Body and mind, like man and wife, do not always agree to die together.

Charles C. Colton (?1780-1832), Lacon

DEATH IS A mysterious and enigmatic milestone that is a natural and absolute progression of life. However, innumerable patients endure considerable anguish during the dying process, in part because many physicians neglect treatment of the various domains of suffering that preclude a peaceful, tranquil, and dignified death. And although physicians are increasingly cognizant of end-of-life issues, spiritual suffering is frequently ignored or dismissed. Such indolence to the spiritual dimension can be arguably traced to Rene Descartes, who proposed the separation of mind and body, allowing science to escape the domination of the clergy by assigning the noncorporeal, spiritual realm to the church and the physical world to science. Lamentably, Descartes’ model advanced the fallacy that the suffering and treatment of disease are separate from the person experiencing the suffering. Such ideology devalued the importance of personhood, promoted an overreliance on diagnostic procedures and interventions, validated only physical pain as factual, and discouraged empathic communication. Fortunately, new sociobiologic models emerged in the 1960s, followed by the introduction of a biopsychosocial model by George Engel in 1977. The paradigm from these models assert that psychologic and social factors, in addition to biologic factors, are involved in the disease process, and that the sick and infirm are ill in all domains simultaneously. Engel’s archetype has helped abate the reductionism of Descartes’ biomedical model and emphasized that illness is a biopsychosocial phenomenon that involves the whole person. Nevertheless, ignorance of spiritual issues persists in contemporary Western medicine, although spirituality is gradually achieving recognition by the mainstream medical establishment.

Although spirituality is frequently confused with religion, they are two distinct but complementary entities. Spirituality is concerned with universal issues of purpose and meaning of life and is the part of the human essence that strives for transcendental values. Spirituality is characterized by the capacity to seek purpose and meaning, to have faith, to love and forgive, to worship, and to see beyond present circumstances, and enables a person to rise above or transcend suffering. Transcendence is integral to the struggle to extend the self beyond the common confines of life experiences and achieve new perspectives on human existence, and this assumes greater subjective importance as one nears the end of life. Spiritual issues commonly contemplated by dying patients include the following: Why do people live? Does life have meaning? Are people a part of something larger than themselves? Is there a higher power such as God? Why do people suffer? Why do people die? Does death have any meaning? Why is this happening to me?

In comparison, religion encompasses structured belief systems that address spiritual issues, often with a code of ethical behavior and a philosophy. Central to most religious congregations is the belief in a God or supreme being with reverence for and a desire to please that God. Religions can provide foundations for making sense of existence, and through rituals, creedal beliefs, participative community, and ceremonies, provide mechanisms for expressing spirituality. Unfortunately, religious ideologies may also evoke spiritual anguish and fear, particularly when pious doctrines promise eternal damnation for explicit behaviors and beliefs.

CLINICAL EVALUATION

Clinically, spiritual suffering is complex and nebulous and often difficult to assess. Moreover, physicians rarely inquire about spiritual concerns, although a few patients may directly solicit help with spiritual issues. Spiritual suffering often manifests as physical or psychologic problems and shares many features with depression, including feelings of hopelessness and worthlessness as well as a sense of meaninglessness. Spiritual suffering may also exacerbate, and be exacerbated by, psychosocial distur-
bances and other physical symptoms such as pain, confounding diagnostic and therapeutic strategies. Spiritual suffering should be suspected when the patient’s physical symptoms are puzzling and inexplicable and do not respond to effective and aggressive interventions, emotional responses are out of proportion to the loss, and therapeutic compliance is variable. However, the most effective approach to diagnosing spiritual anguish is to establish rapport and a caring relationship with patients and then to ask about death-related concerns and beliefs. Although patients vary in their desire to pursue spiritual or existential concerns, most are amenable to discussing spiritual issues with a physician who exhibits interest and empathy, communicates well, displays nonjudgmental respect for the patient’s beliefs, and takes time to listen. Consequently, physicians must be able to formulate spiritual questions, and acknowledge that examining spiritual issues may promote healing, even when no answers are proffered. For physicians attuned to clinical guidance, Puchalski offers an acronym that can be utilized to assist in obtaining a spiritual history: FICA. The letter F incorporates faith or beliefs, I importance and influence, C community, and A address (Table 1). However, if physicians are uncomfortable or apprehensive discussing spiritual issues, or constrained by time or productivity commitments in a parsimonious health care environment, they can devise a self-completed patient questionnaire based on Puchalski’s acronym and seek assistance from nursing, allied health professionals, and the clergy. In fact, a multidisciplinary approach is frequently necessary to adequately address spiritual concerns in an empathetic and efficacious manner.

### Table 1. Spiritual History

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<td>I</td>
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<td>Community</td>
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- **F**
  - What is your faith or belief?
  - Do you consider yourself spiritual or religious?
  - What things do you believe in that give meaning to life?

- **I**
  - Is it important to your life?
  - What influence does it have on how you take care of yourself?
  - How have your beliefs influenced your behavior during this illness?

- **C**
  - Are you part of a spiritual or religious community?
  - Is this of support to you, and how?
  - Is there a person or group of people whom you really love or who are really important to you?

- **A**
  - How would you like me, your health care provider, to address these issues in health care?

**NOTE:** Adapted from Puchalski.

To support and assist in the treatment of spiritual suffering, physicians must respect the diverse beliefs of patients, be willing to listen and discuss issues of spirituality, acknowledge and provide for the rituals and ceremonies of religious affiliations, and refer to appropriate health care professionals trained in spiritual health. In addition, physicians must be comfortable with spiritual concerns, demonstrate empathy, and have exemplary listening and communication skills. The latter is a critical skill and uses both verbal and nonverbal approaches; often, the most significant communication tool is silence, coupled with nonabandonment. Physicians must also discard rigid boundaries of medical care, engage in a search for meaning, and realize that they cannot always provide answers, and instead join the patient and family in the questions and mysteries that surround death.

Specific and concrete interventions useful in alleviating spiritual distress include controlling physical symptoms; providing a supportive presence; encouraging life review to assist in recognizing purpose, value, and meaning; exploring issues of guilt, remorse, forgiveness, and reconciliation; abetting and facilitating religious expression; reframing goals into short-term endeavors that can be accomplished; and encouraging use of meditation, guided imagery, music, reading, poetry, and art that focus on healing rather than cure. Storey and Knight have developed a concise and useful acronym to assist in spiritual therapy, and although rather simplistic, it is a readily recalled approach for physicians unfamiliar with spiritual concerns. The letters are LET GO, which represent Listening to the patient’s story, Encouraging the search for meaning, Telling of your concern and acknowledging the pain of loss, Generating hope whenever possible, and Owning your limitations. To this end, oncologists need to gain competence in palliative medicine and refer patients to chaplains, spiritual directors, and/or community resources, such as hospice, when appropriate.

With the approach of death, patients frequently begin an inward journey to consider the questions of human existence and the meanings of life and death. Consequently, physicians must consider the whole person when caring for terminally ill patients and acknowledge that the spiritual dimension is an integral component of the dying process. Every person who faces death desires that his or her life had purpose and meaning; therefore, physicians are obliged to provide support and assistance in addressing spiritual concerns, and in doing so, afford a peaceful death.
REFERENCES

Spirituality and the dying patient