals of palliative care, which is synonymous with holistic care.

3. 12 ENCOUNTERS WITH PATIENTS

During the course of his work Kearney encounters patients who do not respond to palliative care. Being trained in psychotherapy and spiritual direction, with experience of Jungian analysis and training in dream work, he is in a position to offer patients inner therapies based on mythological and psychological models, to compliment the physical or outer care of the patient. The first patient in this group was a young woman with recurring terminal cancer. She was in pain and very fearful which further exacerbated her distress. She was terrified of moving in case her pain worsened. In consultation with staff and family members it was agreed to sedate her. Any attempt to lighten this sedation provoked further distress. It was decided then to

[289] Henry Reed, "The healing power of communication" http://www.creativespirit.net/henryreed/bookreviews/4book9708.htm viewed 06-06-05, p. 1-2.

continue the palliative sedation in order to offer her a humane alternative to conscious suffering. The second patient had terminal cancer but did not accept it, and became increasingly distressed. She was an Evangelical Christian and believed that God was just testing her faith. Then, one day she felt much better, believed that she had been healed and died peacefully. The third patient was an agnostic with terminal cancer. His drinking had led him to loosing his job, and becoming estranged from his family. He was short of breath, looked terrified and did not wish to discuss his illness. Becoming even more fearful he accepted a bed in the hospice. After his admission he appeared more secure in his new surroundings. Gradually he began to feel better, and experienced contentment even happiness and truth. He could not explain why but felt that it had come from within himself. He now had no fear of dying, and died very peacefully. Here we have an example of patient-oriented care, and how the provision of a healing environment is conducive towards assisting patients to accept their illness, and lessen their fear of impending death

The arrival of patients 2 & 3 in a place of inner healing and fearlessness contrasted starkly with the first patient's unresolved anguish. What brought about such radical transformation in these two very different people is not known. Whatever had happened it was because of some subtle yet powerful change within the individuals themselves.[290] The fourth patient treated by Kearney was in his second week in the hospice, and said that his pain was 'the worst it had ever been'. It was felt that his deep emotions were using his pain as a megaphone. In his case Kearney recommended guided visualization, to give his patient access to his unconscious mind, where deep emotions were buried. During guided visualization, his patient

[290] Michael Kearney, *Mortally Wounded*, 27

began to grieve for his father, who had died. He felt that his father could have helped him in his distress. In the week after this, the patient showed a definite improvement, and his pain partially responded to drug treatment and he felt that he could live with the remaining pain. His encounters with the images that arose from his deeper inner experience, transformed the quality of his living and dying.[291] Through guided imagery and visualization techniques Kearney was able to assist a patient' to resolve his grief occasioned by the death of his father, after which his pain was lessoned. Lessons can be learned from the successful treatment of this distressed patient, which could be of benefit to other patients in general medicine.

3. 13 GUIDED IMAGERY AND THE MEDICAL MODEL

There are numerous areas in healthcare where guided imagery has improved patient well-being. Firstly, it can be a means for healing and transformation. Imagery enables patients to make sense of physical and emotional illness, and can be healing. Elliot states that by expanding the patient's awareness of the interconnection between body, mind and soul the outcome of the disease process can be affected. In reviewing the use of guided imagery Tusek & Cwynar recommended its use in an acute care setting where again, the patient is distressed emotionally as well as physically. The experience of being hospitalized can evoke feelings of fear, anger, helplessness and isolation. More patients are relying on the use of guided imagery to provide a significant source of strength, support, and courage as they prepare for a procedure or manage the stresses of a hospital stay. Within a holistic approach, Miller points out that nursing staff can play a pivotal role in providing patients' with self-care

strategies, which can be empowering, it is cost-effective and sometimes it can be fun.[292]

Kearney also uses Myth, The Chiron Myth, as an aid to the patient who has difficulty accepting that his death is imminent. Basically the mythological model has five distinct parts: the wounding, the struggle, the choice, the descent, and finally the return. These represent two radically different viewpoints. The first of these is called 'the heroic stance' which becomes evident in the successes and struggles of the early part of the story. The pivotal moment where this viewpoint shifts to another comes as Chiron chooses to let go of his immortality as he swaps places with Prometheus. From that point onwards his actions come from a new viewpoint 'the way of descent'. This turn-about marks a transition from one realm to another: from the above to the below, from the known to the unknown.[293]

Chiron's early life, first as conscientious pupil of Apollo, later as teacher of the sons of Grecian Kings, show that he was closely identified with the heroic stance. This is the same heroic attitude that underpins scientific Western healthcare where it is referred to as the 'medical model'. This medical model states that (all) illness of the body and mind has an underlying cause; if one can find this cause (diagnosis) and proceed to remove, reverse, replace or bypass it (treatment) one can return to the status quo (cure).

---

[292] H. Elliott, "Imagework as a means for healing and personal transformation." *Complement Ther Nurs Midwifery*, 9 (2003) 118-124. See also, D.L. Tusek , R.E. Cwynar, "Strategies for implementing a guided imagery program to enhance patient experience," *AACN Clin Issues*, 11 (2000) 68-76, and T. Miller, "The use of guided imagery in perioperative nursing," *Semin Perioper Nurs*. 7 (1998) 108-113.
[293] Michael Kearney, *Mortally Wounded*, 44

It is evident that the medical model works well. It has led to cures being found for an ever increasing number of illnesses. It has resulted in an extension in quantity of life and an improvement in quality of life for countless sick individuals. Where the medical model and heroic stance, which informs it, runs into trouble is in confrontation with insoluble problems. This happened in the Chiron Myth when Chiron is wounded ironically by Hercules, the very embodiment of the heroic principle. Hercules was Chiron's former pupil. The analogous situation in Western healthcare is when a patient's illness is diagnosed as terminal. No matter how we deal with it, we will, like Chiron be mortally wounded.[294] While the medical model is successful in treating many sick patients, it is inadequate in the face of suffering, and a more holistic medical model is needed. The addition of guided imagery, and the provision of a healing environment, to the medical model proved successful in treating patients. The provision of a holistic medical model which I am promoting in this thesis, would also retain the current medical model, to which other therapies or treatments would be added.

3. 14 PARADIGM SHIFT

A paradigm shift is a change in the conceptual framework, a mental frame of reference or way of viewing a situation. Every time we look at and then respond to a given set of circumstances, we do so in the context of a particular paradigm. We may see and respond to exactly the same situation in a variety of ways depending on what paradigm we are operating from. The heroic stance represents one paradigm i.e. the Greek Myth of Chiron. It offers a mythological way of understanding, both the nature

---

[294] Michael Kearney, *Mortally Wounded*, 44-46

of such distress and how an individual might begin to move beyond such suffering to a place of healing, a state of acceptance.[295] The heroic stance is usually the dominant paradigm at the earlier stages of a terminal illness and is apparent in efforts made to alleviate and contain the physical, the emotional, and social aspects of the individuals suffering. This paradigm helps to create the emotional conditions that facilitate the essential paradigm shift. A time comes for all who are dying when they know that they and those around them have done all that is possible to do, when they realize that the heroic stance has achieved all it can and where a continued struggle against the inevitable is not only futile but damaging and is adding to their suffering. When, at this moment, such individuals let go of their struggle, the new paradigm, the way of descent, has already begun. For people who suffer, a move into the way of descent represents a radical change in perspective. Even though circumstances may remain exactly the same, they will now experience them in another way. It is as if they have moved from a cramped place where fear was dominant to a more open space. A lessoning of emotional pressure, and feelings of sadness and the re-emergence of a sense of meaning are some signs that this shift has occurred.[296]

Kearney, in observing those close to death, sees that some patients make the transition from what we now term, the heroic stance to the way of descent. This comes easily to some patients. They have made their choice. Conscious of the support and care of those around them, and the weariness of their bodies from their struggles they prepare for their decent. The image work is particularly valuable in that it creates the circumstances whereby individuals like this patient who are ripe to make the decision but get trapped in the process, are enabled to make their penultimate

[295] Ibid.
[296]Michael Kearney, *Mortally Wounded*, 45-52

decision as they set out on their last journey, into the unknown, through uncharted territory to the way of descent.[297]

And, so Chiron died and descended into the underworld of Tartarus. In the patient's story, his descent was into dreamtime, where his attitude was all important. He had to make his final choice, and did just that. He was ready for what he encountered in his imagination. He noticed, interacted with and allowed himself to be surprised, and educated by its images. He trusted his depth and in turn this enabled the autonomous, healing aspects of depth to begin working on him.[298]

Although this patient was not cured, he had less pain, and needed less medication. His attitude to his illness had changed, and he became more peaceful. These changes could be attributed to the emotional catharsis and articulation when he expressed his grief for his father, all this due to the healing power of the imagination. Kearney was pleased with the patient's resolution of his problems. Whereas early on he despaired of finding a way to alleviate this suffering, and felt a failure, now however he felt enriched, it had been a learning experience for him. He felt sure that his patient had now become a wounded healer a sure mark of the return. The patient's return, refers to the changes which became apparent, he seemed different and yet 'more himself,' it was an enigmatic sense of transformation, characteristic of the return. [299]

---

[297] Ibid.
[298] Ibid.
[299] Michael Kearney, *Mortally Wounded*, 47-53.

The possibility of arriving at a place of healing and of personal growth at the end of life is an issue which Kearney deals with in his second book, *A Place of Healing*, Kearney once again raises many issues which were introduced in his first book *Mortally Wounded* and treats them in greater depth, with some differences. He places particular emphasis on 'new ways of seeing' and treating pain and suffering. He uses metaphor to illustrate three possible options to choose from in the treatment of the terminally ill: a psychological metaphor, a scientific metaphor and a historical/mythological one. He outlines the strengths and weaknesses of each approach and points out the links with current medical practices.

3. 15 THE MEDICAL MODEL

The medical model is the dominant paradigm in western healthcare, it reflects a value system which prizes rational analysis and the ability to intervene in a logical way to change and control events. That this paradigm has been highly successful is evident in its ability to prevent, treat, and cure an ever-expanding range of life-threatening illnesses. However not all human distress is responsive to the interventions of the medical model, as is the case in psychological and existential suffering. The medical model, while it has its strengths it also has its limits. From the patients' point of view, illness is manifest through pain and suffering.[300] A crucial aspect of the experience of pain is in the person's sensory and emotional reaction to it. Cecily Saunders in her use of the term 'total pain'[301] further emphasizes how pain is a dynamic construct made up of interweaving layers of physical, social, emotional, and existential distress. The vast majority of such pain can now be fully controlled or

[300] Michael Kearney, *A Place of Healing*, 3.

[301] Cecily Saunders, *The management of terminal malignant disease* (London: Edward Arnold) 194.

significantly eased using a multidisciplinary approach and the holistic expertise accumulated in palliative care and specialist pain clinics.

From time to time Kearney finds patients, for whom the medical model fails. He speaks of patient A, with recurring prostate cancer. No lasting pain relief was found and his disease progressed, causing paralysis and great distress. It became clear that palliative care alone was insufficient.[302] At this stage of his patient's illness, Kearney, with the consent of his patient decided to do some 'inner work'. The patient began to keep a journal and reflect on his dreams. He was asked to try to find a connection with anything in the dream that seemed important to him. This helped the patient to begin to find some comfort and peace.[303] We see how Kearney's specialist training was vital for the alleviation of pain, in this patient. This expertise could be part of a holistic medical model and could transfer to clinical practice in general medicine, or it could be part of interdisciplinary support.

Although the medical model helped patient A in the earlier phases of his illness and in a variety of ways throughout the later stages of his illness, its limitations became apparent in the face of the insoluble problems of his spinal cord compression and the resulting emotional and psychological torment, it was felt that further interventions would be futile. All the carers could do was to continue to treat what problems could be treated, and to stay with their patient in his sufferings. As Cassell puts it: "The test of a system of medicine should be its adequacy in the face of suffering…modern medicine fails that test… For pain, difficulty in breathing, or

---

[302] Michael Kearney, *A Place of Healing*, 9.
[303] Ibid. 12-13

other afflictions of the body, superbly yes, for suffering no."[304] If we are to find creative and effective ways of working with patients in suffering, we must describe more accurately and understand in greater depth the 'other way' the 'second model', which became operative alongside the medical model during patient A's final weeks.[305] This is reminiscent of the comment by Teilhard de Chardin, in regard to Galelio

> As in the time of Galileo, what we most urgently need is much less new facts than a new way of looking at the facts and accepting them. A new way of seeing, combined with a new way of acting that is what we need.[306]

The provision of a holistic medical model for the alleviation of pain and suffering has precedence in Hellenic medicine, which was based on the co-existence of both traditional (Asclepian) and rational (Hippocratic) medicine symbolises the necessary co-existence and co-operation of both systems, a synthesis of their concepts deemed essential to solve problems. His entire work was inspired by humanistic ideals and an undeviating dedication to the patient. Modern medicine can derive valuable lessons from the Hippocratic tradition. For the coming 21st century, medicine senses more than ever the need to combine the concepts of humanistic values and the Hippocratic messages with the technologic 'imperative' or the medical model. Marketos and Skiadas point out that this bond is necessary to the improvement of medicine in the future because, currently, the enormous biomedical technology so far has contributed little to the traditionally human fields of psychosomatic and functional disturbances,

---

[304] Eric Cassell (1991) op cit., preface, vii. The failure of medicine to meet the test put by suffering, which is really the failure of physicians to deal adequately with the suffering of their patients, only comes to be considered a failure because of personal and social expectations that are only recently emerging.....Doctors do not deal with suffering in the abstract, they treat persons who are afflicted by something that leads to the suffering. The separation of the disease that underlies the suffering from both the person and the suffering itself, as though the scientific entity of disease is more real and more important than the person and the suffering, is one of the strange intellectual paradoxes of our time.

[305] Michael Kearney, *A Place of Healing*, 14

[306] Pierre Teilhard de Chardin, *Activation of Energy*. (London, Collins, 1970) 294-5

posing new dilemmas and threatening scientific problems.[307] The holistic medical model which I am proposing in this thesis would provide care for the whole person, psychologically, socially, spiritually and physically.

3.16 A CRITIQUE OF THE WORKS AND PRACTICE OF CASSIDY AND KEARNEY WITH RESPECT TO A HOLISTIC MEDICAL MODEL OF CARE

The difficulty with Cassidy's work is that it is entirely centered on palliative care. The patients she sees and treats are with her for only a short span of time given that they are suffering from cancer, which the conventional medical model has failed to cure. They arrive at the hospice in pain and suffering at the end-of -their lives. So Cassidy is dealing with a specific group of patients, in a hospice environment. Their treatment consists of palliative care, which is patient centred and tailored to the individual requirements of each patient. Responding to the concept of 'total pain" as established by Cecily Saunders, patients are treated for their pain and other symptoms which include psychological, spiritual, and social aspects. Research has shown that physical pain cannot be treated in isolation from other aspects of distress, but must be addressed *simultaneously*. These patients are also supported by a multidisciplinary team.

The level of emotional energy Cassidy spends, in order to do her job is substantial, which she frequently referred to as costly caring. She dedicates a great deal of time to each individual patient. She prepares meticulously for her first encounter with a new patient, speaks to them, and listens to them as they narrated the stories of their illness. She establishes a therapeutic relationship with them, treats

[307] S.G. Marketos, P.K. Skiadas, "The modern Hippocratic tradition. Some messages for contemporary medicine." *Spine* 24 (1999) 1159-63.

them with dignity and provides the privacy, which they need. This level of attention to detail, and the amount of time dedicated to this work would not be readily available in a general hospital. Cassidy herself remarked that the same combinations of drugs used in palliative care provided in some hospitals did not achieve, pain relief, in a hospital setting. In the rush and business of a general hospital the environment is not conducive to the alleviation of pain and suffering. Patients' fears and worries are not dealt with. No consultant in general medicine at present has enough time to sit at a bedside, draw diagrams to explain the progress of their disease, or speaks to relatives. Neither do general physicians establish close relationships with patients, and many patients can feel depersonalized as a result. Current policy in acute hospitals is to apply the medical model, diagnose and treat the patient, and discharge them as quickly as possible. Time does not allow for individual care and quick discharge means that patients must heal themselves. Research has shown that the current medical model is inadequate in the face of suffering, more is needed. Specialists in palliative care know that a hospice environment is conducive to healing, and that the right combination of drugs in conjunction with a holistic medical model can successfully alleviate most pain and suffering.

Like Cassidy's work Kearney's too, is centered in palliative care, dealing with cancer patients, who are in pain and suffering at the end of their lives. However unlike Cassidy, Kearney is also a specialist in the areas of image work, visualization and dream work, as well as psychotherapy, Jungian analysis, and psychological techniques. Kearney's work would not easily be transferable to a general hospital. To begin with he spends a great length of time with his patients'. He is aware of the importance of listening to them, for meaning as well as for information, and is aware

of the psychological difficulties of some patients who have an inordinate fear of death and annihilation. He provides a close relationship with his patients and holistic care in attending to their needs of body, mind and soul. He goes to great lengths to assist patients who were fearful and unable to let go. He uses his expertise in the use of story, myth and symbol to reach their subconscious where their fear lay. He also believes in a paradigm shift and looks at the problems of his patients from many different perspectives. Kearney's contribution to the field of palliative care is considerable, and we have evidence of how a holistic model of medicine can alleviate pain and suffering even for very distressed patients. With the appropriate training of medical and ancillary staff, together with multidisciplinary support, and a conducive environment for healing, a holistic medical model of healthcare could provide the alleviation of pain and suffering in a general healthcare setting.

3.17 CONCLUSIONS

Cassidy's account of the palliative care provided for terminally ill patient's is substantial, and a number of themes become obvious. I believe that many of the treatments and strategies used to care for these patients could be transferred to other general medical patients, who suffer from unrelieved pain. She speaks of the fear experienced by patients, when they learn that treatment has been unsuccessful and that their death is imminent, and for this reason she prepares well for her first encounter with a new patient. Her first concern is to convey to the patient that she is interested in them as persons as well as patients. She invites them to narrate their story of illness, and listens carefully. Her first priority is to establish a therapeutic relationship to enable the patients to benefit from her treatments and care as the disease progresses, and pain increases. Care is patient-oriented and tailored to

individual need. She believes in providing competent care with empathy and compassion conscious of upholding the dignity of the patient. She also believes in treating her patients with honesty and authenticity respecting their beliefs and practices. She accepts that her patients' have a constellation of needs, and spiritual care is promoted through the practice of presence, compassion and hopefulness. She fosters personal integrity, believes that all patients are infinitely precious and affirms their lives as fruitful, and meaningful. Finally she promotes interpersonal connection, aware that what terminally ill patient's want most of all, is a spirit of companionship, somebody who will remain with them, through all the difficulties they experience, until their journey ends.

Kearney's account of caring for the terminally ill is different. Palliative care is a given, and his primary concern is with patients who are distressed and have difficulty coming to terms with the fact that their death is imminent. His task is to discover the best way to communicate with these patients. Distressed patients are full of fear, anger, helplessness and isolation. His strategies for communication include the use of myth, used to explore unknown phenomena, which provides context and illumination for understanding the mysteries of existence. Another strategy involves viewing patients as stories, enabling the understanding that events and experiences in life have a unique context for each individual. Witnessing patient narratives he listens for meaning. Sensitive listening and dialogue assists the patient to make connections between his story and others even Scripture. Story can transport patients into the realm of the imagination. Storytelling allows for transformation. Story is heard by the ear but is listened to in the subconscious mind. Gaining access to the subconscious of the patient is important for Kearney since this is where fear resides, causing patients

great distress. Taking patients through guided imagery can provide a source of strength, support and courage, which can lead to healing. Asking patients to recount their dreams, also provides a way of unlocking the unconscious. Through the encounter with the imagination, the patient can be educated by images, become transformed, allowing healing to begin. Through the use of myth, patients' may be encouraged to undergo a paradigm shift, where their viewpoint shifts and they undergo a radical change in perspective. They move away from fear and with a lessoning of emotional pressure they realize that everything possible has been done for them, and continuing to struggle is pointless.

Looking at myth in its constituent parts: wounding, struggle, descent and return there are certain commonalities with the medical model. The patient suffers from his disease, (diagnosis) the struggle represents searching for ways to relieve it, (treatment). The descent represents success (cure) and the return (healing). However the medical model does not alleviate all human distress or promote healing, as is the case in psychological and existential suffering. A more holistic medical model of care is required. Pain and suffering consist of interweaving layers of physical, social, emotional and existential distress. A holistic medical model, which I am promoting in this thesis would provide for the patient as a whole. While retaining the rational medical model, a patient-oriented holistic medical model would require the addition of other treatments and therapies, in the case of patients suffering from cancer, meditation, relaxation, and psychotherapy have proved beneficial.

The necessity of a healing model to supplant the medical model has as its origins the Hellenic medicine of ancient Greece. Hellenic medicine was based on the

co-existence of both Asklepian (traditional) and Hippocratic (rational) medicine. A synthesis of their concepts were essential to promote healing. We have much to learn today from the history of medicine. Just as modern medicine is inadequate in the face of pain and suffering, Hippocratic (rational) medicine needed the addition of Asklepian (traditional) to bring about healing. So also modern medicine (rational) needs the addition of adjuvant methods to supplement it, in order to provide a more holistic medical model, which I am promoting in this thesis.

Amongst the numerous valuable lessons to be learnt from the experience and clinical practice of Cassidy and Kearney the importance of good communication and the establishment of relationships especially the doctor-patient relationship becomes apparent. In order to provide a philosophical underpinning for these relationships, in the next chapter I will explore the insights of Martin Buber who has dealt at length with many kinds of relationships, and is best known perhaps for his I-Thou.

CHAPTER FOUR: HOLISTIC MEDICAL PRACTICE IN THE LIGHT OF BUBER'S PHILOSOPHY OF DIALOGUE

4 .1 INTRODUCTION

In this chapter I present the argument that Buber's philosophy of dialogue provides a philosophical basis for a holistic medical model.[308] The holistic clinical practice of the two authors, Cassidy and Kearney will be reconsidered in the light of Buber's philosophy. It is hoped that this examination will illuminate further the nature of a holistic medical model and substantiate its use. To counterbalance the rational stance of the current medical model, the inclusion of the social, emotional, spiritual and existentialist concerns of the patient must be taken into account. The problem with the current medical model is that it restricts itself to physical evidence alone at the top of a hierarchy and devalues any evidence lower down. This is no longer appropriate, a more holistic medical model is called for, with a widening process that would include philosophical and spiritual perspectives, as well as the social and physical concerns of the patient. Without these difficulties may arise where issues of human suffering are concerned.[309]

Martin Buber's philosophy has developed concepts of relationship and dialogue that could provide insights into the doctor-patient relationships. Buber's philosophy of dialogue views human existence in two different kinds of relationships: I-It and I-Thou. The I-It belonging to the normal everyday relation of human beings

---

[308] Martin Buber, *I and Thou*, trans. R. G. Smith (London: T & T Clarke, 2003)

[309] R.G. Evans, "Patient centered medicine: reason, emotion, and human spirit? Some philosophical reflections on being with patients." *J Med Ethics: Medical Humanities* 29 (2003) 8-15.

towards the things around them, the medical model belongs to this realm of order. The I-Thou relationship is where the human being enters with his whole being, in meeting, in a dialogue, with another. Buber explains his standpoint as operating on "a narrow ridge" the dialogue happens between two people, yet the meaning is not found in either of the two partners, nor in both, but only in the dialogue itself, in this "between" where they live together. He outlines behavioral characteristics of participants in genuine dialogue, that is "directness and wholeness; will and grace; and the presence of mutuality." The presence of mutuality, or the "between" is central to Buber's thought. One of Buber's insights concerns the "Eternal Thou." For Buber, such interhuman meetings are a reflection of the human meeting with God. This philosophical stance has radical implications for human relationships, including relationships within the practice of medicine, as will be demonstrated.

I will begin with a brief biography of Martin Buber after which I will examine in some detail his philosophy of dialogue. Then, taking Cassidy and Kearney in turn I will examine their model of clinical practice in the light of insights gained, with a view to identifying key aspects of the holistic practice of medicine

4. 2 MARTIN BUBER: A BRIEF BIOGRAPHY

Martin Buber was born in Vienna in 1878 and was brought up until the age of fourteen in the Galacian home of his grandfather Solomon Buber, one of the last great scholars of the *Haskalah* (Jewish Enlightenment)[310]. In his grandparents household Buber experienced the harmonious union of authentic Jewish tradition with the

[310]C. W. Mayhall, Timothy B. Mayhall, *On Buber*, (Canada,Wadsworth: Thomsan, 2004) 7.

liberating spirit of the Enlightenment or *Haskalah*. In particular he absorbed the atmosphere of healthy piety and respect for learning, which were to set the framework for his whole life. Of his father he wrote:

> He took part in the life of all the people who were dependent on him: the laborers, the peasants, and the tenants. He concerned himself with their family lives, with the upbringing and schooling of the children. This solicitude was directly personal. This same way of acting in relationship to people carried over into the town. He understood no other help than that from person to person.[311]

Buber came to appreciate his father's role as the instructor of the more practical and relational aspects of society, which one day he would thoroughly explore in intimate detail. At school, Buber studied languages and the humanities, and philosophy. True philosophy, he learned, should move beyond the simple academic exercise of history and into life application; answers to the essential questions of being should translate into more meaningful interpersonal relationships. In: *The Way of Response*, Buber writes:

> Existence will remain meaningless for you if you yourself do not penetrate into it with your active love and if you do not in this way discover its meaning for your self. Everything is waiting to be hallowed by You; it is waiting to be disclosed in its meaning and to be realized in it by you. He who loves brings God and the world together.[312]He felt called by God to establish a nation which would promote a genuine community and a just way of life.[313]

For many years Buber served as professor of the Jewish history of religion and ethics in Frankfurt University. This was also the year of the publication of his best known book *I and Thou*, 1923.[314] A very prolific author, some of his most famous works include: *Between Man and Man, Daniel, Hasidism and the Modern Man, I and*

[311] Ibid. 8
[312] Martin Buber, *The Way of Response*, (New York: Schocken, Books, 1966)
[313] James J. Bacik, *Contemporary Theologians*, (New York: Triumph Books, 1991) p. 247
[314] See, 161

Thou, On Judaism, Two types of Faith, The Legend of the Baal-Shem, Tales of Hasidism, The Way of Man, The Way of Response, and *The Knowledge of Man.*[315]

Buber's writings span six decades and cover a wide range of interests. His most constant theme perhaps is best defined by the phrase "the way of response." His idea is that it is only through the *other* "that I become fully I." His religious life was influenced through his study of Hasidism and he used the re-telling of stories as a method to instruct local communities. He saw Hassidic stories as promoting an invitation to live a joyous community life and to find holiness in everyday life. Buber understood story to be a medium within which various existential themes of life: belonging, yearning for companionship, loss of homeland, courage in adversity, could be woven and transmitted from one generation to the next. The telling of a story could convey the struggle to understand the mystery of life, the dilemmas encountered and how challenges could be met. Above all story could convey both the uniqueness of individual experiencing and the connectedness of all things.[316] His broad education and diverse writings supported his scriptural inspired understanding of the interpersonal dimension of life. Through his open and courageous way of life Buber calls us to a life of dialogue, characterized by personal involvement and deep respect for everything, which constitutes our world. Buber is a man of many talents: as prophet he proclaims the importance of the personal realm, as poet he points to the depths of human existence, and as a wise teacher he guides us in the quest for

---

[315]Martin Buber, *Between Man and Man*, Trans. R.G. Smith, (New York: Macmillian, 1965) *Hasidism and the Modern Man*, trans. M. Freedman (New York: Horizan Press, 1958) *I and Thou*, trans. R.G. Smith (London: T &T Clarke, 2003) *On Judaism*, trans. E. Jospe (New York: Schocken, 1967)*Two Types of Faith*, (London: Routlege & K. Paul, 1951)*The Legend of the Baal-Shem*, trans. M. Freedman (New York: Harper. 1955) *Tales of Hasidism*, trans. O. Marx (New York: Schocken, 1948) *The Way of Man*, (London: Carol Publishing World, 1995) *The Way of Response*, (New York: Schocken, 1966) and *The Knowledge of Man* (New York: Humanity Books, 1998).

[316] J. C. Gunzburg, *The Power of Story*, in, Healing Through Meeting, (London: Routledge, 1957) 27-31.

authentic personal relationships.[317]Human existence for Buber is essentially relational. He sees human persons as social beings necessarily related to nature, to other human beings, most fundamentally to God.

4. 3 BUBER: A PHILOSOPHY OF DIALOGUE, I-THOU, AND I-IT

The negative consequences of doctors' failure to establish and maintain personal relationships with patients are part of a humanistic crisis in medicine today. To resolve this crisis, a new model of patient interaction is proposed, based on Buber's philosophy of dialogue. This model shows how the doctor can successfully combine the personal (I-Thou) and impersonal (I-It) aspects of medicine[318]. There is an initial meeting stage, which initiates the doctor-patient relationship, and requires mutual confirmation; next, an examination stage, which requires a shift from a personal to an impersonal style of interaction, followed by an integration phase through dialogue or "healing through meeting" stage, which involves the integration of the impersonal medical data into the ongoing dialogue between the doctor and patient, as a basis for decision making[319] This model of doctor patient interaction, is patient-oriented and holistic, and can be incorporated into a holistic medical model of care, which I am promoting in this thesis.

Buber's philosophy of dialogue views human existence in two fundamentally different kinds of relationships: I-It and I-thou.[320] The I-it relation belongs to the normal everyday relation of human beings towards the things that surround him/her,

---

[317] J.J. Bacik, *Contemporary Theologians*, 251

[318] Martin Buber, *I and Thou*, trans. R. G. Smith, (London: T.&T. Clark, 2003), 15

[319] H. Abramovitch, E. Schwartz, "Three stages of medical dialogue". *Theoretical Medicine* 17 (1996) 175-187.

[320] Ibid.

viewed from a distance. The current medical model belongs to the I-it realm of relation. This is characterized by objectivity, abstraction, detachment and experience. The I-thou relationship is radically different. The human person enters into it with his innermost and whole being, in meeting, in a real dialogue, that is what both parties do. The I-thou relationship is characterized by spontaneity, subjectivity, reciprocity and recognition as well as acceptance of the unique other, these entities are important for whole human beings. For, Buber, inter-human meetings, are also a reflection of the human meeting with God. Buber's main theme is that human existence may be defined by the way in which we engage in dialogue, with each other, with the world, and with God. Buber's thought suggests three conceptual shifts: from disease-centered to person-centered; from crisis to everyday management; and from principles and contracts to relationships.[321] Here, Buber sets out the necessary criteria for the development of a successful model of inter-human interaction, in a holistic way, involving whole human beings, which has implications for the doctor-patient relationship.

In *I and Thou*, Buber introduces his famous distinction between I-It and I-Thou, which underlies the whole book. Buber's entire dialogical philosophy is grounded in these two primary pairs, or two types of interactions:

> To man the world is twofold, in accordance with his twofold attitude.
> The attitude of man is twofold, in accordance with the twofold nature of the primary words he speaks.
> The primary words are not isolated words, but combined words.
> The one primary word is the combination I-Thou
> The other primary word is the combination I-It; wherein, without a change in the primary word, one of the words He or She can replace It

[321] F. Cohn, " Existential medicine: Martin Buber and physician-patient relationships." *J Contin Educ Health Prof* 21 (2001) 170-181.

> Hence the I of man is also twofold
> For the I of the primary word I-Thou is a different I from that of the primary word I-It.[322]

In the opening verse-paragraph of *I and Thou*, Buber lays down the cornerstone of his *Life of Dialogue*. The world itself is not twofold. Instead, two ways of standing in the world, or communicating (translated above as a 'twofold attitude') flow through each person into 'the real world' of lived experience[323] These two word pairs are primal because they establish two fundamental modes of speaking in the world.[324] There is no I taken by itself. I exists only in relation to the other, whether we turn to the other as wholly Thou or objectified It. Whoever speaks one of the primal words enters into the I, the chosen subject position, and stands there In the I-It relation. I remains outside these interactions by controlling the beginning, middle and end, the subject discussed, and how it is defined. In I-Thou relationships, on the other hand, I yield control by fully entering into relationship naturally and spontaneously.[325] The I-Thou interactions are direct and open moments of mutual presence between persons according to Buber, and are necessary for becoming whole human beings. When I address you as Thou, I enter into direct relationship with you as a uniquely whole person, not merely as an identity.

---

[322] Martin Buber, *I and Thou*, trans. Ronald G. Smith, (London: T.&T. Clark, 2003), 15

[323] Since Buber anchors everything that he will say in *I and Thou* in this opening passage, we need to ascertain exactly what he meant by "twofold attitude"(*Haltung). Haltung* refers to a persons stance in the world. It is reflected by the difference between two primary, or grounding words (*Grundwörter*) that one speaks: *I-Thou* and *I-It.* The translation "attitude" used by Smith is too psychologically oriented. The German word *Haltung*, is more relational. It refers to the way I associate myself to what is present with me to my basic bearing, or life orientation.

[324] Martin Buber, *I and Thou* op. cit. Buber's foundational distinction is clearer in German between I and Thou relationship (*Ich-Du Beziehung*) and *I-It* relation (*Ich-es Verhältnis*) . Both words are translated by Smith as "relation," *Beziehung* means relationship between persons that include past, present, and future dimensions. These two life stands are primal, or basic, because they constitute what is most fundamental about human life.

[325] Kenneth P. Kramer, M. Gawlick. *Martin Buber's I and Thou, practicing living dialogue*, (New York: Paulist Press, 2003)18-18.

I-Thou thus refers to a two-sided event in which our personal uniqueness enters into relationship with another's personal uniqueness, as if a child has been laid in our arms and we are called to respond to it with our whole person. Certainly, Buber's ever renewed reason for writing was his conviction that each of us is capable of entering into I-Thou relationships with one another, through which surprising and new dimensions of reality arise. However, there is no pure I-Thou relationship without an I-It point of reference. Nor can we have an I-Thou relationship with everyone in every situation. We can however, remain open and willing to intend I-Thou interactions with those of similar intentions. A question arises, if a continuous relationship is neither possible nor desirable, how frequently does it occur? Buber addresses this question in *Philosophical Interrogations*

> Since the perfect I-Thou relationship in general makes no statement concerning itself, I do not know how frequent or how rare it is.....For I believe that it can transform the human world, not into something perfect, but perhaps into something very much more human, according to the created meaning of (a person), than exists.[326]

It is also important to remember that by Thou Buber does not mean either 'God' or You as an object of my perception, or He, or She, or It. Rather, with the word '*Du*' Buber refers to the presence of uniqueness and wholeness emerging from genuine listening and responsible response. When I enter a real relationship with another as a Thou, I voluntarily become another's Thou. I-Thou relationship, then, is exclusive and momentary, cannot be held on to, and does not permanently hold. When Buber asked himself, what does one experience of the Thou? He gave two seemingly contradictory responses: "nothing" or "everything". By "nothing" he meant no

[326] Martin Buber, *Philosophical Interrogations*, (ed.) Sidney and Beatrice Rome (New York: Hope, Rinehart & Winston, 1964.) 38-39.

particular object. By "everything" he meant the unique presence of wholeness.[327] Buber. did not consider his statements as sure or absolute, but "as being on a narrow ridge" Here Buber suggests a paradigm shift, in order to look at the question of dialogue, which in this thesis concerns the dynamics and complexities of the doctor-patient relationship.

4. 4 THE NARROW RIDGE AND THE BETWEEN

Referring to his work, Martin Buber describes his standpoint as operating on a 'narrow ridge' between the gulfs where there is no sureness of expressible knowledge but the certainty of meeting that remains undisclosed". This statement includes the insecurity of his I-Thou, or dialogical philosophy, which he formulated as a third alternative to the insistent either-or of our age. Thus, Buber's "narrow ridge is no happy middle ground, which ignores the reality of paradox and contradiction, it is rather a paradoxical unity of what one understands only as alternatives," I and Thou, love and justice, good and evil, or love of God and fear of God, unity and duality.[328] According to the logical conception of truth, only one of the two contraries can be true, but in the reality of life as one lives it they are inseparable, the person who has acted knows that he was and is in the hand of God. The unity of the contraries is the mystery at the innermost core of the dialogue. Buber introduces new perspectives, which question the fundamental channels of our thinking, and forces us to think, in a new way, if we are to follow him[329]

---

[327] K.P. Kramer, M. Gwalick (eds.) *Martin Buber, I and Thou*: practicing living dialogue (New York: Paulist Press, 2003) 19-20.
[328] M. Friedman, *Martin Buber: the life of dialogue*, (New York, Routledge, 2002), 3-4
[329] M. Buber, *Israel and the World: essays in a time of crisis*, (New York: Schocken Books, 1948)17.

In his later work Buber sets out his attempt to ground his vision in a 'personalist' philosophy. In order to analyze the "universal structures of reality" he developed the category of the "between'. Buber insists that the really real is the "between" the sphere which is created by the interaction between two people. This sphere is common to both parties in the relationship and transcends what properly belong to each of them. The genuine meaning of personal life cannot be found within individuals, or even in two people in a relationship, but only in the 'inter-human', which binds them together and makes communication possible. Reference to the Spirit or spiritual life must be located in the 'between.'[330] This analysis of the dynamics of communication, with its emphasis on humanism has relevance for communication not only between the doctor and patient, but also with other healthcare personnel as well.

The attempt to describe the structures of reality leads Buber to his understanding of human existence. As human beings, we come to existence only in relationships, it is our way of being-in-the world. We have the capacity to distance ourselves from others, but we can also reach out to them in order to 'encounter' them in mutual interests. As persons of potential we have the capacity to enhance our relationships. A patient-centered style would take account of the patient's subjective experience, gain an understanding of his/her hopes, their fears and expectations, in their life context, in other words it means getting to know the other as a fellow human being. Although Buber's peers were critical of his work, nevertheless his views can sharpen our awareness of the relational aspects of our life and summons us to a life of

[330] J.J. Bacik, *Contemporary Theologians*, 253

dialogue. Buber's patient-centered style of interaction is essentially holistic, and takes place, between whole human beings.

A life of dialogue suggests an ideal mode of existence: relating openly with others by respecting their uniqueness; aligning ourselves with cultural forms such as religion and art by probing their inner meaning; and encountering the 'Eternal Thou' in everyday life by refining our awareness of the divine presence. Thus, Buber offers both a vision and a programme to recover the personal dimension of life in a world filled with depersonalizing forces. Our world is an It world of things, where we can feel trapped in meaninglessness, and existential angst unless we stand in solidarity with others, open ourselves up to dialogue and satisfy our need for relation, a permanent relation is that with God. A spiritual component is an essential element in the provision of a holistic medical model, especially for those who are suffering and/or in pain. In Cassidy's work *Sharing the Darkness*, she speaks of the needs of the dying, and what they need above all else is a companion someone who will stay with them, share the pain, and face the darkness with them.[331]

4. 5 COMMUNICATION IN A LIFE OF AUTHENTIC DIALOGUE

Martin Buber, first proposed the transforming possibilities of genuine dialogue in order to address the breakdown in communication which often obstructs human relationships. Whether descriptive of a failed doctor-patient relationship, disagreement or misunderstanding, various dimensions of human interactions continue to receive widespread attention across a spectrum of fields and social situations. The consensus of feeling being that meaningful communication is

[331] Sheila Cassidy, Sharing the Darkness (London: Darton, Longman and Todd, 1985)

absolutely necessary to the survival of individuals and nations. Martin Buber's states:

> That people can no longer carry on authentic dialogue with one another
> is not only the most acute symptom of the pathology of our time,
> it is also that which most urgently makes a demand on us.[332]

In response to this difficult situation Buber in his work *I and Thou* suggested a liberating alternative: a life of 'genuine dialogue' based on his understanding of 'engaged' interaction. According to Friedman, it must be understood first, that Thou is not an object but a relationship in which partners are mutually unique and whole. This living realization is neither subjective nor objective, but inter-human.[333] It emerges from the place that Buber calls the realm of the 'between.' This is why Buber writes: 'All real living is meeting.' Genuine meeting occurs when people enter dynamic solidarity with one another. This deep bonding is contained neither in one, nor the other, nor in the sum of both but becomes really present between them. It is relationships which gives meaning to our lives.

What is common to every person according to Buber is speech-with-meaning, speech through which we become human with other humans. Buber's *Life of Dialogue* is the ever-renewing presence of alternative life stances.[334] In his view, human life is lived in a continuous interplay between two primal attitudes or ways-of-speaking about I-It and I-Thou, with all that they involve. These life stances are not for Buber absolute alternatives, but rather complementary opposites that continually

---

[332] K. P.Kramer, M. Gawlick, (eds.) *Martin Buber's I and Thou: practicing living dialogue*, (New York: Paulist Press, 2003) viii,
[333] Ibid.15, See also, M.S. Friedman (ed.) *Martin Buber: the life of dialogue* (London: Routledge, 2002) 65-70
[334] 334 K. P.Kramer, M. Gawlick, (eds.) *Martin Buber's I and Thou: practising living dialogue*, (New York: Paulist Press, 2003) 16.

interchange with one another. In the beginning, therefore, it is crucial to grasp the fact that when Buber speaks of the two primal word pairs, he means to indicate two fundamental ways of responding to, or communicating with whatever is before us. When we say I, we use one or the other ways of speaking. Thus, according to Buber, by speaking in either one or the other primal modes, we continually reposition ourselves relationally. Knowing how human relations are continually interwoven between the personal and the impersonal provides a better understanding of an ideal patient-doctor relationship, where the patient is addressed as a whole human being, social, emotional, and spiritual. It also clarifies the doctors' response, and how it moves from the interpersonal (I-Thou) of history taking, to the physical examination (I-It) when the patients' illness is diagnosed and treatment is discussed and negotiated. This is where the holistic medical model, which I am proposing, is applied to the patient.

In I-It relations, for example, the patients' disease is objectified and reduced to the content of the observers own experience.[335] In I-Thou relationships, on the other hand, the dialogue is open and mutual (reciprocity) where for example, the exchange is patient-oriented, and the patient is involved in the decision making. Both methods of speaking are necessary. While our lives in the world benefit in practical ways because of I-It relations, developing personal wholeness requires I-Thou relationships. According to Buber, one becomes human only in I-Thou relationships, because these call a person into unique wholeness, as Buber states: "I become through my relation to the Thou. As I become I, I say Thou, that is I become

[335] Ibid. 16-17.

genuinely human with and through Thou." [336] This can be achieved in the application of a patient-oriented holistic medical model.

4. 6 DIRECTNESS AND WHOLENESS, WILL AND GRACE, AND PRESENCE OF MUTUALITY

Having discussed the central I-Thou axis of relationship, and the concepts of the "narrow ridge" or the "between, " Buber next outlines three behavioral characteristics of participants in genuine dialogue, that is directness and wholeness, will and grace, and the presence of mutuality:

> Meeting, the Thou meets me through grace—it is not found by seeking.
> But my speaking of the primary word to it is an act of my being.
> The Thou meets me. But I step into direct relation with it. Hence, the relation means being chosen and choosing, suffering and action in one; just as any action of the whole being, which means the suspension of all partial actions and consequently of all sensations of actions grounded only in their particular limitation, is bound to resemble suffering.
> The primary word I-Thou can be spoken only with the whole being
> Concentration and fusion into the whole being can never take place without me.
> I became through my relation to the 'Thou;' as I become I, I say 'Thou;'
> As I become I, I say Thou
> All real living is meeting[337].

From this pivotal passage outlining the undivided wholeness of genuine meeting (in the sense of engaging and being engaged) the rest of Buber's I and Thou proceeds. The decisive single sentence 'All real living is meeting' is crucial for Buber, because genuine meeting requires an altogether different kind of attentiveness, a living relationship of whole person to whole person. "All real living is meeting" does not

[336] Ibid. 17
[337] Ibid. 21

mean that the objective other is unreal, but that, the It finds its reality when brought into the direct presence of an affirming I. Genuine meeting embodies directness and wholeness. By directness Buber means immediacy, presence without agendas. In his definition of wholeness Buber includes both 'choosing' to enter relationship, and 'being chosen' by one who also chooses to enter into relationship. Dialogical wholeness, then, involves both "surrender and action." Smith translates the key German word (*Leidenschaft*) 'Passion' as 'suffering'. But in this context 'Passion' means more, moving toward 'surrendering' into relationship[338]

As Buber demonstrates in various contexts, I become fully myself in and through relationships with the Thou: "I become through my relationship to the Thou; as I become I, I say Thou". In other words when genuine meeting happens, my will and identity are passionately involved. The implications of this insight also reverberates throughout the text. Yet, no matter how much I 'will' genuine relationship, finally the *Thou* meets me through the effective grace of reciprocal acts of compassion. Action and surrender, will and relational grace, generate the interactive immediacy of meeting. For Buber, *grace* is not a theological term but the spontaneously undetermined presence of mutuality, which cannot be activated by will alone. If 'will and grace' provide the necessary preconditions for meeting, the *presence of mutuality* characterizes its genuine nature. This precise level of insight enhances our understanding of all relationships

The *I-Thou* relationship, is simultaneously inclusive and exclusive. It is inclusive in so far as the world dwells in me as an image and I dwell in it as a thing

[338] Ibid. 21-22

but it is exclusive when, as Buber writes, the *Thou* steps forth and confronts me and 'fills the heavens'. When the relationship between *I* and *Thou* is genuine, there exists a mutual giving. 'You say *Thou* to it and give yourself to it, it says *Thou* to you and gives itself to you'. In other words, *I and Thou* give to one another in the mutual reciprocity between two persons, Buber writes:

> Relation is mutual. My *Thou* affects me as I affect it
> We are moulded by our pupils and built up by our works.
> The 'bad' man, lightly touched by the holy primary word,
> becomes the one who reveals
> how we are educated by children and by animals!
> We live our lives inscrutably included within the streaming
> Mutual life of the universe.[339]

According to Buber, this primary togetherness—the mutual life of the Universe is formed by real immediacy. Therefore, genuine meeting involves mutual 'stand-taking' and mutual self giving. And, since genuine *I-Thou* relationships are mutually present, the reality of that relationship—meeting others and holding our ground in the meeting—cannot be reduced to a distinct or an abstract feeling for example 'emotion recollected in tranquillity'. But the question now arises as to what should we understand here by 'mutually present'. If for example Buber's understanding of love and ask ourselves where does love occur? Inside a person or between persons ? According to Buber feelings may accompany love, but they do not constitute love. While feelings dwell in a person the way a person dwells in the world, a person in love dwells *in* the mutual presence of love. Real love is deep bonding between *I and Thou*.[340] In this context it becomes apparent that *I-Thou* moments consist not of two experiences dwelling distinctly in two persons but a third dimension, the dimension of

---

[339] Kenneth P. Kramer, M. Gawlick, (eds.) *Martin Buber's I and Thou, practicing living dialogue*, 23
[340] Ibid. 24

the *between* in which shared experiences enlivens the *I-Thou* relationship: in the *between*, real meeting happens, there is elemental togetherness, vital reciprocity, memorable common fruitfulness, and mutual bonding. The presence of mutuality, or 'the between,' is central to Buber's thought.[341]

4.7 THE ETERNAL THOU

One of Buber's significant insights in *I and Thou*, he called the 'Eternal Thou'. As he indicated on several occasions, the central principle of his life's work was that the *I-Thou* relationship between persons intimately reflects the *I-Thou* relationships humans have with God. Genuine relationship with any Thou shows glimpses of the 'Eternal Thou'.[342]Thus Buber's use of the word Thou has a twofold concern: both a temporal Thou (who can become It) and the 'eternal Thou' (who cannot become It) The following passage which occurs in part I of *I and Thou* is repeated again in the middle of part III.

> In every sphere in its own way, through each process of becoming
> That is present to us we look out toward the fringe of the
> Eternal Thou; in each we are aware of a breath from the
> Eternal Thou; in each Thou we address the eternal Thou.[343]

The Eternal Thou is not to be regarded as a separate being who is brought into the relationship. In contrast to all other existing beings, the 'Eternal Thou' cannot be reduced to even the 'loftiest' conceivable objective image. The eternal presence of God is instead glimpsed in the immediacy of the relationship itself. The importance

---

[341] Kenneth P. Kramer, M. Gawlick, *Martin Buber's I and Thou, practicing living dialogue*, 24. See also M. S. Freedman, (ed.) *Martin Buber: the life of dialogue*, 69

[342]Martin Buber, *I and Thou*, 99

[343] Martin Buber, *I and Thou*, 130, see also Kenneth P. Kramer, M. Gawlick, *Martin Buber's I and Thou, practicing living dialogue*, 24-25

of a spiritual element in a holistic medical model, for those who believe in the eternal presence of God cannot be underestimated, especially for patients who are experiencing pain and suffering. According to Buber the 'exalted' melancholy of our fate, is that every Thou in our world must become an It: The intense presence of Thou moments inevitably flows away, becoming objects, ideas relegated to past experience. The I-It relation refers to a one sided experience of 'knowing,' 'using' and putting things in 'categories'. In this objective experience of the world with its plans, schemes and purposes.[344] This could apply to healthcare services, and charters of rights for patients.

While I-Thou relationships are wholly personal, I-It relations are removed. I-It knowledge, or subject-object knowing, contains largely socially conditioned categories of self-thought. Although the title *I and Thou* conveys the dialogical necessity of striving for genuine interaction with the world, Buber found it impossible to disregard the functional necessity of subject-object knowing. He makes this clear in *Philosophical Interrogations*:

> I have often indicated how much I prize science so-called 'objective knowledge' without it there is no orienting connection with the space-time sphere in which we have to pass our individualized life on earth. Without the splendid condensations, reductions, generalizations, symbolizations that science turns out, the handing down of a 'given' order from generation to generation would be impossible.[345]

[344] Martin Buber, *I and Thou*, 58.

[345] Martin Buber, *Philosophical Interrogations* , 48, see also Martin Buber, *I and Thou*, 130, and Kenneth P. Kramer, M. Gawlick, (eds.) *Martin Buber's I and Thou, practicing living dialogue*, 26-27.

The current medical model is science based, and has proven its efficacy in both curing and eradicating diseases, and in the provision of markers and endpoints, which define disease, and assists in the diagnosis and treatment of patients. However this model is insufficient in the face of suffering, for this reason, I am advocating a holistic medical model, which would retain the current medical model, and add on further therapies and treatments in order to provide for patients in their wholeness, social, emotional, spiritual, physical, and psychological. The melancholy of our ability to imagine that we are removed from the objects of our senses, leaves every Thou in the world fated to become a thing among things:

> It does not matter how exclusively present the Thou was in the direct relation. As soon as the relation has been worked out or permeated with a means, the Thou becomes an object among objects—perhaps the chief, but still one of them, fixed in its size and its limits[346]

This passage is tinged with sadness, the recognition that the mind not only holds the capacity for ordering the world, but that it also elevates its own melancholy, even while it mechanically limits the capacity for the genuine unfolding of every human life. These types of expressions remain exclusively within one frame of reference and typically involve evaluation, judgment, justification, and association. This could apply to the medical model. While this form of discourse is necessary to serving the means and ends of healthcare, I-It discourse alone is not enough to restore fuller humanness. Clinging to the chrysalis of objective experience, severely limits our ability to acknowledge what Buber considers our fundamental birthright. Without the opportunity to fulfill our need for transforming relationships, our quality of life

---

[346] Martin Buber, *I and Thou*, 31, 58.

suffers. This exemplifies the deficiencies inherent in the current medical model, and justifies changing to a holistic medical model.

One of the recurring phrases in Buber's thesis is '*All living is meeting.*' He reinforces his thesis by tracing the experience of an infant emerging into 'relational consciousness.' Buber begins: 'In the beginning is relationship', here he refers to the prenatal life of a child in pure union with its mother.[347] It is from the natural combination of mother and child Buber writes, that the primary awareness of the I-Thou relationship begins. In this perspective the presence of the Thou corresponds to the development of the human being and we are all born with an 'inborn Thou.' In the womb the child is unfolded in a natural relationship the bonds of which are broken at birth. From the first moment of life, the child reaches out for contact confirming otherness. It is only through developing this 'inborn Thou' that a child eventually becomes a person.[348] In Buber's formulations the 'inborn Thou' is both a 'category of being' and a 'model for the soul:'

> The inborn thou is realized in the lived relations of that which meets it. The fact that this Thou can be known as what is over against the child, can be taken up in exclusiveness, and finally can be addressed with the primary word, is based on the *apriori* of relation.[349]

It is because the lived experience of the Thou is both *a priori* and inborn that Buber placed it 'in the beginning.' The I-Thou relationship comes before the self existence of either I or Thou alone. Through seeing, hearing, and touching, writes Buber, a child finds his or her own world. The "inborn Thou" manifests itself only through entering into relationship with another Thou. As the child becomes conscious of I, by

---

[347] Kenneth P. Kramer, M. Gawlick, (eds.) *Martin Buber's I and Thou, practicing living dialogue,* 28
[348] Ibid. 28.
[349] Martin Buber, I and Thou, 42-44.

learning to perceive his or her separateness from what is reached for, the child learns to form objectifying relationships. From this separation the child confronts the world[350]

Summarizing the ambiguity of the human situation, Buber concludes by indicating that every particular Thou is bound to become I-It: without It a person cannot live. But one who lives with It alone is not a person. While a person cannot become fully human without a Thou, a human being cannot live without an It. Buber himself lived much of his life in the It world of gathering materials and analyzing their meanings across disciplines.[351] This demonstrates the interdependence of the two modes of being-in-the world as described by Buber. This could also refer also to the comparison between the medical model, which lacks humanism, and the holistic medical model I am proposing. While the current medical model is sufficient where the elements of physical examination, diagnosis, and treatment are concerned, (I-It) nevertheless, it is insufficient in dealing with matters of pain and suffering, because pain is multidimensional, and patients' are whole human beings, in other words, the totality of the whole person is involved, social, emotional, and spiritual as well as physical, and research has shown that in the case of the terminally ill especially, each element of the patient's pain must be addressed simultaneously before the successful alleviation of pain and suffering can be achieved.

[350] Ibid. 29
[351] Ibid. 31.

4.8 CASSIDY'S HOLISTIC CLINICAL PRACTICE, IN THE LIGHT OF MARTIN BUBER'S PHILOSOPHY OF DIALOGUE

Buber, has been able in both I-Thou and in later writings to recover and express the unique force at work in the Christian tradition as well as the Hebrew. Buber's work is embodied in a faith, which, has hope as one of its chief elements in *I and Thou*; his main concern is how to understand the experience of relationships, with each other and with God, and do justice to its inner nature. In common with the work of Sheila Cassidy, he speaks of a direct or immediate relation with God, whom he refers to as the *Eternal Thou*[352] Cassidy has a deep sense of faith in God, which sustains her, in her work with the sick and suffering and through her personal ordeal of torture and suffering. She felt his presence at her side, throughout her ordeal in prison, and gradually realized that God was calling her to do his work.[353] Her work is interspersed with theological insight. In "Sharing the Darkness" referring to her constant exposure to pain and death, she said:

> I believe that our spiritual attitude to suffering is crucial because it not only determines the way we relate to those for whom we care but our very survival as carers. If our attitude is illogical because of ignorance or a flawed theology, we run the risk of being so overwhelmed by pain that we "burnout". If, however we are able to maintain a Paschal overview, keeping the resurrection in the same perspective as the cross, then our inevitable human sadness will be tempered by the joy we experience in our faith in the loving purposes of God.[354]

Buber speaks out of what he himself regards as a relationship with God, which is basic to humanity: a reflection which he believes is largely unrecognized today,[355] and

[352] Martin Buber, *I and Thou*, 99-104
[353] Sheila Cassidy, "*Sharing the Darkness*" 65
[354] Ibid. 65.
[355]Martin Buber, *I and Thou*, 5

is largely absent in the practice of medicine using the current medical model. This is why a holistic medical model could be of benefit to patients. A spiritual element is essential for healing. Buber agrees, he believes that a relationship with God is essential for the recovery of true humanity in all spheres of life. This relation he presents in I-Thou, with a variety and richness of experience, can convey the sense of that relation as a presence.[356]

The medical model belongs to Buber's I-It realm of physical examination, diagnosis, treatment, cure, and his I-Thou mode of being is concerned with relationships; where genuine meeting occurs, when two people enter dynamic solidarity with each other. The bond or realization is inter-human, and emerges from the place Buber calls the realm of the "between."[357] Buber describes the possibility of a therapeutic relationship that approaches the I-Thou realm, which offers ways of being in the presence of suffering.

In her work *Sharing the Darkness* Cassidy writes about the meaning and the cost of caring.[358] It is an exploration, a series of reflections and an account of caring for others, of recognizing a need and moving out to meet it. Most of her work belongs to the realm of I and Thou [359]. Her description of the incurable and dying is of people, on a journey, traveling fearfully into the unknown. Her *Good Friday People*, in particular, belong to Buber's realm of I and Thou. Those who accompany the dying, share in a 'spirituality of presence' and companionship, which belongs to the I

---

[356] Ibid. 5

[357] Martin Buber, *I and Thou*, 78. See also F. Cohn, "Existential medicine: Martin Buber and the physician-patient relationships." *J Contin Educ* 21 (2001) 170-181.

[358] Sheila Cassidy, *Sharing the Darkness*, 19

[359] Kenneth Noble, *Doctor to the dying* http://wwwforachange.co.uk/aug94/Cassidy.htm Viewed 05-08-03. P. 1-3. Sheila Cassidy, *Sharing the Darkness*, p. 4-5.

Thou, way of being. Those who care for the dying, she believes, must enter into their darkness and go part of the way with them on their frightening journey. This is true compassion: entering into the suffering of another, sharing their pain, and desolation.[360] Shelia Cassidy is a strong advocate of patient centered medicine and a holistic medical model in providing relief from pain and other distressing symptoms. Pain relief is seen as part of a comprehensive pattern of care encompassing the physical, psychological, social and spiritual aspects of suffering which must be addressed simultaneously. This holistic care embodies alternating between Buber's I-It and I-Thou realms of being and caring, [361]

In *Sharing the Darkness* Cassidy relates what the hospice movement is saying to main-stream medicine.[362] She feels that those who care for suffering and dying patients' are spokesmen for the sick. They listen to the cries of the people who are terminally ill and try to speak out for them:

> They want to be treated as normal responsible people. They want to have their illnesses explained to them in words that they understand and they want to be consulted about its treatment. They want to retain their dignity as individuals and to keep some control over their lives. They want to participate in their care and share in the decision-making. They want doctors to be honest with them. More than anything they want us to combine our competence with compassion, and when their hands are empty, to stay and share the frightening darkness.[363]

In this passage we have an interweaving of the realms of I-It and I-Thou. When Cassidy outlines her preparation for an encounter with a new patient, which is patient oriented, it takes place in a predominantly I-Thou realm of being. She treats her

---

[360] Shelia Cassidy, *Good Friday people* (London: DLT, 1988), also "Together in the Darkness," *The Tablet*, Nov. 29, 1997, p.1-2. Viewed 05-08-03. Balint, W. Shelton, "Regaining the initiative, forging a new model of the patient-physician relationship" *JAMA* 275 (1996) 887-891.

[361] Bill O'Neill, Marie Fallon, "ABC of palliative-care and pain control" *BMJ*, 35 (1997) 801-804.

[362] Shelia Cassidy, *Sharing the Darkness*, 15, 27-28.

[363] Ibid. 19-20.

patient's with sensitivity, and listens attentively to their stories. She gives her patients an opportunity to express their anger and sadness. She wants to know how they feel about having a terminal illness, and facing imminent death, and what resources they can draw on to support them at this critical period of their lives. The information she gleans from this encounter will be used to tailor treatment to the individual needs of her patient. She communicates with them on a person to person basis, and affirms their worth. Good doctor-patient communication is vital in the establishment of a therapeutic relationship. Cassidy's encounter with her new patients are clearly forged in the I-Thou, realm of dialogue[364]

Cassidy's experience in clinical practice in the successful alleviation of pain and suffering is documented in her works, which have relevance for the treatment of the sick and suffering. Cassidy's attention to detail has always been her forte, and she believes that the heroic struggle of patients to cope with inordinate suffering, should be made known to others, so that lessons can be learned in how to treat critically ill patients. According to Cassidy there are two essential components of good caring: competence and compassion.[365] Well meant kindness is not enough, nor are learned communication skills, but the two together can transform despair into hope, dignity, and courage. One of the most important aspects of caring is helping people cope with impending death is by exploring their fears and debunking the myths and facing the real difficulties truthfully.[366] Professional loving is about competence, empathy and

[364] Martin Buber, *I and Thou*, 24-25. See also, R.M. Zaner, "Medicine and dialogue" *J Med Philos* 15 (1990) 303-325., See also H Abramovitch, E. Schwartz, "Three stages of medical dialogue" *Theor Med* 17 (1996)175-187.
[365] Sheila Cassidy, *Sharing the Darkness*, 29
[366] Ibid. 29, See also, David Clarke, "Between hope and acceptance, the medicalisation of dying," *BMJ*, 324 (2002), 905-907., Martin Buber, 15.

communication.[367] Cassidy's insight into the needs of the sick and suffering is obvious throughout her work. These insights are transferable to all patients whether in hospital, nursing home or other healthcare facilities, as part of a holistic medical model.

4. 9 KEARNEY'S WORK IN THE LIGHT OF BUBER''S PHILOSOPHY OF DIALOGUE

Genuine dialogue and open communication is vital in the practice of medicine. The quality of the patient-doctor relationship is crucial for a good outcome in the diagnosis and treatment of disease. This is especially true when caring for the terminally ill. Treatment must be patient-oriented and tailored to individual needs through negotiation and consultation. This describes the possibility of a therapeutic relationship in Buber's *I-Thou* realm, which offers guidance in ways of being in the presence of suffering.[368] In his work entitled *Mortally Wounded.* Michael Kearney explores the nature of soul pain in those close to death.[369] He does this by sharing and reflecting on the stories of a number of individuals with advanced illness in the light of two models, one mythological, and the other psychological. Some of these stories illustrate a particular way of working with the deep inner aspects of a dying person's experience and shows that the work is essentially a co-operative adventure with the healing forces of the person's own psyche. Kearney believes that this inner or depth work is the essential complement to the outer care of the individual, and may enable

---

[367] J.V. Jordan, "The role of mutual empathy in relational/cultural therapy". *J Clin Psychol* 56 (2000) 1005-1016.
[368] J. Balint, W. Shelton, "Regaining the initiative, forging a new model of the patient-physician relationship." *JAMA* , 275 (1996), 887-891. See also, D. Rotor, " The enduring and evolving nature of the patient-physician relationship" *Patient Education Counselling* 39 (2002) 5-15.
[369] Michael Kearney, *Mortally Wounded*, 57, 60-66

that person to find his or her own way through the prison of soul pain to a place of greater wholeness, a new depth of living and a falling away of fear. Kearney acknowledges the importance of Buber's work for medical practitioners:

> Martin Buber believed in the potent healing effect of story on the aching soul. He understood story to be a medium within which various existential themes of life belonging, yearning for companionship, loss of homeland, courage in adversity, the blossoming of love, could be woven and transmitted from one group to another and from one generation to the next. The telling of a story could convey the struggle to understand the mystery of life, the dilemmas encountered and the myriad ways that such challenges could be met. Above all, story could convey both the uniqueness of individual experiencing and the connectedness of all living things.[370]

'Healing through meeting' is a theme, which Buber uses repeatedly. In it Buber talks about the risk of walking in this relational way into therapeutic relationships with people but he states his belief that it is through this kind of deep meeting in this risky place that healing can take place. It is in this way through presence, authenticity and opening to the other that we are in relationship to that healing possibility. The connection between the unconscious of the patient and therapist describes what Martin Buber called interpersonal spirituality. He named it the response to an I-Thou relationship. In this timeless realm, according to Buber there is 'Healing through meeting.' As therapeutic language would put it, the therapists capacity for depth of unconscious response, both to self and to client, encourages the expansion of the client's own self-acceptance, and then the client can come to participate freely with the therapists 'Thou' as an 'I' to the therapists 'Thou'. Then too, the client can bring this 'I-Thou' range to bear on all other relationships in his or her life. In these spiritual terms, the ground of a clients suffering, is self-rejection. Spiritual health on

---

[370] John C. Gunzberg, *Healing through meeting, Martin Buber' s conversational approach to psychotherapy*. (London: Jessica Kingsley Publishers, 2003) 13-23

the other hand is self-acceptance with the spontaneous compassion towards self-acceptance brings with it. In this depth of 'Healing through meeting' the client is met beyond the clients self maintained limit, so that he or she in turn can meet the inner self more fully.[371] Buber's philosophy of dialogue, and insights into the psychological difficulties facing the critically ill, fits very well with my vision of the necessity of a holistic medical model, which would take cognizance of the total needs of the suffering patient, social, emotional, physical as well as spiritual.

Kearney also highlights the fact that the telling of our stories is at the core of human communication. While we have developed many forms of communication, which carry our messages across vast reaches of space and time, 'Story,' in the oral tradition, still transports us into the essential realms of imagination as no other form can. Storytelling allows for transformation. It draws from wellspring-deep human symbols, archetypes and puts those images into words.[372] To be healthy children and healthy adults, we need to live a symbolic life. Martin Buber is of the belief that 'play is the exaltation of possibility' and in a way that is what story is. It exalts what we can be, what we can become, and our potential to transform. Whenever, and wherever stories are told a cord is plucked within the understanding of the listeners. Often the story is heard by the ear, but listened to by the sub-conscious mind where its deeper meaning resides. Stories, myths, or fables, seep into the listeners inner resources and awaken the imagination. Storytelling facilitates a connection between the biblical words, the stories of their lives and the kingdom of God. Kearney shares Buber's

---

[371]Stephen Schoen, " Psychotherapeutic spirituality and its ethics." *Ethical Directions,* vol. 22, no.2, p.1-3
See also, "The truth in story." An interview with Merna Hecht, by Kari Berger, in *The Ecology of Media* 23(1989) 58.
[372] M. Kearney, *A Place of Healing* (New York: Oxford University Press, 2000)16

view concerning the dynamics and power of story as a form of communication, and how it can be used therapeutically for patients' who have difficulty in their dying.

Kearney suggests that we all share primal fear, an instinctive fear of the dark. This existential and primal fear of the unknown causes a particular form of human suffering he calls 'soul pain'.[373] For those patients who are having a difficult time in their dying and seem impossible to comfort Kearney thought that if he could lead these vulnerable individuals to a place where they could find a creative way of responding to the challenge of soul pain, that it might open up a path to the very heart of living, even in the shadow of death. With a lessoning of fear, creativity is possible, and this can lead to healing. Fear inhibits healing.[374]

Michael Kearney is familiar with the impact the holistic approach of multi-professional expertise and compassionate attention to the whole person, can make for the terminally ill. This makes the process of dying easier by expertly controlling the individual's pain and other physical symptoms while fostering open and honest communication with them and their families. The hospice movement has its source in the caring impulse at the heart of the health professions. Kearney believes that it has evolved in this century as a redress to the imbalance created by increasingly scientific and technological medical system. The holistic medical model which I am promoting in this thesis would take care of the needs of the critically ill and dying patients, The current medical model would be insufficient.

---

[373] M. Kearney, Mortally Wounded (Dublin: Marino Books, 1996) 13.
[374] Michael Kearney *A Place of Healing*, 16, see also James Hillman, *The dream and the underworld*, (New York: Harper & Row, 1979), 116.

In his most recent work, *A Place of Healing,* Kearney outlines his ideas about healing, which coincide remarkably with Buber's views. Kearney observed how some of his terminally ill patients reached a place of healing shortly before they died, whilst others remained distressed. And while the medical model was successful in treating many patients, it failed to work for those who were suffering both spiritually and existentially. By using a psychological metaphor, to examine the source of this distress, he looked at the human psyche from two different points of view, which he termed the surface and deep minds. The surface or conscious part of the mind could be accessed through logical concepts, in normal waking consciousness, using the medical model. The subconscious or intuitive aspect of the deep mind, active during nocturnal dreaming is connected to the emotions and the physical body, its vocabulary being image symbol and myth. This realm of the psyche could only be reached through the subconscious. Because story is a powerful way of reaching the subconscious, the use of visualization, image work or story became therapeutic ways of dealing with spiritual or existential difficulties, which enabled patients' to move on towards a place of healing.[375]

Kearney acknowledges the pivotal role that honest and open communication plays in the life of human persons. Buber gives us an example of his philosophy of genuine dialogue in his I-Thou relationships. Here two people meet as existential equals, as whole persons, in mutuality and reciprocity. The outcome from this meeting lies in the 'between', not in either party. This can describe the ideal relationship that exists between doctor and patient. The treating of a patient as a

[375] Michael Kearney, *A Place of Healing* 16.

whole person, body, mind, spirit and emotion is evident in both *Mortally Wounded* and *A Place of Healing.*

Buber however does not wish to denigrate the importance of scientific knowledge. Kearney agrees. Evidence based medicine (EBM) is an essential part of patient investigation, diagnosis and treatment, and belongs to Buber's *I-It* realm of being. However the medical model has its limitations. Science investigates the human person not as a whole, but in selective aspects and as part of the natural world. Scientific method in fact is the human person's most highly perfected development of Buber's *I-It* philosophy or subject object way of knowing. Its methods of "abstracting from the concrete actuality and of largely negating the inevitable difference between observers reduce the 'I' in so far as possible, to the abstract knowing subject the passive and abstract object of thought." Just for these reasons scientific method is not qualified to discover the wholeness of man. Kearney knew from his clinical work that another system along with the medical model was needed to bring about healing in his terminally ill patients'. His second book 'A place of healing' outlines his research work and successful treatment of patients through the addition of his healing model, which depended largely on providing access to the subconscious through dialogue and communication with the patient.[376] It is of interest that Kearney in his work looked at the scientific method of Hippocrates, who also needed the addition of a healing component to treat patients even at that time in history.

---

[376] D.B. Morris, "How to speak postmodern: medicine, illness and cultural change," *Hastings Cent Rep* 30 (2000) 7-16, see also, Martin Buber, *Knowledge of Man*, 9-10.

The works of Cassidy, Kearney, and Buber converge with respect to the centrality of God in their lives, and in their provision of a spiritual component for patients in their care and the possibility of transcendence and hope for a new life with God after their death. Having explored the clinical work of Cassidy and Kearney I believe that their work has a significant contribution to make, in the provision of holistic, patient oriented medical care. Furthermore their specialist training and experience in the provision of palliative care is also a valuable asset applicable to many sections of healthcare

4.10 CONCLUSIONS

The holistic model of medical care as illustrated here by Cassidy and Kearney in the context of palliative care, finds a philosophical underpinning in the dialogical philosophy of Martin Buber. Buber and Cassidy share a strong belief in God. Cassidy felt called by God to do his work, and she did this by dedicating her life to the care of the terminally ill. Buber felt called by God to promote genuine community and a just way of life. He firmly believed in the holiness of everyday life. He was also concerned by the inability of people to communicate with each other and proposed the transforming possibilities of genuine dialogue. His concepts of relationship and dialogue, corresponds to Cassidy's need to establish a therapeutic relationship with her terminally ill patients. Buber's formulations of I-thou and I-It have relevance for Cassidy in her clinical care of the terminally ill. The medical model of diagnosis, treatment, and cure belongs to Buber's I-It realm of being, which Casssidy finds insufficient, of itself in caring for the terminally ill and dying patient. Nevertheless His I-Thou concept of dialogue offers a new model for being in the presence of suffering as exemplified by Cassidy, in her sensitive empathic listening as patients

narrate their story of pain and suffering. Through her empathic listening the patient reaches out to her, and it is in the telling of their story that Cassidy reciprocates by reaching out to them. This is what Buber was referring to in his concept of the" between," where the relationship is forged, each by reaching out to the other and meeting in the " between." Her whole outlook and way of being-with her patient's in their suffering is empathic, compassionate and patient centred. She is sensitive to all their needs. Her interaction with her patients fits well within the realm of Buber's I-Thou concept of relationship and philosophy of dialogue. Her insight in dealing with her patients' is holistic, and it would be appropriate as part of a holistic medical model, which I am promoting in this thesis.

Buber's conviction of the power of story is mirrored by Cassidy, who encourages patients' to narrate their story of illness and pain. She believes that it is in the narration of their story that patients come to terms with their illness. Buber also believed story to be a medium within which various existential themes of life could be conveyed to the listener. This dialogical exchange is couched very much in Buber's I-Thou philosophy of dialogue. Cassidy's concern with the quality of her listening is shared by Buber when he refers to the presence of uniqueness and wholeness emerging from genuine listening and responsible response. He speaks of the undivided wholeness of genuine meeting, requiring a living relationship of whole person to whole person. Cassidy's holistic clinical care of her patients, provides treatment for "total pain" which takes care of the whole person. In achieving wholeness patients arrived at a place of reconciliation and peace enabling a meaningful death experience for them and their family. Buber's philosophical underpinning of Cassidy's clinical care of her patients affirms the value of her

contribution towards the care of the sick and suffering, thus making her contribution eminently suitable for use in many fields of medicine, and as part of a holistic medical model which I am promoting in this thesis.

Kearney's holistic clinical care of the terminally ill and his provision of patient-orientated treatment is arrived at through negotiation and consultation with his patient. Buber's concepts of dialogue and communication provides a framework for Kearney based on his formulations of dialogue, expressed in terms of I-Thou and I-It realms of being . In *Mortally Wounded*, Kearney explores the nature of existential pain experienced by some patients who, despite the application of the medical model and palliative care, still suffer from unrelieved pain. In his treatment of these patients Kearney shares and reflects on the stories of patients through the use of psychological and mythical metaphors to enable patients to gain access to their dormant healing processes, which were inaccessible due to their fear of imminent death.

Kearney shares Buber's belief in " the power of story". Its potent healing effect reflected a medium through which existential suffering could be challenged and met. According to Buber there is also " healing through meeting." The connection between the unconscious mind of the patient and therapist encourages compassion towards self-acceptance and this therapeutic relationship makes healing possible. Buber also believes that in order to be healthy we need to live a symbolic life. Stories, myths or fables are heard by the ear but listened to by the self-conscious mind where deeper meaning resides. This is where existential fear can reside blocking creativity and inhibiting healing. Story can activate what we can be, what we can become and our potential to transform ourselves and reach a place of healing even

though death is imminent. This is what Kearney sought for his patients and he succeeded in alleviating pain and suffering, as fear slipped away and patients arrived at a place of reconciliation and healing. Kearney's healing model in addition to the medical model provided a holistic medical model of clinical care needed to alleviate the pain and suffering of his terminally ill patients

What all three authors Cassidy, Kearney, and Buber, shared was a strong Christian belief in God interwoven with their experiences of the sick and suffering. Each dealt with the notion of fear, and how it interfered with healing. Kearney identified the location of fear, as residing in the patient's unconscious. They also shared a strong conviction that the quality of the doctor- patient relationship was of the utmost importance in their continuing care of their patients, which Buber affirmed with his unique insight into the dynamics of the patient doctor relationship. Buber's power of story was mirrored by Cassidy in her description patient's narrative and Kearney used story and myth therapeutically. The alternating stance of his concepts of dialogue, I-Thou and I-It in the application of the medical model and the necessity of adding a healing model, was also shared by Cassidy and Kearney. This has implications for my thesis in proposing a holistic medical model. Cassidy and Kearney's awareness of their patient's 'total pain' and concern that patients be treated as whole persons is also shared by Buber in his concern for uniqueness and wholeness. Finally, all three authors believed in treating patients with empathy and compassion, in their concern for the dignity of the patient at all times.

CHAPTER FIVE: A THEOLOGICAL FOUNDATION FOR A MODEL OF HOLISTIC MEDICAL CARE, EXPLORING THE CONTRIBUTION OF JOHN PAUL II.

5.1 INTRODUCTION

In the previous chapter we have provided a philosophical underpinning for the holistic medical model of healthcare proposed in this thesis. In this chapter I further advance a theoretical underpinning by providing a theological foundation for same. The field of theology offers a profound reflection on the meaning of human suffering which, is a central aspect of this thesis. Interwoven in this reflection are theologies of salvation, redemption, theodices of evil, as well as scriptural reflections on the healing of the sick. Certain themes become evident in this examination of suffering in the Christian tradition, such as: the meaning of suffering, theologies of salvation and redemption; Christ centered approach to suffering and healing; social responsibility in the context of healthcare; faith, hope and love as central virtues in human illness; human dignity and human rights, solidarity and civilization of love. In this chapter I will examine these themes by means of an analysis of the works of John Paul II; most particularly: *Redemptor Hominis*, (1979), *Salvifici Doloris*, (1984); *Donum Vitae*, (1987), *Evangelium Vitae*, (1995).[377]

In this chapter my aim is to identify central elements of a holistic medical model, by means of exploration of the work of John Paul II. While, from a Roman Catholic perspective, this does not preclude people of other faiths, benefiting from this holistic medical model, since the spiritual component can accommodate other beliefs and the reasons advanced, transcend 'faiths.'

---

[377]See also John Paul II, *Dives in Misericordia*, (1980); *Fides et Ratio*, (1998); *Novo Millenio Ineunte*, (2000); *Evangelium Vitae*, (1995).

I begin by describing John Paul's interest in science, and healthcare issues, including how he keeps well informed about advances in medical research, especially new ways of alleviating pain and suffering.[378] His views on scientific achievements which, while generally positive, include a warning not to substitute it for other human activities. He also cautions against specific medical practices, and the associated ethical issues involved. I will be advancing in my thesis a proposal for a holistic medical model for the alleviation of pain and suffering in the patient as a whole human being, socially, emotionally, spiritually as well as physically.

Following on this I will define and describe suffering as understood by John Paul II. I will mention the fact that suffering is multidimensional, and that a holistic medical model, with multidisciplinary support, is the most appropriate option in its treatment. I will be describing different interpretations of suffering; Hebrew, post-exilic and Israelite looking at the implications for a holistic approach. Using John Paul II's document *Salvifici Doloris*, I will advance a holistic medical model, which looks at suffering from many different perspectives.[379] Drawing also on the works of other theologians I propose to review Schillebeecks concerns over merited and unmerited suffering.[380] I will examine Keenan's view and his concern for theodicy, and how to distinguish between merited and unmerited suffering which has implications for medical responses.[381]

---

[378] John Paul II, *Science and human values*, Meeting on Relativistic Astrophysics, Rome, (1985)
[379] John Paul II, *Salvifici Doloris*, (1984) viewed 08-12-99, p. 1-27.
[380] Edward Schillebeeckx, *Christ* (New York: Seabury Press, 1980) 675.
[381] James F. Keenan, "Suffering and the Christian tradition." *Yale Journal for Humanities in Medicine, May,* 2002.http://info.med.yale.edu/intmed/hummed/yjpm/spirit//suffering/jkeenan1.htm Viewed. 01-05-05, p. 1-8.

In the third section on suffering in the context of salvation and redemption I will look at the implications of faith perspectives on healing and the provision of meaning in the care of suffering. I will describe salvation and show why it must be faced in the context of the redemption, and how we can participate in it through our suffering. Suffering reached its culmination in the passion of Christ and redemption was achieved through his suffering. In *Salvifici Doloris,* suffering is described as happening in order to release love, and to transform it into a civilization of love.[382] John Paul II discusses the Redeemer of the world in *Redemptor Hominis*, how Christ the Redeemer reveals man to himself, and how the redemption was accomplished in the paschal mystery leading through the cross to the resurrection.[383] This salvation-redemption model reflects the meaning systems of numerous patients, even from faith's other than Christian, and therefore is significant in terms of the patient's perspective.

In the fourth section on a Christocentric theology of suffering I will explore the Christian perspective; how, because of Christ's saving work, man lives in hope of eternal life. I will be showing that Christ drew close to all who suffered and became sensitive to their needs. This has implications for the manner in which we treat the sick and suffering. I will discuss his mission, which was to strike at the root of evil, and in the plan of eternal love by means of his cross, he was to accomplish. I will show how sins were cancelled out, by the very fact that Christ took them upon himself. Christ suffered voluntarily and innocently and in the depths of his suffering he felt rejected and abandoned by the father. In their suffering patients can identify

---

[382] John Paul II, *Salvifici Doloris*, (1984) viewed 08-12-99, p. 1-27.
[383] John Paul II, *Redemptor Hominis*, (1979)

with Christ especially those who are alone and feel abandoned, and isolated because of their illness or disability, they can find solidarity with Christ in his suffering.

I will explore the Christocentric virtues of faith, hope and love, recommended by John Paul II as resources available to the sick.[384] He reminds those who care for them to recognize the face of Jesus in the in the sick. Patients can transform their situation into an expression of grace and love, and their pain can become salvific and add to the completion of Christ's suffering. In the treatment of the sick and suffering I will be promoting a holistic medical model, emphasizing a spiritual component as an important resource in the overall care of the patient.

In the section on contemporary challenges in healthcare I plan to discuss the challenges to the teaching of the Church, which have been influenced by advances in medical science, and the directives on moral and ethical issues set out in Donum Vitae.[385] *Evangelium vitae* is the most complete statement on the inherent value and dignity of human life.[386] The issues raised concern the eclipse of the value of life; a culture of death; threats to the incurably ill and dying; control of life and death; and unprecedented attacks on life. John Paul II states that a climate of uncertainty has led to a culture of death, which has led in turn to a climate of war against the weak. In the holistic medical model, which I am proposing I will be addressing the patient as a whole person, socially, emotionally, spiritually and physically, with special emphasis on the alleviation of pain and suffering. The safeguarding of the sacredness of life is part of the ethical duty of those who care for the sick.

---

[384]John Paul II, *Message of the Holy Father for The First Annual Day of the Sick*, (1993)
[385]Congregation for the Doctrine of the Faith, *Donum Vitae*, (1987)
[386]John Paul II, *Evangelium Vitae*, (1995)

In the section on care of the sick and suffering and the dignity of the human person I refer to the celebration of the world day of the sick, where John Paul II speaks of how the Church is guided in her view of suffering, and promotes the integrity of the human person, his dignity and his rights. He acknowledges the work of doctors, who witness to Christ through works of charity and dedication, help to eliminate the causes of suffering and in practicing their profession have an opportunity to promote the dignity of the human being. John Paul II also states that illness will strike us all and effects people at every level from the physical to the psychological, and how medicine must strive to treat patients as whole persons at all time respecting their dignity. This view is holistic. I will be re-iterating the words of John Paul in my promotion of a holistic medical model, paying special attention to the alleviation of pain and suffering which is an integral part of this thesis. John Paul II expects Catholic doctors to defend human life at all times, see Christ in every ailing person, and in this way humanize their care.

In the final section on healthcare and society I will be presenting deliberations and proposals as set out under the guidance of the Pontifical Council for Health Pastoral Care, highlighting the contemporary challenges and moral questions arising with a view towards achieving the humanization of medicine in a society which is becoming increasingly globalized.[387] Amongst the issues to be discussed are: the frontiers of modern technology, new spaces for healthcare services, new healthcare workers, new services offered to the sick, new and emerging illnesses, medicine and cultural changes, the contemporary questions of moral theology, prospects offered to modern medicine by inter-religious dialogue and finally the training of healthcare

---

[387] Pontifical Council for Health Pastoral Care on the subject, *Health Care and Society*, in the New Synod Hall of the Vatican, (2000)

workers and chaplains. These discussions are wide ranging, holistic and inclusive reflecting the needs of society at the present time. An exclusive over reliance on the science of medicine and new technology has proved inadequate, in the face of suffering and does not meet the healthcare needs of society at the present time. A more inclusive holistic medical model, which I am promoting in this thesis, is needed to encompass the needs of patients in their many dimensions, psychological, social, physical and spiritual.

In John Paul II's address to the Americans he is critical of their society in which the powerful predominate, setting aside the powerless.[388] He speaks of the incurably ill and elderly subjected at times to euthanasia, and the unnecessary use of the death penalty. His directive is to support a culture of life as a matter of pastoral priority, as well as his commendation of the good work of charities and various religious institutions who guide and care for the sick. He states what he expects from Catholic hospitals, and deals with issues such as: hospitals as centers of hope, which promote, along with chaplaincies and ethics committees, compassionate care for the sick, and sensitivity to the needs of the poor and marginalized. This work he reminds them should be done in a genuine witness to charity, bearing in mind that health is a gift from God, and man merely its steward. In his address to those engaged in research he reminds them of their ethical obligations, to defend life and have regard for the inviolable dignity of the sick person. He also addresses priests and religious and encourages them to be disciples of Christ the Good Samaritan. John Paul II's

---

[388] John Paul II, *Ecclesia in America*, Post-Synodal Apostolic Exhortion, on The Encounter with the Living Jesus Christ: the Way to Conversion, Communion and Solidarity in America, (1999)

vision of healthcare covers a wide range of expertise. This is achievable using a holistic medical model, which I am advocating, along with multidisciplinary support.

5.2 THE PROBLEMS OF SCIENCE ARE THE PROBLEMS OF MAN

John Paul II's involvement and interest in matters of science and healthcare is evident from his writings. Early in his Pontificate, in 1974 he addressed members of the European Physical Society.[389] For him it is a continuation of previous experiences, when still in Poland and Krakow, to meet with scientists, especially with physicists for different talks. John Paul II encourages the scientists in their work and assures them of his ongoing support, and discusses with them the mutual position of scientific knowledge and faith. In the holistic medical model, which I am promoting in this thesis, I will be acknowledging the contribution of the dominant medical model, evidence-based medicine, which is science based.

Addressing the scientists as researchers he encourages the rightful freedom of their research and method, according to the legitimate autonomy of culture and especially of the sciences recalled in *Gaudium et Spes*, (no. 50)[390] "Science in itself is good since it is knowledge of the world, which is good, created and regarded by the Creator with satisfaction, as the book of Genesis says: "And God saw everything that he had made, and behold, it was very good" (Gen 1:31) He refers to *Redemptor Hominis* 1979, where he states the necessity of a moral rule and ethics, which enable

---

[389] John Paul II, *Ecclesia in America*, An address to members of the European Physical Society, (1979)
[390] Vatican Council II, Austin Flannery (ed) Dominican Publications Ireland, (1975) Pastoral Constitution of the Church in the World, *Gaudium Et Spes*, promulgated by Pope Paul VI, (1965)

man to take advantage of the practical applications of scientific research[391]. He speaks of the duty of scientists:

> It is incumbent on scientists of different disciplines and particularly physicists, who have discovered immense energies, to use all your prestige in order that, scientific implications abide by moral norms in view of the protection and development of human life.

When scientists advance in their search for the secrets of nature, God's hand leads them towards the summits of the mind as noted by Pope Pius XI in *Motu proprio*, (1923) who set up the Pontifical Academy of Scientists; the scientists called to be members of it "did not hesitate to declare, rightly, that science, in whatever branch it may be, opens and consolidates the way leading to Christian Faith."[392]

Attendance at Scientific Meetings attests to John Paul's interest in science and knowledge. At a Meeting on Relativistic Astrophysics he addresses the participants saying how he honored the world of science and all men and women who contribute to an increase in human knowledge and to the possibilities of peace.[393] He assures them of the common resolution of the Church and science to serve side by side, in friendship and mutual support, the cause of man. He speaks of these scientific achievements as proclaiming the dignity of the human being, which greatly clarify man's unique role in the universe. Where medical research is concerned, he looked forward to new medicines being provided to alleviate pain and suffering, which has

---

[391] John Paul II, *Redemptor Hominis*, (1979)

[392] The Pontifical Academy of Sciences, has its origin in the Accademia dei Lincei, established in Rome in 1603, under the patronage of Pope Clement VIII, by the learned Roman Prince, Federico Cesi. The leader of this academy was Galileo Galilei. Dissolved by the death of its founder but, re-created by Pope Pius IX in 1847 and given the name Accademia Pontifica dei Nuovi Lincei. Pope Pius XI then refounded the Academy in 1936 and gave it its present name, bestowing it with statutes, which were subsequently updated by pope Paul VI, 1976, and by Pope John Paul in 1986.

[393] Pope John Paul II, *Science and Human Values*, Address to an International Group of Scientists, taking part in, The Marcel Grossman Meeting on Relativist Astrophysics, 1985.

direct relevance for this thesis. As a peacemaker, his interest in the production of new energies was positive, provided it was used for the betterment of mankind, and not for the production of nuclear weapons. In his compassionate concern for all humanity, John Paul II kept in touch with all new developments in science and biomedicine, and stressed that medicine needs to be re-humanized. In the holistic medical model, which I am promoting, the current science based medical model (EBM) will be retained. However, because the medical model is insufficient where the treatment of pain and suffering is concerned, additional therapies and treatments will be encompassed, to treat the patient as a whole human being, psychological, social, physical and spiritual, with multidisciplinary support.

John Paul II reminds us that in the absence of a mature interaction between science and practical and theoretical endeavors of politics, economics, art, philosophy, ethics and theology, the new vision and technological powers provided by science, could lead to human catastrophe (n.1). He speaks of how the inadequacy of responsible interaction on many levels represent a great missed opportunity for creating a new genuine humanism of profound depth, beauty, moral and spiritual, with nobility and personal sensitivity (n.1). He also states that science, however important, cannot be a substitute for other human activities. Above all it cannot be a substitute for faith, moral values, art or political science. The contribution that science can make through its dynamism and its constant reaching out towards truth is to give inspiration and a richer physical context or vision to other human activities (n. 3). Science can finally lead humanity to bow before the Creator of the Universe, who from the Christian viewpoint is revealed as the Redeemer of man (n. 3).

John Paul II believed that Science in general, and medical science in particular, is justified and becomes an instrument of progress and happiness only in the measure in which it serves the well-being of man. In *Gaudium et spes* (no. 36) while recognizing:

> the just and legitimate autonomy of science, does not dispense from respecting moral norms, which gives the authentic meaning to the same autonomy so that it functions in service to man 'created in the image and likeness of God,' goal and measure of every scientific endeavor.[394]

While the Church encourages the researchers to work for the well-being of humanity, nevertheless she teaches that everything that is scientifically possible need not necessarily be morally acceptable. He cites the use of embryonic stem cells and the duty of scientists to protect life irrespective of its stage. He believed that embryonic stem cells should not be used as 'guinea pigs'. He was not against using human adult stem cells. One of the diseases, which could benefit therapeutically from stem cells is Parkinson's disease, which John Paul II suffered from, and for this reason he had a special interest in new techniques or medicines which could alleviate the suffering of others, who suffered from this degenerative disease. On behalf of John Paul II, Jean-Marie Mpendawatu addressed the 8th World Congress on Parkinson's disease, which is dedicated to the study and the exchange of clinical knowledge and experience on Parkinson disease in its various diagnostic, therapeutic and rehabilitation aspects.[395] John Paul II sent a message of encouragement and hope to the 3000 participants as a:

> testimony of the solicitude of the Church for the most noble mission of scholars, researchers, and doctors involved in the search to find efficient medicines, techniques, and methods of care and assistance to improve the health conditions of people afflicted by the Parkinson disease.

---

[394] Paul VI, The Pastoral Constitution for the Church in the World, *Gaudium et Spes*, (1965).
[395] John Paul II. The Intervention of Rev. Msgr. Jean-Marie Mpendawatu, Official of the Pontifical Council for Health Pastoral Care at the 8th World Congress on Parkinson disease, Rome, 2004.

The members of the congress were informed that *4 million sick people are waiting to hear the good news of the Congress.* The recent discoveries in biology and the current fundamental research give hope to the sufferers of this debilitating disease. The first line of research studied, has produced interesting experiments to inhibit the process of the auto destruction of the cells. The second trend is to transplant human or animal stem cells. The most recent treatments involve the application of electrodes to the brain.

John Paul II's concern for the sick and suffering is evidenced in the long journeys he undertook to visit the sick and speak compassionately to them, assuring them of his solidarity with them. At the same time he kept informed with respect to new treatments and believed that every effort be made to alleviate the pain and suffering which is part of humanity. The holistic medical model, which I am proposing in this thesis, would aim to alleviate suffering in its different dimensions, taking into account the totality of the whole human person. Some patients suffer psychologically especially if they do not understand the meaning which suffering has in their lives, and, the lack of understanding as to the extent of their pain and distress by others, adds to their suffering.

5.3 THE MEANING OF SUFFERING

An early Hebrew view interpreted suffering as God's punishment for sin, expressed as pain since the beginning of time (Gen 3:16-19). Other writers understood suffering as divine retribution for both personal and communal sin; furthermore the evil acts of one person could draw down suffering on subsequent generations as well

as, on a nation itself (Num 12:1-15; Deut 8:28; 2 Sam 24: 10-17). Ezekiel did not agree to a theology of individual retribution, in other words, suffering is punishment only for one's own sin (Ezek 31:29-30) Ezechiel's theory however, was inconsistent with the suffering of the innocent. The Psalmists became a voice for the suffering of innocent people over the perceived injustice of prospering sinners (Ps 6 ; 4; 34:17; 88:47). Even Job could only recommend silence before the inscrutable wisdom of God (Job 42: 1-6). Other post-exilic scriptures found the answer to human suffering in the concept of God's eschatological justice, which would reward the good and punish the wicked (Dan 12:1-3; 2 Mac 7:9, 11, 23)

The experience of exile led many prophets to see suffering as both an individual and national conversion (Isa 25:8; 35:4-10; Jer 31:15-20). Isaiah's "Servant songs" (Isa 42:1-4; 49:1-7; 50:4-11; 52: 13-53: 12) went further and interpreted the suffering of the Israelites as an indirect or vicarious atonement for the sins of nations. This insight was helpful to the authors of the NT, in understanding the significance of the death of Jesus as vicarious atonement for the sin of the entire human race (1 Pet 2:24; Rom 3:25).

In *Salvifici Doloris* 1984, John Paul II discusses the Christian meaning of suffering from several perspectives beginning with the theme of suffering.[396] (n.2) This theme is dealt with in three sections: suffering is a universal theme and belongs to man's transcendence; suffering must be faced in the context of the Redemption; and suffering evokes compassion and respect.[397] (n.4) The theme of suffering accompanies man at all times on earth, and seems to be essential to the nature of man.

[396] John Paul II, *Salvifici Doloris*, (1984)
[397] Romans 8: 22

It is as deep as man himself and belongs to man's transcendence, where man is destined to go beyond himself and to which he is called in mysterious ways. The theme of suffering must also be seen in the context of the Redemption because it was accomplished through the cross of Christ, and through his suffering everyman becomes a way for the Church.[398]

In *Salvifici Doloris* also, John Paul II points out that suffering happens at different times, in different ways along the path of life and it is on this path that the Church must meet man.[399] (n. 3) Human suffering evokes compassion and respect, nevertheless it can also intimidate because suffering is a mystery. (n. 4) Special respect for every form of human suffering must be given, from the depths of our hearts and also because of our faith. The world of human suffering in its subjective dimension is almost inexpressible and not transferable (n.5). The field of human suffering is multidimensional. The science of medicine and the art of healing deals with this vast area. It is broader, and more complex than sickness, is based on the double dimension of man and refers to physical and spiritual aspects. Physical suffering is experienced by the body and moral suffering is pain in the soul. It is pain of a spiritual nature, and the psychological, which accompanies both moral and physical suffering (n. 5). The alleviation of pain and suffering is complex. For patients with a terminal illness, such as cancer, the most appropriate treatment can be palliative care, which is essentially holistic, based as it is on the premise that patients are suffering from 'total pain' and the whole patient, psychological, social, spiritual and physical, must be treated simultaneously. Patients frequently suffer from spiritual

---

[398] John Paul II, *Redemptor Hominis*, (1979)
[399] John Paul II, *Salvifici Doloris*, 1984.

pain after treatment with hi-tech medicine, and the protectiveness of the hospice experience for deflecting the possibility of spiritual pain, must be emphasized.[400]

The document continues, Sacred Scripture gives us many examples of suffering experienced by man (n. 6). Amongst these are: moral suffering and the danger of one's death or death of one's children, persecution, loss of homeland, loneliness, remorse, unfaithfulness, ingratitude of friends and neighbors, and misfortunes of one's own nation. As part of psychological suffering there is the experience of evil, which causes the individual to suffer and although psychological suffering is not linked to a specific area yet it constitutes multifactorial elements of pain, sadness, disappointment, discouragement and despair, according to the intensity of the suffering and his/her specific sensitivity (n. 6). Psychological suffering, is multidimensional and treatment using the application of the current medical model is insufficient. The use of psychological approaches are necessary to augment the current medical model such as education, reduction of anxiety, and improving coping ability are suggested. Good communication skills and a therapeutic relationship with their doctor are also of benefit to these patients.[401]

It can be said that man suffers whenever he experiences any kind of evil. Only the Greek language and the NT use the verb pascho (I am affected by… I suffer) and suffering is no longer directly identifiable with evil. Man experiences evil and in doing so, becomes the subject of suffering (n.7). Human suffering happens in a specific world and through personal suffering each individual belongs to that world.

---

[400] P. McGrath, "Spiritual pain: a comparison of findings from survivors and hospice patients." *Am J Hosp Palliat Care,* 20 (2003) 23-33.
[401] N. Adams, L. Field, " Pain management 1: psychological and social aspects of pain." *Br J Nurse,* 10 (2001) 903-911.

People who suffer become similar to each other through the analogy of their situation. At different periods of time suffering is particularly concentrated, for example: at times of natural disaster, epidemics, and war. Now we have the threat of nuclear war, which could cause an accumulation of suffering (n. 8).

Next, in *Salvifici Doloris*, 1984, Pope John Paul speaks of the place where the true answer to the 'why' of suffering resides and instructs us to look to the revelation of divine love, the ultimate meaning of everything that exists he continues:

> Love is the richest source of the meaning of suffering, which always remains a mystery. Christ causes us to enter into the mystery and to discover the "why" of suffering, as far as we are capable of grasping the sublimity of divine love." (This concept is difficult to grasp) He continues and states that in order to discover the profound meaning of suffering we must follow the revealed word of God. We must accept above all His word, in the light of the Revelation, as the definitive source of everything that exists. Furthermore, love is also the fullest source of the answer to the meaning of suffering, and this answer has been given by God to man in the cross of Jesus Christ[402] (n. 13)

The view of other theologians on suffering includes Edward Schillebeecks who similarly describes how people from other religious perspectives deal with the question of suffering.[403] Even though each religion has its own specific response to suffering, nevertheless all agree that emphasis must be placed on the word good and not evil and suffering. They share a common goal, to overcome suffering. Schillebeecks suggests that the Jewish stance towards suffering, expressed in Scripture, shows how "Israel has no problems with suffering which men bring upon themselves through their own sinfulness.... It protects and guards against itself

[402] John Paul II, *Salvifici Doloris*, (1984)
[403] Edward Schillebeeckx, *Christ* (New York: Seabury Press, 1980) 675

against unmerited suffering, quite independent of man's own folly."[404] Because of belief in God Israel did not hesitate to direct hard questions to God 'Is God asleep'? Ps 44.23, 26. Schillebeecks adds that Christians view God and suffering as diametrically opposed; where God appears, evil and suffering have to yield. He writes that, Jesus breaks with the idea that suffering necessarily has something to do with sinfulness. We have examples in Scripture. We have the description from John's gospel of the man born blind (John 9.2) and in Luke's gospel we have the account of the murdered Galileans (Luke 13: 1-5) where we see that it is possible to draw conclusions from sin to suffering, but not from suffering. Schillebeecks also believes that some suffering may actually be of benefit to some individuals, in that it may help them to become more sensitive and compassionate. Yet, he insists that there is an excess of suffering and evil in our history. It is a barbarous excess, for all the explanations and interpretations. For example, there is too much unmerited and senseless suffering for us to be able to give an ethical, hermeneutical and ontological analysis of our disaster. And, Scripture cannot, explain away suffering. He writes:

> The Christian message does not give an explanation of evil or our history of suffering. That must be made clear from the start. Even for Christians, suffering remains impenetrable and incomprehensible, and provokes rebellion. Nor will the Christian blasphemously claim that God himself required the death of Jesus as compensation for what we make of our history.[405]

James Keenan is another theologian, similarly concerned with suffering in the Christian tradition and discusses it in two different contexts.[406] The first concern is the academic question on the meaning of suffering and the second arises when our

[404] Ibid. 677
[405] Ibid.
[406] James F. Keenan, *Faith Under Fire* (Minneapolis: Augsburg Publishing House, 1980) 144.

help is sought to understand it. The main academic question is in the question of theodicy, that is, how we can reconcile suffering and a merciful God?[407] Keenan proposes to structure his response and direct it towards one who is suffering. He is of the opinion that Schillebeeckx makes too much of unmerited suffering. While Keenan agrees that some suffering is tragically unmerited he questions the difference between merited and unmerited suffering? How can we know? He poses hard questions: does the AIDS patient have to be a child or haemophiliac? Or, must the cancer patient take every precaution against carcinogens? Or, does a political prisoner have to be politically prudent? We tend to moralize over other people's suffering. One wonders if there is such a thing as a natural death? And so a Christian tradition, and a theology of suffering is intimately linked with theologies of death, which are interwoven with theologies of Salvation and Redemption. In order to deal with suffering in our lives, it is important that we know the meaning of it, and search for ways of alleviating it. The alleviation of pain and suffering is specifically addressed in this thesis, and because suffering is multidimensional I am promoting a holistic medical model, supported by multidisciplinary care, to care of the whole person, emotional, social, physical and spiritual.

5.4 SUFFERING IN THE CONTEXT OF SALVATION AND REDEMPTION

In *Salvifici Doloris*, suffering is intimately connected with a theology of salvation, which refers to events, which demonstrate God's deeds for the salvation of the world.[408] (n. 14). Salvation means liberation from evil and for this reason it is

---

[407] James F. Keenan, "Suffering and the Christian tradition," *The Yale Journal for Humanities in Medicine*, 2003. On line: http://info.med.yale.edu/intmed/hummed/yjpm/spirit//suffering/jkeenan1.htm Viewed, 30-04-03, p. 1-8.
[408] John Paul II, *Salvifici Doloris*, (1984)

closely linked to the problem of suffering. God gave his Son to the world to free man from evil. His saving mission was to strike evil at its transcendental roots, which it developed in history. Through his salvific work the Son liberates man from sin and death. This victory over sin and death throws new light on every suffering, the light of the gospel, the good news. Man could live on earth in sanctifying grace with the hope of eternal life. Redemption is central to Christian theology because it explains to Christians the proclamation of Jesus as the Christ, our Redeemer and Savior (n. 3) Redemption was accomplished through the cross of Christ, through his suffering so that man would not perish but have eternal life.[409]

Most commonly salvation history is used in a special sense to refer to those events, which the Bible narrates as manifesting God's deeds for the salvation of the world. A general outline of such a history would begin with exodus (Exodus 14-15: 21; Deut 5: 15; 6: 20-23; Josh 24: 6-7, 16-17; Isa 51: 10; Hos11:1; 13: 4-5; Mic 6: 4; Psalms, passim) The divine purpose is revealed in the covenant (Exod 19: 1-6) wherby Israel became God's own people, settled in the land earlier promised to the patriarchs (Deut 4: 1; 6: 18-19, 23; 34: 4 ; Josh 1: 2-6) Israel also came to recognize guidance in the events surrounding the lives of the patriarchs (Gen 12-50). Creation too, and humanity's first encounter with sin and punishment (Gen 1-11) illustrated God's saving design from the beginning.

The NT era opens with Jesus proclaiming the fulfillment of the OT prophecies (Lk 4: 16-21; Mt 13: 17). He announces that the kingdom of God is near (Mk 1: 15), that in fact it is present in his works (Mt 12: 28; Lk 10: 17-19; Jn 12: 31-32) but

[409] Ibid.

requires repentance and return to God (Mk 1: 15) There is a paradox here: salvation has come in Jesus (Jn 5: 25-27; Heb 2: 10-18), yet its final realization is in the Parousia, Jesus return at the end of history in judgment (Mt24: 29-32-46; Acts 3: 20-21.) The subject of much debate, salvation history has moved between its special biblical sense and the broader theological context where it affirms that salvation takes place in history and that all history is salvific.

There is no way in which secular history can be isolated from salvation history, in the sense that there is no moment when one's historical existence in not also affected by grace. God's salvific will, therefore, is directed toward redeeming the sinful condition of humanity. It means that salvation will be brought about within the historical context of human activity itself, and has past, present, and future phases. This offer of salvation, hidden from secular history, must be made clear through the interpretive works of God and especially through Christ.

Through his salvific love the Son liberates man from sin and death. In doing this he blots out from human history 'the dominion of sin, which took root, under the evil spirit,' beginning with original sin, which means that now man had the possibility of living in sanctifying grace. Furthermore he takes away the dominion of death, by his resurrection, beginning with the process for future resurrection of the body. These two entities of sin and death were conquered by the suffering, death, and resurrection of Christ. These are essential conditions of eternal life, for man's union with God.

Consequently, through Christ's salvific work, man exists on earth with the hope of eternal life and holiness. Although man is not freed from suffering

nevertheless the victory over sin and death throws a new light upon every suffering, that is, the light of the salvation. This is the light of the gospel, that is, the good news. And at the heart of this light, is the truth expressed by Christ to Nicodemus "for God so loved the world, that he gave his only Son" (John 3: 16). Precisely through his own suffering and death on the cross, he accomplished the work of salvation, which in the plan of eternal love has a redemptive character (n. 16). For patients who are suffering from chronic or unrelieved pain, spiritual care can be a means of support that enables patients to find the strength to endure their suffering.

Spiritual care also contributes to healing. Researchers point out, that the absence of care, is detrimental to the healing process, and the level of health achieved by the patient is determined by the extent to which their spiritual needs are met.[410] Spiritual care is required at a deep level and if not attended to can effect the patients ability to fight their disease. Spiritual care is one of the elements of a holistic medical model of care, which I am promoting in this thesis.

Christ's words show how essential it is for eternal life of the individual to stop as the Good Samaritan did at that suffering, to give help. Suffering is present in the world in order to release love, in order to give birth to works of love towards neighbor, in order to transform civilization into a civilization of love. In this love the salvific meaning of suffering is completely accomplished. Actions about love, acts linked with human suffering enable us to discover at the basis of all human suffering the same redemptive suffering of Christ (n. 30). In assessing patients to ascertain whether their needs have been met the search must entail qualities of care:

---

[410] L. Ross, "The spiritual dimension: its importance to patient's health, well-being, and quality of life, and its implications for nursing practice." *Int J Nurse Stud,* 32 (1995) 457-468.

compassion, gentleness, joy, peace, kindness, respect, sensitivity and faith along with unconditional regard, and access to religious framework in keeping with the patients' culture and beliefs.[411] When these qualities are applied to the patient, they can enfold a person in a spirit of hopefulness, can lift the human spirit, assisting the patient to live or die more comfortably.

Love is always greater than the whole of creation, the love that he (the Son)is himself, since "God is love" (Jn 4: 8, 16). Above all love is greater than sin, than weakness, than the "futility of creation" (Rom 8: 20), it is stronger than death, a love always ready to raise up and forgive, always ready to meet the prodigal son (Lk 15: 11-32)...This revelation of love is also described as mercy and in man's history.... has taken a form and name Jesus Christ. Man cannot live without love. He remains a being that is incomprehensible for himself, his life is senseless, if love is not revealed to him, if he does not encounter love, if he does not experience it and make it his own, if he does not participate intimately in it.

One of the notable features of Pope John Paul's theology of suffering from the perspective of a Christian vision of holistic healthcare is that it is highly Christocentric. In the next section we will examine this Christocentric dimension more closely and show how it can transcend the Christian vision alone to incorporate a vision for all of humanity. We will locate this vision in biblical sources, examining in particular the transformation of suffering from a Christocentric perspective and focus also upon the Christian virtues of Faith, Hope and Love, which are central to the theology of John Paul II, and fundamental to human healing. The holistic medical

[411]Ibid.

model which I am proposing in this thesis would care for the human person in all dimensions of his/her wholeness, psychological, social, physical and spiritual.

5.5 A CHRISTOCENTRIC THEOLOGY OF SUFFERING

The Christocentric virtues of Faith, Hope and Love are at the heart of Pope John Paul II's writings In his address to the sick and suffering on the occasion of the first World Day of the Sick,[412] 1993, John Paul II refers constantly to the virtues of faith, hope and love, as resources available to sustain the sick and elderly, and those who care for them, throughout their living and dying. Amongst the sick and suffering he addresses are: those who are lacerated by wars and conflicts, children reduced to "a shell of their former selves" who have been subjected to hardships of every kind, and affected against their will, because of violence due in many instances by selfishness. The Pope also addresses those who reside in healthcare facilities, hospitals, clinics, and leprosariums, centers for the disabled, nursing homes, or people on their own undergoing the calvary of sufferings which are often neglected, pain not always relieved and sometimes even aggravated by lack of adequate support (n. 1-2). At the present time there is an alarming level of ignorance about pain and its treatment among physicians, nurses and other healthcare providers. The result is that patients suffer pain unnecessarily, even up to the point of death.[413] Courses in pain and symptom management are not readily available. Fortunately, with education, doctors and nurses can vastly improve their ability to assess and manage patient's pain.

---

[412] John Paul II, *Message of the Holy Father for The First Annual Day of the Sick*,(1993) Rome.
[413] Catholic Health Association, Task Force on Pain Management, "Pain management. Theological and ethical principles governing the use of pain relief for dying patients." *Health Progress*, 74 (1993) 30-39, 65.

Pope John Paul II acknowledging patients illnesses and consequential frustration, appeals to his audience to view their difficult situations in the perspective proper to Faith. If our illnesses are seen as outside our faith how then can we discover the constructive contribution of pain? Or, how can we give meaning to anguish, unease, and physical and psychic ills, which contribute to our suffering? Or, what justification could we find for the decline of old age and the goal of death, which despite scientific and technological progress remains to be faced (n. 2-3).

Addressing the providers of healthcare, they are urged to administer monies wisely and equitably, to ensure prevention of disease and care during illness, for all. What people hope for is a humanization of medicine and healthcare. In order to achieve this what is needed is a transcendent vision of man, which stresses the value and sacredness of life in the sick person as an image and child of God. Because pain and suffering affect all human beings, the appropriate response is love for all suffering peoples, which would truly be the sign and measure of the degree of civilization and progress of a people (n. 4). In *Salvifici doloris*, 1984, John Paul II assures us that illness borne in the light of Christ's death and Resurrection, is no longer seen as a negative event.[414] Rather, it is seen as a visit by God, an opportunity to release love, and give birth to works of love towards neighbor, in order to transform human civilization into a civilization of love (n. 30).

In 1994, Pope John Paul addressed the sick and suffering at Chestochowa, on the occasion of the Second World of the Sick.[415] He greets in particular those who

---

[414] John Paul II, *Salvifici Doloris*, 1984

[415] Pope John Paul II, *Message of the Holy Father for the Second World Day of the Sick*, Czestochowa, (1994)

have the grace of faith in Christ, Son of the living God, who, united with all suffering, was crucified and rose again for the salvation of all. He encourages these people to undergo their suffering as salvific pain. He reminds the sick and suffering that Jesus Christ went about doing good and healing the sick (Acts 10.38). John Paul II also wishes to be alongside the sick, consoling them, thus sustaining their courage and nourishing their hope, to enable them to offer themselves as a gift of love to Christ, for the good of the Church and the world.

Referring to *Salvifici Doloris*, 1984, John Paul II recalls instances of suffering in Scripture and re-iterates his message that “Only in the mystery of the Incarnate Word does the mystery of man find true light.”[416] The Son united with the Father with love, with which he has loved the world, and man in the world” (n.16). In the cross of Christ, Redemption was achieved by His suffering, and, Christ opened his suffering to man. It is reason, when illuminated by faith understands that all suffering can, through grace, become a prolongation of the mystery of the Redemption, which, although complete in Christ constantly remains open to all love which is expressed in human suffering (n. 24).

John Paul II reminds those who care for the sick, like the Good Samaritan, to always respect the dignity of the sick as persons, and with the eyes of faith, recognize the presence of the suffering Jesus in them. He asks them to guard against indifference, which can result from habit and furthermore to add heart to their professionalism which alone can give them humanity (n. 29). A recent review of the definition of dignity identifies not only the intrinsic, unconditional quality of human worth, but

[416] John Paul II, *Salvifici Doloris*, (1984) 14

also the external qualities of physical comfort, autonomy, meaningfulness, usefulness and interpersonal connection.[417] For many elderly individuals, death is a process, rather than a moment in time, resting on a need for balance between the technology of science and the transcendence of spirituality. A holistic medical model, would encompass the total needs of the sick, elderly and the dying as whole persons, psychological, social, physical and spiritual, with respect for their dignity, culture and beliefs.

Referring to the World Day of the Sick, the Pope states his reason for its celebration, which is to make people aware of the serious and inescapable problems concerning health policy and care. He believes that progress in science and technology engenders hope. The sick, sustained by their faith are enabled to take the opportunity opened up by Christ, to transform their situation into an expression of grace and love. Then their pain can become salvific and add to the completion of suffering in Christ for the benefit of his body the Church.

Many patients die in acute care hospitals, often in physical pain, without attention to the emotional and spiritual suffering. This represents an ethical failure of our current health-care system. At the present time a new specialty of hospitalist is emerging providing care for acutely ill hospitalized patients, many of whom will die.[418] Thus the hospitalist may become the primary deliverer of palliative care, which is essentially holistic. Hospitalists can provide enhanced care by emphasizing interdisciplinary communication and the provision of emotion and spiritual care and

---

[417] K. Proulx, C. Jacelon, " Dying with dignity: the good patient versus the good death." *Am J Hosp Palliat Care* 21 (2004) 116-120.
[418] J. C. Muir, R.M. Arnold, " Palliative care and the hospitalist: and opportunity for cross fertilization." *Am J Med,* 111 (2001)10S-14S.

bereavement issues. What is required is a holistic medical model, supported by interdisciplinary care, which is being promoted in this thesis. Healthcare at the present time is facing many bioethical challenges, due to the rapid progress in biomedical science.

5.6 CONTEMPORARY CHALLENGES IN HEALTHCARE

Some of the most acute challenges to the teachings of the Christian Faith coming from the field of medicine are biomedical techniques, which make it possible to intervene in the early stages of the life of a human being. This interference in the process of procreation prompted doctors, theologians and scientists to question whether these interventions were in conformity with the principles of Catholic morality. Directives were sought from the members of the Congregation for the Doctrine of the Faith and after wide consultation instructions were issued in *Donum vitae,* 1987.[419] The instructions came in three parts. The first has for its subject the respect for the human being from the first moment of existence. The second part deals with the moral questions raised by technical interventions on human procreation, and the third offers some directives on the relationships between moral law and civil law in terms of the respect due to embryos and fetuses as regards the legitimacy of techniques of artificial procreation.

To begin, the fundamental principle was stated, that the gift of life entrusted to man calls him to appreciate the inestimable value of what he has been given and take responsibility for it. This fundamental principle must be at the centre of ones

---

[419] Congregation for the Doctrine of the Faith, *Donum Vitae*, 1987.

reflection in order to solve the moral problems raised by artificial interventions on life, as it originates, and on the process of procreation. As a result of progress in the biomedical sciences man has now at his disposal more effective therapeutic resources; however, this gives him new power with unforeseeable consequences, over human life at its very beginning and in its final stages. In *Donum Vitae*, 1987, the criteria of moral judgment as regards the applications of scientific research and technology are: the respect, defense, and promotion of man in his primary and fundamental right to life; his dignity as a person, who is endowed with a spiritual soul and with moral responsibility and who is called to beatific communion with God.[420]

The mystery of the Incarnation means understanding life as a gift from God, to be looked after responsibly and used for good: health is thus a positive attribute of life, to be sought for the good of the person and of one's neighbor.[421] However, health, is a penultimate good in the hierarchy of values, which should be fostered and considered with a view to the total, and thus also spiritual, good of the person. A holistic medical model would provide whole person care in all its dimensions including a spiritual one.

There is no denying that science and technology are now valuable resources at man's disposal when placed at the service of the human person but they cannot of themselves show the meaning of existence and of human progress. It is true to say that science and technology as well as the biomedical sciences must for their own intrinsic meaning, have unconditional respect for the fundamental criteria of moral law, that is at the service of the human person, of his inalienable rights and his true

[420] *Donum vitae*, (1987)
[421] John Paul II, *Contemplate the face of Christ in the sick*, Rome (2000)

and integral good according to the design and will of God. The rapid development of technological discoveries gives great urgency to this need to respect the required criteria because science without conscience can only lead to man's ruin. We need the wisdom of the Christian faith if discoveries made by man are to be further humanized.

Donum Vitae was followed by the encyclical *Evangelium Vitae* 1995, by John Paul II arguably presents his most complete statement on the inherent value and dignity of human life[422]. He begins by stating the incomparable worth of the human person and thereafter speaks of new threats to human life. Amongst the issues he raises are: the eclipse of the value of life; a culture of death; artificial reproduction; prenatal diagnosis; threats to the incurably ill and dying; the control of life and death; demographics in the context of low economic and social development and unprecedented attacks on life. John Paul II reminds us of a passage from the second Vatican Council which forcefully condemned a number of crimes and attacks on human lives. In *Evangelium Vitae*,[423] he re-iterates the condemnation in the name of the whole Church against whatever is opposed to life itself such as any type of murder, genocide, abortion, euthanasia, or willful self-destruction, whatever violates the integrity of the human person, such as mutilation, torments inflicted on body and mind; attempts to coerce the will itself; whatsoever insults human dignity, such as: inhuman living conditions...all these things are infamies. They poison society and do more harm to those who practice them than to those who suffer from the injury (n. 3).

[422] John Paul II, *Evangelium Vitae*, (1995)
[423] Ibid.

Next he refers to the threats to life opened up by recent scientific and technological progress leading to new forms of attacks on the dignity of human beings.[424] These are crimes against life in the name of the rights of individual freedom, choices once unanimously considered as criminal and rejected by the common moral sense are gradually becoming socially acceptable. He also mentions sectors of the medical profession who are increasingly willing to carry out these acts against the person. Those whose profession is called upon to defend and care for human life is distorted and contradicted, and the dignity of those who practice it is degraded. He particularly mentions the disturbing fact that conscience itself, darkened by widespread conditioning, is finding it increasingly difficult to distinguish between good and evil in what concerns the basic value of human life (n. 3, 4).

The care of the seriously ill and dying patients calls for a philosophic and ethical basis, without which unacceptable practices may develop. The possibilities include: inadequate communication of information, withdrawal of the physician, patient labeling and poor health care.[425] Palliative care must be based on a philosophy that acknowledges the inherent worth and dignity of each individual person. In addition, it must take place within the framework of four ethical principles: autonomy, beneficience, nonmalficience, and justice.

It is suggested that through a crisis in culture, skepticism arose concerning the foundation of knowledge and ethics, and the meaning of rights and duties. Circumstances were extenuated through situations of poverty and the resultant anxiety

---

[424] Ibid.

[425] E. Latimer, "Caring for the seriously ill and dying patients: the philosophy and ethics." *CMAJ*,144 (1991) 859-864.

of trying to cope with these difficulties. In some cases pain was involved through instances of violence, especially against women, made the task of defending and protecting life became extraordinarily demanding. This view demonstrates how the value of life underwent an eclipse and even though conscience did not cease to point to it as a sacred or inviolable value, certain crimes against life in its early or final stages, through the use of medical terminology which distracts from the right to life of the actual human person. This innocuous situation evolved over time (n.12).
This climate of moral uncertainty has grown leading to an emergence of a *culture of death*. This has come about with the assistance of powerful cultural, economic, and political currents, which encourage the idea of an efficient society. This in turn has led to a climate of war of the powerful against the weak a life requiring care might be seen as a burden and perhaps rejected. Thus a conspiracy against life arose and paved the way towards the spread of abortion and the development of the negative values inherent in the contraceptive mentality the opposite to responsible parenthood and respect for life.[426] *Evangelium vitae*, 1995 (n.12) These issues are wide ranging and are beyond the scope of this thesis. Accordingly I will simply mention other issues dealt with in this lengthy document, for example: artificial reproduction, which may appear to be a service but actually opens the doors to new threats against human life. Prenatal diagnosis rejects life when it is affected by any limitation or handicap can lead to infanticide, reverting to a state of barbarism. Threats to the incurably ill and dying, gives temptation to resolve the problem by hastening death (n. 16) Fears of abandonment and isolation in institutions have increased the public demand for euthanasia and assisted suicide. To quell this movement Catholic healthcare providers must provide a caring community, where patients and caregivers enable each other to

---

[426]John Paul II, *Evangelium Vitae*, (1995)

confront the fear of death and find support in living with human limitation.[427] The Catholic Church supports the concept of advance directives, which provide an opportunity for people to express their values and the ways they could expect those values to be honored in decisions about medical treatment. Institutions should demand sufficient resources for holistic care including appropriate end-of-life-care of the dying. A holistic medical model, which I am promoting, would include a spiritual component, supporting fundamental human and religious values.

Catholic healthcare institutions can have a counter influence on the euthanasia movement if they strive to relieve all forms of pain: physical, social, psychological and spiritual. This is essentially holistic care. Effective pain management includes not only specialized clinical care to control physical pain, but also counseling and human support to counteract psychological pain, community support groups to counter social pain, and pastoral care resources to address spiritual pain.[428] Optimal support would also include a hospitable environment, policies on advance directives, collaborative decision-making as well as ethics committees that are competent in end-of-life decisions. In a holistic medical model, which I am proposing in this thesis, the patient as a whole would be treated and alleviation of pain would be seen as a priority. The safeguarding of the sacredness of life would be part of the ethical dimension of this care. A holistic medical model would provide the current medical model, evidence based medicine, as well as other provisions of care and therapies, in order to encompass the total needs of the patient. It would be patient-oriented, and supported

[427] Catholic Health Association, "Care of the dying: a Catholic perspective Part II: Social and political context, Catholic providers must exemplify a caring community." *Health Progress,* 74 (1993)16-21, 41
[428] Ibid. 22-26, 31.

by multidisciplinary care. The care would not be limited to members of the Catholic faith, since the spiritual component embraces people of all faiths and none.

5.7 DEVELOPMENTS OF BIOMEDICAL RESEARCH: A CHRISTIAN VISION.

At the Ninth General Assembly of the Pontifical Academy for Life, which took place at the Vatican in 2003, recent innovations in the sciences were discussed.[429] Biomedicine has made enormous progress in the development of technology and computer science that has extended the possibility of experimentation on living beings especially the human being. As a result there have been advancements in the fields of genetics, molecular biology, as well as in organ transplantation and in the neurological sciences. Pope John Paul II recently pointed out that: it is a recognized fact that improvements in the medical treatment of disease primarily depend on progress in research (n. 2). It appears that every new discovery in biomedicine seems destined to produce a cascade effect, opening new prospects and possibilities for the diagnosis and treatment of numerous diseases that are still incurable. The focus in this ethical endeavor is the human person:

> as an indivisible unit of body and soul, the human being is characterized by his capacity to choose in freedom and responsibility the goal of his own actions and the means to achieve it. ....Thus God favors and supports the efforts of human reason, and enables the human being to recognize so many "seeds of truth" present in reality, and finally, to enter into communication with the Truth itself which He is.

In *Fides et Ratio*, 1998, in principle there are no ethical limits to knowledge of the truth, that is, there are no barriers to the human person in applying his intellectual

[429] Pontifical Academy for Life, *Ethics of Biomedical Research for A Christian Vision*, Ninth General Assembly of the Pontifical Academy for Life, 2003, given in Rome at St. Peter's 1996.

insight what the Holy Father has wisely defined the human being as the one who seeks the truth[430] (n. 28); but, on the other hand, precise ethical limits are set out for the manner the human being in search of the truth should act, since what is technically possible is not for that very reason morally admissible.[431] In *Donum Vitae*, (n. 4) it is therefore the ethical dimension of the human person, which he applies through the judgments of his moral conscience that connotes the existential goodness of life.[432] Any ambiguities or misunderstandings can be guided by the statement of John Paul II that the Church respects and supports scientific research when it has a genuinely human orientation, avoiding any form of destruction of the human being and keeping itself free from political and economic interests (n. 2).

> In this respect gratitude must be expressed to the thousands of doctors and researchers of the whole world who with great professionalism dedicate their energy to the service of the suffering and the treatment of pathologies. The Pope recalled that all believers and non believers, acknowledge and express sincere support for these efforts in biomedical science that are not only designed to familiarize us with the marvels of the human body, but also to encourage worthy standards of health and life for all (n. 2).

Other concerns include an ethic of biomedical research; respect for the true good of the human person; therapeutic and non-therapeutic experimentation; the need to do sufficient experimentation on animals prior to the clinical experimental phase; the vulnerability of human subjects, because of their state of life, who undergo research such as, human embryos; the fact that it is never licit to do evil intentionally in order to achieve ends that are good in themselves; the fact that the human embryo

---

[430] John Paul II, *Fides et Ratio*, (1998)
[431] Congregation for the Doctrine of the Faith, Instruction on: *Respect for human life in its origin and on the dignity of procreation, replies to certain questions of the day*, (1987)
[432] John Paul II, *Donum Vitae*, (1987)

deserves the full respect due to every human being. These ethical issues must be given attention and respect in all areas of healthcare and research.

Based on the findings of the Pontifical Academy for Life a manifesto was proposed on the premise that scientific developments have brought about important cultural and social transformations, which have modified certain aspects of human life.[433] These advances have given rise to great hope for improvements for the future of the human person. However there are doubts of an ethical and religious nature that demonstrate the necessity for constant dialogue between the sciences and broader human sciences and philosophy in order to operate in a more ample perspective so that the acquisition of knowledge may effectively serve the true good of the human person. The dissemination of these facts to those involved in medical research is of the utmost importance.

The complexity of human life and human nature are such that a multidisciplinary approach would lead to a better understanding of the human being in his integrity and contribute to a meaningful growth of a science that would truly be for the human being, according to the Pontifical Academy for Life such an interdisciplinary dialogue:

> By re-focusing attention on the centrality of the human person would make the scientists more aware of the ethical implications of their work and, conversely, would incite those involved in philosophical and theological anthropology to assume toward the scientists a mission of dialogue, collaboration and practical support, with the mutual intention of developing cognitive and applied tools for the service of the human community[434].........

---

[433] Pontifical Academy for Life, *Ethics of Biomedical Research for a Christian Vision*, Ninth general Assembly of the Pontifical Academy for life, 2003

[434] Ibid.

In this section we have explored theologies of salvation and redemption at the level of the human person. But fidelity to the Christian tradition requires a concern for individual persons within the context of community. We are therefore led to examine social responsibility in the context of pain, suffering and healthcare. The fact that many patients suffer from unrelieved pain is one of the primary concerns of this thesis

5.8 SOCIAL RESPONSIBILITY IN THE CONTEXT OF HEALTHCARE

The ethical dilemmas encountered by healthcare workers have implications in relation to the Hippocratic Oath as well as for Christian morality. To assist healthcare workers a charter was drawn up by the Pontifical Council for Pastoral Assistance to Healthcare Workers. This was published in 1994 by John Paul II of the Pontifical Academy of Life.[435] The charter deals with the essential tasks of healthcare workers and centers its directives around the three themes of: procreation, life and death. The directives demonstrate the position of the Church on the fundamental problems of bioethics while safeguarding the sacred limits imposed by the promotion and defense of life, is highly constructive and open to true progress in science and technology when this progress is welded to that of civilization. This Charter has relevance for my thesis based on the provision of a holistic model of care beyond the current medical model.[436] This holistic medical model, would include the current science based medical model, however, since it is insufficient where the alleviation of pain and suffering is concerned it requires additional therapies and treatments to provide care for the whole patient, psychological, social, physical as well as spiritual. The Charter is interesting because it provides a theological underpinning for healthcare personnel

---

[435] Ibid.

[436] John Paul II, Pontifical Council for Pastoral Assistance to Healthcare Workers, (1994)

working within a holistic medical model, with an informed awareness of the bioethical issues involved.[437] There are a total of 150 directives, however I will be selecting examples which I find relevant to my own work.

According to Cardinal Fiorenze Angelini, President of the Pontifical Council for Pastoral Assistance to Healthcare Workers, the activity of the healthcare worker is said to be a form of Christian witness.[438] Furthermore, it can be said to be part of the new evangelization which in service to life, especially for those who suffer, has in imitation of Christ's Ministry, its qualifying moment. Healthcare workers provide a valuable service to life which expresses a human and Christian commitment carried out as dedication to and love of neighbor. It is a form of Christian witness (1) where they are called to be guardians and servants of human life, *Evangelium vitae, (*1995)[439]

> It is to this that professional or voluntary healthcare workers devote their activity. Those are doctors, nurses, hospital chaplains, men and women religious, administrators, voluntary care givers for those who suffer, those involved in the diagnosis, treatment and recovery of human health. The principle and symbolic expression of 'taking care' is their vigilant and caring presence at the sick-bed. It is here that medical and nursing activity expresses its human and Christian value. (CHCW, n. 1)

The council has stated that health care activity is based on interpersonal relationships of a special kind where there is a meeting between trust and conscience. (2) The sick person who is ill and suffering and therefore in need, entrusts him/herself to the conscience of another who comes to his assistance to care for him and cure him. This is the healthcare worker. (3) The sick person is never just a clinical case but always a sick person towards whom he shows a sincere attitude of sympathy. (4) This requires

[437] Ibid.
[438] Ibid.
[439] John Paul II, *Evangelium Vitae*, 1995

love, availability, attention, understanding, sharing, benevolence, patience, and dialogue. Professional expertise is not sufficient, personal empathy is also required. The phenomena of sickness and suffering go beyond medicine to the essence of the human condition in this world. The socio/medical service of personnel who are guided by an holistic human vision of illness can offer a wholly humane approach to the sick and suffering patient. (n. 6) To care, lovingly for a sick person is to fulfill a divine mission (n. 8) a redemptive mission. In Scripture Jesus says "I came that they may have life, and have it abundantly" (Jn 10: 10). This is that human life, in all its stages can achieve its full significance, *Evangelium vitae*, 1995[440](no.1). Service to life by healthcare workers, is a therapeutic ministry, a message that activates the redeeming love of Christ. Doctors, nurses, and other healthcare workers and voluntary assistants, are called to be the living image of Christ and of his Church in loving the sick and suffering (23), witnesses of the gospel of life. (24)

The healthcare worker draws his "behavioral directives" from the field of bioethics. There is also a need to develop in the this worker an "authentic faith and a true sense of morality in search of a religious relationship with God, in whom all ideals of goodness and truth are based." (27) Healthcare workers cannot be overburdened with unbearable responsibilities arising from biotechnical possibilities, many of which are at an experimental stage, open to modern medicine. The setting up of ethical committees in medical centers is to be encouraged, with a view towards safeguarding the patient's dignity and medical responsibility itself.

---

[440] Ibid.

According to the charter the concept of health has to do with prevention, diagnosis, treatment, and rehabilitation as well as the physical, mental, and spiritual well being of the person.[441] This describes a holistic medical model. The term and concept of medicine refers to actual health policy, legislation, programming and structures. (30). "The full concept of health reflects directly on medicine," and while institutions are a necessity, no institution can substitute for the human heart, human compassion, human love, human initiative, when it is a question of helping another in his/her suffering (31). This can lead to a humanization of medicine. This humanization strengthens the basis of the 'civilization of life and love' without which the life of individuals and of society itself looses its most genuinely human quality[442](27). The present charter published by John Paul II, wished to guarantee the ethical fidelity of the healthcare worker: the choices, and behavior a service to life. It suggests that this fidelity is outlined through the stages of human existence: procreation, living, dying, as reference points for ethical/pastoral reflections.

On the eight World Day of the Sick, in Rome, 2000, Year of the Great Jubilee, John Paul II re-examines the reality of illness and suffering.[443] He does this in the light of the Incarnation of the Son of God in order to draw new light to basic human experiences. He examines in particular the progress in the treatment of suffering and improved health care: prolonging life, improving its quality, alleviating suffering, increasing a persons potential through the use of good reliable medicines and increasingly sophisticated technologies. He also draws attention to achievements in a social context for example, an awareness of the right to treatment and its expression in

[441] John Paul II, Pontifical Council for Pastoral Assistance to Healthcare Workers, 1994.
[442] John Paul II, *Evangelium Vitae*, 1995
[443] Pope John Paul II, *Message of the Holy Father for the World Day of the Sick*, Rome, 2000.

judicial terms, charters of the rights of the sick, together with a better qualified nursing service as well as voluntary services. Nevertheless there are still areas where the alleviation of pain and suffering has not been achieved. The Pope speaks of "rivers of human pain" beginning with the wound of original sin, wars, bloodshed, as well as diseases, drug dependency and AIDS. Other areas include organized crime, and proposals for euthanasia. With increasing secularization and the "eclipse" of faith people are no longer able to grasp the meaning of pain and the comfort of eschatological hope. In spiritual terms, the Church strives to accompany those in their struggle against pain and the commitment to improve health as well as to reveal the "richness of the redemption brought about by Christ our Savior".

Historically men and women imitate Christ in their love for the poor and suffering and have initiated many ways of providing social assistance. Together with the Fathers of the Church, founders and foundresses of religious institutions, in silence and humility have dedicated their lives to the service of their sick neighbor. The Church itself inspired by the gospel of charity contributes to hospitals, healthcare structures and volunteer organizations. Nevertheless, there are still areas of social inequality in accessing healthcare resources. This inequality undermines rights to basic medicines while elsewhere medicines are wasted and misused. Others lack the minimum food to eat, leaving them vulnerable to every kind of disease, trauma and death.

John Paul II reminds us of how the gospel of the Good Samaritan communicates healing love and the consolation of Jesus Christ. This happens through

the commitment and skilled service of healthcare workers [444] *Christifidelis Laici*, 1988 (n. 53). Through professional and voluntary work in healthcare, their service can become a prefiguration of definitive salvation. In the face of suffering and death the sick need companionship, sympathy and support. A vision of health must respect the whole person, physical, psychological, spiritual and at a social level. This can be achieved through a holistic medical model, which I am promoting in this thesis.

John Paul II calls on international, political, social and healthcare organizations to be promoters of concrete projects to fight all that is harmful to the dignity and health of the person.[445] His outlook is holistic, and provides a theological underpinning for my proposed holistic medical model, in the alleviation of pain and suffering.

5.9 CARE OF THE SICK AND SUFFERING: THE DIGNITY OF THE HUMAN PERSON

On the celebration of the world day of the sick (2002) Pope John Paul II speaks of how the Church is guided, in her view of suffering, through her conviction of the human person created in the image of God, and endowed with God-given dignity and inalienable human rights.[446] Human beings, not wealth or technology, are the prime agents and destination of development. Therefore, the kind of development that the Church promotes reaches far beyond questions of economy and technology. It begins and ends with the integrity of the human person, his dignity and his rights. Various international declarations of human rights are a sign of growing attention on a world-wide level to the dignity of the human person. Yet many people are still

[444] John Paul II, *Christifideles Laici* (1988). On: *The vocation and the mission of the lay faithful in the Church and in the world.* Post-Synodal Apostolic Exortation, Rome.
[445] John Paul II, *Message of the Holy Father to the sick on the year of the Great Jubilee*, Rome, (2000).
[446] John Paul II, *Message of the Holy Father for the World day of the Sick* (2002).

subjected to degrading forms of exploitation and manipulation, in different parts of the world.

In *Ecclesia in Africa* (n. 82) Pope John Paul ll reiterates his view on the dignity and the role of man and woman.[447] The dignity of man and woman derives from the fact that when God created man, "in the image of God he created them" (Gen 1:27) he endowed them with intelligence and will, and therefore with freedom. The account of our first parents' sin confirms this (Gen 3). The psalmist sings of man's incomparable dignity "Yet you have made him little less than a god; with glory and honor you crowned him, gave him power over the works of your hand, put all things under his feet" (Ps 8: 6-7). In creating the human race male and female God gives man and woman an equal personal dignity with rights and responsibilities proper to the human person. The Church deplores African customs and practices which deprive women of their rights and respect due to them, and the Church must make every effort to foster the safeguarding of these rights.[448]

Pope John Paul II addressed the 23rd National Congress of the Italian Catholic Physicians Association[449] in Dec 2004. Speaking at the conference The Holy Father expressed the solicitude of the Church for the sick and points out that concern for the sick always goes hand in hand with the preaching of the gospel, and is expressed in nursing care and treatment that has benefited large numbers of suffering persons. The John Paul II speaks to the Catholic doctors and reminds them that they are called as believers to witness to Christ through works of charity and dedication for the

[447] John Paul ll, *Ecclesia in Africa*, 1995
[448] Ibid.
[449] John Paul II, addressed a message: "*Always remember that healing ultimately comes from the Most High.*" to the 23rd National Congress of the Italian Catholic Physicians Association, from the Vatican, 2004

promotion of peace and justice, and effectively helping to eliminate the causes of suffering that humiliate and sadden mankind.[450] John Paul II believes that medicine properly understood, speaks the universal language of sharing, paying attention to every person without distinction and welcoming all to alleviate the sufferings of each one. John Paul II's vision is inclusive and holistic. He believes that there is no human being who has not known or will not know illness. It can afflict us all and affects the person at every level, from the physical to the psychological. Medicine therefore must strive to make people whole in keeping with the needs of the whole person, without discrimination. Doctors are also advised not to neglect the person's spiritual dimension. If, in trying to cure and alleviate suffering, you are clearly aware of the meaning of life and death and the role of pain in human life, you will succeed in promoting authentic civilization.

John Paul II concludes by speaking to the doctors of the Christian vision of service to one's suffering neighbor cannot but be advantageous to the correct practice of a profession of fundamental social importance. Biomedical research also expects to be en-livened by a Christian inspiration so that it may contribute better and better to the true well-being of humanity. John Paul II wishes that the doctors could see Christ in every ailing person, collaborating with those who are involved in pastoral care, of the sick. In this way their contribution of professionalism together with warmth of heart can humanize their care always remembering that healing ultimately comes from the Most High (Sir 38: 1-2).

[450] Ibid.

At a meeting with the sick and suffering at the Shrine of St Lazerus, Cuba, in 1998, Pope John Paul ll reminds the sick that Christ is close to all those who suffer.[451] He addresses in particular those most afflicted, the elderly who are alone, and all those suffering in body and spirit. The Pope assures them of his love, the solidarity of the Church and the fraternal warmth of all men and women of good will. He next addresses those caring for the sick, in particular the Daughters of Charity.[452] He thanks them for bringing the gospel of life through charity, which is the glory of the Church and sign of fidelity to the Lord, Vita Consecrata, 1996 (n. 82). Speaking to doctors, nurses and assistants, he reminds them that the Church values their work, stirred by the spirit of service and solidarity with their neighbor, which remembers the work of Jesus who cured the sick (Mt 8: 16). He praises the efforts being made in the area of healthcare. Next, he speaks of the parable of the Good Samaritan (Lk 10: 29) which reminds us of the gospel of solidarity with our suffering neighbor and which has become one of the essential elements of moral culture and of universally human civilization, *Salvifici Doloris,*1984[453]. The Good Samaritan in real terms is as follows:

> That human beings must feel personally called to witness to love in the midst of suffering. And, although institutions are indispensable, no institution can be a substitute for the human heart, human understanding, and human love...when meeting the suffering of another (n. 29)

John Paul II reminds us that when the soul of a nation suffers, this must be a summons to solidarity to justice, to the building of a civilization of truth and love. Solidarity, justice and love are principles, which would be enriching for all people.

---

[451] John Paul II, *Offering your suffering to God.* Meeting with the sick and suffering, at the Shrine of St. Lazarus, El Rincon, Cuba, 1998.
[452]John Paul II, *Vita consecrata*, Post-Synodal Apostolic Exortation, given in Rome at St. Peter's, 1996.
[453] John Paul II, *Salvifici doloris*, (1984).

5.10 RELATIONSHIPS AND THE CIVILIZATION OF LOVE

In *Dives in misericordia* (1980) John Paul II speaks of mercy and how it is an indispensable element for shaping human relationships between people, in a spirit of deepest respect for what is human.[454] It is impossible to establish a bond between people if they wish to regulate their mutual relationships, solely according to a measure of justice. John Paul II believes that in every sphere of interpersonal relationships justice must be modified or corrected to a certain extent by that love which as St. Paul says is patient and kind (Cor 13: 4) or in other words have the characteristics of that merciful love which is so much of the essence of the Gospel and Christianity.

We must also remember that, furthermore, merciful love also means the cordial tenderness and sensitivity so eloquently spoken of in the parable of the prodigal son (Lk 15:11) and in also in the parables of the lost sheep and the lost coin (Lk 15: 1-10). Consequently, merciful love is supremely indispensable between those who are closest to one another: between husband and wife, between parents and children, between friends; and it is indispensable in education and pastoral work. Its workings however are not limited to this. It was Pope Paul VI who more than anyone else, indicated a civilization of love as the goal to which all efforts in the cultural and social fields as well as in the economic and political should aspire to.[455] He cautioned that good will could never be reached if in our thinking and acting we stop at the criteria of an eye for an eye and a tooth for a tooth, (Mt 5: 38) and do not try to transform it in its essence, by complementing it with another spirit. The Second

---

[454] John Paul II, *Dives in misericordia*, (1980)

[455] *Insegnamenti di Paolo VI*, XIII (1975), p. 1568 (Close of the Holy Year, Dec. 25, 1975)

Vatican Council also speaks repeatedly of the need to make the world more human, and states that this is precisely the mission of the Church in the modern world.[456] It is suggested that society can become ever more human only if we introduce into the setting of interpersonal and social relationships, not merely justice, but also merciful love which constitutes the messianic message of the Gospel.

Society can become ever more human only when we introduce into all the mutual relationships which form its moral aspect, forgiveness which is so much the essence of the Gospel. Forgiveness demonstrates the presence in the world of love, which is more powerful than sin. Forgiveness is also the fundamental condition for reconciliation, not only in the relationship of God with man, but also in the relationships between people. Living in a world without forgiveness would be nothing more than a world of cold and unfeeling justice, where each would claim his/her rights and where the latent feelings of selfishness in man would transform society into a system of oppression of the weak by the strong, or of permanent strife between one group and another. According to Pope John Paul II, this is the reason that the Church must consider it one of her principal duties-at every stage of history and especially in our modern age-to proclaim and introduce into life the mystery of mercy supremely revealed in Jesus Christ.

In *Salvifici doloris* Pope John Paul II stresses the importance of loving our neighbor. The Good Samaritan showed himself to be a real neighbor because he carried out the commandment to love.[457] He saw the man who was beaten, robbed,

---

[456] Pastoral Constitution on the Church in the Modern World, *Gaudium et spes*, No. 40, 1966, pp. 1057-1059; Pope Paul VI: *Paterna cum benevolentia*, in particular no's. 1-6, 1975, p. 7-9, 17-23.
[457] John Paul II, *Salvifici Doloris,* (1984).

and left half dead, he had compassion for him, and took care of him. He had the interior disposition of the heart, and this fits every individual who is sensitive to the suffering of others. This is an expression of our love and solidarity with the suffering other. It can be said that suffering in its different forms can unleash love in the human person, the unselfish 'I' on behalf of other people, especially those who suffer. John Paul II makes the point that the world of human suffering unceasingly calls for, so to speak, another world: the world of human love; and in a certain sense man owes to suffering that unselfish love which stirs his heart to action. The person who acts as a good neighbor, shows fundamental human solidarity. John Paul II sets out for us an admirable set of principles in order to guide us towards a humane way of being in the world: merciful love, forgiveness as well as justice and mercy, love of neighbor and solidarity with the suffering of others. We can see the Good Samaritan in the work of doctors, nurses, healthcare workers, and individual carers. Medicine has developed and specialized even further in our times and we can say that medical staff try to understand the sufferings of their patients and deal with them with even greater skill. It follows that the parable of the Good Samaritan of the Gospel has become one of the essential elements of moral culture and universally human civilization.

John Paul II finds individual contributions no less valuable than the work carried out in institutions. Some people are prepared to work with various forms of suffering which can only be alleviated in an individual and personal way. In families help means acts of love of neighbor done to members of the same family and mutual help between families. These good works merits our thanks to the fundamental moral

values such as human solidarity, the value of Christian love of neighbor, which form the framework of social life and inter-human relationships in the developed world. Finally, in *Salvifici doloris,* 1984, he reminds us of the messianic program of Christ, which is at the same time the program of the kingdom of God.[458]

> Suffering is present in the world in order to release love, in order to give birth to works of love toward neighbor, in order to transform the whole of human civilization into a civilization of love.
>
> It is in this love that the salvific meaning of suffering is completely accomplished and reaches its definitive dimension; in order for the civilization of love to flourish and produce fruit in this vast world of human pain.

The message from John Paul II to the suffering is to put their trust in Christ, and offer their sufferings to His. A good healthcare system needs a holistic medical model, to offer patients care of the whole person, physical, social, and psychological, with particular emphasis on a spiritual dimension, which for those suffering from unrelieved pain can be a source of consolation and healing.

5.11 HEALTHCARE AND SOCIETY: DELIBERATIONS AND PROPOSALS

Under the guidance of the President of the Pontifical Council for Health Pastoral Care, cardinals, archbishops, bishops, members of religious orders, and members of the laity from sixty six different countries involved in various ways in the

[458] John Paul II, *Salvifici Doloris*, (1984)

world of suffering and health and/or specialized in the various disciplines of the humanistic, social, biomedical and pastoral-theological sciences gathered together.[459] The general subject healthcare and society was discussed and debated in the light of the Word of God and theology so as to highlight contemporary challenges and moral questions with a view to achieving the humanization of medicine in a society which is becoming increasingly globalized. Amongst the topics discussed were: the frontiers of modern technology, new spaces of health care services, hew healthcare workers, new services offered to the sick, new and emerging illnesses, medicine and cultural changes, the contemporary questions of moral theology, the prospects offered to modern medicine by inter-religious dialogue with Judaism, Islam, Hinduism and Buddism and finally the training of healthcare workers and chaplains.

As a result of their deliberations, observations and questioning a number of proposals emerged: In agreement with the teaching of St. Paul II on the Christian meaning of suffering, they emphasized that the pain and illness which medicine seeks to alleviate and /or cure are a part of the mystery of man created in the image and likeness to God and redeemed by the Word made Flesh and find in the mystery of the cross their salvific meaning. They re-affirmed the task of medicine is to prevent illnesses and promote health understood as full harmony and healthy balance at a physical, spiritual, and social level. Hence the imperative that medicine must serve the overall good of the person...They restated that in ethical assessment of the questions and dilemmas raised by medicine, the human person remains the measurement and the criterion of the ethical and anthropological approach to the

[459] The Fifteenth International Conference, of the Pontifical Council for Health Pastoral Care on the subject "*Health Care and Society*" in the New Synod Hall of the Vatican, (2000)

choices taken by researchers and healthcare workers. They called on healthcare workers not to limit their service to merely helping in the treatment of physical pathology but to go well beyond this and to provide human, moral, and spiritual support to sick people based upon an approach to life which is able to supply an answer to the mystery of pain and death. A number of calls emerged from the 15th conference as follows: To recognize pastoral care in health as an integral and defining part of caring for the sick person in order to achieve his or her recovery. To make maximum use within the world of medicine of the advantages of globalization but at the same time to correct its negative effects on healthcare. To offer the organizations of the United Nations our co operation.....

Finally, the conference expressed a belief that careful attention be given to the moral, religious, and technical training of healthcare workers, so that they can reach the ethical requirements asked of them by society. They favored the strengthening of Catholic healthcare structures so that they can meet the challenges of globalization; the continuation of inter-religious dialogue with non-Christian religions so that certain shared values can be sown in the world, values such as: respect for human life, helping the sick person with compassion tolerance.... greater attention paid by the Church and government authorities to the moral, human, and medical healthcare problems and difficulties of people in prison.

John Paul II instructs Catholics, who are working in the area of healthcare to do all that they can to defend life when it is most seriously threatened and to act with a conscience correctly formed according to the teaching of the church. He cites numerous health facilities through which the Catholic Church offers a genuine

testimony of faith, charity and hope contribute to this ideal. He mentions the good work of the various religious institutions and volunteers who promote and guide the care of the sick. John Paul II also speaks of what he expects from Catholic hospitals. They must be:

> centers of life and hope which promote, together with chaplaincies, ethics committees, training programs for lay health workers, personal and compassionate care of the sick, attention to the needs of their families and a particular sensitivity to the poor and the marginalized. Professional work should be done in a genuine witness to charity, bearing in mind that health is a gift from God, and man merely its steward and guardian.

Referring to his Apostolic Letter[460] *Novo Millennio Ineunte*, 2000, he reminds people that service to humanity includes that, those using the latest advances in science, especially in the field of biotechnology, must never disregard ethical requirements, by invoking a questionable solidarity which eventually leads to discrimination between one life and another and ignoring the dignity which belongs to every human being. (n. 51). He welcomes scientific and technological progress, and values the dedication and professionalism which contributes to the quality of service to the sick, while respecting their dignity. He reminds those who care for the sick that:

> every therapeutic procedure, all experimentation and every transplant must take into account this fundamental truth, thus it is never licit to kill one human being in order to save another. And while palliative treatment in the final stages of life can be encouraged, avoiding a 'treatment at all costs' mentality, it will never be permissible to resort to actions or admissions which by their nature or in the intention of the person acting are designed to bring about death.

He also urges a renewed commitment to the pastoral care of the sick in the education and formation of priests and religious, because it is in the care of the sick more than

---

[460] John Paul II, *Novo Millennio Ineunte*, to the Bishops, Clergy, and Lay Faithful, at the close of the Great Jubilee of the year (2000)

any other way that love is made concrete and a witness of hope in the Resurrection is offered. He also addresses chaplains, religious, doctors, nurses, pharmacists, technicians, administrative personnel, social assistants and volunteers: he speaks of how The World Day of the Sick offers a special opportunity to continue to be generous disciples of Christ the Good Samaritan. He also encourages them to recognize in those who suffer the Face of the sorrowful and glorious Lord, to be ready to bring help to those afflicted with new diseases, such as AIDS, and with older diseases, such as tuberculosis, malaria and leprosy. In conclusion the John Paul II expresses hope that they will learn to recognize and welcome the Lord who calls you to be witnesses to the Gospel of suffering, by looking with trust and love upon the face of Christ Crucified and by uniting their suffering to his.

5.12 CONCLUSIONS

This thesis explores the possibility of providing a holistic model of healthcare for the alleviation of pain and suffering. Through an in-depth examination of the work of Pope John Paul II it became evident that he provides a theological underpinning for an approach to holistic medical care, and a human anthropology which emphasizes the dignity and equality of all human beings at all stages of life. It is of interest that he has written letters to the sick, annually since 1993 in which is outlined a profound theology of human suffering and healing. Of particular relevance to this thesis is that his theology incorporates those who care for the sick. He also includes a vision for Catholic healthcare rooted in the theological virtues of faith, hope and love. He speaks of contemporary challenges to the teaching of the Christian Faith arising from biomedical techniques, recommending attention to ethical and

moral values, and the safeguarding of the most vulnerable members of society, particularly at the beginning and end of their lives, and overall to promote a humanization of medicine.

Of particular value for the sick and suffering were his annual letters addressed to them. He used pastoral language supported by academic scholarship. He spoke to them with compassion for their plight assuring them of his solidarity and that of the Church. He discussed difficulties that were unique to the countries he visited. His use of the media meant that he reached people, through television, in their hospital beds, nursing homes, centers for the disabled, and healthcare facilities, as well as those who looked after them. People saw him, listened to him and were uplifted by him. He knew the importance of establishing relationships. He addressed people of all ages, including the elderly and the young. He assured them of his love, and the love of Christ their Savior and Redeemer. He came to bring them "the good news" of the gospel. His theology is of particular relevance for my thesis because of the inclusivity of his teaching, his whole approach is holistic. What is amazing was the depth of his knowledge in the fields of science and medicine, and eagerly awaited new technologies and medicines to treat the sick and suffering. It is obvious from his interest in science, and his respect for researchers who devote their time towards developing new ways of alleviating pain and suffering, which is one of the main concerns of this thesis. Conscious of the questions which arise about the meaning of suffering John Paul II addressed these concerns in depth in *Salvifici doloris.* 1984. His addresses to the sick and his writings attest to the depth of his knowledge of pain and suffering, conveying to the sick and suffering that he understands their pain and the extent of their suffering. His approach is holistic in that he defines suffering as

"the disruption of inner harmony" caused by physical, mental, spiritual and emotional forces, experienced as "isolating and threatening our existence." His approach has direct relevance for my thesis where I search for a model of holistic care to alleviate pain and suffering.

My vision of a holistic medical model, retains the current medical model (EBM), but in order to provide care of the whole human person, additional treatments and therapies will be promoted to complement the scientific based medical model. This holistic medical model will be patient-centered and supported by multidisciplinary care. Care would be available to all, irrespective of belief or culture. It would be empathic, compassionate and seek to alleviate pain and suffering, and provide appropriate end-of-life-care, as well as spiritual support, to promote healing, in a caring environment, and ensure that the dignity of the person is upheld both in their living and dying.

John Paul II in addressing the sick and suffering conveys to them that they are not alone on their path of life, because it is on this path that the Church must meet man. He speaks of the compassion and respect due to those who suffer. While pain and suffering can be debilitating and challenging, suffering without meaning causes the greatest hardship of all. When people are in pain and distressed they may be psychologically disturbed, and this is why I have chosen to promote a holistic medical model which would attend to patients' needs as a whole, socially, emotionally, spiritually and well as physically. In his teaching Pope John Paul II expresses his theologies of salvation and redemption in the context of faith, hope and love. To understand suffering we must put our trust in the word of God. His Son, through his

salvific work liberates man from sin and death giving him the hope of eternal salvation. The redeemer suffered instead of man for man and each man can share in the redemption, through his own suffering. Each individual is expected to "stop" as the Good Samaritan did to give help. In his explanation of suffering John Paul II states that "suffering is present in order to release love, in order to give birth to love towards our neighbor and to transform civilization into a civilization of love." Suffering viewed in the perspective of faith can assist people to face pain and suffering and the debilitations of old age. These theologies of salvation and redemption provide a theological underpinning for a holistic medical model of care for the sick and suffering.

Pope John Paul II's vision includes a Christocentric theology of suffering. He demonstrates how in our suffering we can identify with Christ. In this way he personalizes suffering. Christ drew close to all who were sick and became sensitive to all kinds of suffering. His suffering had human dimensions he suffered voluntarily and innocently. Christ gave the answer to the meaning of suffering not only through the "good news" but also through his suffering. At the depth of his suffering Christ felt abandoned by the Father. Pope John Paul II's refers to the sick who reside in numerous health care facilities or at home "on their own, undergoing a Calvery of sufferings" who are often neglected, pain not always relieved and sometimes aggravated by lack of support. He understands their anguish, their unease as well as their physical or "psychic ills" which contributes to their suffering. At certain times during the course of illness, patients' begin to feel abandoned, for example when cancer treatments fail, and nothing more can be done for them in a general hospital, doctors and nurses visits become less frequent, and patients' become isolated. A

spiritual component, as part of a holistic medical model can be of benefit to patients such as these, whose spiritual sense may be heightened as a result of their illness and poor prognosis. Healthcare workers must not limit their service to merely helping in the treatment of physical pathology but to go well beyond this and to provide human, moral, and spiritual support to sick people. These recommendations have relevance for my thesis and provide a theological underpinning for a holistic medical model of care to alleviate pain and suffering, which was the goal of this thesis.

CHAPTER SIX: FINAL CONCLUSIONS

My concern throughout this thesis has been the unmet needs of people with unrelieved pain and suffering, and my goal throughout has been to formulate a holistic medical model of care that meets their needs, control pain and alleviate suffering. Pain research led to many discoveries. It was ascertained that pain as well as being a sensory and emotional experience includes perception and subjective interpretation. Studies at a physiological level led to the discovery that chronic pain promotes an extended and destructive stress response characterized by neuroendochrine dysregulation which can lead to impaired mental and physical performance. This constellation of discomfort and functional limitations creates a cycle of stress and disability rendering patients incapable of sustaining productive work, family life and supportive social interactions. This causes patients to suffer.

Suffering, is more than pain, and can be perceived as a threat to the integrity of the person. It can lead to helplessness as it exhausts psychosocial and personal resources for coping that threatens the intactness of the person as a complex social and psychological entity. Technology today is integrated into modern medical practice and the possibility of objectifying patients' distress is increased. An objective view that values hard data is the dominant medical model today and the provision of holistic care for the patient may be overlooked where pain and suffering is concerned. Suffering is a broader state that encompasses more dimensions than pain, and is still prevalent in society today. The discovery that that the brain is the central organ involved and that the spinal cord facilitates the transmission of pain to the brain precipitated the search for pain relief which would reduce suffering. Many plant

extracts were used and opium the most potent of these came from the poppy flower. Endorphins, similar compounds to opium have receptors throughout the nervous system and opiate based drugs like morphine form much of the basis for the drugs used to treat pain and alleviate suffering today. This knowledge in turn led to the development of aspirin and developments in anaesthesia led to pain free surgery. When it was discovered that pain could lead to suppression of the immune system and could indirectly lead to promote tumour growth, led to stark phrase *pain could kill.*

The current medical model is insufficient where pain and suffering are concerned. A holistic medical model would provide a broader base for dialogue to encompass a spiritually formed philosophical viewpoint and deal with ways of being in the presence of suffering. Not wishing to denigrate the current medical model (EBM) what I am arguing against is the exclusive use of EBM. It has become clear that in order treat patient's pain and alleviate suffering it is necessary to go beyond this model, to formulate a holistic medical model which would provide whole person care, psychological, social, spiritual as well as physical. Clinical studies acknowledge the value of well-being scales where spirituality expresses itself in phenomena such as finding purpose in life, faith, prayer, the ability to forgive, find meaning in suffering and express gratitude for life. All of these entities can be found within the matrix of spirituality and are associated with better health outcomes, greater longevity, and health-related quality of life as well as less anxiety, depression and suicide. Diseases such as cancer respect no boundaries, and other debilitating diseases cause much pain and suffering as disease progresses and pain increases. This is the challenge facing healthcare providers today. Understanding the dynamics of pain is the first step towards its alleviation.

There are valuable lessons to be learned from the holistic clinical practice of Sheila Cassidy, and although she was providing palliative care, her insights and practices would be of benefit in other areas of medical practice, and fit well into a holistic medical model, which I have been formulating during the course of this thesis. Cassidy's first priority is the establishment of therapeutic relationships with her patients'. She provides a suitable environment, by ensuring that her patients have privacy. She invites patients to narrate their story of pain and suffering. In doing so patients' reach out to her for assistance, and in her receptive listening Cassidy assimilates the patients' pain and suffering; it is in this reciprocity that, the therapeutic relationship is forged, where the patient can see that the doctor is interested in them as persons as well as patients. The locus for the inter-human relationship is where Martin Buber, philosopher, termed the 'between.'

Amongst Cassidy's therapeutic skills is her empathic insight into her patient's world, her sensitivity towards the needs of patients in their distress, and her searching for ways to relieve it. She combines compassion with competence, and her perception of her patients is that their needs are legion: physical, intellectual, emotional, spiritual and social. She advocates holistic care and pain relief is part of it, but diseases such as cancer know no boundaries, the physical and the psychological become inter-twined, fear exacerbating pain. Likewise, spiritual issues are inseparable from physical and psychological ones, for a depressive illness can induce a pathological sense of guilt, making a patient feel beyond the reach and love of God. This burden of illness has been classified, by 'Cecily Saunders' as 'total pain' and each area of pain, psychological, emotional, spiritual as well as physical must be treated simultaneously, before pain control can be achieved. This exemplifies holistic care.

Another lesson from Cassidy's clinical practice is her espousal of the spirituality of companionship. From active listening she has discovered what patients, at the end-of -their lives want, most of all, is a companion to stay with them, watching and waiting, sharing their pain, fear and desolation. From her deep faith Cassidy recommends the necessity of having a Paschal overview to hold in the same focus the harsh reality of suffering and the truth of the resurrection. Spiritual care is usually provided by chaplains who deal with the transcendent nature of life and with his understanding of theology can direct the patients towards wholeness and help them to accept their whole lives, facilitating reconciliation and healing, leading to peace. Kearney's work with the terminally ill, distressed patients and his expertise in dealing with them has much to offer, not only to the field of palliative care but to the care of other patients suffering from other progressive, debilitating diseases. I believe that many of his expertise could be incorporated into a holistic medical model of care, which I am promoting in this thesis. Kearney fosters open and honest communication with his patients and their families in order to transform patients frightening existence into a time of continued growth and completion. Kearney uses a holistic approach, paying attention to the whole patient, psychological, social and spiritual as well as physical. He believes that patients should be treated with compassion. According to Kearney, this caring impulse has evolved in the 21st century as a redress to the imbalance created by increasingly scientific and technological medical systems. Kearney also favours a healing environment that best facilitates inner healing. This means providing a combination of pain control, together with medical and nursing care. Patients could also benefit from companionship, to assist them in establishing a

secure inner space for that patient to be in. Access to spiritual care as well as multidisciplinary support would also be part of this holistic approach.

Kearney's patients can be divided into two groups. The first group consisted of patients' whose cancer was not cured by the dominant medical model, who were referred to the hospice for palliative care. Even though these patients were fearful, in pain and suffering, and experiencing a sense of loss and separation from their families, nevertheless in the secure hospice environment, with pain control, medical and nursing support, a renewal of spirituality and a spirit of companionship, this group of patient's responded well to palliative care, which is essentially holistic. A second group of patients arrived at the hospice distressed, fearful and struggling to come to terms with their terminal disease and imminent death. In addition to palliative care these patients needed a healing model. This deals with the intuitive or unconscious aspect of the mind, where fear and dread resides. Through psychological therapy, image work, dream analysis, or stories, patients experienced a lessoning of fear and a reduction in pain and suffering. Thus Kearney established that distressed terminally ill patients needed the addition of a healing model to the conventional medical model, in order to bring about reconciliation and peace for these patients. Through the process of becoming psychologically and spiritually more integrated and whole, patients became more completely themselves and more fully alive even in the face of imminent death.

Martin Buber's insights concerning human inter-relationships and dialogue are of value in the development of a therapeutic relationship between doctor and patient, recognizing that ways of being in the presence of suffering requires a deeper

appreciation of human interaction, a form of discourse beyond the language of models and skills. This outline of the dynamics of inter-relations and dialogue provides a valuable contribution to the formulation of a holistic model of care, to alleviate pain and suffering. Buber's philosophy of dialogue views human existence in two fundamentally different kinds of relationships, I-It and I-Thou. The current medical model is situated in the I-It realm of being, characterized by objectivity, detachment, abstraction, and experience. The I-Thou realm of inter-relations comprises: spontaneity, subjectivity, mutual exchange, recognition and acceptance of the unique other. Buber's thought also offers three conceptual shifts that facilitate the development of a therapeutic relationship in medical practice (a) from disease centered to patient centered, (b) from crisis to everyday management and (c) from principles and contacts to relationships, culminating in the appreciation of patients as whole human beings and seeing how this can be fractured through pain and suffering.

As the patient is interviewed and given a physical examination the discourse between patient and doctor constantly changes from I-It, to I- Thou and also has the potential to move to the Eternal Thou or God. In the narration of their illness patients reach out to the doctor for assistance, and in the empathic listening the doctor assimilates the patients pain and suffering. This reciprocity happens in Buber's concept of the 'between' or the locus where the relationship is forged. Buber is also concerned with the quality of listening when he speaks of the undivided wholeness of genuine meeting requiring a living relationship of whole person to whole person. In achieving wholeness patients are enabled to arrive at a place of reconciliation and peace. Buber also espouses healing through meeting where the connection is made between the unconscious of the patient and that of the doctor, and encourages

compassion towards self-acceptance. This therapeutic relationship makes healing possible. Buber also believes in the 'power of story' because it is listened to in the subconscious where existential fear resides blocking creativity and healing. However, story activates what we can be, or what we may become, our potential to transform ourselves and reach a place of healing and reconciliation. Buber's insight into the dynamics of inter-relationships and methods of discourse provides deeper insight and clarity into the phenomenon of pain and suffering. Buber's paradigm shift also provides concepts of inter-relations such as: 'the between,' 'undivided wholeness,' 'healing through meeting,' and 'the power of story' illustrates the criteria which facilitate the patient to arrive at a place of healing and reconciliation.

This thesis explores the possibility of formulating a holistic medical model of healthcare for the alleviation of pain and suffering. The in-depth examination of the work of Pope John Paul II provides a theological underpinning for an approach to holistic medical care. In letters to the sick, he outlines a profound theology of human suffering and healing. He also includes a vision for Catholic healthcare rooted in the theological virtues of faith, hope and love. Of particular value for the sick and suffering were his annual letters addressed to them. He used pastoral language. He spoke to them with compassion assuring them of his solidarity and that of the Church. He became available to the sick through his travels and the use of the media. People saw him, listened to him and were uplifted by him. He assured them of his love, and the love of Christ their Savior and Redeemer. He came to bring them the good news of the gospel. John Paul II's manner of address exemplifies the setting up of a therapeutic relationship, and promoting a holistic approach to healthcare, which has direct relevance for this thesis.

John Paul II keeps up-to-date with developments in medical research, and commends researchers who develop new ways of alleviating pain and suffering which is one of the concerns of this thesis. He addressed scientists, and attended conferences. Therefore, when he addressed the sick, he was aware of the pain and debilitating effects of various diseases. This is why he could empathize with them, and not least because of what he suffered in his declining years when he spoke to them as fellow sufferers. This further consolidated the therapeutic relationship he had with them. The ability to empathize with the sick within a therapeutic relationship can have a healing effect, and is one of the most important elements for the successful treatment of the seriously ill person, and a necessary part of a holistic medical model, which I am formulating throughout this thesis.

Conscious of questions about the meaning of suffering John Paul II addresses these concerns in depth in *Salvifici doloris.* His approach is holistic, he speaks of physical, mental, spiritual and emotional forces, experienced as isolating and threatening our existence. This has direct relevance for my thesis where I promote a model of holistic care to alleviate pain and suffering. In his explanation of suffering John Paul II states that suffering is present in order to release love, in order to give birth to love towards neighbour and the transformation of civilization into a civilization of love.

Pope John Paul II's vision includes a Christocentric theology of suffering. He speaks of how we can identify with Christ who drew close to all who were sick and became sensitive to all kinds of suffering. John Paul II refers to the sick who reside in

numerous health care facilities or at home undergoing a Calvery of sufferings, often neglected, pain not always relieved and sometimes aggravated by lack of support. He understands their anguish, their unease as well as their physical or "psychic ills" which contributes to their suffering. This is a holistic approach to care, which links with this thesis. John Paul II reminds doctors that they are called as believers to witness Christ through works of charity and help to eliminate the causes of suffering, how it can affect us all at every level from the physical to the psychological, and how medicine must strive to attend to the needs of the whole person. This approach is also holistic, which I am promoting in this thesis. John Paul II also reminds doctors that they must defend the inviolable dignity of every human person and in this way their contribution of professionalism, with warmth of heart can humanize their care.
of John Paul II.

Throughout this thesis, the holistic medical model which I am now advocating is patient-oriented and humanistic in the provision of whole person care to include the physical, mental, social and spiritual concerns of the patient, supported by multidisciplinary care. The provision of such care would require good communication and active listening skills to facilitate the establishment of a therapeutic relationship between doctor and patient, which is essential in getting a good outcome for the patient. Good communication skills are also required when informing patients about their illness. Patients have stated that they want their illness explained to them in a language that they understand, and that they wish to be part of the decision-making concerning the best treatment for them and their illness. At all times the patient must be treated in a humane manner and be treated with compassion as well as empathy to foster healing. The focus must be on the patient and not the

disease. Where given the opportunity, many patients like to narrate their story of illness and pain, and where pain relief is concerned the therapy must be tailored to meet the individual needs of that patient as exemplified in the work of Cassidy, Kearney and the philosophy of Buber.

I also recommend a healing medical model to supplement the current medical model, which I refer to as a holistic medical model, which would consist of the current medical model (EBM) and other additional treatment or therapies as required to return the patient to wholeness or full health. This could be attendance at a rehabilitation centre, to learn new ways of coping with disease and disability or participating in existential / other group therapy which would deal with the philosophy of life; meaning and purpose in life, providing support for emotional disorders, or mental illness with the availability of spiritual support if required. Attendance at a day care centre can provide socialization and support for the elderly who live alone, and community day care for the disabled or Altzeimer patient can provide support for patients and carer's alike. The availability of supplementary services for the elderly and disabled in the community in the form of nursing, chiropody and occupational therapy is also desirable.

The provision of holistic care for all patients has implications for medical education, expansion of the health services, development of general practice, and the provision of community care for the disabled, the elderly and the mentally ill. Where medical education and the provision of hospital care is concerned additional training of medical students in holistic care would entail training doctors to interact as part of a multidisciplinary team; learn how to establish therapeutic relationships with their

patients and provide a combination of evidence based medicine and patient-oriented medicine, with development of communication skills to bridge the gap between them. Doctors also need to have the ability to assimilate the scientific knowledge of disease and treatment with the understanding of the individual patient and apply good clinical judgment; be trained to explore the psychosocial needs of patients and to direct patients to pastoral or spiritual care, which can bring them a sense of meaning, hope and peace of mind; and to refer them to other specialists if further treatment is required in another specialty.

The expansion of general practice and development of community care has long been neglected. The provision of holistic care services would entail capital expenditure to provide residential and day care centers; the training of additional public health nurses, and nurse practitioners; the training of healthcare workers and carer's, s together with the provision of ancillary services such as physiotherapy and rehabilitation, as well as care for the mentally ill, the disabled and the dying. All of these services are needed if holistic care, and continuing care is to be provided for all.

BIBLIOGRAPHY

PRIMARY SOURCES

Buber, Martin *Israel and the world, essays in a time of crisis*, New York: Schocken Books, 1948

_________ *Philosophical interrogations*, ed. Sidney and Beatrice Rome, New York: Holt, Rinehart & Winston, 1964.

_________ *The way of response*, New York: Schocken, Books, 1966

_________ *The knowledge of man* in: Elements of the interhuman, New York: Humanity Books, 1988.

_________ *The Knowledge of man, Selected essays* trans. R.G. Smith, M. Friedman, ed., New York: Humanity Press, 1998

_________ *Between man and man* trans. R. G. Smith, New York:Routledge, 2002.

_________ *I and Thou*, trans. R. G. Smith, London: T. & T. Clark, 2003.

Cassidy, Sheila *Good Friday people* London: DLT, 1988

______ *Sharing the darkness* London: DLT, 1988

______ *Audacity to believe*, London: D.L.T, 1992

______ *Light from the dark valley*, London: D.L.T., 1994

______ *On Death: being together in the darkness.* The Tablet, http://www.thetablet.co.uk/ogi-bin/archivedb.ogi retrieved 29-11-97

Kearney, M. *Mortally wounded, stories of soul pain, death and healing.* Dublin: Marino Books, 1996

______ *A place of healing: working with suffering in living and dying.* New York: Oxford University Press, 2000

John Paul II,

_____________ *Salvifici Doloris*, (1984)

_____________ *Science and Human Values* (1985)

_____________ *Christifideles Laici* (1988)

_____________*Evangelium Vitae*, (1995).

_____________*Ecclesia in America*, (1999)

John Paul II *Message of the Holy Father for The First Annual Day of the Sick*, (1993)

___________*Message of the Holy Father for the Second World Day of the Sick*, (1994)

___________*Contemplate the face of Christ in the sick*, Rome (2000)

___________ *Message of the Holy Father for the World Day of the Sick* (2000)

___________ *Message of the Holy Father for the World day of the Sick* (2002).

SECONDARY SOURCES: BOOKS

Bacik, J.J. *Contemporary Theologians*, New York: Triumph Books, 1991

Becker, E. *The Denial of Death*, New York; Free Press Paperbacks, 1973.

Cassell, Eric, *The Nature of Suffering and the Goals of Medicine*, Oxford: Oxford University Press, 1991.

M. A. Flatula, *The Constitution of the Sacred Liturgy*,12, The New Dictionary of Theology, J.A. Komonchak, M. Collins, D. A. Lane eds. Dublin: Gill Macmillan, 1992

Flannery A. ed. *Gaudium et Spes*,. Vatican Council ll, Dublin, Dominican Pub.1996

Frankl, Viktor *Man's Search For Meaning*, New York: Simon & Schuster,1984

Gawain. S., *The Four Levels of Healing*: a guide to balancing the spiritual, mental, emotional and physical aspects of life. Novato: Nataraj, 1997

Gunzberg, John C. *Healing Through Meeting: Martin Buber's conversational approach to psychotherapy*. Jessica Kingsley Pubs. 2003

Hauerwas, S., Naming the Silences: *God, medicine and the problems of suffering.* Edinburgh: T. and T. Clarke, 1990

Hillman, J. *The Dream of the Underworld.* Harper & Row, 1979

Hillman, James *A Blue Fire: selected writings by James Hillman,* ed. Thomas Moore, Routledge, 1990

Hollister W. J. *The Death of a Woman.* New York: St. Martin's Press, 1981

Horgan, J. *The Undiscovered Mind: how the brain defies explanation.* London: Weidenfield and Nicholson, 1999

Hannah, B. *Encounters with the Soul and Active Imagination*, as developed by C. J. Jung, Sligo Press, 1981.

Hillman, James *The Dream of the Underworld,* Harper & Row, 1979.

Koeing, *The healing power of faith: science explores medicine's last great frontier* New York: Simon and Shuster, 1999

Flatula, M.A., *Suffering*, Komonchak, J.A., Collins M., D. A. Lane, eds. The New Dictionary of Theology, Dublin: Gill Macmillan, 1992

Kreinheder, A. *Body and Soul: the other side of illness.* Inner City Books, Studies in Jungian Psychology by Jungian Analysts, 1991

Kubler Ross, E. *On Death and Dying*, London: Tavistock, 1970

Kurtz, S. and Draper, J. *Teaching and Learning Communication Skills in Medicine.* Oxford: Radcliffe Medical Press, 1998

Laing, R.D. *Wisdom, Madness and Folly.* London: Macmillan, 1985

Lewith, G. Reilly, D., *Integrating the Complementary.* NHS yearbook, London: Medical Information Systems, 1999

McNeil, Donald P,. Morrison, D. P., Nouwen, H. eds. *Compassion: A Reflection on the Christian Life,* New York: Doubleday, 1982.

Matson, F. *Without / Within: behaviorism and humanism.* Monterey, CA: Brooks / Cole, 1973.

Mayhall, C. Wayne and Mayhall, Timothy B. *On Buber*, Wadsworth, Transcontinental-Louiseville, 2004

Meier, C. *Healing, Dream and Ritual.* Switzerland: Daimon, 1989

Misselbrook, D. *Thinking about Patients.* Newbury: Petroc Press, 2001

Nouwen, H. *The Wounded Healer*. New York: Doubleday, 1972

Pellegrino. E.D. and Thomasa, D. C. *Helping and Healing*. Washington: Georgetown University Press, 1996

________ *The Christian Virtues in Medical Practice.* Washington, Georgetown University Press, 1996

Pendleton, D., Schofield, T., Tate P., et.al., *The Consultation: an approach to learning and teaching.* Oxford University Press, 1984

Pope John Paul II, Encyclical Letter, *Dives in Misericordia.* Washington: U.S. Catholic Conference, 1981

Saunders, Cicely *The Management of Terminal Malignant Disease*. Edward Arnold, 1993

__________ *Living with Dying: a guide to palliative care*. New York: Oxford University Press, 1995

Sherwin, S. ed. *Politics of Women's Health.* Philadelphia: Temple University Press, 1998

Spink, K. *Jean Vanier and L'Arche*: *A Communion of Love.* New York: Crossroad, 1991

Swinton, J. *Spirituality and Mental Health Care: rediscovering a forgotten dimension* London: Jessica Kingsley. 2001

Teilhard de Chardin, Pierre, *Activation of Energy*. London: Collins, 1970

Temkin, Owsei and Temkin, Lillian eds. *Ancient Medicine: selected papers of Ludwig Edelstein.* Baltimore; John Hopkins's Press, 1967

The Hastings Centre: *Guidelines on the Termination of Life-sustaining Treatment and the Care of the Dying*; A Report by the Hastings Centre, Indiana University Press, 1987

Unamuno, Miguel de *The Tragic Sense of Life*, trans. Kerrigan, A, Dover Publications,1992.

Vanier, J. *The Broken Body, Journey to Wholeness.* London: D.L.T. 1988.

Zohar, D. *The Quantum Self.* London: Flamingo, 1991

Zohar, D. and Marshall, Ian, *The Quantum Society*. London: Flamingo, 1994

Zohar, D. and Marshall, Ian, *Who's afraid of Schrödinger's cat*? London: Bloomsbury, 1997.

SECONDARY SOURCES: JOURNALS

Abramovitch, H. and Schwartz, E. "Three stages of medical dialogue" *Theor Med* 17 (1996) 175-187

Anfossi, M., Numinico, G. "Empathy in the doctor-patient relationship," *Journal of Clinical Oncology*, 22 (2004), 2258-2259.

Angeletti, L.R. "The dream in the medicine of Asklepieia," *Med Secoli.* 4 (1992)71-82.

Astrow, A.B. Puchalski, C.M., Sulmacy, D.P. "Religion, spirituality and healthcare: social, ethical, and practical considerations". *Am J Med* 110 (2001) 283-287.

Astrow, A.B., Sulmacy, D. P. "Spirituality and the patient-physician relationship" Student *JAMA*, June 16, 2004.

Baldacchino, D. Draper, P., "Spiritual coping strategies: a review of the nursing literature" *J Adv Nurs.*34 (2001) 833-841.

Balint, J. and Shelton, W., "Regaining the initiative, forging a new model of the patient-physician relationship." *JAMA* , 275 (1996), 887-891.

Bazzo, D.J. and Moeller, R.A. "Imagine this! Infinite uses of guided imagery in women's health, *J Holist Nurs.* 17 (1999) 317-330.

Bensing, Jozein " Bridging the gap. The separate worlds of evidence based medicine and Patient-centred medicine." *Patient Education Counseling* 39 (2000)17-25.

Benzein, E., Norberg, A., Saveman, B.I. "The meaning of the lived experience of hope in patients with cancer in palliative home care." *Palliative Medicine*, 15 (2001) 117-126

Berger, Kari "The truth in story." An interview with Merna Hecht, in *The Ecology of Media* 23(1989) 58.

Beveridge, Allan "Time to abandon the subjective-objective divide?" *Psychiatric Bulletin* 26 (2002), 101-103.

Biglan, K. M. and. Holloway, R.G "Surrogate endpoints in Parkinson's disease research," *Curr Neurol Neurosci Rep*, 3 (2003), 314-320.

Block, K.I. Block, P., Gyllenhaal, C., " The role of optimal healing environments in patients undergoing cancer treatment: clinical research protocal guidelines." *J Altern Complement Med,* 10 Suppl 1 (2004) S157-S170.

Bollwinkel, E.M. "Role of spirituality in hospice care," *Ann Acad Med Singapore*, 23 (1994), 261-263.

Borkan, J. M and Clerkin D.C. "An agenda for primary care research on low-back pain". *Spine*, 15 (1996), 2880-2884

Borkan, J. M and Clerkin D.C. "A report from the Second International Forum for Primary Care Research on Low-back Pain, re-examining priorities." *Spine*, 23 (1998), 1992-1996.

Breen, J. "Transitions in the concept of chronic pain." *Adv Nurs Sci*, 24 (2002), 48-59.

Breitbart, W., Rosenfeld, B., Pessin, H., Kaim, M., Funesti-Esch, J., Galietta, M. ,Nelson, C.J. and. Brescia R. "Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer," *JAMA*, 284 (2000), 2907-2911.

_________ "Spirituality and meaning in supportive care: spirituality and meaning centered group psychotherapy interventions in advanced cancer." *Support Care Cancer* 10 (2002) 272-280

Brett, A.S. "Inappropriate treatment near the end of life: conflict between religious convictions and clinical judgment," *Arch Intern Med*, 163 (2003), 1645-1649

Burch, G.E. "Developments in clinical electrocardiography since Eindhoven." *American Heart Journal,* 61 (1961), 324.

Burns, S. "The spirituality of dying. Pastoral care's holistic approach is crucial in hospice." *Health Prog*ress 72 (1991), 48-52

Burton, R. Spiritual pain: a brief overview and an initial response within the Christian tradition. *J Pastoral Care Counsel* 57 (2003) 437-446.

Byock, Ira R. "The nature of suffering and the nature of opportunity at the end of life,"*Clinics in Geriatric Medicine*, 12 (1996) 237-252.

Callahan, D. "Restoring the proper goals of the healing arts." *Chronicle of Higher Education*, 25 (1997) A52.

Cameron Muir, J. and Arnold, Robert M. "Palliative care and the hospitalist: an opportunity for cross fertilization," *The American Journal of Medicine* 111 (2001)10-14.

Carson, M.G.and Mitchell, G..J. "The experience of living with persistent pain." *J Adv Nurs Sci* 28 (1998), 1242-1248.

Chandler, E. Spirituality, *Hosp J.* 14 (1999) 63-74.

Charon, R. "The patient-physician relationship. Narrative medicine: a model for empathy, reflection, profession and trust" *JAMA*, 286 (2001), 1897-1902

Clarke, D. "Total pain, disciplinary power and the body in the work of Cicely Saunders," 1958-1967," *Soc Sci Med.* 49 (1999), 727-736

________ Between hope and acceptance, the medicalisation of dying," 324 (2002), 905-907

Cohn, F. "Existential medicine: Martin Buber and physician-patient relationships." *J Contin Educ Prof.* 21 (2001), 170-181

Cowan, J. D. and Palmer, T. W. "Practical guide to palliative sedation," *Curr Oncol Rep.* 4 (2002) 242-249.

Cowling 3rd, W.R. "Healing as appreciating wholeness." *ANS Adv Nurs Sci* . 22 (2000) 16-32.

Culliford, Larry "Spirituality and clinical care," *BMJ*, 325 (2002), 1434-1435

Cunningham, A.J., Edmonds, C.V." Group psychological therapy for cancer patients: a point of view, and discussion of the hierarchy of options." *Int J PsychiatryMed* 26 (1996) 51-82.

Cressy, R.W. Winbolt-Lewis, M., " The forgotton heart of care: a model of spiritual care in the NHS," *Accident & Emergency Nursing,* 8 (2000) 170-177

Curlin, F.A., Roach, C.J., Gorawara, B.R., Lantos, J.D., Chin, M.H., "When patients choose faith over medicine: physician perspectives on religiously related conflict in the medical encounter," *Arch Intern Med,* 165 (2003) 88-91.

De Marco, David, "Medicine and spirituality." *Ann Intern Med,* 133 (2000) 920-921.

Dickenson, G. E. and Field. D. " Teaching end-of -life issues : current trends in the United Kingdom and United States medical school." *Am J of Hospice and Palliative Care* 19 (2002) 181-186.

Donnelly, W.J. "Taking suffering seriously: a new role for the medical case history." *Acad Med* 71(1996) 730-737.

Donovan G. K. "Decisions at the end of life" *Catholic Tradition* 3 (1997), 188-203.

Draper, P. Mc Sherry, W. "A critical view of spirituality and spiritual assessment." *J Adv Nurse*, 39 (2002) 1-2.

Du Bois, J.M. and Burkemper, J. Ethics education in U.S. medical schools: a study of syllabi, *Academic Medicine* 77 (2002), 432-437.

Durkin, M.B."Pain and suffering: a spiritual dimension and holistic healing" *Health Progress* 73 (1992) 48-53, 70

Dyson, J., Cobb, M., Forman, D. "The meaning of spirituality; a literature review," *J Adv Nurs*, 26 (1997) 1183-1188.

Edelstein, Ludwig "Greek medicine in its relation to religion and medicine". In *Ancient Medicine*, (Baltimore: John Hopkins University Press, 1967) 225-246.

Efficace, F. and Marrone R. "Spiritual issues and quality of life assessment in cancer care." *Death Stud.* 26 (2002) 743-756

Eisenberg, D.M,. Davis, R.B., Ettner, S.L., Appel, S., Wilkey, S., Van Rompay M. and
Kessler, R.C. "Trends in alternative medicine use in the U.S., 1990-1997: results of a follow-up national survey." *J Am Med Soc* 280 (1998), 1575-1669.

Eisenberg, S.A., Lehrer, P.M., Hochron, S. "The effects of suggestion and emotional arousal on pulmonary function in asthma: a review and a hypothesis regarding vagal mediation." *Psychosom Med* 54 (1992) 192-216.

Eisenberg, L. "Is psychiatry more mindful or brainier than it was a decade ago?" *British Journal of Psychiatry*,176 (2000), 1-5.

Ellen L. Idler, Ellen L." Religion, health, and non-physical senses of self." *Social Forces*, 74 (1995) 683-704

Eller, L. S. "Guided Imagery interventions for symptom management," *Annu Rev Nurs Res*. 17 (1999) 57-84.

Eller, U. and Dannappel, T. "Concept of interdisciplinary pain therapy" *Ther Umsch* 56 (1999), 446-449

Elliott, H. "Imagework as a means for healing and personal transformation." *Complement Ther Nurs Midwifery*, 9 (2003) 118-124

Engel, G.L. "The need for a new medical model: a challenge for biomedicine. *Science 196* (1977) 129-135.

Evans, A.S. "Causation and disease: effect of technology on postulates of causation". *The Yale Journal of Biology and Medicine,* 64 (1991), 513-528

Evans, R.G. "Patient centred medicine: reason, emotion, and human spirit. Some philosophical reflections on being with patients." *J Med Ethics: Medical humanities*, 29 (2003), 8-15

Evens, M. and Greaves, D. "Exploring the medical humanities," *British Medical Journal*, 319 (1999), 1216.

Everson, S.A., Kaplan, G.A., Goldberg, D.E., Salenon, R., Jukka, T."Hopelessness and a four year progression of carotid atherosclerosis: the Kupuio ischemic heart disease risk factor study." *Arteriorscler Thromb Biol* 17 (1997) 1490-1495.

Fabrega, H. "Scientific usefulness of illness." *Perspectives in Biology and Medicine*, 22 (1990), 557

Geffen, J.R. "Creating optimal healing environments for patients with cancer and their families: insights, challenges, and lessons learned from a decade of experience." *J Altern Complement Med* 10 Suppl 1 (2004) S93-S102

Glymour, C.and Stalker, D. "Engineers, cranks, physicians, magicians," *New England Journal of Medicine* 308 (1983), 960-964

Graber, D.R. and Johnson.J.A. "Spirituality and healthcare organizations." *Journal of Healthcare Management / American College of Healthcare Executives* 2001; 46: 39-50, discussion 50-52.

Greenstreet W. "The concept of total pain: a focused patient study," *Br J Nurs.* 10 (2001), 1248-1255

Gureje, O., Von Koriff, M., Simon G. and Gater, R. "Persistent pain and well being. A World Health Organisation study in primary care." *JAMA* 280 (1998), 147-151

Guzman, J Esmail, R., Malmivaara, K., Ervin, E. and Bombardier. C. "Multidisciplinary rehabilitation for chronic low-back pain: systematic review". *BMJ,* 322 (2001), 1511-1516.

Halsted, M.T. and Hull, M. "Struggling with paradoxes: the process of spiritual development in women with cancer," *Oncol Nurs Form*, 28 (2001),1534-1544

Hatch, R.L., Burg, M.A., Naberhaus, D.S., Helmish, L.K."The spiritual involvement and 46(1998) 476-486.

Hermann, C. P. "Spiritual needs of dying patients: a qualitative study." *Oncol Nurse Forum* 28 (2001) 67-72.

Hill, T.P. "Treating the dying patient: the challenge for medical education," *Arch Intern Med.* 155 (1995) 1265-1269

Hofmann, Bjorn "The technological invention of disease." *Journal of Medical Ethics, Medical Humanities,* 27 (2001), 10-19

Hunt Jr., A.D. "Educating doctors: crises in medical education, research and practice." International Association for the Study of Pain (Taxonomy), "Pain terms: a list with definitions and notes on usage." *Pain* 8 (1980) 249-252

Jackson, S.W. "Catharsis and abreaction in the history of psychological healing." *Psychiatr Clin North Am.* 17 (1994) 471-491.

_________ "The imagination and psychological healing," *J Hist Behav Sci.* 26 (1990) 345-358

__________ "The wounded healer,"*Bull Hist Med.* 75 (2001) 1-36

Jamshidi, R. Hamid and Cook, David A. "Some thoughts on medical education in the 21st century". *Medical Teacher* 25 (2003) 229-238, *JAMA* 277 (1997) 1815

Jordan, J.V. "The role of mutual empathy in relational/cultural therapy". *J Clin Psychol* 56 (2000) 1005-1016

S Kaasa, Materstvedt., L.J. Tidsskrift, Hope, *for Den Norske Laegeforening*, 119 (1999)1313-1315

Kearney, Michael "Hospice Medicine, in Changing Health Care." eds. A. Cribb and D. Seedhouse, John & Sons. (1989).

Kearney, Michael "Spiritual Pain," *The Way*, 30, (1990) 47-54.

______________ "Palliative Medicine, Just another specialty," *Palliative Medicine*, 6 (1992) 39-46.

______________ "Image-work in a Case of Intractable Pain" *Palliative Medicine*, 6 (1992) 152-157.

Kiecolt-Glaser, J.K. Glaser,R. " Psychoneuroimmunology: can psychological interventions modulate immunity"? *J Consult Clin Psychol* 60 (1992) 569-575

Kinast, R.L. "Theological reflection enhances pastoral care skills". *Hospital Progress 1984*; 65: 44-45

King, M. Speck, P., Thomas, Angela " Spiritual and religious beliefs in acute illness, is this a feasible area to study?" *Social Science and Medicine*, 38 (1994) 631-636

Kliewer, Stephen, " Allowing spirituality into the healing process." *The Journal of Family Practice,* 53 (2004) 616-624.

Koening, Harold G. "Religion, spirituality, and medicine: application to clinical practice," *JAMA*, 284 (2000), 1708.

Koenig, H.G., "Taking a spiritual history" *JAMA* 291 (2004) 2881.

Koenig, H.G. George, Linda K., Titus, Patricia "Religion, spirituality, and health in medically ill older patients." *J Am Geriatr Soc* 52 (2004) 554-562.

Koenig, H.G., "Spirituality, wellness, and quality of life" *Sexuality, Reproduction, and Menopause*, 2 (2004) 76-82.

Leeder, S.R. and Rychetnik, L. "Ethics and evidence-based medicine." *Med J Aust* 175 (2001) 161-164.

Leather Barrow, Martin, "Limits to medicine: medical nemesis," *BMJ*, 324 (2002) 923.

Lin, Hung-Ru and Bauer-Wu Susan M. "Psychospiritual well being in patients with advanced cancer, an integrative review of the literature" *J Adv Nurs* 44 (2003) 69-80.

McClain, Colleen S., Rosenfeld, Barry, Breitbart, William "Effect of spiritual well being on end-of-life care," *The Lancet* 361 (2003) 1603-1607

Marshall, D.A., "Optimal healing environments for chronic cardiovascular disease." *J Altern Complement* Med, 10 Suppl 1 (2004) S147-S155.

McClain, Colleen S. Rosenfeld, Barry and Breitbart, William "Effect of spiritual well-
being on end-of-life despair in terminally-ill cancer patients," *The Lancet*, 361 (2003), 1603-1607

McGrath, P. "Spiritual pain: a comparison of findings from survivors and hospice patients," *Am J Hosp Palliat Care*, 20 (2003), 23-33.

Marinozzi, S. "From Asklepieia to monasteries: the places of medical art in antiquity". *Med Secoli.* 14 (2002) 21-37

Marketos, S. G. "The parallels between Asclepian and Hippocratic medicine on the island of Kos." *Am J Nephrol.* 17 (1997) 208-208

Marketos, S. G. and Skiadas, P.K. "The modern hippocratic tradition. Some messages for contemporary medicine." *Spine* 24 (1999) 1159-1163

McClain, C. S., Rosenfeld, B., Breitbart, W. "Effect of spiritual well being on end-of-life care," *The Lancet* 361 (2003) 1603-1607

Mc Ewen, B.S., "Protective and damaging effects of stress mediators," *New Engl J Med* 338 (1998) 171-179

Miller, T., "The use of guided imagery in perioperative nursing," *Semin Perioper Nurs.* 7 (1998) 108-113.

Miller, William R. "Researching the spiritual dimensions of alcohol and other drug problems," *Addiction* 93 (1998), 979-990

Morris B.B. "How to speak post-modern: medicine, illness and cultural change," *Hastings Cent Rep* 30 (2000) 7-16.

Mount, B. and Kearney M. "Healing and palliative care: charting our way forward". Editorial in *Palliative Medicine*, 17 (2003) 657-658.

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

Nagai-Jacobson, M.G. and Burkhardt M.A. "Viewing persons as stories: a perspective for holistic care." *Altern Ther Health Med.* 2 (1960) 54-58.

Narayanasamy, A., Ownes, J." A critical incident study of nurses responses to the spiritual needs of their patients, *J Adv Nurs* 33 (2001) 446-455

Narayanasamy, A., Clisset, P., Parumal, L.Thomson, Deborah, Annasamy, S. Edge, R."Responses to the spiritual needs of older people" *J Adv Nurs,* 48 (2004) 6-16

Narayanasamy, A., "A review of spirituality as applied to nursing" 36 (1999) 117-125.
O'Keeffe, Declan *Medicine Weekly*, October (2003) 18

O'Neill, B. Fallon, M. "ABC of palliative-care and pain control" *BMJ*, 35 (1997) 801-804.

Oldnall, A. "On the absence of spirituality in nursing theories and models." *J AdvNurse* 21 (1995) 417-418.

Orr, R.D and Genesen, L.B. "Requests for inappropriate treatment based on religious beliefs," *J Med Ethics*, 23 (2001), 142-144

Papathanassoglou, Elizabeth D. E. and Patiraki, Elizabeth I. "Transformations of self: a phenomenonological investigation into the lived experience of survivors of critical illness," *Nursing in Critical Care*, 8 (2003) 13

Pardini, D.A.. Plante, T.G. Sherman A and Stump, J.E. "Religious faith and spirituality in substance abuse recovery: determining the mental health benefits". *J. Subst Abuse Treat,* 19 (2000), 347-354.

Pargament, K.I., Koenig, H.G., Tarakeshwar N. et al., "Religious struggle as a predictor of mortality among medically ill elderly patients: a two year longtitudinal study," *Arch Intern Med* 161 (2001) 1881-1885.

Koenig H.G., Tarakeshwar, N., Hahn, J.. Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients. *J Health Psychol* 9 (2004) 713-730.

Poat, Stephen G, Puchalski, Christina M.and. Larson, David B. "Physicians and patients spirituality: professional boundaries, competency, and Ethics". *Annals of Internal Medicine*, 132 (2000), 578-583

Pope John Paul II "Humanize Hospital Work" Address to the Sixty First Chapter of the Hospital Order of St. John of God, *L'Osservatore Romano* 16, No. 768, Jan. 24, (1983) 3

Post, Stephan G., Puchalski, Christina M., Larson, David B, "Physicians and patients spirituality: professional boundaries, competency, and Ethics". *Ann Inter Med,* 132 (2000), 578-583.

Powell, L.H., Shababi, L., Thorenson, C.E., "Religion and spirituality. Linkages tophysical health." *Am Psychol* 58 (2003) 36-52.

Pulchalski, Christina. M. and Larson. D. B. "Developing curricula in spirituality and medicine," *Academic Medicine* 73 (1998) 970-974.

Puchalski, Christina M. "Touching the Spirit: the Essence of Healing". *Spiritual Life* 45, (1999) 154-159

__________ "The Critical Need for Spirituality in Our Healthcare System" *Religion and Healing,* 14 (2001) 9

__________"Spirituality and Health: the Art of Compassionate Medicine," *Hospital Physician,* March (2001) 30-36.

__________"Spirituality in health: the role of spirituality in critical care." *Crit Care Clinic* 20 (2001) 487-504.

Raholm, M.B. and Lindholm, L. "Being in the world of the suffering patient: a challenge to nursing ethics." *Nurse Ethics* 6 (1999) 528-539.

Raholm, M.B. "Weaving the fabric of spirituality as experienced by patients who have undergone a coronary bypass surgery." *J Holist Nurse* 20 (2002) 31-47.

Ranson, David "A Spirituality of Healing and the New CHA Code of Ethical Standards", *The Australasian Catholic Record*, 72-73.

Reese, D.J and Brown. D.R. "Psychosocial and spiritual care in hospice: differences between nursing, social work, and clergy." *The Hospice Journal* 1997; 12: 29-41

Reilly, D.T., " Young doctors' views on alternative medicine. *BMJ* 287 (1983) 337-339.

Reilly, D.T., Taylor, M.A. "Review of the postgraduate education experiment, developing integrated medicine: report of the RCCM research fellowship in complementary medicine, "*Complement Ther Med* 1 (Supl1)1993, 29-31.

Reilly, David "Enhancing human healing: directly studying human healing could help to create a unifying focus in medicine." *BMJ* 322 (2001) 120-121

Roche, J. "The story: a primary spiritual tool: stories can be a healing power in the dying process." *Health Prog* 75 (1994) 60-63

Roser. W.W. "The decline and family practice as a career choice." *Canadian Medical Association Journal* 166 (2002) 1419-1420.

Ross, Linda, " The spiritual dimension: it's importance to patients' health, well-being and quality of life, and its implications for nursing practice." *Int J Nurse Stud,* 32 (1995) 457-468.

Rotor, D. " The enduring and evolving nature of the patient-physician relationship" *Patient Education Counselling* 39 (2002), 5-15

Rousseau, P. "Hospice and palliative care," *Dis Mon.*, 41 (1995), 769-844

Roter, D."The enduring and evolving nature of the patient-physician relationship" *Patient Educ Couns* 39 (2000) 5-15

Sackett, David L., "Evidence-based medicine, what it is, and what it is'nt." *BMJ*, 312 (1996) 71-72.

Sakalys, J.A. "Restoring the patient's voice, the therapeutics of illness narratives." *J Holist Nurs.* 21 (2003) 228-241

Scheurich, Neil, " Reconsidering spirituality and medicine." *Academic Medicine*, 7 (2003) 356-360.

Shannon, S.E. Tatum, P., " Spirituality and end-of-life care." *Mo Med,* 99 (2002) 571-576.

Smucher, C.J. "Nursing, healing and spirituality." *Complement Ther Nurs, Midrifery*, 4 (1998) 95-97

Rousseau, P. "The ethical validity and clinical experience of palliative sedation," *Mayo Clin Proc.* 75 (2000) 1064-1069.

Satterly, L. "Guilt, shame, and religious and spiritual pain." *Holist Nurs Pract.* 15 (2001) 30-39

Saunders, Cicely "Dying with cancer," *St. Thomas Hospital Gazette*, 56 (1958) 37-47

____________ "Care of the dying 3. Control of pain in terminal cancer" *Nursing Times*, Oct. 23 (1959b), 1031-1032

___________ "Care of the dying 4, Mental distress in the dying," *Nursing Times*, Oct. 30 (1959c), 1067-1069.

_______ "Uncertainty and fear", *District Nursing*, Dec. 1962b, (2002)

_______ "Uncertainty and fear,"Proc. Conference on "Long term illness and its implications"*Queen's Institute of District Nursing*, London (1962),7-9.

_______ "The treatment of intractable pain in terminal cancer, *Proceedings of the Royal Society of Medicine* 56 (1963), 195-197

_______ "The care of the terminal stages of cancer," *Annals of the Royal College of Surgeons* 41, Suppl. (1967), 162-169.

_______ "I was sick and you visited me," typescript of a talk given at *St. Mary's Hospital, London,* May 30, 1961; Cicely Saunder archive, St.Christopher's Hospice, Sydenham.

Saunders, John "The practice of clinical medicine as an art and a science," *Journal of Medical Ethics*, 26 (2000), 18-22

Shanner, Laura "Alternative knowledge's, alternative healing: What justifies the label standard?" *Health Ethics Today*, 11(2000) 1-1

Shannon, S.E. Tatum, P., "Spirituality and end-of-life care." *Mo Med,* 99 (2002) 571-576.

Sheldon, Mike "Whole Person Medicine," *Nucleu*s, (2004)18-25.

Siegel, E.W. "Perceived barriers to social support from family and friends among older adults with HIV/AIDS." *J Health Psychol*, 8 (2003), 738-752.

Sloan, R.P., " Religion, spirituality, and medicine," *Lancet*, 353 (1999) 664-667.

Sloman, R., Brown, P. Aldana, E. Chee, E."The use of relaxation for the promotion of comfort and pain relief in persons with advanced cancer." *Contemp Nurse* 3 (1994) 6-12.

Smucher, C.J., "Nursing, healing and spirituality." *Complement Ther Nurs Midrifery,* 4 (1998) 95-97

Staats, Peter S. "Pain management and beyond: evolving concepts and treatments involving cyclooxygenase inhibition."*J Pain & Symptom Management*, 24 (2002), S4-S9

Stempsey W.E. "End-of-life decisions: Christian perspectives." *Christ Bioeth*, 3 (1997), 249-261

Strandmark, Margaretha "Ill health is powerlessness, limitations and suffering," *Scand J Caring Sci* 18 (2004), 135-144.

Strang, Peter, Strang, Susan, Hultborn, Ragnar and Arner, Staffan "Existential pain, an entity, a provocation, or a challenge?" *J Pain and Symptom Manage.* 27 (2004) 241-250.

Stuckey, Cheryl L., Gold, M.S. and Zang Xu "Mechanisms of pain." *Proceedings of the National Academy of Sciences 98* (2001), 11845-11846.

Sulmacy, D. P. " Is medicine a spiritual practice"? *Acad Med* 74 (1999) 1002-1005.

___________ "A bio-psychosocial-spiritual model for the care of patients at the end of life." *The Gerontologist*, 42 (2002), 24-33

Swinton, John, "Spirituality and Mental Health Care: Rediscovering a "forgotten" dimension. Psychiatric Bulletin 26 (2002) 118-118

Tayler, E. Amenta, M., Highfield. M." Spiritual care practices of oncology nurses."*Oncology Nursing Forum*, 22 (1995) 31-39.

Thorenson, C.E., Harris, A.H., "Spirituality and health: what's the evidence and what's needed?" *Ann Behav Med,* 24 (2002) 3-13

Thorpe, K. Barsky, J. "Healing through self-reflection." *J Adv Nurs.* 35(2001) 760-768.

Titus, Patricia "Religion, spirituality and health in medically ill older patients," *J Am Geriatr So*52 (2004) 554-562.

Tonelli, M.R."The limits of evidence based medicine." *Respir Care*, 46 (2001)1440-1440.

Toombs, S.K. "The temporality of illness: four levels of experience." *Theoretical Medicine*, 3 (1990), 227-241

Turkoski, B. and Lance, B. "The use of guided imagery with anticipatory grief. *Home Healthc Nurse*, 14 (1996) 878-888.

Tusek , D.L. and Cwynar, R.E. "Strategies for implementing a guided imagery program to enhance patient experience," *AACN Clin Issues*, 11 (2000) 68-76

Twycross, R.G. "The challenge of palliative care," *Int J Clin Oncol.* 7 (2002), 271-8
von Gunten, C.F., Ferris, F.D.,.Emanuel, L.L "The patient-physician relationship. Ensuring competency in end-of-life care communication and relational skills," *J.A.M.A.*, 285 (2000) 3051-3057

Ventegodt, S., Anderson, N.J., Merrick, J." Principles of existential holistic therapy and the holistic process of healing." *Science World Journal* 3 (2003) 1388-4000.

__________. Anderson N. J., Merrick, J. " Holistic medicine: scientific challenges." *Scientific World Journal,* 13 (2003) 1108-1116.

Wallace, K.G., Reed, B., Pasero, C., Olsen G.L. "Staff nurses perceptions of barriers to effective pain management," *J Pain Sympton Management* 10 (1995) 204-213.

Wanzer, S.H., Federrman, D.D., Cranford, R.E. et al. "The Physician's responsibility toward hopelessly ill patients: a second look," *N Eng J Med.* 320 (1989) 844-849.

Wendler, M.C., "Understanding healing: a conceptual analysis" *J AdV Nurs*, 24 (1996)846-842.

Wiebe, S. "The principles of evidence-based medicine" *Cephalalgia.* 20, Suppl. 2 (2000) 10-13.

Wein, S. "Sedation in the imminently dying patient," *Oncology* 14 (2000) 592, 597-8.

Welman, M. and Faber P.A. "The dream in terminal illness: a Jungian formulation," *J Anal Psychol* 37 (1992) 61-81

Wenrich, Marjory D., Curtis ,J., Randall,. Ambrozy, Donna,, Caraline, Jan D,. Shannon Sarah E. and. Ramsey, Paul G. "Dying patients need for emotional support and personalized care. Perspectives of patients with terminal illness, Families, and health care providers." *J Pain and Symptom Management*, 25 (2003), 236-246.

Whiteneck, M.R. "Rite of Anointing of the Sick. Scripture readings illuminate meaning of suffering." *Hospital Progress* 65 (1984) 40-43.

Whittle, M. "Ultrasonographic soft markers of fetal ultrasound: Detecting them may do more harm than good." *BMJ,* 314 (1997), 918-919

Williams, Allison, "Therapeutic landscapes in holistic medicine," *Soc Sci Med*, 46(1998) 1193-1203.

Zaner, R.M. "Medicine and dialogue" *J Med Philos* 15 (1990) 303-325.

Zerwekh, J. "Transcending life: the practice wisdom of nursing hospice experts." *Am J Hosp Palliat Care*, 10 (1993), 26-31

OTHER SOURCES: ELECTRONIC

Aesculapius, http://www.in-ta.net/info/aesculapius/ Retrieved 24/03/04

Blatner, A. "Re-story-ing the soul: transformational power of the healing arts," http://www.blatner.com/adam/level2/restorsoul.htm. Retrieved 02/11/04

Brody, H. "Philosophic Approaches," in: Miller & Crabtree, eds. *Using Qualitative Methods*: http://www.phen.ab.ca/materials/het/het 11-03a.html retrieved on 23-10-2003.

Craig, E. ed. *Routledge Encyclopedia*, Martin Buber (1878-1965) (London: Routledge, 1998) Ethics / Biology Link. Retrieved 23-10-2003 http://www.coc.cc.ca.us/departments/Philosophy/ermmlimitsofSCI.html.

Marchant, Jean "Ministering to persons who are dying". Retrieved 04-07-03 http://www.rcab.org/healthcare/notesministering%2to%20dying.htm

National Institute of Neurological Disorders and Stroke (NINDS) in the United States.

"Pain-hope through research." Retrieved 12-07-03
http://www.ninds.nih.gov/health-and-medical/pubs/pain.htm

Pain Alleviation and "Anaesthesia" 19th century and earlier. Retrieved 12-07-03.
http://www.library.ucla.edu/libraries/biomed/his/painexhibit/panel1.htm$hoffman

"Pain and the dying: the Hospice Movement and the work of Cicely Saunders."
http://www.library.ucla.edu/libraries/biomed/his/painexhibit/panel19.htm

Pope John Paul ll's Apostolic Letter "Salvifici Doloris" retrieved 08-12-99
http://listserve.american.edu/catholic/church/papal/jp.ii/salvific.doloris

The Irish Times "Storytelling as Ministry" http://www.allleseeds.org/Art_min.htm
Retrieved 02/11/04

OTHER VATICAN DOCUMENTS CONSULTED

John Paul II, *Vita consecrata*, Post-Synodal Apostolic Exortation, given in Rome at St. Peter's, 1996

John Paul II, *Offering your suffering to God.* Meeting with the sick and suffering, at the Shrine of St. Lazarus, El Rincon, Cuba, 1998.

John Paul II, Message: "*Always remember that healing ultimately comes from the Most High.*" to the 23rd National Congress of the Italian Catholic Physicians Association, from the Vatican, 2004

Congregation for the Doctrine of the Faith, Instruction on: Respect for human life in its origin and on the dignity of procreation, replies to certain questions of the day, Donum vitae (1987)

Pontifical Council for Pastoral Assistance to Healthcare Workers, (1994)

Pontifical Council for Health Pastoral Care on the subject, *Health Care and Society*, (2000)

Pontifical Academy for Life, *Ethics of Biomedical Research for a Christian Vision*, (2003)

Other

Catholic Health Association, Task Force on Pain Management, "Pain management. Theological and ethical principles governing the use of pain relief for dying patients." *Health Progress*, 74 (1993) 30-39, 65.

Catholic Health Association, "Care of the dying: a Catholic perspective Part II: Social and political context, Catholic providers must exemplify a caring community."*Health Progress,* 74 (1993)16-21, 41.