Embracing the Paradox:

Spiritual Issues in General Practice

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Abstract

Human beings know they are born to die. Coming to terms with this paradox sends them on a lifelong spiritual journey. This research sets out to explore the way spirituality is understood and experienced by general practitioners in New Zealand both for themselves and as presented by patients.

Formal research was conducted over two years, but the roots of this thesis subsist in many years of General Practice in a number of different cultures. A pragmatic generic qualitative method was used. Semi-structured interviews were undertaken with general practitioners from a wide variety of practices and across a considerable range of experience. In addition a number of group sessions and workshops were also conducted on themes emerging from the interviews.

Findings that emerged from both interviews and groups showed the immense diversity of both understanding and experience of spirituality. Participants expressed an openness to spirituality along with a widespread rejection of religion. The dynamic and interrelated nature of the various aspects of spirituality connecting self, others, the natural world and the transcendent was also evident.

The thesis concludes with an exploration of the nature of spirituality in general practice. It looks at the way general practitioners seek to enable hope, meaning and healing, while bearing witness to suffering and death. It considers ways of sustaining and enabling spirituality. It suggests that there is a conflict of paradigms between a reductionist biomedical approach and care of the whole person. There is a vital difference between cure and healing. This finding raises important issues in terms of management and training of general practitioners.
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Chapter 1

Embracing the Paradox

I look behind and see one footprint on the threshold of a new beginning.

Introduction
Journey of this thesis

Three aspects of my own journey - an interest in whole person medicine, the interface between spirituality and health and the experience of working in many different cultures preceded this particular journey. A deep curiosity about how general practitioners understood and experienced spirituality and the realization that there was very little about their spiritual journeys in the medical literature made it an ideal topic for original research.

Journeys, by their very nature, require a move from the known to the unknown. For doctors, one of the difficulties of journeys is that they go from a controlled environment to an uncontrolled one, and biomedicine has trained doctors to believe that being in control of self, patients and diseases is of overriding importance. Their lived reality is quite different.

The first human paradox is coming to terms with mortality. It is this that causes humans from birth to engage in spiritual journeys seeking meaning, purpose, connection and the transcendent. Doctors are often unaware of the connections of patients as whole human beings, of all the factors that contribute to illness, and of their own inner life. While they are told that good doctoring is about knowing all the facts and being in control, the reality of life is that they do not know the facts and are not in control. That was the second paradox needing to be embraced.

Human beings are not simple. When I started this research I had no idea how complex and convoluted it would become. It has taken me from paleo-anthropology to cosmology, to the sages and saints of East and West, from neurophysiology to philosophy and from myths to mysticism.
I started with a definition of spirituality as a complex and multidimensional part of human experience with cognitive, experiential and behavioural aspects (Anandarajah, et al., 2001). It quickly became obvious that such a complicated phenomenon could not be captured in a simple definition. It was necessary to understand the context of spirituality in the unique human person, in the culture and place.

This thesis is therefore focused on how spirituality is understood and experienced by general practitioners in New Zealand for themselves and in their practices.

Section 1

The first section of this thesis consists of this introduction and overview of the thesis, Chapter 1, together with Chapters 2 and 3. These three chapters set the scene for the results of interviews in section two and the discussion and conclusions in section three.

Chapter 1 is the introduction and overview of the thesis.

Chapter 2 is the literature review. This begins with a consideration of spirituality in its physical, emotional and experiential aspects. First it looks at the embodied state of spirituality and its neuroscientific aspects. Next it explores the lived experience of spirituality as a quest and in relation to the transcendent.

This chapter goes on to explore world-views. Pre-modern, modernist and postmodern worlds coexist at this time, sometimes in the same person. Some traditional spiritualities persist, often side by side with cultures that have embraced the scientific understanding of the world to the exclusion of any other. The important connections between spirituality and religion and the essential differences between the two are discussed. The problem of language about spirituality in a secular society is considered.

It goes on to consider the relationship of health, sickness and spirituality in ancient health and medical practices in both Eastern and Western hemispheres. The ethical beliefs of both included an understanding of the spiritual and its importance in healing as an enabler of integration and growth. Healing was the focus of medicine until the emergence of biomedicine.
It looks at the emergence of biomedicine as the dominant medical paradigm and notes how it displaced spirituality from medicine, replacing it with psychology and psychoanalysis. The scientific biomedical paradigm had no tools to analyze spirituality, nor a wish to do so. It was simply ignored because it did not fit the reductive, scientific understanding of humanity.

An interest in spirituality in health began to resurface in the early 1970s, particularly in palliative and geriatric care. This interest strengthened over the following thirty years as the limits of biomedicine became clearer. The re-emergence followed a reverse pattern to its loss, for psychological medicine was one of the first disciplines to recognize its importance.

Spirituality also emerged, in management and public health, as an important factor in well functioning, supportive, communities. The literature on the spirituality of General Practitioners is discussed as is its increasing inclusion in the training of medical students.

Chapter 2 concludes with an understanding of spirituality as an underlying aspect of humanity, creating connection. This connection is both with the deepest aspect of the human self and with others, the natural world and the transcendent.

The process of growth and development in spirituality continues throughout life. The seeking of connection creates community, without which there is no human flourishing. The illustration below is used to try and enable an understanding of this dynamic process. The space within each leaflet and the space around them depicts the transcendent, showing the total inter-relationship of all these domains.

Figure 1: Growth and development of Spirituality
Chapter 3 looks at the aim and research design, method and methodology. The original research question was modified by the literature review, in which very little information on the spirituality of general practitioners (GPs) was found. The research was therefore focused primarily on the personal experience and understanding of spirituality by general practitioners.

The participants were all practicing general practitioners. They were sought from a wide variety of practices and their time of graduation ranged 1963 to 2004. An attempt was made to include members of the four main cultural groups in New Zealand, Maori, New Zealand European (sometimes called Pakeha), Pacific Island and Chinese.

The nature of the rather intimate material being sought confirmed the decision to use a qualitative method of analysis. The interviews varied from one hour to two and a half hours. The interview structure was modeled on a clinical interview, a daily tool for the participants. Some participants commented they ‘felt like a patient’ but most were quite comfortable with the interview. The way into the research question was a conversation with participants on their reason for choosing medicine and about their patients and families. Only after this were they asked about their own spirituality.

Due to the immense richness of the transcripts, the decision was made to analyse the transcripts manually. Data analysis was concurrent with the interviews. Constant comparative analysis was carried out in reiterative cycles. Further confirmation of the findings emerged from responses to papers and workshops on spirituality given to groups of general practitioners throughout the past three years.

Section 2

This section consists of the results from the twenty-two transcripts, analyzed in chapters 4, 5, 6, and 7.

Chapter 4 looks at participant spirituality. It explores their understanding of it and its relationship to their culture and religious beliefs. Spirituality is understood as a universal aspect of humanity with particular unique aspects for each person while religions are viewed as a way of ordering spirituality.
The results demonstrated the variety and complexity of spiritual beliefs and experiences. It also showed how New Zealand is a secular society, meaning that it is not religious. What became abundantly clear was that those who were not religious were indeed spiritual. This secular spirituality had links to childhood connections to religion for some and for others appeared to be an inherent human characteristic.

The many and varied aspects of the spiritual experiences of participants were then explored (Chapter 4:3). The majority (17) described one or more spiritual experience that could be classified as mystical and included two participants who thought they had never had a spiritual experience. The presence of positive and remembered emotions suggested they had indeed had spiritual experiences, but failed to recognize them.

Concluding this chapter is a discussion on the relationship and experience of spirituality and emotions. While there is a focus on the positive emotions by participants there is also mention of spiritual experiences accompanied by negative emotions. These seemed more difficult to recognize and accept.

**Chapter 5** continued the analysis of participant spiritual experiences in relation to others, the natural world and the transcendent. It looked at the values, meaning and purpose that medicine has in their lives, as a way of connecting deeply with their patients. It explored their reasons for choosing and staying in medicine. It considered memorable patients and revealed that these are linked to spiritual events around births, deaths and transitions. It also looked at memorable doctors.

The next part of the chapter reflects on spiritual experiences of participants in relation to illness and death in their own family. It then goes on to look at connections that formed community.

Experiences of deep connection with the natural world seemed to be common in New Zealand. This may simply reflect the beauty of the land although it has to be wondered whether Maori spirituality affects all who come to live here. Experiences of connection to the transcendent are then considered. Such experiences were common, but not usually mentioned spontaneously. They are a hidden dimension of general practice.
The chapter finished with a discussion of extraordinary human experiences. These include Extra Sensory Perception (ESP), déjá vu, clairvoyance and mystical awareness (Chapter 5:10). These were remarkably common. Even participants who did not think they had had a spiritual experience described them in others and indeed sometimes described them in themselves.

Chapters 4 and 5 show the interconnecting and resonating nature of spirituality within and between the individual, others, the natural world and the transcendent. They illustrate the way in which a spiritual experience in one domain of life often leads to connection with other domains.

**Chapter 6** looks at ways of sustaining spirituality in the context of the whole person including body, mind, spirit and community connections. It focuses on the ways participants think about and care for themselves as whole persons.

It starts with a discussion about self-awareness, coping with stress, and the need to find balance or harmony throughout life. What emerged here was the difference between men and women, even though both have been trained in the same way. This may reflect a difference in self-acceptance. Women allow themselves to be stressed and deal with it, while men tend to ‘tough it out’ and ignore the stress until it becomes overwhelming. Learning to set clear boundaries between work and time out was important. Once again the women tended to do this better, while the men complained of their practice expectations but seemed unable to get these modified.

In order to relax and combat stress the participants both took holidays and had passive activities like reading, listening to music or watching television. They also had a large number of creative activities that enabled them to relax. These too were very varied. They had in common that the products of creativity, whether artistic or practical were enabling of connection with others, suggesting that at one level they were spiritual activities.

Not unexpectedly, family and friends provide the major support for participants. The next most important support was supervision and mentoring, which were used by nine participants. Peer groups, meditation and personal psychotherapy were all found useful. Four mentioned religious groups as important to them.
Exercise figured largely as a means of de-stressing. Once again the exercise was often with others, and enabled human connection and community as well as connection with the natural world. Mountains and sea figured prominently in connections with the natural world and spiritual experiences.

The last part of this chapter deals with secular and religious rituals and prayer. Secular rituals were used to mark a boundary between work and home life. The religious rituals were used both for the participant’s wellbeing and for the wellbeing of others.

I found it extraordinary that so many of the participants prayed, given that only four of them were regularly involved in formal religious activities. They prayed for themselves and for patients, and some encouraged patients and even communities to pray for those who were ill. It would appear that prayer is a widespread human activity even if there is sometimes a lack of clarity about the focus of that prayer.

Chapter 7 outlines the education about spirituality that participants had received in their undergraduate and postgraduate careers. It is a short chapter because education about spirituality ranged from none to maybe twice for some participants. The one place they did seem to hear about spirituality was in the Maori health course.

Those who had experienced working cross culturally were made more aware of the importance of spirituality. The other places where it was mentioned were in obstetric training, General Practice Training Programme (GPTP), palliative care and in care of the elderly.

The last section of this chapter looks at suggestions from participants of ways of improving education and understanding of spirituality. There is general agreement that this would be useful and enable better care of patients and better self-care of doctors.

A number of participants suggested that it would be good for others to have the opportunity of discussing spirituality in a non-threatening environment. This would help them clarify their own understanding and enable them to develop resilience for dealing with the normal stresses of life and the particular stresses of being a general practitioner.
Section 3

This section deals with the discussion and suggestions for future action.

Chapter 8 is a discussion of the results. It is in five parts.

1) The Nature of Spirituality looks at the nature of spirituality in the light of participant understanding and the literature. It concludes that spirituality is universal, even for those who seem unaware of their own spirituality, develops over life and connects participants to their own depths, to others, the natural world and the transcendent however that is perceived.

2) The Heart of the Matter considers the way in which connections, disconnection and transitions from birth to death reveal spirituality and send patients and participants on spiritual journeys. It goes on to reflect on the conflicts of paradigms both in world-views and in the practice and management of medicine.

The hegemony of the biomedical model seems to have led hospitals to being places of cure or cure-oriented technology, not healing. They offer little to the chronically sick and the dying. This has proved detrimental for patients care and indeed care of medical staff, as communities of care have vanished.

Changes in models of health care management have also had very detrimental effects, largely due to their focusing exclusively on biomedicine supported by objective evidence, and failing to address the unique and particular in each doctor patient communication. Such changes destroyed the communities of care that previously existed in hospital wards, departments and universities, by introducing competition for resources in place of cooperation for the best care of patients.

3) Making Meaning looks at the central encounters of general practitioners that give them satisfaction. Finding meaning in the face of mortality appears to be the task of all human beings. The central activity of general practitioners is to bear witness to suffering and enable hope in the face of mortality.
In doing this, general practitioners encourage patients to continue to find meaning in their lives. It is ‘being there’ over long periods that the participants identified as keeping them in practice. They also identify an emotional price, since deep connection with patients renders the doctors vulnerable. The resonance of personal suffering and patient suffering is also mentioned.

Healing is not achieved without deep personal connection between doctor and patient, which touches into the spirituality of both. It is about a re-integration of self. It may be accompanied by cure but can also happen in a patient who is dying. Participants were aware of a similar process in healing patients and teaching students.

4) Connecting With the Transcendent deals with the spiritual experiences of GPs which are very common. Paranormal experiences and mystic experiences have a long history in health care and were certainly present in the transcripts. What was fascinating was the presence of mystic experiences in the participants regardless of whether they were religious or not. This seemed to confirm the understanding that spirituality is an inbuilt human characteristic. Connection with the transcendent sometimes seemed ‘outside time’ and some participants ‘ran out of words’ to describe it.

5) Sustaining and Developing Spirituality looked at ways spirituality could be enabled. This focuses on the need for community and the way community is being lost in a post-modern age. Social mobility, global connections and the rapid urbanization of the world have accelerated this. Another factor is the rise of individualism and materialism. The need to sustain spirituality and take time to reflect is discussed. More than half the participants admitted they had reached burn-out at some point in their lives.

The chapter finishes looking at current education about spirituality. This is little developed in New Zealand medical schools, apart from in the Maori health curriculum. Such education would not only enable better patient care but also better self-care of doctors.

Chapter 9 looks at the possibilities for the future and proposes areas for further study.

It first considers the ‘conspiracy of silence’ about spirituality in medical schools, due to the strength and preponderance of evidence based medicine which is unable to measure spiritual issues, because it has no appropriate tools to do so.
Given the large number of health ‘reforms’ that have achieved very little in terms of health gains I suggest that a change in focus of management practices and the formation of ‘clinical communities’ in general practice and in hospitals would enable better patient care. Along with this there is a need for proactive self-care for doctors. Mentoring and/or supervision need to be encouraged.

Further research on spiritual welfare of doctors at different stages in their careers and in different specialties would be very useful. The need for ongoing spiritual reflection is no less than the need for ongoing clinical skills development. The link between spiritual attentiveness, self-care and resilience also needs further investigation. Further studies on the spiritual experiences of doctors are important since there is very little material about this in the medical literature.

Finally there is need for serious study on the effects of changes in medical practice that loosen the connections between patients and doctors. These were the very connections that the group of doctors interviewed identified as keeping them in medicine. They could be described as the spiritual heartstrings, the connecting threads of medicine.

**Conclusion**

What has become increasingly clear is that we live in a universe that is intimately interconnected. We are all parts of one another and have a responsibility to care. This is not of course a new idea, but has been the persistent message of wise people around the globe.

The renewal of interest in spirituality has been gaining strength for the past thirty years as the impact of untrammeled exploitation of the earth and humanity in the name of economic development has become clearer. The negative impact of urbanization and pollution as a result of this is likely to increase in the coming years.

Technology has enabled the growth of a global community through the Internet and the media. The presence of this global community has reduced the power of individual governments and made the possibility of human cooperation a more creative option than
competition. There is at best a search for renewed community as a basic human need, or at least a search for connection.

Human beings continue to seek meaning even with the avalanche of information and knowledge now available through the Internet. Knowledge is not the same thing as wisdom. Reducing being to the merely empirical does not satisfy the human quest for the transcendent. The links of spirituality with resilience, art, and creativity were revealed in this study.

The most exciting finding in the research was how very present spirituality was in the lives and relationships of the participants and their patients. Far from being a rarity, or excluded, it emerged continually in the narratives. Spiritual experiences moved back and forth in a wonderful dance connecting with self, other, the natural world and the transcendent.
Chapter 2

Literature Review

1 Introduction

This chapter reviews the literature on spirituality. The first section will look at the evidence for spirituality as a universal aspect of humans. It discusses embodiment, neuroscience and spirituality. It then considers spirituality as a quest for meaning and purpose and discusses ways of perceiving the transcendent, including extraordinary human experiences.

The next section looks at the effect of changing world-views throughout history. It will look at the effects of this on the perception and understanding of spirituality from pre-modern times, through the modernist period and finally look at post modernism. Traditional spirituality and the connection between spirituality and religion will also be considered in this section.

Spirituality in health and sickness is discussed in the third section, from a historical and geographic perspective. This section then looks at the effect of a changing paradigm of medicine with the rise of biomedicine and the expulsion of spirituality. The last part of this section looks at the re-emergence of spirituality in health and medicine and the evidence for effects of spirituality on health and sickness. It will then consider healing and self-care in relation to spirituality. It will then look at education in medicine about spirituality.

The next section looks at ways of describing and defining spirituality. The chapter ends with a section on spirituality as connection and a summary.
2 What is Spirituality?

Man lives in three dimensions: the somatic, the mental and the spiritual…. Three factors characterize human existence as such: …spirituality … freedom, …responsibility. The spirituality of man is no epiphenomenon. It cannot be derived from and causally explained by something not spiritual; it is irreducible and indeducible (Frankl, 1954).

1 Spirituality is inherent in human beings

There has been debate about the meaning of spirituality for a very long time. In classical Greece and Rome it was seen as the aspect of humans to do with the soul or spirit. Aristotle believed the soul was a form of the body that had no separate existence and animals and plants also had souls. Plato and the Christian philosophers that followed him suggested the soul or spirit was the essential immaterial part of the human being that enlivened the body and left it at death. This sense of the spirit allowed for connection between both the embodied spirits and the disembodied ones (Honderich, 2005). This concept of the spirit is still accepted by many today.

Perhaps it is important to remember that the early psychologists took over the concept of soul and mind from earlier philosophers. Frankl stated unequivocally that spirituality is inherent in human beings and not derived from anything non-spiritual (Frankl, 1973). It is interesting that psychiatrists have come back to the concept of soul – which they rejected in the last century. The description given here is analogous to the spirit.

As we use it here soul describes the essence of each person, being a unique manifestation of the animating principle (spirit) that enlivens each individual ...it also characterises the most elevated expression of human values, unselfish love, compassion and wisdom. Lastly soul conveys a sense of wholeness, indivisibility, indestructibility and therefore for many, eternal life (Cook, et al., 2009 p 204).

Those working with children and spirituality discovered there is indeed evidence that spirituality is inherent and presents early in life in children. This so even if they come from families who have no religious connection and are not interested in the spiritual. The interesting thing is that it took over half a century before the evidence for this was collected. The table below was developed as a result of work on the inherent spirituality of children (Nye, et al., 1996).
### Table 1: Categories of Spiritual Sensitivity

<table>
<thead>
<tr>
<th>Awareness Sensing</th>
<th>Here and Now Tuning Flow Focusing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mystery Sensing</td>
<td>Awe and Wonder Imagination</td>
</tr>
<tr>
<td>Value Sensing</td>
<td>Delight and Despair Ultimate Goodness Meaning</td>
</tr>
</tbody>
</table>

It therefore seems reasonable to suggest that spirituality is an inherent aspect of humanity because it is perceptible and expressed in young children and adolescents even if they have had no contact with religion. Another worker in this field confirmed this: “I believe it (spirituality) is a built-in, biologically structured dimension of the lives of all members of the human species” (Hay, 2006 p 49).

More evidence for this biological basis of spirituality will be discussed later (Chapter 2:2:3).

Other researchers found evidence that children are naturally contemplative and this can be encouraged (Jennings, 2008). Children can be encouraged to grow spiritually by giving them opportunities to practice belonging, connecting, awareness, awakening and values for living (Benson, et al., 2008). The sense of awe, joy, goodness, and meaning mentioned in the table are positive emotions that are often associated with spiritual experiences.

Vaillant’s book on Spiritual Evolution defines the positive emotions as faith, love, hope, joy, forgiveness, compassion, gratitude awe and mystical illumination. In this book he appears to suggest that spirituality is primarily connected with the positive emotions (Vaillant, 2008). In fact there is ample evidence from historic writings on spirituality that it is sometimes associated with very negative emotions of abandonment and despair – the dark night of the soul (John of the Cross, et al., 1976). The positive emotions appear to enhance health just as the negative ones may damage it (Chesney, et al., 2005).

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1 I would agree with this. When my eldest grandchild was around four years old she would spend long periods of time in her tree house. I once asked her what she was doing up there. ‘I’m thinking and watching the sea,’ she said.
Spirituality has important existential aspects, according to Frankl (Frankl, 1973). He suggests that it is about freedom, meaning, purpose, growth and development as a response to the experience of transcendence. Spirituality is closely involved in the process of growth and development in three ways – as an awareness or awakening; as interconnecting and belonging; as a way of living (Jennings, 2008). These correspond to the three domains of Anandarajah of head, heart and hands (Anandarajah, 2008).

In order to connect, people need to be open to, aware and accepting, both of that with which they wish to connect and of themselves. They also need to be willing to take the risk of change because deep human connection brings about transformation. Such connection may reveal aspects of self or other that have previously been hidden. At times of transformation the ego or false self seems to be thinned or attenuated so that the real self and spirit can emerge a little more. It is a painful and bereft time of living with paradox. There is an experience of liminality, of being on the threshold, where the transcendent and the material connect (Franks, et al., 2007). “In this sense spirituality is not just one form of development but the glue that holds everything together” (Cook, et al., 2009 p 86). It is akin to the ‘thin places’ in Celtic spirituality where there is an immanent sense of the presence of God. Such sacred places exist in many traditional cultures, including Maori culture. A recent consensus definition of spirituality supports the concept that spiritual human connections may be with self, other, the natural world or the transcendent (Puchalski, et al., 2009).

This underlying spirituality may be developed and deepened by reflection, creative and artistic endeavours, and ritual and celebration, both religious and secular (Luboshitzky, et al., 2001). Spirituality is found in all cultures. While the metaphors used for explaining it differ between cultures, the experiences described are remarkably similar as will be discussed later in this chapter.

2 Spirituality and embodiment

Spirituality is an embodied awareness and experience, with tendrils that reach every part of the human person, starting at birth. When connection occurs with other humans it allows the tacit understanding of the other. Spirituality is experienced with emotions and physical feelings. As will be seen later, spiritual distress may present as physical symptoms just as physical symptoms and distress may be alleviated by spiritual awareness or practices.
When medical practitioners consider human bodies merely as objects they fail to attend to the sense of integration and wholeness of the patient in their relationships.\(^2\)

Persons do not simply experience their bodies as external objects of their possession or even as intermediary environment which surrounds their being. Persons experience themselves simultaneously *in and as* their bodies (Csordas, 1994 p 54).

This means that the experience of embodiment is also the beginning of our understanding of culture (Shilling, 2007). Embodiment begins with the place of pregnancy in the culture and continues with the way in which bodies are understood. Modern Western culture tends to see bodies as individual instruments or objects to be used, rather than gifts to be cared for. Other cultures see the body as an inherent part of an extended family, arising from the land, and do not have a concept of the isolated individual.

Communication, which is the basis of human connection and spirituality, is also an embodied activity. It involves listening, and hearing and speaking, as well as touch, taste, smell, and intuitive connection or tacit knowledge. Intuitive connection is often ignored because it is difficult to explain and understand by the materialistic, deductive scientific paradigm predominant in our world. It is, however, clear that human communication does not stop at the skin. It seeks connection with what is experienced as within and there are ways in which communication takes place that are not understood. Intuitive connection has a sense of the whole, as tacit knowledge does. Tacit knowledge perceives the whole of that which we are aware and know. Using it we can enter into the mind or world-view of another person seeking to learn how to ‘dwell within them’ and understand them (Polanyi, 1967). We cannot share the experience of another person but we can intuit what it might be like. This is the basis of empathy, which is critical to the forming of healing relationships. It appears to depend on mirror neurones sensing the way in which another is feeling and replicating that feeling within (Cattaneo, et al., 2009).

Because our body is involved in the perception of objects, it participates thereby in our knowing of all other things outside…. Thus do we form … an interpreted universe populated by entities ... which we have interiorized for the sake of comprehending their meaning (Polanyi, 1967 p 29).

When tacit awareness is used to connect with another human person the one approaching tries to ‘stand in the shoes’ of the other person. This is very different from describing the other

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\(^2\) The most dramatic example of this I heard was a patient who had IVF. She told me that she sometimes felt her child belonged to the obstetrician who had created the embryo rather than to her.
from one’s own viewpoint. It is an act of creative imagination, of self-awareness, as well as careful attention to the other’s words, emotions, gestures, facial expression and body language. It may also involve their physical production of hormones and pheromones and an unconscious response to them. If a reductive or intellectual process is used to try to understand such a complex process, it is fragmented and the sense of the whole is lost. This is because fragments cannot show the ever-changing interconnections, richness and complexity of it. Foucault uses the word ‘basilisk gaze’ to mean a stare at something clinically or statically and fail to see the dynamic whole (Foucault, 1973).

With tacit knowledge we gaze at the whole person rather than looking at fragments of them. This is well shown in the picture above. Here it is used in the sense of a look that embraces with unguarded love and compassion the totality of the one gazed at. This is the gaze that lovers or mothers and infants share, as can be seen above.³

Some general practitioners may gaze with such compassion at a well-known patient who enters their surgery. However biomedicine trains doctors to look at the patient in order to see clinical signs, using scientific reductive methods. As soon as they focus down onto the

³ When my children were young they always recognised this look as different and would demand, ‘Why are you looking at me like that?’ in a puzzled but pleased way.
disease or pathology they stop seeing the whole person. That is Foucault’s basilisk stare. In fact general practitioners oscillate between these two ways of looking and use both for making a diagnosis.

This very well put by Verghese’s paper entitled *Culture Shock — Patient as Icon, Icon as Patient*. He is here using Icon in its IT sense, rejecting it as inadequate for connecting with the patient. Clinicians have to really encounter their patients at the bedside.

For the clinician, the bedside is hallowed ground, the place where fellow human beings allow us the privilege of looking at, touching, and listening to their bodies. Our skills and discernment must be worthy of such trust (Verghese, 2008 pp 2748-51).

Kleinman also sees the direct link between suffering and the spiritual which is of central importance in medicine:

… pain as sacred in itself, an aspect of the suffering self that acts as a mediating bridge between the person and God…. I have sometimes wondered ... if bodily experiences of pain, depression, exhaustion and other chronic symptoms, are not alternative forms of criticism and protest (Kleinman, 2006 pp 136, 139).

Because spiritual experiences and transformations are embodied they are accompanied by both physical and emotional sensations. Social and psychological transformations may trigger spiritual ones in humans, and vice-versa. The body carries memories within it at many different levels from the memories of the immune system to particular infective agents, to memories of past losses that are often attached to a particular pain in the body.5

There is also some interesting work on cellular memories arising out of heart transplants, suggesting that these are stronger than was believed and may affect the feelings and behaviour of the transplant recipient (Dossey, 2008).

Shilling, in a fascinating paper on cultures of embodiment, discusses the way in which the dominant technological society in the Western world, with its focus on instrumental rationalism and mastery over nature, has made efficiency, control, work and consumption the focus of life. It excludes both the transcendent and the immanent spiritual because these

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4 The basilisk in Greek mythology was king of the serpents, reputed to have hatched from a cockerel’s egg, whose gaze would strike anyone dead.

5 When people are grieving they often get the same kind of pain each time – headaches, abdominal pain, sore neck, backache. Learning to recognise this can be helpful in treatment.
cannot be measured by scientific tools. Thus the body becomes an individual object to be used or exploited. It may seem to have lost all connection to others. This may be the root cause of the rise in suicides in the young in the West.

A key feature of technological culture is its promotion of a form of bodily being that can deny individuals experiences of immanence and transcendence … that has been central to traditional sociological concerns about the problem of personality and the increase of anomie and suicide in industrial societies (Shilling, et al., 2007 p 540).

Schilling contrasts this with the Taoist concept of a body in harmony with and connected to the flow of energy in the cosmos. He goes on to explore the understanding of the body in communion with the transcendent, in Charismatic Christian communities. This may lead to transformation of the person.

3 Neuroscience and spirituality
Science has extended our understanding of the embodied physical effects of spiritual activities. Neuroscientific investigations, particularly MRI studies have shown that certain areas of the brain are active during spiritual activities, for example, meditation (d'Aquili, et al., 1993). They have also shown resonance between people who are meditating even when they are in different rooms screened for electromagnetic radiation (Wackermann, et al., 2003).

The stress reducing consequence of meditation and its subsequent physical effect on blood pressure and other physical stress symptoms have also been well documented (Cook, et al., 2009). MRIs have also tracked the brain centres that are active when the positive emotions of love, compassion and connection are felt (Cattaneo, et al., 2009). These are not in the neo-cortex or thinking brain but in the limbic system, which is an older part of the brain common to all mammals.

There are also mirror neurons that resonate with pain witnessed in others. These are thought to be the basis of empathy and compassion and deficits in this system have been found in patients with autism, where lack of perception of feelings of others is a major issue (Cattaneo, et al., 2009). “Thus the mirror neuron network… appears to be one key to emotional intelligence” (Vaillant, 2008 p 154).

The positive emotions of love, joy, hope, forgiveness, compassion, faith, awe and gratitude bind us to other humans and to the transcendent however we define it. They enable the
formation of community. Vaillant suggests these are present in the experience of spirituality and are common to all humans.

This book defines spirituality as the amalgam of the positive emotions that bind us to other human beings and to our experience of God as we may understand Him/Her. Love, hope, joy, forgiveness, compassion, faith, awe and gratitude are the spiritually important positive emotions (Vaillant, 2008 p 4).

This evidence does not imply that spirituality has been captured like an impaled butterfly. It merely confirms what has been known since Spinoza’s time – that human beings are embodied, whole, dynamic beings.

Let us now turn to the delicate issue of “locating” the spiritual in the human organism. I do not believe there is a brain centre for spirituality…. The spiritual is a particular state of the organism, a delicate combination of certain body configurations and certain mental configurations (Damasio, 2003 p 286).

Damasio goes on to say that the spiritual has three aspects, harmony, enabling growth and spiritual experiences. These are able to be encouraged by ritual. He also links these to positive emotions.

First, I assimilate the notion of spiritual to an intense experience of harmony…. Second spiritual experiences are humanly nourishing…. Third we have the power to evoke spiritual experiences… Prayer and rituals… The contemplation of nature, the reflection on scientific discovery and the experience of great art… This is an opportunity to generate positive emotions where negative emotions would otherwise arise… (Damasio, 2003 pp 284-5).

Frankl noted and underlined this dynamic nature of spirituality and its mystery. It is this unfolding nature of spirituality that makes a static definition so inadequate. “Normal somatic functions are conditional to the unfolding of spiritual life, but they do not cause or produce it” (Frankl, 1954 p 979).

The behavioural aspects of spirituality may be religious or not as suggested above. Rituals that affirm and facilitate spiritual experiences include spiritual reading, mindfulness, prayer, liturgy (Carmody, et al., 2008). They may also include practices like meditation, lighting candles and any other behaviours which enable a connection with the transcendent. For those who have a natural spirituality they would include seeking space and time in places in the natural world that have particular meaning and resonance. Contemplating great art and literature, or listening to music may also affirm and enable spiritual growth and experience.
It is clear that seeing patterns of neurological function does not in any way explain the soul, mind or spirit.

Yet spiritual experiences, religious or otherwise, are mental processes. They are biological processes at the highest level of complexity. Accounting for the physiological process behind the spiritual does not explain the mystery of the life process to which that particular feeling is connected. It reveals the connection to the mystery but not the mystery itself (Damasio, 2003 pp 284, 286).

This suggests the mystery transcends the personal and biological limits. The author goes on to speak of the intensity, joy, human nourishment and creative and positive effects of such experiences. Spiritual growth is enabled by a number of things. “Awareness or awakening, interconnecting and belonging, and a way of living” (Emmett, 2008 p 48).

The spiritual inner life needs to be nurtured and enabled to connect with sacred symbols and ethical action (Longfellow, 2008). It may involve any of the following and more. Celebration, rituals, festivals, creativity and special places and seasons can all contribute (Luboshitzky, et al., 2001). The loss of festivals in secular society has diminished that opportunity.

In this section we have considered spirituality as an inherent quality of all human beings. It is experienced through emotions and physical feelings because it is an embodied experience. It has existential aspects and changes and grows throughout life. It connects us to our deepest selves, to others, to the natural world and to the transcendent.

4 Spirituality as a quest for meaning and purpose
Human beings seek answers to the existential questions: “What are we?”, “Where have we come from?”, “Where are we going?” They search for that which transcends themselves throughout their lives.

The overarching concern of contemporary spirituality is to achieve authentic human existence. This can be considered the goal of all spirituality, as of all religion, fulfilment of the human personality as well as the fulfilment of history and completion of cultural expression. Authentic existence has no absolute terminus, as it has no complete mode of expression (Berry, 1977 p 1).

These existential questions re-emerge throughout life at times of transformation, particularly of attachment and loss. Since the first human transformation is birth and the last is death this is a never-ending journey. On this journey humans are always accompanied and enabled by
others. After a transformation, a sense of disjunction gradually re-emerges and the whole cycle is repeated. This demands a letting go, or loss of the previous self and an attachment to the new self. In proceeding on this journey of spirituality there is increasing integration of the self, which is most noticeable after major transformations (Johnston, 1978 p 109). Just as human intellectual and social boundaries are expanded by contact with other cultures, so spiritual limits are expanded by deep contact with others, the natural world and the transcendent.

Spirituality includes a search for meaning, purpose and truth in life: the beliefs and values by which a person lives; the feelings of freedom, hope, connectedness, love and inner peace of a person and their converse of impasse, despair, abandonment, anger and chaos; it encompasses both the internal and external relationships of a person with the natural world, themselves, others and the transcendent (Delgado, 2005; Culliford, 2006; Anandarajah, 2008). The transcendent relationship may sometimes be found through religious practice but may also be found in the natural world, and in creative action whether in the arts or in relationships (Damasio, 2003; Delgado, 2005; Cook, et al., 2009 p 147).

Spirituality expresses the deepest level of human existence, the sense of true self. This is marked in all human societies by the giving of a personal name. In some societies this name is considered sacred and deeply spiritual and may not be shared with strangers. It therefore expresses the uniqueness, the sacred centre of each human being. This uniqueness demands that we listen to others and to the world about us and communicate with them as equals in dialogue. We grow in self-awareness when others can then share their unique insights about the world and us.

Spirituality propels us into a lifelong journey of discovery of deeper levels of self. This is not a self-centred journey, but one that can only be taken in the company of other humans and an ever deepening awareness of our world. Dialogue involving mutual reverence of the other is not about debating but listening and hearing. "Society is the miracle of moving out of oneself" (Levinas, 1990 p 9).

Spirituality connects human beings with the numinous, transcendent and eternal. Such experiences may be passionate, awesome and fearful or may be comforting, peaceful and give a deep sense of integration and wholeness (Damasio, 2003). It is further defined by the time

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6 This was so in Tanzania where to share your particular given name was to put yourself at risk of being cursed.
in history, the place and the culture in which it is experienced. Spirituality may be both creative and enabling of growth and destructive and limiting. It is both paradox and mystery.

Spirituality allows the paradox of life in the face of certain death to be energising not overwhelming. It provides a liminal space in which to be free to grow, although it can also at times be an experience of impasse where only waiting in hope is possible.

Impasse cannot be solved by rational solutions and is particularly difficult for those who have grown to maturity in a world where fixing problems was what they, with the help of science were supposed to do. Yet all humans start their lives with an experience of impasse during the process of being born. This gives a model for all future impasses.

5 Modes of perceiving the transcendent

The transcendent refers to that which is beyond the material or rational world. It is a word much used as an alternative to sacred, for those who are secular or have rejected religion.

Connecting with the transcendent as an aspect of spirituality may be understood in five ways.

1. It may be theistic – as connection to God, a supreme being or force.
2. It may be atheistic, where the concept of a supreme being is rejected.
3. Where there is a sense that all things are a unity and constitute the divine being it is pantheistic.
4. In a panentheistic world there is a sense that all things are in the transcendent, which nevertheless also transcends them.
5. Finally there may be no sense of divinity but a sense of the greatness and connectedness of the natural world as transcending the smallness of human beings. This natural spirituality is common today.

Hay formulated the list of ways of spiritual awareness below from a large archive of spiritual experience in Britain, held in the Religious Experience Research Unit at Oxford University. These were used later to structure questionnaires (Hay, 2006).

1. Awareness of patterning of events or synchronicity
2. Awareness of the presence of God
3. Awareness of a presence not named
4. Awareness of prayer being answered
5. Awareness of a sacred presence in nature
6. Awareness of the presence of the dead
7. Awareness of an evil presence
8. Awareness that all things are one (unity)

The next section looks at these in more detail.

6 Extraordinary Human Experiences

Such mystic experiences are common to all cultures and have similar manifestations, though the explanations of these are culturally and religiously conditioned (Hood, et al., 2001). The experiential aspects of spirituality include emotional and physical manifestations. Such experiences are known as Extraordinary Human Experiences (EHE).

The earliest description of mystic experience in scientific literature was from James (James, 1985). He described four aspects of powerful spiritual experiences.

- They are ineffable – “more like states of feeling than states of intellect” (James, 1985 p 302)
- They have a special noetic quality of value to the individual experiencing them – “insight into depths of truth unplumbed by discursive intellect” (James, 1985 p 302)
- They are transient – “Mystical states cannot be sustained for long. Except in rare instances, half an hour, or at most an hour or two, seems to be the limit beyond which they fade into the light of common day.”
- They are passive.

Although the oncoming of mystical states may be facilitated by preliminary voluntary operations when the characteristic sort of consciousness once has set in, the mystic feels as if his own will were in abeyance, and indeed sometimes as if he were grasped and held by a superior power (James, 1985 p 302.)

These may include a deep sense of being at one, of union with the environment, the self, others and occasionally with a supreme being (James, 1985; Kacela, 2006; Wardell, et al., 2006). The other characteristic of such deep experiences is that they are memorable and people recall them vividly years after the event. Such spiritual experiences may seem to be outside time, like the example below.

Time seemed to stop. A sense of infinite power and peace came upon me. I can best liken it to a combination of timelessness with amazing fullness of existence
to the feeling one gets watching the rim of a great silent fly-wheel or the unmoving surface of a deep strongly flowing river (Davies, 1995 p 25).

These findings were confirmed by a very detailed study of mystic states from a cross-cultural viewpoint (Bartocci, et al., 2005). This paper then considered how psychological and neurobiological research attempts to explain the breakdown of boundaries between self and the external world. It concluded by suggesting that mystic states, while resembling psychoses, are an adaptive and healing process for resolving psychological crises and periods of transition. Religious mystic states that remain connected to cultural inheritance, are healing and enabling, whereas psychoses are disconnected from cultural inheritance and fragmenting.

In mystical states there is a sense of change of sense of self in relation to the transcendent.

We pass into mystical states from out of ordinary consciousness as from a less into a more, as from a smallness into a vastness, and at the same time as from an unrest to a rest. We feel them as reconciling, unifying states. They appeal to the yes-function more than to the no-function in us. In them the unlimited absorbs the limits and peacefully closes the account (James, 1985 p 330).

Descriptions of mystical experiences exist in the ancient literature of all the major religions. These pre-date James by several thousand years. There are also many metaphysical concepts in the various religions that ascribe mystic experiences theistically to a divine reality or atheistically to an unnamed greater power. However all these philosophical ways of perception share common elements. At their deepest they lead to a feeling of enlargement, union or freedom and nothingness. In Buddhist meditation this nothingness is contemplated as a path to enlightenment (Johnston, 1978).

The absolute must be considered first as absolute nothingness.... While the self remains enlightenment will not come. It is when the illusory self dies that the real self is born and the inner eye awakens and comes to see…Far from being negative, enlightenment is an experience of joy, liberation and release from anxiety... It is paralleled in all the mystical traditions where there is a time when one becomes liberated from fear and says with Julian of Norwich ‘All will be well, and all will be well and all manner of things will be well’ (Johnston, 1978 pp 109, 113).

This author then goes on to reflect on this tradition in Christian mysticism as the ‘dark night’ in St Paul, St John of the Cross and other authors. It is only in dying to self that a person can become aware of the divine. He finally concludes that at depth, in contemplating the Absolute
all is mystery. “If no one understands nothingness neither does anyone truly understand God... We are all reduced to silence in the face of mystery” (Johnston, 1978 p 114).

James suggested a mystical ladder for spiritual experiences with a progress from one rung to the next (James, 1985). At the lowest rung of the mystical ladder, James places the feeling a person may have of the deepened sense of the significance of a word, or a familiar idea or experience, or the feelings which may come from the appreciation of lyric poetry or music. The next step on the ladder includes déjà vu experiences, which James believes are mystical to the extent that “they bring a sense of mystery . . . and the feeling of an enlargement of perception” (James, 1985 p 305). “Then come experiences such as feelings of indescribable awe. After that, the next more fully developed states of mystical consciousness are those of mystical trance” (Suckiel, 2002 p179).

Greeley followed James’ classification but modified it to five groups of ‘extraordinary human experiences’. These are déjà vu, clairvoyance, extra sensory perception, connection with the dead and mystical experiences (Greeley, 1975). These also match the experiences described by Hay described above. The other aspect of some mystic experiences is that they ‘break in’ unexpectedly and unbidden. Characteristically such powerful spiritual experiences are remembered, even when they are sometimes dismissed by the person having them. These may be life changing and are sometimes accompanied by a sense of being outside time (D'Aquili, et al., 1998).

The organisation of mystic experiences into circumstances, manifestations and interpretation is a useful one. I have therefore included a chart based on work by Wardell on a taxonomy of mystic experiences (Wardell, et al., 2006). This looks at the internal and external circumstances, manifestation and interpretation of mystic experiences.

Such experiences are remarkably common. Thirty-six per cent of a general population group surveyed in England had had a mystic experience of the presence of a ‘Power’. This included 23% of those who said they were atheist, agnostic or did not know (Hay, et al., 1978). In a large study in the USA paranormal experiences were common. Fifty-nine per cent of subjects described déjà-vu – having a sense of being in this place or situation before; 58% ESP – perceiving things by extra sensory means; 27% contact with the dead and 28% clairvoyance –

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7 For many years I corresponded with a friend who was a contemplative religious sister. She belonged to a meditation group that included Hindu, Christian, Buddhist and Islamic members. She always said how powerful the experience of being at one they had in meditation was, though they remained divided over dogma.
knowing things in the future. In this study triggers of mystic experiences included music; art; beauty of the natural world; quiet reflection; small children; creative activity (Greeley, 1975). A more recent study by Thalbourne shows such experiences may have become more common (Thalbourne, 2004).

Spiritual experiences are sometimes triggered by the natural world, particularly in wilderness experiences (Ashley, 2007). There is a long history of such wilderness events, a meeting with the transcendent, in all the major religious traditions.

As can been seen in the chart below, spiritual experiences induce emotions and feelings that make them memorable. Positive connectedness induces positive emotions. These are feelings of awe, love, hope, peace, forgiveness and gratitude (Greeley, 1975; Kacela, 2006; Vaillant, 2008). They enable resilience in the face of challenges and pain.

Table 2: Taxonomy of Mystic Experience (after Wardell)

<table>
<thead>
<tr>
<th>Circumstances</th>
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<tbody>
<tr>
<td><strong>external</strong></td>
</tr>
<tr>
<td>everyday</td>
</tr>
<tr>
<td>symbolic</td>
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<tr>
<td>ordinary</td>
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<table>
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<tr>
<th>Manifestations</th>
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<tbody>
<tr>
<td><strong>embodiment</strong></td>
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<tr>
<td>visual</td>
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<tr>
<td>auditory</td>
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<tr>
<td>olfactory</td>
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<tr>
<td>taste</td>
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<tr>
<td>tactile</td>
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<tr>
<td>physical</td>
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<tr>
<td>kinesthetic</td>
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</tbody>
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<table>
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<tr>
<th>Interpretation</th>
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<tbody>
<tr>
<td><strong>personal meaning</strong></td>
</tr>
<tr>
<td>insight</td>
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<tr>
<td>action</td>
</tr>
<tr>
<td>ambiguity</td>
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</tbody>
</table>
Negative connectedness may induce feelings of fear, hatred, turmoil, alienation and despair. They are also often associated with struggle and suffering in the face of challenges and pain (Black, 2005; Chochinov & Cann, 2005).

Healing is one of the observable manifestations of transcendent experience, and is important in a study of medical participants. It occurs both for doctors and for patients (McCaffrey, et al., 2004). Some doctors pray for patients in their surgeries. Others simply pray for them out of their surgeries or for themselves (Daaleman, et al., 1999; Klitzman, et al., 2005; Anandarajah, et al., 2007; Johnstone, 2009). There is some evidence that prayer may help in enabling forgiveness or healing of relationships (Lambert, et al., 2010).

The depth of feeling in the spiritual experiences and the fact that they are remembered with great detail over many years suggests their central importance to the individuals concerned (d'Aquili, et al., 1993; Wardell, et al., 2006).

3 Changing World-views

This section looks at the way in which spirituality as an embedded aspect of culture was displaced by the rise of scientific reductionism after the enlightenment. Scientific reductionism is now under threat from post-modernism which allows the possibility of mystery again. It was precipitated by a changed world-view from an ordered and layered structure to one in which order and chaos co-exist and everything is interrelated.

1 Pre-modern world

Prior to 1500 the pre-modern world was an ordered structure with spiritual and physical realms in their places and the transcendent God(s) in charge. The spiritual world was thought to be above the physical and the underworld below. Gods and spirits were given power over all mystery.

This was what Charles Taylor, speaking of Europe, called the ‘enchanted world’. In this world spirits, good and bad, were ever present and the natural world, the Cosmos and the state were ruled over by God, as were the lives of each person.
Unbelief in such a society is almost inconceivable. The self is not buffered or separated from the environment in which a person exists. In order to survive religious and spiritual activities and rituals enable safety (Taylor, 2007a).

Taylor also raises the concept of a shared social imaginery in a community or society.

Our social imaginery at any given time is complex. It incorporates a sense of the normal expectations that we have of each other; the kind of common understanding which enables us to carry out the collective practices which make up our social life…. we have a sense of how things usually go…. how they ought to go… what mis-steps would invalidate the practice…. It can never be adequately expressed in the form of explicit doctrines, because of its very unlimited and indefinite nature (Taylor, 2007a p 172).

In this enchanted environment time existed in two forms - secular or ordinary time and higher time which was unchanging and eternal. Secular time followed the unchanging seasons of each year. Such a world accepted wisdom as outstripping human rationality. Such wisdom was a tacit knowledge, both wider and more penetrating than mere human knowledge.

2 Growth of Modernism
The modern world started to emerge with the development of natural science around 1500CE. The rediscovery of classical philosophy and science preceded this, as a result of increasing links with the Arab nations. Nature for itself, rather than as an expression of the Divine, became an interest. The Christian church resisted the scientific exploration of mystery as this was seen as sacrilegious, a lusting after the power of God. Changing the social order reduced the power of the church.

Galileo was seen as a threat to the church because he changed the order of the cosmos, so that no longer was earth the centre. This had serious implications for the stratified order of society. This understanding of the cosmos, together with the reformation, proposed a new model of creation in which humans had knowledge, power and responsibility to order and control their environment and themselves.

During the Enlightenment, the Age of Reason, in the 17th century, René Descartes and others, developed a philosophy based on observable phenomena in which relationships in the cosmos and natural world were seen as fixed and orderly, obeying natural laws and still under the reign of God. This model of the universe persisted until the mid nineteenth century, with
many embellishments by other scientists, like Newton, who developed laws for physics. While he was not anti-religious, many others were. The French Revolution, which was profoundly anti-religious, marked the end of this phase in history.

It is interesting to reflect that intellectual expansion of the European Enlightenment coincided with European physical expansion across the globe. The rise of order in the natural world resulted in the taking control of disorder, as the responsibility of enlightened human beings.

The ‘buffered self’ came into being when the ancient, spirit filled cosmos, was replaced by this ordered universe, and humans took charge of their environment (Taylor, 2007a). No longer was the spiritual all pervasive. Religion became privatised and the sacred was banished from public spaces.\(^8\)

The growth of science impinged on both immanent and transcendent aspects of reality and individualism-fractured community. The inner realm of mind and spirit was expanded and developed by depth psychology. The focus of this was on the individual, not the community. Hay suggested that privatising spiritual awareness resulted in the loss of awareness of ‘the face of the other’ which is an inherent aspect of human spirituality (Hay, 2006 p 231). This is also the central concept that Levinas raised (Levinas, 1990).

Time too changed its meaning from the higher and ordinary time in the pre-modern era, to its current meaning as a utility. The natural rhythms of the seasons that controlled the lives of ordinary people gave way to the tyranny of the clock, to artificial light and buildings and shopping malls with controlled climates in them (Davies, 1995). Higher and sacred time has all but disappeared in the modern world – the only trace of it left is in ‘holidays’ (holy-days).

In the mid 19\(^{th}\) century further major changes took place, starting with the developing understanding of geology. In 1815 William Smith published the first geological map of Britain (Winchester, 2001). This was followed in 1859 by the publication of *The Origin of Species* by Charles Darwin. This new understanding of the history of the world directly challenged the creationist view then held by Christian churches. The issue was exactly the same as that of Galileo, where the scientific truth was at odds with the faith belief. Like

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\(^8\) I was very struck by this in Christchurch, where the Cathedral which, had been the centre of the city, was surrounded in the mid 20\(^{th}\) century by financial institutions that were much larger than the cathedral.
Galileo, Darwin also challenged the order of humans in creation by proposing the theory of natural selection.

From the end of the 19th century growth of scientific knowledge expanded very rapidly. Again this intellectual expansion accompanied an industrial and geographical expansion of European nations across the globe in the pursuit of economic gain and political power. Accompanying this a number of political and economic changes ushered in a time of anti-religious and totalitarian regimes in Russia, Eastern Europe and later in China.

The other major scientific advances in the late 19th and early 20th centuries were in physics. First Einstein developed his theory of relativity in which time, mass and energy were no longer separate but intimately connected. This allowed the concept of a universe that expanded from a point, when difference between past, present and future did not exist (Davies, 1995 pp 181-2).
In such a world, if spirituality is primarily about connection, it has tendrils that reach both forwards in time to descendents, and backwards in time to ancestors, as well as to others, the natural world and the transcendent.

The development of quantum physics made an understanding of the physical world even more elusive, for it allowed for the physical world to exist in two modes at once. More recently the suggestion that dark matter makes up most of the universe, is making mystery once again central to understanding the universe. This is a major paradigm shift from the ordered world of Descartes and Newton.

<table>
<thead>
<tr>
<th>Pre modern</th>
<th>‘Enchanted’</th>
<th>Uncertainty</th>
<th>Resigned to fate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-1500 Traditional societies</td>
<td>Uncertain Religion protects</td>
<td>Resigned to fate Accepting of world</td>
<td>Village community Future – moral actions</td>
</tr>
<tr>
<td>Layered cosmos Ruled by fates</td>
<td>Need for moral actions Time is ordinary+sacred</td>
<td>Spirit filled world Time is gift/seasons</td>
<td></td>
</tr>
<tr>
<td>Myths give meaning</td>
<td>No boundary with sacred</td>
<td>Connected/acceptance</td>
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</tbody>
</table>

| Modern 1500-present | Dis-enchantment Rise of science | Pseudo-certainty Hope of better future | Flourishing – human work City/state community |
| Control by humans | Human effort/discipline | Future – human task |
| Fragmented vision Universe | | Time - measured value |
| Natural laws Suppression of R/S | Time is all ordinary Loss of sacred time/space | Buffered self Loss of sacred |
| -18th C French Revolution -20th C Russia/China Search for meaning | | |

| Post Modern 1900-present | ?Re-enchantment Quantum world | Uncertainty Global warming/nuclear | Human fallibility Non-linear time |
| Uncertain Relativity Expanding universe | Search for wholeness Process not state | Global community Re-connected |

### Table 3: Changing world-views

<table>
<thead>
<tr>
<th>Pre modern</th>
<th>‘Enchanted’</th>
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| Modern 1500-present | Dis-enchantment Rise of science | Pseudo-certainty Hope of better future | Flourishing – human work City/state community |
| Control by humans | Human effort/discipline | Future – human task |
| Fragmented vision Universe | | Time - measured value |
| Natural laws Suppression of R/S | Time is all ordinary Loss of sacred time/space | Buffered self Loss of sacred |
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| Post Modern 1900-present | ?Re-enchantment Quantum world | Uncertainty Global warming/nuclear | Human fallibility Non-linear time |
| Uncertain Relativity Expanding universe | Search for wholeness Process not state | Global community Re-connected |
We live in a world where the predominant paradigm is still scientific. It is not surprising therefore, that there is a tendency among some scientists (and doctors) to deny the reality of the spiritual dimension and maintain that all human function and activity can be explained scientifically, using rational reductive reasoning. This suggests that they believe that there is only one paradigm for looking at the world. This ignores the very way in which we perceive that which is outside ourselves, as Polanyi suggested forty years ago.

Yet it is taken for granted today among biologists that all manifestations of life can ultimately be explained by laws governing inanimate matter….. The most striking feature of our own existence is our sentience. The laws of physics and chemistry include no concept of sentience, and any system wholly determined by these laws must be insentient. It may be in the interests of science to turn a blind eye on this central fact of the universe, but it is certainly not in the interests of truth (Polanyi, 1967 p 37).

Frankl also makes this point very clearly:

There is a danger that we may corrupt a man… if we make man into a homunculus. The modern homunculus is not produced in the alchemist's vaults and in retorts, but wherever we present man as an automaton of reflexes, as a mind-machine, or as a bundle of instincts, as a pawn of drives and reactions, as a mere product of instinct, inheritance, and environment. I am absolutely convinced that the gas chambers of Auschwitz, Treblinka and Maidanek, were ultimately not prepared in some Ministry or other in Berlin but rather at the desks and in the lecture halls of nihilistic scientists and philosophers (Frankl, 1954 p 979).

There is an even earlier and sharper comment by Alister Hardy:

I believe that the dogmatic assertions of the mechanistic biologists, put forward with such confidence as if they were the voice of true science, where they are in reality the blind acceptance of an unproven hypothesis, are as damaging to the peace of mind of humanity as was the belief in everyday miracles in the middle ages (Hay, 2006 p 45).

Since that time there have been many others who wished to promote a single paradigm for existence. The dogmatic assertions of biologists still continue. Richard Dawkins is one of the most public of these. He too makes statements extending the claims of science beyond their limits: “The universe we observe has precisely the properties we should expect if there is at bottom, no design, no purpose, no evil and no good, nothing but blind, pitiless indifference” (Dawkins, 1995 p 133).

In such a vision humans are strangers, alienated from the world. This is a form of scientific fundamentalism, scientism – claiming only science has the true picture of the world. It is
intellectually equivalent to the vision of religious fundamentalists who believe they know the mind of God and despise unbelievers.

In spite of its explicit suspicion of religion, scientism remains tied to the same dualistic myths that have caused Christian and other religious spiritualities to distrust and even despise the natural world. Scientific and religious Puritanism have a common ancestry, a fear of the physical in its swampy, wild and untamed naturality... Its complicity in the power obsession of an industrial age... is already widely acknowledged (Birch, 1990 p 163).

But the scope of science is not metaphysical. It is the world of nature.

The scope of science is the world of nature, the reality that is directly or indirectly observed by our senses... Outside that world, science has no authority.... Science has nothing to say about values, whether economic, aesthetic or moral (Ayala, 2007 p 172).

This point is supported by Schilling, who points out that using the scientific paradigm exclusively literally excludes any other possibility (Shilling, et al., 2007). “…technological culture seeks to exclude individuals from contact with either transcendence or immanence.... seals the world within a self-referential frame in which instrumental efficiency is the criterion for action” (Shilling, et al., 2007 p 543).

A number of authors suggest that spirituality is important for survival (Vaillant, 2008). The National Academy of Sciences in a report “Teaching about Evolution and the Nature of Science” said: “Religion and science answer different questions about the world. Whether there is a purpose to the universe or a purpose for human existence is not a question for science...” (Ayala, 2007 p 174).

Throughout the 19th and 20th centuries the advance of science persuaded many people that human endeavour would reveal all that could be known about the natural world. The concept of mystery became that for which science has not found an answer. The belief that the scientific paradigm was the only way to explain the human person and the universe led to the rise of scientism. It also led to the rise of scientific materialism in which the purpose of human life became consumption and acquisition on an individual basis, ignoring the needs of others. In addition reductionist scientific methods were thought to explain all creation.

The age we live in is extraordinary in many ways (Ayala, 2007; Blumenkrantz, et al., 2008). It is the first time in history a predominant world-view has attempted to ignore the spiritual
aspect of humanity. Scientific rationalism and materialism proposed that human scientific endeavours would ultimately lead to a perfect society in which all practical problems were solved and all would be fed and nurtured. When this rationalism was allied to individualism, consumerism and utilitarianism it led to a fragmentation of society and destruction of the environment, not to speak of a fragile economy. This is clearly visible in the current age where it seems the disconnection of human beings from one another is reflected in the disconnection between human beings and the natural world.

Ironically the more that was understood about the details of the natural and human worlds the more an overall picture was lost. The layered, ordered, medieval universe gave way to the expanding and evolving universe. The coherent and supportive community lost ground to a competitive society in which the survival of the fittest individual was seen as paramount. Hay links the rise of individualism with a denial of relational consciousness and social cohesion and a reduction in moral behaviour and responsibility. He also makes the link between this and the rise of surveillance as a loss of trust occurs (Hay, 2006 p 256).

In fact the development of scientific knowledge, like the development of any knowledge comes at a price. The expansion of human scientific endeavours now threatens the survival of the planet on which we live by global warming and global pollution. Growth in scientific knowledge required the breaking down of the complex into the simpler – reductionist science stares at fragments of matter rather than gazing at, contemplating the whole and wondering at the amazing connections that engage us with it and each other.

Within the last half-century ...scientists ...had to give up the illusion that, once known, the basic laws would, all by themselves, yield complete understanding of the world we live in... In a word they discovered complexity (Espagnat, 2006 p 433).

It appears we are in a process of change from a modernist world-view in which human endeavour allied with scientific rigour would alone solve all the existential problems of living, to a post modernist one in which the promises of scientific materialism applied without wisdom have proved to be fragmenting and destructive. We are also moving into a new understanding of the physical world as mysterious and expanding. This seems to be in keeping with the human search for the unknown transcendent, put so well by Espagnat.

… the human mind is first of all orientated towards expectation and quest.... it is a mind whose nature is to tend, with confidence and perseverance, towards

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9 I think this was clearly marked in New Zealand in the late 1980’s by the introduction of competition within university campuses so that different departments instead of cooperating generously in research retreated from each other. Conversation became muted and sometimes non-existent.
something it will never reach and that therefore, same as a horizon, partakes of transcendence.... Contemporary physics... bars reducing Being to material components and thereby makes it impossible... to believe consciousness to be just a product of matter, that is of empirical reality (Espagnat, 2006 p 463).

Yet the two ways of viewing reality, the scientific and the spiritual, are analogous to the two ways of vision. Both are needed for human flourishing. Day vision, mediated by the rod cells in the retina sees colours and sharp vision. Night vision mediated by the cone cells in the retina sees shapes in dim light. Both sorts of vision are important for survival.

3 Post Modern world
The model of a quantum universe is one in which order and chaos coexist. It suggests that interconnection is so intense even observing a phenomenon changes that phenomenon. It identifies the interconnection of all things at the smallest and largest dimensions. In this vision of creation all the certainties of a fixed Newtonian universe have disappeared.

According to modern quantum mechanics, again, all sorts of new ways of looking at reality are now demanded of us, possibly including the abandonment of the simultaneous application of determinacy, causality, and mechanical descriptions in space-time frameworks (Honner, 1998 p 266).

Post modernism suggests that there are no easy fixes and we live in a world where chaos intrudes into order, where no one is to be trusted as an expert. It allows for the re-emergence of mystery and expresses disenchantment with the damage that scientific materialism and individualism was doing to the earth and humanity. It may also reflect the observed damage that unrestrained scientific materialism was doing to societies and the environment.

The other aspect of the current age is global communication. The Internet and global media make it impossible to retreat into national isolation, or indeed personal isolation. Global disasters elicit global responses of compassion. It seems to me that these very challenges are also opportunities to free religious spirituality from some of its limiting and claustrophobic aspects. They are also an urgent request for true dialogue between religions and the emerging spiritualities. This is not yet happening, often due to the fearfulness of religious leaders that they are no longer in control of spirituality through dogma. The irony is that they have never been so – it has merely appeared as if they were, for spirituality is essentially about the freedom and uniqueness of human beings.
The kind of spirituality that may develop in an expanding universe is free of the arbitrary limits that were present in the Newtonian world. In such a world, the image of God as a watchmaker cannot be adequate. More and more the spirituality emerging is that of mystics – an ever growing and expanding vision of limitless possibilities both within the unique person and without in the universe. It reaffirms the connectedness of all things and beings. This vision has its terrifying as well as its freeing aspects. It will not provide a basis for fundamentalist views of the world. Neither will it give cosy certainties.

This kind of spirituality has emerged in religious communities (Johnston, 1978; Griffiths, 1989; Johnston, 2000). It is also visible in the Western world in New Age spirituality. New Age spirituality is free of demands for doctrine and order. It represents a spirituality that is highly individualistic (Heelas, et al., 2003; Heelas, 2006). More recently there has been some evidence that it too is developing community aspects that appear to be an essential part of spirituality (Aupers, et al., 2006; Charlton, 2006).

Spiritual time appears to exist in two forms, linear unfolding time and quantum spiral enfolding time: “there is no absolute scale of time and no absolute past and future” (Honner, 1998).

There is even a recent suggestion that the world is fundamentally static and time arises out of the complex network of relationships in which humans exist:

Merleau-Ponty was speaking of our subjective experience of time, and until recently no one ever guessed that objective time might itself be explained as a result of those connections. Time may exist only by breaking the world into subsystems and looking at what ties them together. In this picture, physical time emerges by virtue of our thinking ourselves as separate from everything else (Callender, 2010 p 65).

We live at a time when the world-view has changed rapidly over the past two generations. Nevertheless these three ways of knowing the world coexist. Individuals may hold pre-modern, modern and post modern ways of understanding the world at the same time, sometimes carefully compartmentalised, sometimes as a rich bouillabaisse of concepts that enable growth and express personal freedom to be.

Some people may opt passionately for one world-view and deny all others – scientific or religious fundamentalists. Those who opt for the post-modern world-view continually battle
with despair, possibly as a result of the loss of order of modernism, and in the absence of spiritual awareness. At the same time there does appear to be a renewal of seeking wisdom and the sacred even in those societies where suppression of spirituality and religion was attempted.

4 Traditional spirituality

Societies in which traditional spirituality is supported still exist. In New Zealand the traditional Maori understanding of the world is precisely this – an interconnected and unbounded place in which the local mountain, river and ancestors are as present and important today as they were 500 years ago, and the spirits of places and people are still present. In such a world saying the right prayers and doing the right rituals keeps a person safe while ignoring them or transgressing tapu can have catastrophic consequences.\(^\text{10}\) Rituals are important in correcting transgressions in the spiritual sphere as in making noa what was tapu in Maori tradition – that is freeing from the restrictions imposed by extension of tapu (Shirres, 1997 pp 33, 42).\(^\text{11}\)

Spirituality was also part of the normal greeting in Swahili in Tanzania, where the questions were put in a slightly different way. Where are you from? Where are you going? Is all well with your family, your food garden, your cattle? Only then might the question be delicately put – who are you. Names that were private were not shared in that culture as they might be used for bad purposes, like putting on a curse.

There is great potential for misunderstanding when world-views are as different as the traditional from the modernist view. “Cross-cultural communication is like proof reading. No matter how many times one reads a script a mistake seems to get missed” (Metge, et al., 1978 p 56).

In traditional cultures spirituality is not only about human connection, but connection with the natural world and transcendent. This land connection is extremely important, as certain places resonate with the individual spirituality. Maori spirituality stresses connection to mountain, river, family, ancestors and descendents. These are all addressed in the formal greetings or powhiri.

\(^{10}\) I once had a Maori patient who presented with very high blood pressure. I was puzzled as she did not usually have it and asked her what she thought caused it. She told me she had transgressed a Tapu. I then asked who in the community could lift it. As soon as it was lifted her blood pressure returned to normal.

\(^{11}\) Tapu means restricted or forbidden and with the potential for power. It also means recognising the link with spiritual powers, back to Io, the source of all.
This is what is behind so many movements world wide to reclaim traditional ancestral lands (Cram, et al., 2003). This spirit filled environment also existed in many traditional European cultures until the Middle Ages and traces of it persist in Celtic countries and in the places of healing like Lourdes. In a fascinating paper Dein explored the cross-cultural implications of spirituality and religion. He confirms the underlying and universal nature of spirituality as primarily about connection, ultimate meaning and life force (Dein, 2005). Traditional spiritualities express this clearly in their connections.

5 Spirituality and religion

Spirituality has often been confused with religious belief, but it also exists in those who are not attached to any religion or have vehemently rejected religion. For many people religious belief orders their spirituality in a particular way (Delgado, 2005). There has always been a certain tension between spirituality and religion. Spirituality is about personal and unique connection to the transcendent and therefore not to be controlled or limited by dogma. It is manifested by the positive emotions, according to Vaillant (Vaillant, 2008), and by positive and negative emotions according to other spiritual leaders (John of the Cross, et al., 1976; Johnston, 1978). Spirituality may present a threat to religions, because it is a personal and unique relationship to the transcendent and free of legalistic controls. It may challenge religious organisations to grow and change.

The word for ...mysticism was contemplation...which means looking at, gazing at, being aware of...Some maintained that ...mysticism was for an elite of specially chosen people...others held that mysticism was a universal call. But if mysticism is knowledge through love and if love is the great commandment can we not say that mysticism is the core of authentic religious experience and that it is for everyone. I do not mean just for all Christians but for all (Johnston, 1978 pp 24, 31).

In the history of the Christian church many saints, like Joan of Arc, have been persecuted before being recognised as saints precisely because they followed their inner sense of right action rather than listening to the voice of reason and order in the institution.

The spiritual may break through into the ordinary lives of people, sometimes dramatically. Contemplation or meditation may enable this to happen, taking time to be aware of the deepest sense of self and other. This is not a mere technique but part of the spiritual journey.

Contemplation is not a technique to be mastered, a discipline to be perfected. It is the journey of the spirit into what is already within…. Understandably we flinch
before the realisation that we can experience the vibrancy of God…The “Other” can never be so familiarly present. That is altogether too shocking, certainly too uncomfortable. It is much easier to build a religion and keep God within it. We can live our lives then without touching the sacred at every hand’s turn (O'Leary, 2008 p 15).

When religions stop growing and changing and fail to meet the spiritual needs of people they may also die. This has happened in the past when the understanding of creation changed. It may still be happening.

From this perspective, religion is conceptualized as a variety of frameworks through which spirituality is expressed. …. Through this conceptualization, spirituality becomes an organismic, developmental dimension and religion, a "culturally flavored" framework that helps develop the organismic spiritual potential (Ingersoll, 1994).

Religion is also susceptible to widely varying definitions …it might be helpful to emphasize that religion is concerned with socially and traditionally shared beliefs and experience, but in placing this emphasis we must not lose sight of its personal and subjective dimension…Religion and spirituality are seen bound together in a common search for the sacred (Cook, et al., 2009 p 4).

Religion is continually being invented by the spiritually hungry who are ignorant of or who have been wounded by the Tradition (Jones, 1993)

Spirituality today is changing rapidly – indeed some believe it is moving away from religion and towards a mystical spirituality.

The new spirituality is … existential rather than creedal. …It grows out of the individual person from an inward source, is intensely intimate and transformative, and is not imposed upon the person from an outside authority or source (Tacey, 2003 p 8).

Johnson and Griffiths both confirm this transformation of the spiritual journey, from religious dogma and practice to mysticism (Griffiths, 1989; Johnston, 2000).

While there was little doubt that religions had evolved (Armstrong, 1993), the idea that spirituality has also evolved was first proposed by Teillard de Chardin (Teilhard de Chardin, 1959). It had also been touched on by Canadian psychiatrist William Bucke who was influential in the thinking of William James and proposed the idea of cosmic consciousness as an evolutionary advance in 1902 (Harris, 2009). Vaillant also picks up on the idea of evolving human spirituality in his book (Vaillant, 2008).
There are two schools of thought about the relationship of spirituality with religion: the first one insists that spirituality and religion are aspects of the same thing. This is a common attitude in many American researchers, and is particularly pushed by Koenig. He blurs the distinction between religion and spirituality or considers that they can only be used together.

A recent review of more than 1,200 studies of religion and health reported that at least two thirds of the studies evaluated had shown significant associations between religious activity and better mental health, better physical health or lower use of health services (Koenig, 2001d p 30).

Koenig restricts spirituality to a connection with the sacred, defined in religious terms only.

Religion involves beliefs and practices related to the sacred, where the sacred is defined as God, the numinous (mystical or supernatural) or ultimate truth. Religion is a unique construct, different from other psychological and social phenomena… The word spirituality, when used in research, should be restricted to those things that have something to do with the sacred (as defined above). If there is no connection with the sacred, then it should not be referred to as spiritual or spirituality (Koenig, 2007).

This suggests a pseudo-biomedical model for looking at spirituality, by linking it to religious activity, which can be measured. But does religious activity say anything about the internal intention of a person? It seems to me that measuring religious activity is less informative about the spirituality of the person than spiritual experiences, which are revealed in their narrative and actions.

Traditionally, spirituality was used to describe the deeply religious person, but it has now expanded to include the superficially religious person, the religious seeker, the seeker of well-being and happiness, and the completely secular person…. Either spirituality should be defined and measured in traditional terms as a unique, uncontaminated construct, or it should be eliminated from use in academic research (Koenig, 2008a p 349).

If spirituality is about connection one might ask what is an ‘uncontaminated construct’ of it.

In his latest book Koenig says:

I propose …there should be two definitions of spirituality, one for conducting research and studying the relationship between spirituality and health and one for applying what has been discovered to the care of patients… I believe we should return spirituality to its origins in religion, whether traditional or non-traditional (Koenig, 2008b).
His interest in spirituality is to clarify a definition of it, in order to be able to cultivate it. He subsumes it into religion because religiosity can be measured and spirituality cannot. As can be seen above Koenig also finds the concept of a secular, non-religious spirituality baffling and unacceptable.

Koenig is in company with another author who does not want to have spirituality in medicine at all and wrote somewhat crossly:

In Psycho-Oncology, as in many other scientific journals, an increasing number of publications dealing with religious or spiritual aspects of illness are appearing (Stefanek et al., 2005). Despite my efforts I must unfortunately admit that I fail to understand the point of this tendency to conceptualise existential issues as ‘spiritual’ (Salander, 2006).

It is interesting to have a psychologist wanting to lay exclusive claim to existential issues. Breitbart, the editor of Psycho-Oncology replied. Here secular is being used to mean non-spiritual not non-religious.

He (Professor Salander) is directly challenging the need for the concept of spirituality independent of the terms religious and existential and proposes that spirituality as a concept is irrelevant for the majority of the “secular” world – in particular secularized Europeans (Breitbart, 2007).

The second view proposes that spirituality is an inherent aspect of human beings whereas religion is a cultural interpretation and way of expressing this. Spirituality is about the individual connection to the transcendent, how and wherever that is found. Religion refers to the communal and institutional aspects of a group with particular beliefs and practices. Vaillant suggests that spirituality arises from biology, while religion originates in cultures (Vaillant, 2008). Others also maintain that spirituality is inherent and prior and religion grows out of it and expresses it.

Spirituality is the common context out of which religion grows. But spirituality is not religion...I believe it is prior to religion and is a built in, biologically structured dimension of the lives of all members of the human species. Therefore there are secular as well as religious expressions of spirituality, and many of them (Hay, 2006 p 48).

The issue of secular spirituality is also a matter of debate. Some with deeply religious convictions are unable to accept secular spirituality as a reality while others believe it is a common form of spirituality. Here secular means not religious: “Secular spirituality is no oxymoron. It is a reality for a high percentage of patients, surveys of whom reveal its central
role in preventing and healing disease, also in enduring both distress and disability” (Culliford, 2006).

There are many papers also proposing that a secular spirituality is common in the Western world today (Mueller, et al., 2001; Coyle, 2002; Delgado, 2005; Wasner, et al., 2005; Culliford, 2006; Kuin, et al., 2006; Sulmasy, 2009). I absolutely agree with them. It is particularly relevant in New Zealand where 45% of the population have no religious attachment according to the 2006 census.12

Spirituality is a deeply personal experience that does not depend on being religious or belonging to a faith group. The spirit is the essence of life…. spirituality is a universal dimension of human experience, being of fundamental or ultimate importance (Cook, et al., 2009 p 122).

Spirituality is a universal characteristic as we have already discussed above, whereas religion today is a personal choice. Religions develop dogmas, sets of required beliefs. They provide a community in which to develop spirituality and often have practices and rituals that encourage spiritual experience. They also have had a historic tendency to end up in conflict with each other when each claims to possess absolute truth and labels all others as wrong or evil. This fundamentalism is clearly visible in history and indeed up to the present day.

An important paradox of religion is that it can limit the spiritual growth and vision of individuals, as well as enabling and encouraging them to pursue their spiritual journey. When the image of the transcendent is presented as a controlling, stunting experience, it will affect health and wellbeing in all aspects. Negative, controlling, spiritual or religious concepts can create conflict within the person that may emerge as physical or mental illness (Mueller, et al., 2001).

Sinclair, in contradiction to Koenig, suggests that spirituality can be considered as a non-religious concept. He also makes a plea for spirituality to be explored by health professionals as well as patients and their families.

Spirituality is emerging largely as a concept void of religion, an instrument to be utilized in improving or maintaining health and quality of life, and focused predominantly on the "self" largely in the form of the patient. While representing an important beginning, the authors suggest that a more integral approach needs to be developed that elicits the experiential nature of spirituality that is shared by

12 NZ Census 2006, Department of Statistics
patients, family members, and health care professionals alike (Sinclair, et al., 2006 p 464).

I am not sure spirituality is void of religion, but it does appear to be present whether people are religious or not. This is supported by an interesting finding of Hay that the number of people having spiritual experiences increased dramatically between 1987 and 2000 from a cumulative total of 48% to 76%. At the same time the number of churchgoers dropped by 20% from 1989-1999 (Hay, 2006).

Five important themes emerged in a review of the literature on spirituality and health, and of these difficulty in defining spirituality comes first (Sinclair, et al., 2006).

1. conceptual difficulties related to the term spirituality and proposed solutions;
2. the relationship between spirituality and religion;
3. the effects of spirituality on health;
4. the subjects enrolled in spirituality-related research;
5. the provision of spiritual care.

Others think that the spirituality/religion divide needs to be bridged. Once again I agree. As soon as there are definitions, there is a possibility of disagreement and a platform for fundamentalism. Perhaps a humble approach to mystery is needed. In a delightful paper entitled Can you measure a sunbeam with a ruler?, Lederburg pleaded for mutual tolerance:

The publication of this special issue on the topic of religion and spirituality reflects a growing and serious interest on the part of psycho-oncologists in exploring this area. But this does not mean that controversy is lacking. The sunbeam : ruler dichotomy coined by one of our colleagues … identifies a legitimate question. Can the chasm between those who see only rulers and those who see only sunbeams be bridged in a way that honors both views of reality?(Lederburg, et al., 1999 p 375).

4 Spirituality in health and sickness

1 Ancient history
From the earliest human history there appears to have been a connection between spirituality, religion, health and sickness. Archaeological evidence suggests that trepanning occurred in Neolithic times 10,000 years ago in Western and Eastern Europe. This process of drilling
skulls was also widespread in the rest of the world - in Asia, Oceania, Peru and North Africa. Modern practices of trepanning in traditional medical systems around the globe were to let out the evil spirits that caused severe headaches.

The earliest historical healers in the West worked as priest/healers in the Egyptian and Mesopotamian worlds 2000 to 1000 BCE. The papyri in Egypt and the clay tablets in Mesopotamia bear witness to this close connection. Healing was connected intimately with spirituality and religion. It was also connected with sacred places (Sigerist, 1951). What is interesting is that in all the early medical writings there appears to be an understanding not only that physical ills need to be cured but that harmony or wholeness needs to be restored by healing.

Table 4: Early history of Western medicine

<table>
<thead>
<tr>
<th>Time</th>
<th>Medical Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-10C BCE</td>
<td>Egyptian surgery/medicine</td>
</tr>
<tr>
<td></td>
<td>Mesopotamian Astrology/medicine</td>
</tr>
<tr>
<td>17C BCE</td>
<td>Code of Hammurabi</td>
</tr>
<tr>
<td>11C BCE</td>
<td>Minoan serpent cult</td>
</tr>
<tr>
<td>6C BCE</td>
<td>Ionian</td>
</tr>
<tr>
<td></td>
<td>Medical schools at Cos and Cnidus</td>
</tr>
<tr>
<td></td>
<td>Sicilian school/ dissection/ four elements</td>
</tr>
<tr>
<td>5-4C BCE</td>
<td>Hippocratic medicine ‘scientific’</td>
</tr>
<tr>
<td></td>
<td>Athenian school - Aristotle</td>
</tr>
<tr>
<td></td>
<td>Alexandrian school - library</td>
</tr>
<tr>
<td>3C BCE</td>
<td>Hippocratic collection of writings</td>
</tr>
</tbody>
</table>

The Eastern Mediterranean civilisations all contributed to the development of medicine in Greece. Elements of Minoan (1000BCE), Mesopotamian (1-2000BCE) and Egyptian (1-2000BCE) practice have all been identified. One of the earliest documents dealing with medical practice was the Code of Hammurabi (1760BCE) which specifies fees to be paid and penalties for unsuccessful treatment (Singer, 1928; Sigerist, 1951).

In the Greek and Roman worlds the link between healing and spirituality was also very close. The medical schools at Cos and Cnidus (600BCE) fostered the cult of Asklepios, possibly a physician, but later deified as the God of healing. In contemporary sculpture he is often shown holding a staff entwined with a serpent: this was thought to have originated from the much earlier Minoan serpent worship, and this symbol is still used by medical associations the world over. Alexandria was also the site of a famous medical school where the human
body was dissected. It had the finest library in Europe until it was destroyed in the 4\textsuperscript{th} century CE.

Hippocrates, known as the Father of medicine in the West, was supposed to have been born on Cos around 473BCE. The collection of writings attributed to him date from about 300BCE. They contain descriptions of diseases, which are recognisable and logical. They also describe treatments for disease and prognoses of survival.

In the East a similar trajectory of development took place. In India the classical Vedic medicine was developed from about 1500BCE, although it is suggested its roots go back much further. It was, as in the West, completely integrated into the religious beliefs. “The ancient Vedic medicine, like Greek archaic medicine, had religious and magic elements” (Ninivaggi, 2008 p 11).

Table 5: Early history of Eastern medicine

<table>
<thead>
<tr>
<th>Year BCE</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>20C BCE</td>
<td>Shennong - China</td>
</tr>
<tr>
<td></td>
<td>Yellow Emperor’s Manual of Corporeal Medicine</td>
</tr>
<tr>
<td>5C BCE</td>
<td>Bian Que – rational medicine</td>
</tr>
<tr>
<td>6 C CE</td>
<td>Sun Simiao - Medicine Buddha; Ethics</td>
</tr>
<tr>
<td>15 C BCE</td>
<td>Rig-Veda India – medicine/surgery</td>
</tr>
<tr>
<td>5 C BCE</td>
<td>Nalanda University / Medical School - Buddhist</td>
</tr>
<tr>
<td>2-5C CE</td>
<td>Buddhist medical missionaries E Asia/China/Japan</td>
</tr>
</tbody>
</table>

The Rig-Veda, of India (1500BCE) contains significant medical content. This document was not written down until much later, but was taught by mnemonic learning. Around 500BCE the Nalanda Buddhist University, in what is now Bihar, was set up. This not only taught Buddhism but also astronomy, mathematics and Ayurvedic medicine. From there Buddhist missionaries went out to Sri Lanka, Burma, China, Korea and Japan. The missionaries to China, Korea and Japan took a version of Buddhism known as Mahayana and Ayurvedic medical teachings. Mahayana Buddhism was first developed by a famous Ayurvedic physician, Nagarjuna (Ninivaggi, 2008).

The integration of medicine with the philosophy and religious understanding of the culture was as close in China as in India and the Mediterranean. The roots of Chinese medicine go back 2-3000 years BCE to a legendary figure, Shennong, the Heavenly Husbandman.
In the earliest writing about medicine, *The Yellow Emperor’s Manual of Corporeal Medicine*, the need for harmony between heaven, earth and man was set out in keeping with Confucian ideals. There too, a spiritual element in health and sickness was clearly defined (Ho, et al., 1997). It records that physicians were obliged to participate in a set of rituals and take an oath sworn in blood before beginning the study and practice of acupuncture (Parsi, et al., 2006 p 64).

Bian Que was almost a contemporary of Hippocrates. He lived about 500BCE. He outlined the principles of diagnosis in Traditional Chinese medicine, and also proposed prognoses on the physical symptoms observed. The concept of harmony is important in traditional Chinese medicine.

In another 4th century Chinese medical text, *A Treatise on the Nature of Things*, by Yang Quan, suggests seeking out doctors who practice universal love, or agape: “One should not seek medical help from those lacking in humanity and universal love (boai) and should not entrust oneself to practitioners without wisdom and a well cultivated morality” (Nie, 2006 p 64-5).

Sun Simiao (581-682AD) wrote a treatise on ethics that was the equivalent of the Hippocratic writings in the West. He was also deified and worshipped as the medicine Buddha. His thinking was influenced by Confucianism, Daoism and Buddhism. He certainly suggested the practice of medicine involved the spirit as well as intellect.

Only those who learn with the heart and study meticulously can begin to understand the complexity and subtlety of medicine… For Sun medicine like divination, involves grasping the finest subtleties with the help of ‘divine revelation’ something beyond purely human talent and power…. Sun holds that visible virtuous conduct will be rewarded by humans, and invisible good deeds by the spirits, while immoral behaviour – even that hidden from human eyes - will be punished supernaturally (Nie, 2006 p 66).

Sun’s final book, published when he was 100 years old, proposed ten kinds of good conduct for medical practice.

1. Assist those in need and those with difficulties.
2. Do not kill or injure anyone.
3. Develop an attitude of compassion
4. Respect demons and celestial beings
5. Cultivate a temperate disposition
6. Avoid valuing luxurious items and despising ordinary ones
7. Seek moderation in diet by avoiding wine, meat and rich food
8. Seek moderation in life and avoid indulging in women or music
9. Maintain a well balanced disposition and character\(^\text{13}\) (Nie, 2006 p 70).

The influx of Buddhist missionaries into China in the 2-5 centuries CE also brought Ayurvedic medicine to China, Korea and Japan. There were connections also between the East and West from the time of Alexander the Great (300 BCE) and concepts of health and sickness travelled both ways along the trade routes between East and West.

What is intriguing is that medicine in both East and West was totally integrated into the cultural beliefs and included the spiritual aspect of being. It reflected the intimate connection between the physical world and that of the spirit. It was what Charles Taylor calls ‘the enchanted world’ (Taylor, 2007a). The other striking thing about ancient medicine is that the major medical systems were all developed around the 5\(^{\text{th}}\) century BCE.

Sigerist only deals with the Western world in detail in his book on *Primitive and Archaic Medicine*. He makes a clear connection between the ancient medical systems and religious belief. He also suggests that those countries where ancient systems persist are ‘primitive’ and not scientific. He goes on to describe a number of traditional tribal societies and their medical practices, suggesting that it is possible the practices of ancient times were similar. He also points out the persistence of primitive medicine.

Thus we realise from the start primitive therapy is a combination of empirico-rational, magical and…religious elements. …Primitive medicine is timeless…we know that the elements of primitive medicine may be found in all societies, at all times (Sigerist, 1951 pp 194, 209).

As a man of his time, writing in the middle of the last century, when the model of biomedicine was rapidly becoming the only respectable one, he implies that science has put paid to the primitive ideas. Empirical science was the only rational way to deal with illness. This has not been borne out by the popularity and persistence of traditional societies, traditional medical systems and complementary and alternative medicine.

\(^{13}\) It is interesting to compare this with the recent publication from the NZMC Good Medical Practice (2008). This demands that the doctor have a relationship of trust with patients; is competent in both care and communication; avoids discrimination; ensures continuity of care; acts with integrity; does not exploit patients.
Roman medicine developed on the basis of Greek medicine with influences from the Eastern Mediterranean. It was then carried to the furthest limits of the Roman Empire, where it became blended with whatever local medicine that existed. The Romans also developed hospitals for the poor and for their armies. Galen (130-200CE) wrote profusely about medicine and was an influence for many centuries. He was firmly of the opinion that the spiritual was part of both the creation and the suffering of human beings. This was part of his Stoic philosophy that proposed human needed to find harmony in their place in the order of things. It is interesting that in both East and West harmony not just the treatment of individual disease became important.

The monasteries preserved some of the medical knowledge through the centuries following the breakdown of the Roman Empire, copying classical books in their scriptoria. The Arabs also preserved and developed Classical Greek and Roman medical knowledge particularly after the rise of Islam in the 6th century CE. Rhazes in the 8-9th century CE and Avicenna in the 9th-10th century CE were the best-known authors of medical treatises. They translated the earlier Greek medical books into Arabic and added influences from their own Islamic tradition. Avicenna remained an influence on Western medicine until the 17th century (Singer, 1928). Thus the inheritors of the early Greek and Roman tradition maintained a clear contact with the spiritual in their understanding of health and disease.

During the middle ages Arab medicine was re-introduced into Northern Europe. It was spread by the Christian religious orders who set up the hospitals for medical care of pilgrims and the poor. It was also well established under the Arabic rulers of what is now Spain. Surgery and anatomy were also reintroduced under the Bologna, Montpellier and Padua schools of medicine, and this knowledge was later transferred to Leyden and Edinburgh.

2 Development of modern medicine
During the Renaissance and Age of Reason medicine continued to develop scientifically. However it remained firmly connected to the idea of humans as spiritual beings – perhaps summed up well by Ambrose Paré, the French surgeon (1517-1590): “I dressed him but God cured him” (Singer, 1928 p 94).

Further developments in medicine and surgery continued throughout the next four centuries precipitated by scientific and technological developments, like the microscope, and an ever-
increasing investigation and understanding of the anatomy physiology, biochemistry, of normal human tissue and the epidemiology and pathology of disease. In spite of all these changes, the connection with the spiritual in health and sickness remained until the middle of the last century.

In 1922 an editorial in the BMJ makes very clear the distinction between scientific and ‘religious’ healing, and claims modern medicine is scientific. It also allows the need for spirituality.

That there is a field in which science and religion may be and are of use one to the other all medical men will most readily admit…. But whatever their origin and finer relations no one, surely, will doubt that the main course of ancient scientific medicine was manifestly separate from that of the worship of the god of healing. It is the spirit of Hippocrates and Aristotle, and not that of Aesculapius and Chiron the Centaur, that rules the medicine of our time (BMJ editorial, 1922 pp 882-3).

There was interest in religion and psychology from the late 19th century, particularly following the work of William James (James, 1985). However this fell rapidly in the 1920’s due to the rise of psychoanalysis and its rejection of religion (Beit-Hallahmi, 1974). It was the early psychoanalysts, particularly Freud and his followers, who ejected the spiritual and religious as pathological.

By the middle of the last century scientific fundamentalists claimed that the only paradigm to describe the human person and the material world was the scientific one. In an interesting parallel with religious fundamentalism, possession of scientific truth, hostility to critical evaluation of their beliefs and a rejection of those persons who disagree with them as ‘not true scientists’, are the marks of fundamentalist scientific thought as they are of religious thought (Barr, 1977). In other words, scientism claimed to be the basis of all knowledge.

3 Rise of biomedicine

Biomedicine was the medical form of scientism, emerging strongly as the only way to practice medicine. It rejected the idea of the spiritual, and suggested that science alone was the basis for good medical care, beginning in the late 1950’s. Until very recently the biomedical paradigm was the only acceptable one and medical journals and major medical publishers exercised positive discrimination against anything else. Because it focussed on the physical understanding of disease, it ignored the need for restoration of harmony or wholeness.
that is part of healing. Instead it focussed on cure done by the doctor to the patient, thereby
disempowering the patient and further empowering the doctor.

The majority of the medical profession thought that, given time, science would provide the
answers to all health problems. A few, like Viktor Frankl, neurologist and psychotherapist,
were very clear about the centrality of spirituality in health. He went on to say more about
spirituality in *The Doctor and the Soul*. He would certainly have agreed with the comments of
Kleinman in section 2:2 of this chapter about the interconnectedness of healing: “Man lives in
three dimensions, the somatic, the mental and the spiritual. The spiritual dimension cannot be
ignored, for that is what makes us human” (Frankl, 1973 p 9).

There were a few who resisted the weakening of connection between the doctor and patient.
In 1957 Michael Balint published *The Doctor, his Patient and the Illness* about the
psychological process of connection between doctors and patients. This showed very clearly
the importance of self awareness for doctors, the effect of their own past experiences and the
importance of their connection to patients (Balint, 1957). Balint groups, usually facilitated by
a psychiatrist, enabled doctors to reflect on the psychological processes active in the clinical
relationship particularly transference and counter-transference. In building such awareness
they also enabled a closeness and support in the groups.14

Biomedicine with a focus on the physical and biochemical aspects of health and disease
predominated for most of the last century, particularly from the 1950’s onwards. There was a
definite body/mind dualism with only the body considered relevant.

As a student in the early 1960s, I know there was no mention of anything other than the
scientific information about anatomy, pathology, physiology and pharmacology. Religion was
presented in psychiatry as a delusion. Disease could all be explained physically, the mind was
irrelevant and even its workings could be explained by physical criteria. In the 1960s
laboratory investigations were still extremely primitive and required a chemical laboratory -
deed the subject was known as clinical chemistry. It was a time of very rapid growth in the
technology of medicine, in investigating and treating disease. All the clinical sciences,
radiology, biochemistry, pathology, pharmacology were advancing and becoming central to

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14 As a member of a Balint Group for twelve years, I was struck by the spiritual nature of some of the discussion,
the strength of affection and connection between both doctors and patients and the members of the group. The
group became so close knit that new members found it impossible to join and some left saying so. The group
was led by a psychiatrist and the spiritual aspect was never labelled as such.
making a diagnosis. The focus on competent examination and history taking was becoming less. This too lessened the connection between doctor and patient.

Thus the biomedical model … assumes that the language of chemistry and physics will ultimately suffice to explain biological phenomena. From the reductionist viewpoint, the only conceptual tools available to characterize and experimental tools to study biological systems are physical in nature (Engel, 1977 p 130).

Students were taught that they had a battle to win against disease – the enemy. Failure to cure was tantamount to neglect. Not knowing the facts about disease and treatment was a serious lapse for medical students. Death was a failure of modern medicine, and an embarrassment, so denial of death was widespread. Dying patients had screens drawn round them, and were often by-passed by the clinical team responsible for them. This was also the era in which cardio-pulmonary resuscitation was introduced, strengthening the illusion of defeating death and suggesting strongly that the patient was an object to be saved rather than a person to be related to (Safar, et al., 1963; Eisenberg, et al.).

Taylor’s paper discusses how this encouraged death denial and avoidance.

We very often feel awkward at a funeral, don't know what to say to the bereaved, and are often tempted to avoid the issue if we can…. We don't know how to deal with death, and so we ignore it as much and for as long as possible…. Doctors and others fail to pick up on this desire, because they project their own reluctance to deal with death onto the patient (Taylor, 2007b p 13).

Engel’s ground-breaking paper was an early challenge to the hegemony of biomedicine (Engel, 1977). While he did not write about spirituality he did talk about the need to pay attention to the culture and social aspects of patients in the real world.

But nothing will change unless or until those who control resources have the wisdom to venture off the beaten path of exclusive reliance on biomedicine as the only approach to health care. The proposed biopsychosocial model provides a blueprint for research, a framework for teaching, and a design for action in the real world of health care (Engel, 1977 p 135).

In spite of this, my instruction in clinical medicine was by doctors, mainly men, who had had a liberal education in the humanities as well as science. So although spirituality was not discussed the elements of it – connection, care for the other, a sense of the transcendent - were

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15 I was in Rochester, NY in 1964 when this ‘magical’ treatment was introduced and universally applied to all patients who collapsed. Even as a medical student I had serious questions about the ethical suitability of this. They were dismissed by senior staff there.
present in their modelling of care. These doctors had lived through the pre-antibiotic and pharmaceutical revolution, so focussed attention on looking at clinical signs and listening well to patient stories.

I was also in the first generation of medical students to have teaching in General Practice. The connection there with real human beings in their own environment was far removed from the clinical distance of hospitals at the time - the ward rounds where white coated consultant, registrars, house surgeons and students stood at the end of the bed and looked at the patient as a specimen of a particular disease.

The effect of biomedicine has been to place more emphasis on technology, which developed very rapidly in the past four decades. In 2007 The Journal of the Royal Society of Medicine reprinted an article from its first meeting in 1907 bemoaning the fragmentation of medicine into specialties. This process has been accelerated by the technological revolution. The Royal Society of Medicine now has fifty-five special groups. The author suggests:

It is surely possible to ensure that super-specialisation in medicine is not accompanied by imbalance between specialties and divisive competition for resources...but that planning...always puts the needs of patients first, thus opposing the forces of fragmentation (Scadding, 2007).

Unfortunately such wishful thinking is not successful. The majority of the health budget everywhere goes on high technology super-specialties in hospitals. There is competition for funds in health systems and the glamour of high technology ‘life saving’ surgery wins out every time against the less exciting but more extensive needs for care and support for chronic illnesses and ageing.

By the end of the last century there was little argument about the use of biomedicine as the only reputable medical paradigm. The practice of Evidence Based Medicine (EBM) was the only reputable way of working. This originally arose in the mid 1980s and rapidly became the dominant paradigm in medicine (Lambert, 2006). “Medicine should be based upon the conscientious, explicit and judicious use of the current best evidence,” (Sackett, et al., 1996) and “…best evidence should be identified using epidemiological and biostatistical ways of thinking” (Davidoff, et al., 1995).

This attitude has continued unquestioned until recently, particularly by managers in health, who liked the ‘hard data’ of EBM. Since many of them came from financial and industrial –
not medical – backgrounds, this is not surprising. It may explain why the biomedical model is so deeply entrenched. It promised to control costs and give a rational means of spending the health budget (Gordon, 2006). However it left out the importance of healing as opposed to cure, which is not at all easy to measure since it depends to a large degree on the deep human relationships between doctor and patients which are neither measurable not saleable (Easton, 2002).

EBM provides:
- epistemic power and legitimacy
- normative power
- to practice any other form of medicine is to abrogate one’s moral responsibility (Gupta, 2003; Kerridge, 2009; Kerridge, 2010)

However, the promise of Evidence Based Medicine is an empty one for the treatment of unique individuals. EBM is based on statistics and epidemiology, which is about populations and does not take into account the uniqueness of each individual patient. Neither is it value free and totally objective. It also ignores the experience and tacit and intuitive knowledge of the doctor.

The appeal to the authority of evidence that characterizes evidence-based practices does not increase objectivity but rather obscures the subjective elements that inescapably enter all forms of human inquiry. The seeming common sense of EBM only occurs because of its assumed removal from the social context of medical practice (Goldenberg, 2006 p 2621).

The rejection of scientific reductionism and the need for a broader paradigm of health suggested by Miles and his colleagues has become more persistent (Miles, 2009b, 2009a). This was also identified clearly by Kerridge at the 2009 Australasian Association of Bioethics meeting.

- EBM promised and initially provided a simple approach to complex medical problems, a way to mediate between competing data, interests or claims and a promise of objectivity impartiality, consistence, rationality, truth and certainty.

- But EBM could provide none of these things as evidence is not value-free, self-apparent, disinterested or atheoretical but is socially constructed, relational, gendered, embodied, intersubjective and communal (Kerridge, 2009).

There is no question that the rise of science and the development of modern medicine made prevention, prognosis and treatment much more effective for infectious diseases. Surgery too was able to be proactive and the technology improved very rapidly. Nevertheless in spite of
all these advances, in the last thirty years dramatic advances in surgery and pharmacology have slowed considerably, and promising new technologies like genetic medicine and nanotechnologies have failed to make progress.

Singer says at the end of *A Short History of Medicine*:

> So medicine must end where she began, quaking before the mystery of life, a Mystery which could be resolved if we could express Mind in terms simpler than itself….. But the author of this work believes that the hope of this is in vain and we are here in the presence of one of the ultimate things (Singer, 1928 p 350).

This is echoed by a much more recent book – *The Rise and Fall of Modern Medicine*. In it the author suggests it may be time to reaffirm the importance of the creative relationship between the doctor and patient, rather than focusing on ever more complex and less useful anatomy, physiology, pharmacology or surgery (Le Fanu, 1999).

The biomedical model is not good at finding ways of living with chronic diseases or coming to terms with death which are major components of GP life. Since life inevitably leads to death, coming to terms with our mortality, tendency to deteriorate with age, and suffer from incurable disease is part of human growth. This growth is painful and hard work.

Technological attitudes suggest firstly we should be in absolute control of our lives and secondly that we should be able to maximise our choices. Our present scientific culture has little to offer about ways of coming to terms with chronic illness, ageing and dying. The present push to legalise euthanasia is a response that may owe much to this wish to take control of life and death. After all, logically, killing someone is an admission of clinical defeat. All that euthanasia does is to take action and move the time of death. It gives an illusion of control, rather than facing the fact that death is the natural end of all human lives. It also does not understand the process of healing a whole person as distinct from curing a disease. A patient may find healing even while dying.

The negative effects of biomedicine on embodiment and a sense of wholeness and the impact of technology on health are well summed up by Schilling.

> a key feature of technological culture is its promotion of a form of bodily being that can deny individuals experiences of immanence and transcendence, and it is the denial of these experiences that has been central to traditional sociological
concerns about the problem of personality and the increase of anomie and suicide in industrial societies (Shilling, et al., 2007 p 546).

4 Re-emergence of Spirituality in Health

Science fought its way free of government – sponsored religion only to threaten now to become the new established church (Slobodkin, 1965 p 509).

By the early to mid 1970s some doctors and social commentators were beginning to question the biomedical and limited view of illness as inadequate. One of the earliest critics was Ivan Illich (Illich, 1975), who wrote a book on the expropriation of health by doctors in the USA. He suggested biomedicine had become useless in the face of modern epidemics and there was a growing sense of alienation and helplessness of people. Biomedicine disempowered people to the point where their lives were being medicalized and dependent on experts. Not surprisingly they then felt no responsibility for their own health and healing and were happy to pass the responsibility on to their doctors. This was epitomised by patients who said, when an attempt was made to engage them in conversation about their medical condition, “I’ll leave it up to you, doctor”.

By the late 1970’s after working in a number of different cultures I was also no longer ready to accept this model. I was acutely aware of the medicalization of normal human stress and sadness using antidepressants and particularly anti-anxiety agents.

Health is perceived as the dynamic balance between the physical, mental and spiritual, internal and external environments of the individual. It is the degree of lived freedom, the outcome of each individual striving for wholeness.... A prerequisite of such a system is freedom of access to expert knowledge... and the setting up of a dialogue between expert and non-expert where each recognizes the special knowledge and free responsibility of the other (Holmes, 1979 p 20).

As criticism of the biomedical model grew so did the demands for the return of spirituality. Recognition of the tunnel vision of both medicine and religion was an important step in understanding how dogmatism can ensure less effective care.

Dogmatism is one source of tunnel vision. Both science and religion create dogma in that they provide ways of understanding our world and define sets of rules that govern it. Science and religion also share a risk of unthinking adherence to dogma (Ellis, 2002).

As a result of this criticism the idea of whole person medicine began to emerge. The need to encompass the dimensions of illness as well as disease gained ground. I wonder if some of the
reason for this was the challenge presented by CAM\textsuperscript{16} in which practitioners took time to listen well to the stories of patients (Clark-Grill, 2010).

It is fascinating that Engel, quoted below, was a psychiatrist protesting at the exclusion of psychological and social aspects in the treatment of disease. He proposed a new model of medicine that included the psychological, social and cultural aspects. Over the following thirty years it has been generally adopted as the bio-psycho-social model of illness (Engel, 1977).

The dominant model of disease today is biomedical, with molecular biology its basic scientific discipline. It assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological, and behavioural dimensions of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behaviour, it also demands that behavioural aberrations be explained on the basis of disordered somatic (biochemical or neuro-physiological) processes (Engel, 1977 p 135).

A number of papers suggest that spirituality began to re-emerge as a topic in medical journals from the late 70’s and this trend increased rapidly after 1990 (Lukoff, et al., 1999; Mills, 2002; Weaver, et al., 2006). The reaction against biomedicine may have reflected social turmoil elsewhere when all institutions came under question. This started with the 1968 Paris student revolution and the Vietnam War protests. This was the beginning of the end of modernism and the start of post-modernism.

In a study of published papers on the scientific study of spirituality, religion and health from 1965-2000 the total overall numbers of papers on both religion and spirituality continue to rise (Weaver, et al., 2006). However it was found that the proportion of papers on spirituality increased while those on religion had decreased. This matches the reduction in religious attachment seen in national statistics over the same period.

\textsuperscript{16} Complementary and Alternative Medicine
Figure 3: Number of published titles with keywords "religion" & "health" or "spiritual/spirituality" & "health" in Medline database from 1975-2001. [Adapted](Mills, 2002).

I have updated the figures from Medline to show the continuing increase in papers on both religion and spirituality in the literature in the graph below.

The problems about definitions of spirituality have already been discussed above and persist to this day. There is still a rearguard action being fought by pro-biomedical doctors who think spirituality has no place in medicine. Arguments about the relationship between spirituality and religion also still rumble on.

Cultural changes affect spirituality and over the past thirty-five years there has been a major change in culture in New Zealand from egalitarian to a very individualistic culture. This has had enormous impact on the organisation of health services as well as the practice of medicine (Easton, 2002; Randerson, 2010).
There are however signs that even the health organisations are beginning to recognise the place of spirituality in health care. This is not only from the point of view of good patient care, but also from the management perspective and in public health. Schultz has an interesting paper on the effect of social capital on health (Schultz, et al., 2008). This is certainly supported by Randerson and Easton (Easton, 2002; Randerson, 2010). There is no doubt that management shapes the organisational milieu. Hard-nosed business management produced a health culture that is solely focussed on cure and economics, with consequent loss of trust and reduction in healing. However it is now being discovered that the inclusion of spiritual values in health management promotes better health in the clinical staff, more satisfied patients and a more efficient service (Kaiser, 2000; Reece, 2000; Phelps, 2006; Puchalski, 2006a). This understanding has also emerged in public health discourses (Levin, 2003). Vader makes this very clear.

At the societal level, indicators might be manifestations of solidarity, equity, justice, sexual equality, unity in diversity, participative decision making and power sharing….By ignoring the spiritual dimension of health, for whatever reason, we may be depriving ourselves of the leverage we need to help empower individuals and populations to achieve improved physical social and mental health. Indeed, unless and until we do seriously address the question… sustainable improvements in health and reductions in health gradients within and between societies, may well continue to elude us (Vader, 2006).
The re-introduction of spirituality in health owes much to the development of care of the elderly and palliative care. The medical specialties that have paid most attention to spirituality in health care have been palliative care, mental health and care of the elderly. From its founding, palliative care included spirituality as one of its essential components. The most recent definition from palliative care follows.

Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred (Puchalski, et al., 2009 p 887).

Professionals working in mental health also realised that spiritual care could be an additional help. Primary care has some papers about spirituality but not a great number. Many of the papers on spirituality are in the nursing literature.

5 Spirituality and palliative care

From the late 1970’s spirituality began to emerge as an important aspect of health and sickness care. The modern hospice movement was founded in 1967 and recognised the importance of spiritual issues in palliative care. St. Christopher’s hospice in London was founded in1967 by Cicely Saunders and had as a basic principle attention to the spiritual and existential aspects of the patients. As part of palliative care the connections of the patients to their beliefs, families and friends were recognized and attended to. They are still central to hospice care today.

The whole family is the unit of care and should also be seen as part of the caring team. They should have every available option open to their choice, and expect recognition of their cultural and individual needs (Saunders, 1978).

Since that time the journals of oncology and palliative care have produced many articles on spirituality. The spiritual transformation of hospice care is still in process, challenging limitations of the biomedical model.

Training of health professionals in spiritual care is considered important and useful (Puchalski, et al., 2004; Wasner, et al., 2005; Kuin, et al., 2006; Sinclair, et al., 2006; Puchalski, et al., 2009). This was particularly so, when technology can be used to prolong suffering and dying without improving the quality of life of patients.
We are seeking to empower individuals to discover truth and meaning in their own dying and death. The impersonal medical rituals that keep bodies alive at all costs and ignore the person’s wishes, hopes, and integrity are, unfortunately, still being practiced…. All of our patients will accomplish their own deaths with or without our help…. We are here to bear witness to their stories and to allow their stories to be completed in their deaths. We are not here to impose our stories or our beliefs on them (Cotter, 2007).

Spirituality care is particularly needed because the maintenance of hope is central to good palliative care. Vaillant has a very pertinent comment about hope.

You cannot have hope without the capacity to recognize the reality of loss….without willingness to mourn…Hope you see, does not abolish grief; it only reminds us of the possibility that, as in a winter garden, the seeds of love may be successfully resown (Vaillant, 2008 p 112-113).

Good spiritual care demands the engagement of the doctor at a personal level, and a commitment to see the journey through with the patient (McKee, et al., 1992; Nekolaichuk, et al., 1998; Byrne, 2008; Milstein, 2008). It enables the patient to maintain a sense of meaning and purpose without which hope is not possible. The quote below comes from a patient who was dying.

…a woman asked me why I was here and I replied, because I’ve come home to die. And … I knew I was bringing her hope. To me that’s wonderful thing – that we can always give hope to others, especially in our dying (McCabe, 2008 p 10).

Hope is not a simple concept. It has a number of aspects identified by Cellarius: “From these writings, hope appears to have three main features: it is an active emotional experience; it flees from the bad and aspires to the good; and it has effects” (Cellarius, 2008 p 116).

The struggle to find definitions of spirituality in palliative care, as in other areas of medicine, continues to this day. When the uniqueness of each patient, and their spirituality is acknowledged a joint search for hope and meaning can begin (Walter, 2002).

Spiritual belief may or may not be religious, but most religious people will be spiritual. A non-religious person may still therefore have a deep spirituality and spiritual needs. Spiritual care is not just the facilitation of an appropriate ritual but engaging with an individual’s search for existential meaning, as reflected in the existential domain of the McGill quality of life questionnaire (Speck, et al., 2004).

From around the millennium a number of leading Palliative Care journals produced special issues about spirituality, religion and medical care. *Psycho-Oncology* was very early in
producing a special issue on religion and spirituality in 1999 (Lederburg, et al., 1999). Other important documents were the NICE (UK National Institute for Clinical Excellence) report in March 2004: Supportive and Palliative Care for Adults with Cancer. This proposed that regular assessments be made to evaluate spiritual needs. The World Health Organisation produced a Cross Cultural study of spirituality, religion and personal beliefs as components of Quality of Life in 2006 (WHOQOLSRPB, 2006). The most recent document has been Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference (Puchalski, et al., 2009).

6 Spirituality, mental health and positive emotions

As discussed previously (Chapter 2:4:2) the rise of psychoanalysis was in part responsible for the ejection of spirituality and religion from health. The one psychoanalyst who resisted this was Carl Jung who was certainly aware of and analysed the importance of spirituality. He was well ahead of many others in his extremely perceptive analysis not only of the individual need for spirituality but the effects on communities and nations of losing sight of this (Jung, 1933). An interesting paper studies the trajectory of the psychology of religion showing the intense interest at the start of the last century followed by gradual disengagement (Beit-Hallahmi, 1974). As spirituality was ejected from medicine there was a rise in the use of antidepressants and tranquilizers, in an effort to find a physical treatment for what is often a spiritual ailment (Horwitz, 2009).

It is therefore particularly interesting that mental health has been one of the most active areas in re-discovering the importance of spirituality. Many mental health journals have had special issues on spirituality and religion. In 2002 Annals of Behavioural Medicine had a Special issue devoted to spirituality (Thoresen, et al., 2002). In 2004 Health Communication had a Special Issue devoted to religion and spirituality (Parrott, 2004). Transcultural Psychiatry also produced a special issue on spirituality in 2005 (Bartocci, 2005) and the Journal of Clinical Psychology had an issue devoted to spirituality in 2007 (Pargament, et al., 2007). Recently the special interest group on spirituality of Royal College of Psychiatrists in UK has published a comprehensive book on Spirituality and Psychiatry (Cook, et al., 2009).

Papers fall into a number of categories, both looking at the patient experiences of mental illness (Blazer, 2009) and at how spirituality and religion is linked to positive emotions and can help in sustaining health, in therapy, growth and healing. They include the importance of enquiring about spiritual issues for patients (Baetz, et al., 2009).
We review suggested guidelines for sensitive patient inquiry... We also study practical ways to incorporate psycho-spiritual interventions into patient treatment, with specific reference to more common spiritual issues such as forgiveness, gratitude, and altruism (Baetz, et al., 2009 p 292).

Measurement of spirituality/religion has certainly been a central concern for some prolific authors, particularly those who were convinced of the importance and centrality of the biomedical evidence based medical paradigm (Koenig, 2001a, 2001b, 2001c; Bussing, et al., 2007; Bussing, et al., 2008; Koenig, 2008a; Koenig, 2009; Koenig, 2000). What is also of note is that psychiatrists in the USA are less religious than other physicians there (Bolentino, 2001; Culliford, 2002; Bathgate, 2003; Curlin, et al., 2007).

Spirituality is also important in psychotherapy, enabling growth and wholeness (Oman, et al., 2007; Boyd, 2008). It can give meaning and purpose to life and is particularly important at the end of life (Breitbart, et al., 2004). Clarke, in his paper discusses the need for faith and hope in psychiatry (Clarke, 2003). Spirituality is also clearly identified as linked to hope in psychotherapy (Domash, 2009). Another area of interest is on the effect of prayer on making and healing relationships (Fincham, et al., 2007; Beach, et al., 2008b, 2008a; Marks, 2008; Sullivan, et al., 2008; Lambert, et al., 2010).

Given the history of the extrusion of spirituality by the alliance between promoters of the biomedical model and psychoanalysis it is interesting that psychiatrists and other mental health workers have been particularly active in re-discovering the importance of spirituality in health and sickness. One in seven of the members of the Royal College of Psychiatrists in England now belong to the Spirituality Special Interest Group of the College, which started in 1999.

7 Spirituality and General practice

The journey of a thousand miles begins with the first step, and that means the personal realization by all healthcare professionals that their clients will have their own spirituality—however we, and they, may define that (Johnson, et al., 2003).

It is not easy to live as a healthy human being moving towards wholeness. From birth to death we experience fleeting moments of wholeness in the cycle of growth. Growth towards
wholeness, that is the potential to continue growing psychologically and spiritually throughout life, is a human birthright.  

General practice or family medicine in the past was in contact with the whole lives of the patients from birth to death, so although spirituality was not discussed it was present. This is beautifully illustrated in *A Fortunate Man*, an account of rural general practice in the 1960s (Berger, et al., 1995).

Occasional papers in the literature had referred to the need to maintain spiritual care and pay attention to the spiritual and moral nature of the doctor.

A physician's character is "what God sees him do in the dark." Hippocrates recognized that the profession of medicine is supported by two pillars - science and morals or religion. I greatly fear that at the present time we are paying too much attention to the former, and too little to the latter. We are exalting to the highest heavens, though perhaps none too high at that, the importance of the guinea-pig side of medicine, but we are doing but little to inculcate the basic, spiritual foundations of our vocation (Magan, 1929).

The Art of medicine, based on the understanding of the whole person and their environment, was considered important when General Practice was becoming a specialty in its own right in the 1960s and 70s. However in hospitals where students were being trained biomedicine reigned unchallenged. A few voices were raised in protest at the uniformly orthodox approach to biomedicine but for the most part new specialties like General Practice felt compelled to follow the biomedical line and the dominant medical paradigm of Evidence Based Medicine.

The earliest review that looked at religion and spirituality in articles in the *Journal of Family Practice*. It found that between 1976 and 1986 5% of articles mentioned religion and spirituality (Craigie, et al., 1990). The problems already alluded to, of difficulty defining spirituality and the difference between spirituality and religion, were much debated in the earlier papers (McBride, 1999; Sulmasy, 1999).

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17 The baby had orthogryphosis. All her joints were affected by severe distortion and there is no treatment apart from tendon transplants, which were not available in rural Tanzania. Each time I held a clinic in the hospital her parents would bring her and I would say, "There is no medicine for this disease." They went away sadly each time. I found myself getting irritated that they continued to come and were wasting my time. One day I really looked at them instead of just glancing at the child. I realised that they knew I could not cure this child. They wanted to share with me, and have me acknowledge, how wonderful she was, unique, different and precious. After that, I stopped saying ‘there is no cure’ and commented how well she had grown. This time they went away smiling.
A large number of papers in family medicine dealt with spirituality in relation to patients. Religion and spirituality are supports and comforts to patients and a source of deepening of patient-doctor relationships (Hebert, et al., 2001). In the USA the majority of patients wish they could discuss their religion or spiritual supports with their physician. Referrals to clergy were common – more than 80% of a random sample of family physicians surveyed referred patients to clergy (Daaleman, et al., 1998). There is an interesting difference between the numbers who believe that spirituality should be discussed and the number actually discussing it which is far less.

There were four qualitative studies that looked at the understanding of spirituality and religious beliefs of family physicians. These all concluded a patient-centred approach was needed. They also discussed barriers and facilitators of addressing spiritual issues which included lack of comfort with, training in or awareness of spirituality, no common spiritual language, time pressures, and lack of continuity of care (Ellis, et al., 2002).

Another paper by this author looked at both patients and doctors and whether spiritual differences had an effect.

> Our respondents view spirituality similarly to other aspects of the physician–patient relationship involving differing viewpoints. Where discordance exists, cross-cultural, patient-centered, diplomatic approaches facilitate spiritual discussions (Ellis, et al., 2006).

A further study looked at seventeen family physicians.

> Four main themes regarding physicians’ attitudes, beliefs, and practices were apparent from the analyses; (1) nature of spiritual assessment in practice, (2) experience connecting spirituality and medicine, (3) personal barriers to clinical practice, and (4) reflected strengths of an integrated approach (Olson, et al., 2006 p 234).

A review of articles in the *Journal of Family Practice* from 1976-86 referring to religion and spirituality appeared in 1990. The article is talking of religion not spirituality but talks of it all as spirituality (Craigie, et al., 1990).

> The issue is more than one of measurement and methodology (How will we define spirituality?); it is a more basic philosophical or psychosocial question about the types of human experience that spirituality subsumes. Recent conceptual articles in this area (5,6) suggest that spirituality is multidimensional, encompassing meaning (ethics, values, and principles), ceremony and sacramental activities, and social support (clergy and supportive communities) as well as
"encounters with Deity." (7) Within any or all of these dimensions, moreover, there exists the possibility of destructive as well as constructive effects of spirituality (Craigie, et al., 1990).

This review also found that the areas of spirituality most referred to were as follows. It also notes the experiential aspects were uncommon.

References to social support and influence were the most frequent, followed by references to denominational affiliation, with references to meaning and purpose a close third…."experiential" and "ritual" dimensions of spirituality (were) sparsely represented categories of relationship with God and ceremony… (Craigie, et al., 1990).

While references to spirituality were mostly positive, those for religious attachment there were more negative. This ambivalent effect of religiosity is mentioned in the section below on spirituality effects on health.

References implying a positive valence of spirituality were almost three times as frequent as references implying a negative valence…. Most noteworthy was the predominance of references implying potentially harmful effects of spirituality within the dimension subsuming meaning, purpose, values, and beliefs (Craigie, et al., 1990).

Craigie’s paper looked at nine categories in interviews of family physicians who had expressed an interest in spirituality. I will return to it in the discussion.

Definitions of spirituality
Spirituality as experience
Qualities of viewing and relating to patients
Personal spirituality of the caregiver
Vocation and mission in being a doctor
Clinical: incorporating spirituality in the care of patients
Obstacles and challenges
Spirituality in the context of the organization
Supporting the understanding of spirituality in medical education (Craigie, et al., 1999 p 581).

A review by McKee in 1992 makes a clear distinction between spirituality and religion.

Spirituality has been defined as having to do with "the spirit or the soul, as distinguished from the body, what is often thought of as the better or higher part of the mind."[2] Spirituality has to do with man's search for a sense of meaning and purpose in life[3,4]; it is that part of a person's psyche that strives for transcendent values, meaning, and experience.[5] Spirit is that aspect or essence of a person (soul) that gives him or her power and energy, and motivates the pursuit of virtues such as love, truth, and wisdom.[6] Religion, on the other hand,
is "any specific system of belief, worship, conduct, etc, often involving a code of ethics and a philosophy."[2] It may include doctrine, dogma, metaphors, myths, and a way of perceiving the world (McKee, et al., 1992 p 205).

This paper also identifies five requirements of physicians to meet the spiritual needs of patients.

1. Be trustworthy
2. Treat the patient as a person (not a disease)
3. Be kind
4. Maintain hope

A number of general medical journals have had special issues on spirituality and medicine, but no General Practice or Family Practice journal has yet done so. In 2006 Annals of Internal Medicine and the Southern Medical Journal both produced special issues on spirituality. The Medical Journal of Australia had a whole issue devoted to the subject of Spirituality and Health in 2007 (Williams, et al., 2007). The BMJ has never had theme issues on spirituality. However, spirituality featured in the BMJ issues on “What is Integrated medicine: orthodox meets alternative” (2001), “What is a good doctor and how do you make one?” (2002), “What is a Good Death?” and “Health of Indigenous Peoples” in 2003.

The developing concept of whole person medicine and mindful medicine made it possible to enquire more widely into the beliefs and supports of patients. Interestingly the language used by those who do not identify spirituality is very close to that of those who do (Epstein, 1999; Carmody, et al., 2008). The paper by Grossman makes very clear the connection between mindfulness and improved spirituality (Grossman, 2008).

In a paper on the ABCD of dignity conserving care, Chochinov identifies attitudes, behaviours, compassion and dialogue as the way to deliver the essence of medical care. Non-judgmental self and other awareness and acceptance are the key to such care.

As such, the more that healthcare providers are able to affirm the patient’s value—that is, seeing the person as they are or were, rather than just the illness they have—the more likely that the patient’s sense of dignity will be upheld. This finding, and the intimate connection between care provider’s affirmation and patient’s self perception, underscores the basis of dignity conserving care. Yet, many healthcare providers are reticent to claim this particular aspect of care,
which is variously referred to as spiritual care, whole person care, psychosocial care, or dignity conserving care (Chochinov, 2007 p 184).

Spirituality and religion became legitimate fields of study when surveys showed patients wished them to be included in care (Kliwer, 2004). They also emerged very clearly as part of enabling health and healing and include trust, hope and a sense of being known. Their GPs were present for them and bore witness to their suffering (Scott, et al.).

Three key processes emerged as fostering healing relationships: (1) valuing/creating a nonjudgmental emotional bond; (2) appreciating power/consciously managing clinician power in ways that would most benefit the patient and (3) abiding/displaying a commitment to caring for patients over time. Three relational outcomes result from these processes: trust, hope, and a sense of being known (Scott, et al., 2008 p 315).

There were also many papers about the importance of spirituality in the lives of patients (Hebert, et al., 2001; King, 2006).

Spiritualities are responsive to patient needs by offering beliefs, stories, and practices that facilitate the creation of a personally meaningful world, a constructed "reality" in the face of illness, disability, or death. It is largely through narrative that physicians incorporate into the health care encounter the spiritualities that are central to their patients' lived experience of illness and health (Daaleman, 2004 p 370).

Other authors confirm this deep interest in the spiritual and or religious aspects of their lives by patients (Post, et al., 2000; Bussing, et al., 2007).

This article considers means by which physicians may enable patients to express their spiritual concerns and find support for them, without stepping over professional boundaries or imposing personal views on those of patients….An appropriate model for addressing patients' spiritual concerns should include active-listening skills, identification of spiritual/emotional issues, effective referrals to spiritual specialists, and ongoing communication about this aspect of the healing process (Kliwer, 2004 p 616).

This author also reviewed papers on the effects of spiritual involvement on health and found some positive effects.

The ethics of spirituality care are mentioned in many papers. Boundaries need to be very clear about these matters because of the inequity of role power between patients and doctors. This very important issue features in a number of papers. The physician must respect the patient’s
belief or unbelief and there is to be no imposition of the doctor’s beliefs on the patient (McKee, et al., 1992; Daaleman, 2004; King, 2006; Winslow, et al., 2007).

Much of the literature comes from the United States and particularly from the Southern States and contains both statistics and assumptions about religious belief and attachment that do not apply elsewhere. The level of religious observance and belief is much higher than that in Europe or in New Zealand. A random sample of family physicians in USA on organised religious activity, non-organised religious activity and subjective or intrinsic religiosity had a 58% response rate of which 79% reported strong religious belief and 4.5% no belief in God (Kliewer, 2004).

8 Effects of Spirituality on health and disease
Illich suggested that health is a task for all humans, requiring self-awareness, self-discipline and personal regulation of diet and life style and relatedness: “Man’s consciously lived fragility, individuality and relatedness make the experience of sickness and death an integral part of his life. The ability to cope with this trio autonomously is fundamental to his health” (Illich, 1975 p 169).

It was echoed more recently in a paper on spirituality and medicine: “They believed that to be healthy involves the optimal functions of body, mind, and spirit in whatever the social context” (McKee, et al., 1992).

Interest in the past, as I have noted, was often focussed on the positive effects of spirituality and religion in enabling and improving health. So even here, the interest was pragmatic and utilitarian rather than philosophically based (King, et al., 1994; McBride, et al., 1998; Koenig, 2001d; Koenig, 2001c, 2001a). However, healing can also occur when a patient is dying, enabling the patient to die in peace.

The discovery of meaning in the illness experience helps patients reconcile their distress and leads to a transcendence of suffering. Saunders described this process as “things fall into place” and observed that dying patients who had experienced healing were “quietly accepting it with the heart” (Egnew, 2005 p 258).

Associations between spirituality, health and medical care have certainly been found for a number of factors. These studies were all North American and tend to blur the distinction between spirituality and religion and to ignore the needs of those who are not religious.
Most studies have shown that religious involvement and spirituality are associated with better health outcomes, including greater longevity, coping skills and health related quality of life (even during terminal illness)...Several studies have shown that addressing spiritual needs in the patient may enhance recovery from illness (Mueller, et al., 2001 p 1225).

A review of a number of studies suggested those who regularly attended religious services had lower blood pressure, lower rates of coronary disease and myocardial infarction, emphysema, cirrhosis, and suicide, reduced levels of pain in cancer patients. They also reported better-perceived health, less medical service utilization and decreased functional disability in the nursing-home dwelling elderly. In addition there was improved physical functioning, medical regime compliance, and self-esteem and lower anxiety and health-related worries one year after surgery in heart transplant patients. They also, in this paper, raise questions about the design and selectiveness of these studies and point out that while those who attend religious services regularly appear to have better mortality statistics the reasons for this are unclear (Thoresen, et al., 2002). These studies included four epidemiological studies looking at mortality as the outcome variable.

A later group of papers also suggest the need to address spirituality. It is important to patients and improves health measures including reducing hypertension, improving biochemical measures for lipids and better immune function. Physicians should actively listen and enquire about spiritual and religious concerns and support the spirituality of patients and refer them to ‘spiritual specialists’ when necessary (Brody, et al., 2004; Kliewer, 2004; King, 2006).

More recently these results have been questioned and the differing effects of religiosity and spirituality identified: “Overall, results suggest a different pattern of independent linkages between formal religious participation and spiritual perceptions across diverse dimensions of psychological well-being” (Greenfield, et al., 2009 p 196).

In this very comprehensive paper on the effect on health of spirituality and religiosity the results suggested that religiosity, measured by attendance at religious gatherings, had an effect only on purpose in life and personal growth and was associated with less autonomy in older adults. Spirituality, however, was independently associated with better psychological well being across all dimensions. This was also noted to be stronger in women than men (Greenfield, et al., 2009). Other papers also come to a similar conclusion. Spiritual well being
rather than religiosity is the core domain in assessing QOL in cancer patients (Murray, et al., 2004; Whitford, et al., 2008).

9 Spirituality and healing

From earliest human history spirituality has allowed people to face the truth about mortality and living in an imperfect, evolving world. Moving towards wholeness and health in such a world accepts that not all problems can be fixed. It suggests that living with incompleteness is not unhealthy, it is simply a part of life. Healing is a lifelong task. It is possible to be healed while dying if the conflicts of life have been dealt with and the person is able to live with meaning, peace and hope. This aspect of healing demands that spiritual issues be dealt with.

Healing has been studied as a process. It has been identified as an outcome of healing relationships. It is the outcome of healing relationships with self, others, the transcendent and the natural world.

Healing is an elemental social function and experience. It is equally as primary as the gift or exchange relationship, and comprises one of the fundamental forms of symbolic action, native to all societies…. Healing is the end point of the medical system, the successful re-ordering and organising of the disease experience, and where possible, its control…. Healing occurs along a symbolic pathway of words, feelings, values, expectations, beliefs……which connect cultural events and forms with affective and physiological processes (Kleinman, 1973 p 210).

Healing places are part of traditional medicine and were recognised in ancient medicine in both East and West. What is intriguing is the increase in interest in sacred places of healing that has occurred over the past few years. The number of people going on pilgrimages to sacred places in Europe, like Lourdes in France or Compostella in Spain, has increased greatly. An interesting Canadian paper on this explores the concept of therapeutic landscape (Williams, 2010). Sacred places in Maori spirituality are discussed in Chapter 4:2:2.

Healing goes beyond the biomedical agenda of objective diagnosis and treatment of disease to engaging with the whole person (Kliwer, 2004). It is very clear that healing is a shared process affecting both healer and healed.

Three key processes emerged as fostering healing relationships: (1) valuing/creating a nonjudgmental emotional bond; (2) appreciating power/consciously managing clinician power in ways that would most benefit the patient; and (3) abiding/displaying a commitment to caring for patients over time. Three relational outcomes result from these processes: trust, hope, and a sense of being known. Clinician competencies that facilitate these processes are self-confidence,
emotional self-management, mindfulness, and knowledge (Scott, et al., 2008 p 315).

Healing relationships need self-aware practitioners prepared to work at their own spirituality.

Mindfulness is a quality of the physician as person, without boundaries between technical, cognitive, emotional, and spiritual aspects of practice. Mindful practitioners have an ability to observe the observed while observing the observer in the consulting room (Epstein, 1999 p 835).

Healing behaviour is possible only when physicians are prepared to become vulnerable to and connect closely with patients and integrate spiritual care into patient care.

The advantages [of integration] are to improve how people heal... second, I think you develop a closer bond with the patient and better understanding of them and their family and what they go through with pain and ultimately that leads you to take better care of them (Olson, et al., 2006 p 243).

One expressed that healing occurs as physicians and patients connect as people, stating, “I don’t have to be a spiritual master. I can be a human being, trying to connect with another human being. That is a healing experience” (Ellis, et al., 2002 p 253).

Healing happens as we connect spiritually with another person . . . finding the energy in them that wants to keep going . . . connecting with the real life force in that person (Craigie, et al., 1999 p 580).

General practice is continually dealing with patients who have chronic medical conditions and are going to die. They are not curable so seem to be beyond the pale of biomedicine, whose primary aim is cure. For these it is essential to address spiritual issues, by being empathic and bearing witness to the suffering of patients in a practice that exemplifies the art of medicine. Curlin recognised that this required wisdom and friendship for patients rather than an intellectual discussion between strangers (Curlin, et al., 2005). Arman also acknowledged the deep enriching relationship formed when caregivers bear witness (Arman, 2007). This is primarily focussed on healing and alleviating suffering.

Good medical care now insists so universally on the need for complex investigations even when the diagnosis is obvious that the need to learn about technologies and their uses has taken the focus of medical students away from the patient and towards the technology. The use of computers for storing notes and information has escalated this. There is a worrying tendency to believe in and pay attention to the technical rather than the clinical and personal
facts that emerge in the relationship. This focus fails to recognise the healing that can happen as a result of that relationship.

Doctors who have been trained to be emotionally contained and uninvolved with their patients feel increasingly distanced from patients. Some of them feel the gap painfully.

Now I am searching for a place to belong where I can live and work as a whole person—body, mind, and spirit…Somewhere along the way in my university training and in academic medicine, I learned that to explain is better than to feel and that dissection is the key to understanding…learning and in my new subculture I inadvertently mastered the ability to keep all suffering at arm’s length. This acculturation has amounted to my journey into spiritual exile…I have abandoned my ability to suffer with those who suffer or to mourn with those who mourn. I am “clinically detached” in a pathologic sense (Tilburt, 2006).

Learning to come to terms with the reality of de-humanising influences in biomedical or scientifically driven health care is important. Learning to change them is even more important.

So I know in my heart that the answer to the problems of healthcare lies in healing healthcare not fixing it. Our institutions will finally be safe and caring for patients and families when they are safe and caring for the professionals. We need to change the language we use and we need to make explicit that compassion lies at the very core of everything we do (Youngson, 2006 p 255).

Recognizing a patient's beliefs, and facilitating health care practice which takes into account those beliefs appears to be an important initiative in the management of suffering and loss (Aldridge, 1991 p 425).

It is important not to allow the focus on the physical in the biomedical paradigm to suppress or ignore the spiritual aspect of healing. Neither, however should holistic healing be allowed to be dismissive of biomedicine. Both may be guilty of a fundamentalist attitude to health that is damaging because it prevents dialogue between them.

The never-ending mind-body debate has served to discourage consideration of issues of even more ‘ultimate concern’…than the interplay of mind and body. Foremost is the influence on health and healing of realms of human existence and experience subtler even than what is conventionally conceived of as “mind”: the realms of the numinous, the hidden, the esoteric, the mystical, the superempirical or supernatural, the transcendent, the superconscious, the spiritual (Levin, 2009 p 485).
There is room for more than one paradigm of health and healing. Kleinman speaks of the vulnerability of doctors and medical students to suffering along with and their need to do good and make a living.

I have long found arresting a painting of Pablo Picasso's titled 'Head of Medical Student'. The painting is of a face in the form of an African mask with one eye open, and the other closed. Medical students learn to open one eye to the pain and suffering of patients and the world, but keep the other eye shut to protect their own vulnerability to pain and suffering, to protect their belief that they can do good and change the world for the better, to protect their own self interests such as career building and economic gain (Kleinman, 2006 p 234).

Figure 5: Head of the Medical Student (Study for Les Demoiselles d'Avignon), Pablo Picasso; Museum of Modern Art, New York
Perhaps the most difficult demand of all is to accept the concept of a wounded healer for it is in allowing ourselves to be vulnerable, accepting our own wounds that we are able to enable others to come to healing (Nouwen, 1979). Such a process is best described by poets.

I don’t know how
But suddenly there is no darkness left at all
The sun has poured itself inside me
From a thousand wounds (Vrettakos).

10 Self-care and spirituality
Self-care for doctors is critical not only for their own health but to enable them to function most effectively for their patients. Self-care involves care for the whole self. Gomez and Fisher’s paper looks at four domains of well being: personal, communal, environmental and transcendental (Gomez, et al., 2003). One of the problems for doctors is the temptation to treat both themselves and their families. This is partly about the difficulty they have admitting they and their families also get ill (Krall, 2008; Lamberton, 2008).

The demands of re-accreditation and making financial claims are demanding and stressful for General Practitioners in New Zealand and many complain. Burnout is common in doctors and often results from a lack of awareness and self-care combined with a culture of endurance (Cunningham, et al., 2009; Linzer, 2009; Shanafelt, et al., 2009). Attention to spirituality enables resilience and good self-care (Lloyd, 2006).

Finally, healing relationships gave meaning, joy, and satisfaction to both physicians and patients, suggesting that the solution to problems of physician burnout and patient frustration with medical care may lie not only in improving systems or changing reimbursement, but also in fostering healing relationships (Scott, et al., 2008 p 321).

Self-care is also critical in ensuring healing relationships are possible: “Spiritual self-care can take the form of self-understanding and inquiry regarding beliefs and values, or methods for bringing peace and tranquility, such as prayer, meditation, nature walks, church attendance, or yoga” (Anandarajah, 2008 p 451).

Some physicians are aware of the importance of their own spirituality in medical practice: “Their personal spirituality was seen as a foundation for their own coping with and satisfaction from medicine and their ability to facilitate healing” (Craigie, et al., 1999 p 583), and “The staff should be aware of their own spirituality …in order to offer better health care and address the spiritual needs of patients” (Boero, et al., 2005 p 920).
Allowing themselves to be vulnerable to the suffering of patients needs to be balanced by self-care and requires focussed attention: “Care providers also face an interactional dilemma as they seek to balance their own spiritual needs with those of the care recipients” (Considine, 2007).

Part of self-care is placing clear limits on disruptive patient behaviour that could lead to rupture of the doctor-patient relationship. Such an event is highly stressful for doctors (Stokes, et al., 2003, 2004).

Spirituality is an important factor in doctor resilience, prevention of burnout and health (Felton, 1998; Ovretveit, 1998; Lloyd, 2006).

The … practices used by 130 primary care physicians in Wisconsin to promote their own wellbeing… were spending time with family and friends, religious or spiritual activity, self-care, finding meaning in work and setting limits around it, and adopting a healthy philosophical outlook, such as being positive or focusing on success (Yamey, et al., 2001).

Hassed looks at the ESSENCE model of health care that is equally useful and applicable to patients or health carers. This includes education, stress management, spirituality, nutrition, connectedness and the environment. It can be used for health promotion for all. It includes spirituality but looks at the whole person in their total environment (Hassed, 2005). This makes sense in the light of the diagram illustrating spiritual connections on page 81.

Reaching such a sense of wholeness demands a number of closely related things. It demands a letting go or forgiving of self and others for wrongs or omissions in the past. It demands a letting go of expectations of self and others and living in the present moment. It also demands a sense of gratitude at the gift of life and connection and acceptance of mortality as a normal part of life. In other words it demands a sense of continuing growth, development and compassion towards self and other. This may then lead to an inner harmony and peace. Emmett suggested that connection with others, the transcendent and natural world and creative activities can all enable this (Emmett, 2008).

11 Education about spirituality

With the extrusion of spirituality from health care in the early part of the last century, education about spirituality also vanished. It did not begin to return until the end of the
century. The importance of spirituality was of course understood in the work of Frankl (Frankl, 1954) and Fromm (Fromm, 1947) following the Second World War.

The earliest mention was in a paper in 1992 (Levin, et al., 1997). It emerged in medical education as it did in medical care as a way of enabling health or healing (Shapiro, et al., 2000). Graves’ paper discussed a programme for medical students that includes lectures, small group discussions and on call attendance with hospital chaplains (Graves, et al., 2002).

More recently spiritual education has become very relevant and there have been a flood of papers about spirituality in medical education (Puchalski, 2006b; Deming, et al., 2007). Puchalski states that from a handful of courses in 1992 the number has risen to over 75% of US medical schools having courses on spirituality (King, et al., 2005; Mullan, et al., 2006). One author suggested all Primary care physicians should be taught contemplation.

A key implication of this work is that opportunities be provided to the primary care physician and other health caregivers to undergo contemplative training to cultivate these universal qualities, such as sensitive attention, compassion and positive intention (Davidson, 2008 p 389).

This is supported by the paper by Janssen suggesting that the art of medicine in caring for patients demands self-reflection (Janssen, et al., 2008). Andrew also stressed that there is a need for careful, in depth exploration of spiritual issues, not just a brief screening question as a precursor to referral to a spiritual specialist or chaplain (Garrison, 2006).

In the United Kingdom there are also considerable numbers of courses on spirituality in medical schools. Fifty-nine per cent of those who responded to a national questionnaire provide teaching on spirituality (Neely, et al., 2008). Guck and Kavan studied medical student beliefs and found that spirituality was thought to be more important than religiousness (Guck, et al., 2006).

Medical schools in New Zealand do not have specific formal education about spirituality in the medical curriculum except in relation to Maori spirituality. It also emerges in palliative care sessions in hospices. It is beginning to be raised in the Early Learning in Medicine in Otago Medical School.
12 How then may Spirituality be described?

A definition of spirituality presents an enormous challenge, given the cultural and religious diversity of humanity. There are many ways of describing spirituality. With the increasing interest in spirituality and health many efforts have been made to find a clear definition of it. Definitions of spirituality are all tentative because spirituality and its cultural context are continually changing and developing. Indeed, the longer spirituality is reflected on, the more aspects of it appear. It is analogous to a Monet picture of water lilies – the longer the image is gazed at the more is seen at ever deepening levels.

Hay’s comment sums it up well.

At first we thought we might get…a clear definition…of spirituality… Unfortunately the variety of opinions that emerged simply increased our confusion…. Everybody agreed that while pinning spirituality down to an agreed definition seemed impossible, they were able to recognize it when they came face to face with it (Hay, 2006 pp 129-130).

Religion has been the way in which spirituality was interpreted for most of the history of humanity. Some authors seek to make all spirituality religious and others wish to eject religion from spirituality or see religion as the negative aspect of spirituality.

Unruh’s paper has 92 definitions of spirituality. This author then collected them into seven categories or themes about spirituality.

Relationship to God, a spiritual being, a higher power or a reality greater than the self
Not of the self
Transcendence or connectedness unrelated to a belief in a higher being
Existential, not of the material world
Meaning and purpose in life
Life force in the person, integrating aspect of a person
Summative combining multiple aspects (both secular and religious) (Unruh, et al., 2002 p 8).

Ingersoll had previously proposed a similar set of categories: “…spirituality can be described as synergistically utilizing all of the seven dimensions.

One's conception of the divine, absolute, or "force" greater than one's self.
One's sense of meaning or what is beautiful, worthwhile.
One's relationship with Divinity and other beings.
One's tolerance or negative capability for mystery.
Peak and ordinary experiences engaged to enhance spirituality (may include rituals or spiritual disciplines).

Spirituality as play.

Spirituality as a systemic force that acts to integrate all the dimensions of one's life (Ingersoll, 1994)

Yet another list, extracted from 263 publications, was offered in a recent book on spirituality and psychiatry.

- Relatedness
- Transcendence
- Humanity
- core/force/soul
- Meaning/purpose
- Authenticity/truth
- Values
- Non-materiality
- Non-Religiousness
- Wholeness
- Self knowledge
- Creativity
- Consciousness (Cook, et al., 2009 pp 147-8).

13 Can spirituality be defined?

In the face of this complexity it seems reasonable to ask if spirituality can be defined. While science seeks definitions, in fact many things like genes, or thoughts are indefinable. A definition demands distance from the subject being defined. It is a scientific construct designed to fix the object being defined in a frame. The tendency to want to define spirituality in health reflects the current scientific model of health which is biomedical and reductive. The problem with definitions is that they are static and human beings grow and are transformed from birth to death. This makes trying to define any aspect of them well nigh impossible.

By its very nature spiritually is an inherent part of human beings, in a constant state of growth, development and transformation from birth to death, and is difficult to constrain in this way. So, it must be added, are thoughts, personalities and genes. Neuroscience has revealed some observable consequences of spiritual activity, but it also has non-observable ones that can only be hinted at using metaphor.

Spirituality is expressed in the culture and historical time of the person as well as the environment in which they live (Shilling, et al., 2007). For this reason it is necessary to pay
attention to both language and cultural issues when considering spirituality (Johnson, 2006). This is particularly so in relation to spirituality and health (Eckersley, 2007).

It is perhaps useful to look at some of the major attempts at defining spirituality in health. The definitions at least in part depend on the profession and culture of the definer. There are differences between the European and North American approaches to spirituality and religion. In North America there has been a tendency to assume spirituality and religion were the same thing. This was not so in the European papers. The American focus is often on gathering data about the effects of religious or spiritual involvement, often bracketed as R/S, on health.

The most recent effort of King and Koenig is of four aspects of spirituality.

Belief An assent to or conviction about a domain or existence that goes beyond the material world. This includes all manner of religious or other beliefs that are not based on materialism.

Practice Spiritual or religious practice at this level occurs without conscious awareness of, or relationship to, the spiritual realm addressed. Although it involves exercises of imagination and desire such as contemplation, prayer, reading or reflection, the self is not moved by any direct experience of relationship with or connection to the other.

Awareness There is an awareness of being moved intellectually and/or emotionally. It includes contemplation, prayer, meditation or reflection when there is conscious awareness of, or response to, this dimension.

Experience A discrete experience which may include diffusion of the mind, loss of ego boundaries and a change in orientation from self towards or beyond the material world. The experience usually comes unbidden but may follow a period of reflection, meditation, stress or isolation. Ecstatic experiences are of this type, but experiences may be much less intense and more prolonged (King, et al., 2009 p 121).

They specifically excluded any consideration of the source of spirituality, or any consequences of it and any emotion arising out of it. This certainly seems at odds with the ideas above of an embodied spirituality.

This model closely resembles another that has been developed over a number of years. This one most certainly does include embodiment.

The 3 H model head (cognitive), heart (experience), hands (behaviour) and the BMSEST models (body, mind, spirit, environment, social, transcendent) ...evolved from the author’s experience... with curricula development regarding
spirituality and medicine. The 3 H model offers a multidimensional definition of
spirituality, applicable across cultures and belief systems, that provides
opportunities for a common vocabulary for spirituality (Anandarajah, 2008 p 448).

However I think this model falls short of an ideal, as it presents the physician as giving
spiritual, psychological and physical support to the patients and fails to notice this is always a
two-way connection. It also does not address the process of spiritual growth throughout life.

The definition below covers many aspects of spirituality but does not address the need for
ongoing growth.

Spirituality is the distinctive, potentially creative and universal dimension of
human experience, arising from both within the inner subjective awareness of
individuals and within communities, social groups and traditions. It may be
experienced as relationship with that which is intimately 'inner', immanent and
personal, within the self and others, and /or as relationship with that which is
wholly 'other', transcendent and beyond the self. It is experienced as being of
fundamental or ultimate importance and is thus concerned with the matters of
meaning and purpose in life, truth and values (Cook, et al., 2009 p 4).

Spirituality is central to human development, health and wellbeing. Above all it is about
connection with self, other, natural world and transcendent (Hay, 2006 p 139). Hay describes
his discovery of spirituality as relational consciousness. He suggests it is equivalent to the
natural spiritual awareness described by Alister Hardy (Hay, 2006 p 140). “At its narrowest,
spirituality was limited to a feeling of loving unity with at most one or two other people,
whilst at the other end of the scale it comprehended a relationship with all people and all
things” (Hay, 2006 p 119).

This understanding is supported by Schneiders: “In short, although all humans are spiritual in
the basic anthropological sense …, each individual develops her or his spirituality in a unique
and personal way”… (Schneiders, 2003 p 166).

Health and wellbeing, however, are also about meaning and purpose, which develop as a result
of personal values, growth and integration which are part of the human journey through life.
These too are aspects of spirituality.

Creativity is another of the manifestations of the human spirit. In being creative a sense of
deeper self may be found. The results of creativity facilitate connection with the transcendent,
both for the creator and for others. Great art, writing, and music touch people deeply – but so may food, gardens and beautiful buildings and good teaching and inspired science (Damasio, 2003).

This is very much in agreement with Levinas’ central themes.

It is the daily marvel of the spirit … a flame that burns with its own fervour; the genius that invents the previously unheard of… the love that is inflamed even though the loved one is not perfect; the will that undertakes to do something despite the paralysing obstacles in its way; the hope that lights up a life in the absence of reason for hope; the patience that bears what can kill it…

Creation, freedom, permanent renewal. Does this revolutionary essence of the spirit tell us everything of its mystery? It blows where it will (Levinas, 1990 p 229).

In religious studies there seems to be resistance, perhaps not surprising, to defining spirituality in other than religious terms. The author below suggests that spirituality is used to cover the territory of religion without being easily visible and measurable, and also covered that of humanist psychology of thinkers like Maslow and Frankl.

Spirituality’s ambiguous relation to religion is one area of usefulness, but the term also covers those concerns or dimensions of humanity, which in earlier decades were the domain of existential philosophy and humanistic psychology. “Spirituality” is both a vaguer, murkier variant of “religion” and a way to label universal, essential capacities for freedom and transcendence (Bregman, 2006 p 6).

It is true that this author defines religion very widely, but I am at a loss as to why spirituality is ‘murky’, suggesting morally opaque or questionable depths or experiences.

Separating what spirituality is and how it is experienced is difficult. The concept of soul continues to be used, as the persistent centre of self, the best self (Cook, et al., 2009 p 104). There are also clearly existential aspects of spirituality concerned with values, meaning and purpose. ‘The third aspect of spirituality is that it is dynamic, growing throughout life.

Some suggest that spirituality is a search for the sacred, defined in such a broad way it seems extremely diffuse and imprecise. On the other hand the attempt below does include the concept of life-long spiritual growth ‘a process in motion.’
(Spirituality is) "a search for the sacred" There are two key terms in this definition search and sacred...The word sacred is defined as the holy, those things set apart from the ordinary and worthy of veneration and respect. ...Sacred objects include time and space (the Sabbath, churches); events and transitions (birth, death); materials (wine, a crucifix); cultural products (music, literature); people (saints, cult leaders); psychological attributes (self, meaning); social attributes (compassion, community); and roles (spouse, parent, employer, employee). ... The sacred can be understood from both theistic and non-theistic perspectives.

Spirituality is not static.... It is instead a process in motion (Pargament, 2006 p 13).

There are also problems with the language used about spirituality. Until recently all spirituality was expressed in religious language. Finding non-religious language that expresses spirituality is a particular challenge today. Perhaps the problem with language used about spirituality is the reality that human experiences are always described using metaphor.

Uncertainty of what counts as spirituality is further compounded by ambiguities of language. ...The issue is to do with the function of the metaphors we use when we describe an experience (Hay, 2006).

It is also evident that there is often a rejection of spirituality because it is confused with religion. This may interfere with spiritual growth and development. It is particularly important in New Zealand where 45% of the population at the last census\(^\text{18}\) denied having a religious connection or refused to answer that question.

It should not be assumed that spirituality is either synonymous, or coterminous, with religion, and it is suggested that to adopt this restrictive view is unhelpful in the provision of individualized care (Dyson, et al., 1997 p 1183).

The most recent definition of spirituality came from a consensus conference on Improving the Quality of Spiritual Care as a Dimension of Palliative Care, in the US.

Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred (Puchalski, et al., 2009 p 887).

This proposes both an immanent spirituality within and a transcendent spirituality without and the connections between all aspects. It certainly is in agreement with the model proposed at the end of this chapter.

\(^{18}\) NZ Census 2006, Statistics New Zealand
5 Spirituality as Connection

I have discussed some of the many ways in which spirituality may be understood as an underlying and complex connectedness for all humans. The connections are within, without, among, with the other and others. They are deep, wide, rooted and branched, unique and diverse.

It may perhaps be shown more clearly by the diagram below, although any visual representation of something that is dynamic is inadequate since it cannot show growth and progression in time. The three leaves of the diagram represent the self the natural world and the human other. The space at the centre represents the transcendent within and the space around represents the transcendent without. This ancient diagram, the triquetrum, emerged in Roman art in the third century CE but is most commonly associated with Celtic Christian art. It was used to represent various relationships including that of the Trinity.

The beauty of this diagram is that it shows the intimate interconnection of the whole so that although it is possible to speak about aspects of spirituality in relation to the self, the other and the natural world and transcendent in reality all aspects are interconnected and changes in one aspect inevitably affects all the others. The individual person does not exist in splendid isolation. At any point in time the effects of past experiences, the natural world and the transcendent are also active in relation to others in a fluid flow of connection.
This diagram even allows the concept of an immanent transcendence within and a transcendent without to be seen. There is a connection between the transcendent within and without and the transcendent within each person. This may perhaps throw light on the deep connection that may emerge. The depths of being within, what might be called immanent transcendence, resonates with the transcendent without whether this is in the natural world, in another human being or with the sacred or divine. Such resonance has many names. Some call it intuition or tacit knowledge, relational consciousness or spiritual awareness. Others might call it second sight, vibes, ESP, clairvoyance or a gift of sensitivity.

There is no sense in this model of an isolated self-sufficient human being. The self may be a doctor – the other may be a patient – but could equally well be a family member, friend, pastor or mentor. What I have tried to convey is the interrelated nature of human existence both within and without and in linear and non-linear time.

Spirituality is about both the deepest centre of the human self and the seeking of connection that emerges from this. This connection may be within or without. It connects with the centre of self, other human beings, the natural world and the transcendent however that is defined. The connections between these aspects are fluid and ever changing, connection with one aspect often leading to connection with others. I will return to this in the discussion.
Spirituality causes humans to continually seek connection within and without throughout life in what may be termed a spiritual journey. The seeking of human connection forms community, which in itself also enables and encourages spiritual growth. For some people spirituality is ordered by religion, for others it is not. There is a secular non-religious spirituality.

There appears to be evidence that spirituality, in the sense of seeking transcendence, is a universal human characteristic. This may be found in cross cultural studies and its spontaneous emergence in children discussed above (Chapter 2:2) It appears to emanate from the deepest part of the self, resonates with and seeks connection with the spiritual in others, the natural world and the transcendent without. The religious name for the transcendent is the sacred. Spirituality is prior to science and religion, an inherent property of human beings in the natural world (Hay, 2006).

It is about a life long search for harmony and connection, seeking the sacred or transcendent. It is expressed in the unique capacity to connect, which is exercised in relation to self, other human beings, the natural world and the transcendent, however that is defined. In making connections, it creates dialogue and community thereby empowering humans and enabling continuing growth and transformation from birth to death.

6 Summary

In this literature review I have considered the various meanings of spirituality, as connection and as an embodied search for meaning and purpose. It looked at the modes of perceiving the transcendent and spirituality as connection.

It considered the impact of changing world-views on both the possibility of religious belief and the expression of spirituality. It considered three world views – pre-modern, modern and post-modern. Although the present age might be called post–modern people continue to live in the pre-modern, modern and post-modern worlds.

The next section considered the history of medicine in both the East and the West and the close connection with spirituality for most of its history. It then considered the development
of modern medicine and the rise of biomedicine and the attempt to exclude spirituality in the last century.

The last section considered the re-emergence of spirituality in palliative care, mental health and general practice. It also looked at the effects of spiritual support on resilience, health and recovery from illness. It concluded that spirituality is an essential aspect of all humans which can enable growth, creativity, connection, healing and coming to terms with mortality.

It concluded with a reflection on spirituality as seeking connection, within, without and between the human person, others, the natural world and the transcendent however it is defined. This dynamic human spirituality is in a state of growth and development, through many transitions from birth until death.

The next chapter will deal with the aims, research design, method and methodology of the research for this thesis.
Chapter 3

Aim, Research design, Methodology and Method

![Figure 7: Where do we come from? What are we? Where are we going?, Paul Gauguin. Museum of Fine Arts, Boston.](image)

1 Aim

The primary aim of this thesis is to enquire into the way in which general practitioners understand and experience spirituality for themselves. It explores the understanding of spirituality and the spiritual experiences of the participants as individuals and as family and community members. It also explores the understanding and experience of spirituality in the medical practice of participants. It looks at the reasons why participants chose to do medicine and why they stayed in practice and considers how spirituality may contribute to their resilience and wellbeing. It looks at ways in which they supported their spirituality. It asks how much teaching about spirituality they had in the course of their training. It also asks for suggestions about improving teaching on spirituality for students and practitioners.

Secondly it looks at the understanding and experience of spirituality in general practice. It considered the ways in which spirituality emerges in caring for patients in general practice. It looks at the shared spiritual issues and experiences of doctors and patients. It considers ways
in which spirituality affects the lives and resilience of patients. It also looks at how participants supported spiritual issues in their patients.

The reason for choosing both the topic and the research question arose out of my long-term interest in the link between spirituality and health. I have been exploring this topic with a wide variety of adult groups for over thirty years. I was also aware that spirituality had been important in healing and health in all the cultures I had worked in as a student and as a general practitioner. It was not discussed during my training or in continuing education.

The literature search revealed there was little information about the understanding and experience of spirituality of general practitioners. I therefore extended my experience of group discussions and reflections about spirituality and health, by interviewing participants in depth.

2 Research Question

How do General Practitioners in New Zealand understand and experience spirituality? How do they deal with spiritual issues for themselves and for their patients?

There was also a subsidiary question about what training about spirituality they had as undergraduates and post-graduates and how this might be improved.

These questions allowed me to examine both the spiritual issues for the doctor and the spiritual issues arising in consultations with their patients.

The literature review revealed a very large body of material on definitions of spirituality in itself and in relation to health. Much of this research was done as a result of patients wishing for their spiritual needs to be met. The focus was on a search for meaning and connection and the values and behaviour that will enable it. This focus on the patient was understandable but left a gap in understanding of doctors, particularly since the most recent attempts at defining
spirituality all include the idea that it is dynamic, changing throughout life and that it connects people with each other and the deeper aspects of self.

The literature review also showed the complex relationship between spirituality and religion. Spirituality is an underlying embodied human characteristic that enables growth from birth to death, creativity, connection and healing all of which are aspects of human wellbeing. Religions provide a way of ordering spirituality in beliefs, rituals and community. One of the very clear facts that emerged from the literature review and confirmed by the interviews was that a secular spirituality is common. This is not dependent on religious belief but connects to the natural world.

The conclusion at the end of the literature review was that spirituality is about connection within the deeper self, and without to others, the natural world and the transcendent. For this thesis the prime focus is on spirituality. However it is impossible to exclude religion since this is still a common way of ordering spirituality. Much of the language about spirituality is still religious language.

New Zealand is a very secular country with 45.4% of the population stating no religion or refusing to answer this question in the 2006 census. It therefore seemed more appropriate and interesting to focus on spirituality in this thesis. Further discussion about the meaning of spirituality was discussed in Chapter 2 and will be presented in chapters 4 and 5.

3 Ethical approval

Before the research commenced, approval was obtained from the University of Otago Human Ethics Committee (Reference Number 06/160). A consultation was also undertaken with the Ngai Tahu Research Consultation Committee at the University of Otago and their approval was given.

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19 Information from the Statistics New Zealand 2006 census.
4 Research design and methodology

The original intention was to look at both doctors and patients and their understanding of spirituality. A literature search revealed an extensive literature on religion and spirituality of patients, but very little about the spiritual experiences of general practitioners. After discussion with supervisors, it was decided that only general practitioners would be participants as this would address a gap in the literature.

Preliminary group sessions with general practitioners exploring their understanding of spirituality were proposed, using historic information from workshops on spirituality and health in non-medical groups led by me as a starting point. This was to be followed by individual semi-structured interviews. It was clear from early in the process that interviews would be the most appropriate way to explore the topic in-depth because I was enquiring about intimate concepts and experiences that are not often discussed. Such information is sensitive and seemed best explored in one-to-one interviews using a semi-structured, conversational format: “If you want to know how people understand their world and their lives why not talk to them? Conversation is the basic mode of human interaction” (Kvale, et al., 2009).

It was thought interviews would provide rich transcripts and be a source of multi-layered, complex, interrelated information. This was certainly confirmed when interviews commenced.

One of the issues raised in the early discussion with the Department of General Practice was the nature of medical research. The predominant model of research in medicine is the empirical one. It is a quest for objective truths or evidence that exist outside the human self, awaiting discovery by an objective observer. It demands scientific rigour. It is also the basis of evidence-based medicine (EBM) which is the dominant paradigm of medicine and clinical research, with more than 60% of research papers in the top 5 journals in the world using this method. It was suggested that only evidence-based research would do.

However, at the Australasian Bioethics Association conference in July 2009 the idea of a single medical paradigm was raised as an ethical issue because it excludes other medical paradigms: “It (EBM) is a method, an ideology, a movement, a model, a paradigm, a system of regulation or audit and it has considerable moral and epistemic power” (Kerridge, 2009).
One of the results of this power is that anything about clinical practice that is not evidence based is often dismissed out of hand as irrelevant. There is evidence that medical journals reject papers that are not evidence based. It has also had the effect of persuading some researchers on spirituality to try and fit their research into an EBM model.

There is a great deal of philosophical debate about the validity of scientific logical positivism and the reality of ‘objective’ observers and observations. Kerridge goes on to suggest that this way of observing in medicine limits what it perceives. It will not look at those aspects that cannot be measured objectively.

That it (EBM) is based on a self-sustaining circularity as it gives priority to those things for which there is good data …or at least measurement according to the types of epidemiological or biomedical methods preferred by EBM – the RCT, (Randomised Controlled Trial) systematic review and meta-analysis. (Author’s italics)(Kerridge, 2009).

He reveals quite clearly the paradox inherent in this paradigm.

EBM works with populations and is therefore totally unable to describe the unique, the particular and that which cannot be measured by the methods it uses. It is of course useful for looking at cost of health services and population health, for which it was originally designed.

The present research looked at the spiritual understanding, meaning, experience and practice of the participants. It does not claim that this is applicable to all New Zealand general practitioners. It also asked them to reflect on their experience in consultations of patient understanding, experience and practice of spirituality. It considered ways in which the spiritual may be supportive and enable resilience for both doctor and patient.

It involved a ‘gazing’ at the whole person and their relationships in the encompassing gaze of acceptance20 rather than staring at each aspect of the question with the fragmenting basilisk21 gaze of science. The relationships within the individual participant and without, with others, are part of the enquiry.

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20 An illustration of this gaze can be seen in Chapter 2.2:2. This mother and child show the wonderful mirroring of smiles and gaze where each encompasses the other.

21 Foucault describes this in The birth of the Clinic where the clinical gaze draws life out of the patients by petrifying them.
For such a proposal a qualitative method of analysis seemed more appropriate than a quantitative one. Qualitative methods are most suitable for an exploratory focus, collecting emerging information and data from the participants in a natural setting (Maykut, et al., 1994). That certainly describes this research.

Investigating methods of qualitative analysis was an interesting experience for me. It quickly became apparent that the various methods, pioneered by different researchers, resembled different religious denominations of a fundamentalist nature in their passion for orthodoxy and the detail in which the methods were described.22

Foremost among reactions to the then over-emphasis on 'armchair theory' and 'verification', Glaser and Strauss' (1967) *Discovery of Grounded Theory* suggested sophisticated analytic processes and, provided one came to grips with quite a dense text, gave fairly clear procedures and actions which, if written down, might be followed by others (Johnson, et al., 2001 p 245).

Such detail was a response to the criticisms from those attached to 'scientific' deductive methods who dismissed qualitative research as sloppy, unsystematic and without rigour. Nurses have performed much of the qualitative research in health. The nursing establishment is very attached to use of protocols to order their work. The combination of these factors led to a demand for absolute conformity in procedure in order to have rigour - what Barbour calls 'the tail wagging the dog' (Barbour, 2001).

There are a number of ways of doing and analysing qualitative research. They all set out to answer the research questions and describe in detail how the research was carried out. They demand a systematic process of analysis be clearly described in the research report.

The methodologies favoured in qualitative health research tend to be phenomenology, discourse analysis and grounded theory although other methods like a general inductive approach, ethnography and discourse analysis are also used.

The goal in phenomenology is to study how people make meaning of their lived experience; discourse analysis examines how language is used to accomplish personal, social, and political projects; and grounded theory develops explanatory theories of basic social processes studied in context (Starks, et al., 2007 p 1372).

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22 It brings to mind the ancient story about the blind men describing the elephant, in which each touches a different part of the elephant – a tusk, a leg, an ear and so on - and they fall into violent disagreement about what is the truth about an elephant.
Discourse analysis focuses on the content of the talk and linguistic analysis. While the language used was of great interest in this study it was not the central purpose of this research. The language used was a way in to the ideas, behaviour and understanding of spirituality.

Phenomenology focuses on the specific experiences of the participants and the meaning they find. This was part of what this study set out to do. The description by Merleau-Ponty of being in the midst of things pregnant with meaning and present to be experienced certainly rings true. At times during this thesis my head was very full of presences.

Matter is "pregnant" with its form… Perception does not give me truths like geometry but presences…. Perception is thus paradoxical. The perceived thing is paradoxical; it exists only in so far as someone can perceive it (Merleau-Ponty, 1946 pp 12, 13, 16).

This concept was further expanded by Polanyi, who pointed out that fragmentation of meaning occurs when deductive processes destroy the relationship in which it exists. This is the effect of the basilisk gaze.

It brings home to us that it is not by looking at things but by dwelling in them that we understand their joint meaning. We can now see how an unbridled lucidity can destroy our understanding of complex matters. Scrutinize the particulars of a comprehensive entity and their meaning is effaced, our conception of the entity is destroyed (Polanyi, 1967 p 18).

I certainly resonated with this. I found myself in an impasse at the start of the Chapter 4 when I had to start to dismember the narratives in order to classify and discuss them. It felt like sacrilege to unravel these wonderfully interwoven stories. For example I knew from one participant that reflection on the meaning of spirituality could lead to mountains, then on to family and friends both living and dead, and back to the transcendent. There were many others in which analysis felt like dissection rather than appreciation.

The research question explored both the spiritual understanding and experience of the doctor and the doctor’s understanding and experience of patient spirituality and the relationship between these. However the research also wanted to explore the ways in which spiritual care could support both doctor and patient.

Grounded theory is a method of analysis that seeks to generate explanatory theory grounded in the data collected. It uses an analytical process of the data to identify first open categories, usually many in number. The process of repeated re-analysis to reduce categories or group
them appropriately continues until no further new categories emerge. This process has been described in detail by a number of authors (Glaser, et al., 1967; Strauss, et al., 1990; Maykut, et al., 1994; Miles, et al., 1994; Crabtree, et al., 1999; Denscombe, 2003). However grounded theory seemed to have both linguistic and procedural constraints that limited my ability to let the participants’ voices be heard.

There are also some authors who suggest that there is no need to have a methodological theory to do qualitative research, proposing that it is a remnant of a positivist view of the world in which all knowledge must be supported by evidence. They propose a pragmatic approach to qualitative analysis. Avis suggests that:

Our purpose in qualitative inquiry is to reveal the interrelationships between individual beliefs, cultural norms, and social rules, and to do so in a way that makes beliefs and values of other cultures intelligible against a background of shared assumptions about the world….. Interpreting the behavior of others depends on attributing to others many of our own beliefs; otherwise, we could not individuate or identify the new beliefs that would have to be learned (Avis, 2003 p 1001).

This seems to me close to the understanding that Charles Taylor calls the social imaginary (Taylor, 2007a). This is a shared world-view in which things are understood without being explained because the researcher and the participants share aspects of that view and understand its internal links and coherence. Qualitative research demands that the researcher try to ‘walk in the shoes’ of the participants, a process of indwelling, rather than reordering it to fit an external model (Maykut, et al., 1994). In this it bears a strong resemblance to medical consultations that use tacit knowledge to uncover the patient’s narrative.

A number of methods of analysis of qualitative data all attempt to do the same thing. The data is collected, coded into categories. Categories are developed using content analysis of the text that is then grouped to identify ‘what’ is in the text. These are then re-analysed, sometimes over several cycles, and reduced in number. As a result of this process overarching themes emerge or are revealed. Themes elicit the meaning or essence of the experience for the participant (Morse, 2008). This process happens in grounded theory and immersion crystallisation (Strauss, et al., 1990), editing methods (Crabtree, et al., 1999) and in general inductive analysis (Thomas, 2006). Thomas’ description of this is free of the turgid language of some other methods.
The purposes for using an inductive approach are to (a) condense raw textual data into a brief, summary format; (b) establish clear links between the evaluation or research objectives and the summary findings derived from the raw data; and (c) develop a framework of the underlying structure of experiences or processes that are evident in the raw data. The general inductive approach provides an easily used and systematic set of procedures for analyzing qualitative data that can produce reliable and valid findings (Thomas, 2006).

The purpose of this exercise is to reflect on the text, enquire into whether it answers the research questions in a way that can be applied elsewhere and perform a detailed and reiterated analysis to find the underlying themes. As already observed above, I found the process of fragmenting the original stories difficult to do.

The exploration of spirituality is unique for each individual. There are however, common aspects of spirituality, themes that can also be discovered and reflected on. These are connection with self, other, the natural world and the transcendent. The other aspects that emerged were seeking the sacred, the other, searching for meaning.

A pragmatic view of knowledge allows us to disentangle methodology from epistemology and to separate claims about the validity of evidence from the validity of arguments that the findings of empirical inquiry lead to knowledge (Avis, 2003 p 1003).

This appealed to me because it does not limit the use of tools from different methods but is systematic enough to ensure that the quality of the research can be seen.

This point is certainly reinforced by Mays and Pope. They suggest that researchers consider worth and relevance of the research and formulate a clear research question to which the design of the research is matched. Also needing to be considered are the sampling and context of the study and the care with which data is collected, analyzed and reflected on.

However, qualitative researchers can address the issue of quality in their research. As in quantitative research, the basic strategy to ensure rigour, and thus quality, in qualitative research is systematic, self conscious research design, data collection, interpretation, and communication. (Mays, et al., 2000).

Johnson et al also made an important comment about qualitative methods.

The arguments for pluralism in qualitative research are to us overwhelming. They are epistemological, pragmatic and political. There are no 'pure' qualitative methods. Of course we do not deny the rigour which may be evident when the
steps individuals take to collect, analyse and theorize from data are made plain in writing in a report (Johnson, et al., 2001 pp 248-9).

Throughout this thesis I have attempted to reflect on the emerging themes from the interviews and have continued to seek confirmation for these from the literature and from the group sessions where preliminary results have been presented. At each stage of the process the transcripts and analysis have been discussed both with supervisors and advisors and with a peer group of PhD students. These groups, along with my own experience as a doctor and tutor of medical students, and the experiences of the participants has allowed a kind of triangulation, that is approaching the phenomenon in different ways in order to allow it to be seen more fully. Qualitative research has contributed to the understanding of health and illness from both the primary care practitioner’s and the patient’s point of view. It has also looked at the context of care and care-giver’s experience (Morse, 2007). Both these factors have been part of this thesis.

5 Method

Before embarking on this research an interest in spirituality and health had led to my involvement in a wide variety of workshops and lectures on the topic over the previous 30 years. These were with religious groups from all the main Christian churches in New Zealand as well as other non-religious community groups. The feedback from some of these produced the original list of spiritual issues (Appendix 1).

This list was discussed at a meeting with some members of the Department of General Practice in the Dunedin School of Medicine in March 2007, early in the planning process. Those present were asked to respond to the words, to add more to the list and return it at the end of the session. Their responses were also sought on the content and methodology of the proposal. The interview guide was also discussed with them.

There was general support for the understanding of spirituality in the list, the ways it presented in consultations and the proposed methods and methodology. Some of those present thought there was a need for evidence-based research. One person was adamant that evil could not be part of a discussion on spirituality.
I also explored with my peer group what made practice satisfying for them in June 2006 (Appendix 2).

Three reflective and participatory Continuing Medical Education (CME) group sessions for twenty to thirty general practitioners also contributed to the clarification of emerging categories and themes. The first, in July 2006, focussed on the difference between cure and healing, and the doctor’s response. The issue of spirituality was touched on in this session as was the need for the doctor to be humanly engaged in a healing relationship, rather than distant and objective. The themes from these sessions confirmed those emerging in the interviews.

The second session considered what spirituality was and how it presented in general practice consultations. This was held in August 2008. It used questions from the interview guide and produced categories of understanding spirituality that confirmed those emerging in the interviews. A third session was run in August 2008 as part of Hospice education programme for General Practitioners and practice nurses (Appendix 3). The emerging categories and themes were presented as a poster: First Cry – Last Breath at the BMA conference on Doctor’s Health Matters in London in November 2008 (Appendix 8) once again the emerging themes were affirmed.

1 Sampling method
Purposive sampling identified participants who were active General Practitioners. Some participants were selected because they had no religious connection or interest in spirituality. The sample was not intended to be representative but was intended to provide a wide variety of participants in terms of culture, age, type of practice and spiritual and religious background.

I chose the first participant who then nominated the next one and so on. This process was modified when an imbalance of sexes, or an absence of participants in a particular age, cultural or religious category became apparent. The participant being interviewed was then asked to nominate someone in the missing category. If they were unable to do so it was noted and was either sought from the next interviewee or me directly. The sample contained eleven male and eleven female participants. Some participants were deliberately sought as not having a religious background, or being anti-religious. Four participants had no religious attachment.
at any stage of their lives. It proved difficult to find any who did not believe there was a human spirit.

The participants were invited to consider interview by telephone, and if they agreed, were sent a request letter accompanied by an Information Sheet and Consent Form (Appendix 4). Only one person refused to be interviewed and one said they would be interviewed and then withdrew. All others approached agreed to be interviewed. Many of the participants had been forewarned, by the person who nominated them, which may well have increased the likelihood of their agreeing to be interviewed. Once they agreed, an appointment time and place of their choosing was arranged.

6 Participants

The participants for this study were all active general practitioners in New Zealand. The majority of them came from the South Island with only two from the North Island. Sixteen had relatives who were medical, of whom six were fathers, four were siblings, one was a grandmother and five were children.

Since New Zealand has quite a small GP population and I have practiced here for more than 40 years it would be difficult to find a group of GP’s who were all totally unknown to me. In the sample five were either friends or colleagues and two of these were peer group members. Seven others were acquaintances met at conferences, and ten were unknown to me. I had discussed spirituality with only two participants prior to the interview.

While it was easier to initiate conversation with participants already known to me, there were no major differences between the transcripts from those in this category and those unknown to me. Both groups provided rich accounts of their understanding, practice and experience of spirituality.

1 Culture of participants

The culture of the participants as might be expected, varied considerably. Ten of the participants identified a single culture. Seven were European or Pakeha New Zealanders, two were Maori and one was Chinese. Those who had migrated to New Zealand tended to identify with New Zealand culture as well as their culture of origin.
Some were very general in their cultural self-classification, looking at the social rather than ethnic aspects of culture. Others were extremely specific. Twelve participants identified with two cultures or more. The other cultures included Jewish, English, Scottish, Pacific Island, German, Irish, and Lebanese.

This is not surprising given that 22.9% of people in NZ are born overseas and the GP workforce contains 41% of overseas graduates according to the NZMC figures for 2007 (MCNZ, 2007). The proportion of international medical graduates in this sample was quite low at 14% but the number born overseas was 41%. The NZMC NZ medical workforce in 2007 contains 41% of overseas graduates.

2 Types of practice

The participants came from a wide variety of practices. They came from urban areas, rural towns, and rural remote practices. They also came from single-handed, small group and large group practices. The table below shows the distribution of practitioners. Three worked only as locums and had no intention at the time of interview of joining a practice as a partner.

Table 6: Types of Practice

<table>
<thead>
<tr>
<th>Participant</th>
<th>Urban</th>
<th>Rural town</th>
<th>Remote</th>
<th>GPTP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>6</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

3 Age range of participants

The table below shows the scatter of age and stage of participants with graduation dates ranging from 1963-2004. As might be expected there is a weighting of male participants prior to 1982 (73%) and a rapid rise in female ones after that due to the rapid increase of female students at that time (73%). One participant who graduated in 1992 was in the first class at Otago medical school where the number of women were more that the number of men. One participant started medicine left and had a different career and then came back after twenty-six years. One was doing the General Practice Training Programme and two were close to retirement.
They were well-educated participants. Three had other degrees before they started medicine. One had an MD. Seventeen were FRNZCGP two were MRNZCG. There were also a number of diplomas of obstetrics, child health, Scuba medicine, sports medicine, geriatric medicine and two had FACHPM.

4 Patterns of practice
Some were full time and some part time. Some of those who worked part time did so because they also worked as academics or in another medical specialty. Some worked part time because they had young children. Some felt emotionally or spiritually overwhelmed when they did full time clinical work, others wished to spend time with family or in other creative work.

Table 7: Patterns of Practice

<table>
<thead>
<tr>
<th>Participant</th>
<th>Urban</th>
<th>Rural town</th>
<th>Remote</th>
<th>GPTP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Time</td>
<td>5F 5M</td>
<td>1F</td>
<td>2M</td>
<td>1F</td>
</tr>
<tr>
<td>Part Time</td>
<td>2F 2M</td>
<td></td>
<td>2F 2M</td>
<td></td>
</tr>
<tr>
<td>Academic</td>
<td>1F 1M</td>
<td></td>
<td>1M</td>
<td></td>
</tr>
<tr>
<td>Locum</td>
<td>1F 1M</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching</td>
<td>12</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
Eighteen participants were involved in teaching students. Most of these taught undergraduate medical students but some were also involved in teaching the GPTP and trainee interns. It is interesting that the number of full time and part time practitioners was the same for both sexes. This happened by chance not design. All the academic practitioners also did some general practice. Both the remote practitioners were male.

5 Religious affiliation
The participants were all asked about their previous and present religious attachments if any, and their spiritual or religious practices. These are outlined on the table below. Some had moved through more than one religion. Five had never been attached to any religion. Ten had left the religious attachment of their youth.

Regular religious attendance was taken to mean more than monthly. Occasional attendance was less than three monthly. Some only attended religious services, usually funerals, to support patients.

They were also asked if they prayed. The question was an open one. Some prayed for themselves, or for their patients. Only a few prayed with their patients. What was surprising was the number who prayed while having no current religious affiliation. This table will be further discussed in Chapter 6.
<table>
<thead>
<tr>
<th>Past attachment</th>
<th>Current attachment</th>
<th>Religious attendance</th>
<th>Do you pray?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>R=regular</td>
<td>O=occasional</td>
</tr>
<tr>
<td>Yes 18#</td>
<td>Yes 7</td>
<td>Yes 15</td>
<td>Yes #16 +1 ***</td>
</tr>
<tr>
<td>Anglican 7</td>
<td>Anglican 3</td>
<td>R 2 O 1</td>
<td>7</td>
</tr>
<tr>
<td>Catholic 4</td>
<td>Catholic 1</td>
<td>O 2</td>
<td>2</td>
</tr>
<tr>
<td>Presbyterian 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baptist 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Islam 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PIC* 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methodist 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buddhist 1</td>
<td>Buddhist 1</td>
<td>R 1</td>
<td>1</td>
</tr>
<tr>
<td>Evangelical 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Age 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCC ** 1</td>
<td></td>
<td>O 1</td>
<td></td>
</tr>
<tr>
<td>House church 1</td>
<td>R 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 4 O 11##</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No 4</td>
<td>No 15</td>
<td>No 7</td>
<td>No 5</td>
</tr>
</tbody>
</table>

O=occasional
# Some participants have moved through more than one religion
*Pacific Island Church
** Christian Community Church
## Attend various churches occasionally to support patients.
*** 15 prayed for both self and other; 1 for other, 1 used a prayer wheel. 10 of these had no current religious affiliation.
3 doctors prayed for patients in their surgery
3 said patients prayed for them

### 7 Interview guide

An interview guide was developed using themes from the historical information, first group session and the discussion with the Department of General Practice. This was modified slightly as the interviews proceeded. It was used as an aide-mémoire and was not followed in detail for every interview. Interviews were participant led, informal and conversational as far as possible. The interview guide is shown in Appendix 5.
8 Interviews

Interviews commenced in April 2007. The amount of structure in the interviews varied considerably. Some participants talked at length after a single opening question and others needed more prompting. The decision on the number of participants was made in discussion with my supervisors and advisor.

Interviews were conducted at the time and place of choice of the participant. They varied in length from one to two and a quarter hours. Most were around an hour. Ten were in the participant’s home, seven were in their surgery or office and five were in the researcher’s home. While these were all conducted by the researcher, the initial transcripts were checked by supervisors.

An initial eleven interviews were completed within a year and the decision was then made to continue until twenty had been done. Since there were recording problems in two interviews, an additional two were arranged and completed by August 2008. The data that emerged from all these was extremely multi layered and rich. This confirmed the decision to stop after twenty-two interviews in keeping with the suggestion of Morse that the greater the amount of usable data emerging from the interviews and the more focussed the enquiry, the fewer the number of participants needed (Morse, 2000).

The reason for choosing semi-structured interviews as the method of enquiry was that it would produce the richest information. It also matched the method used by participants, and the interviewer, in their work with patients, and was therefore familiar to them and relatively unthreatening. The density of the information in the transcripts was astonishing. This confirmed for the researcher the use of in depth interviews as an ideal way of obtaining information from general practitioners.

As far as was possible the interviews were conversational and relaxed. I found that having conversations gave much richer responses than being too direct in questioning. I also found that occasionally allowing myself to be drawn into the conversation was helpful in eliciting depth of information from the participants. At times it was impossible not to use clinical skills, when painful memories or events had been under discussion. This enabled participants to collect themselves and be at peace as the interview was drawing to a close.
The process of interviewing was both fascinating and hard work. At times I was left with holding painful or distressing material. For this I used the same process as I do at work. I had supervision during the time of the interviews.

1 Data
The interviews were digitally recorded and transcribed by the researcher word for word. Notes were also made as soon as possible after the interview. To ensure accuracy of the recordings, after each interview the participant was emailed a copy of the word for word transcript and arrangements were made to have a follow up discussion by telephone if they wished. They were asked to email the researcher with convenient times to be telephoned. Four participants responded with written material, which expanded their responses in the interview or included new material. Some made minor corrections to transcripts, usually correcting the grammar.

Eighteen had a formal follow up discussion by telephone, mostly quite brief. The longer ones of these were taped and transcribed and added to the interviews. One had an informal follow up in a social context. Three did not respond to offer of follow up. One requested removal of material that was very personal and painful to recall. Recording problems occurred in two interviews. The data from these interviews was recalled by the interviewer, transcribed, then checked for accuracy with the participants. Two participants died unexpectedly during the course of the thesis.

As will be seen in Chapters 4 and 5 the spirituality of doctors and patients sometimes seemed to resonate and their feelings mirrored each other. This may explain why when doctors talk about their patients they also talk about themselves.

2 Data analysis
The transcripts were read and annotated by the researcher several times. Passages when strong feelings were expressed were noted. Some participants tapped the table with tension and this was clearly audible on the recording. After annotating transcripts were read again and further notes made.

Prior to starting interviews discussions were held with supervisors and advisor about the possible use of computer programmes for word analysis. Both Atlas and NVivo were
suggested and considered. After looking at these programmes and conducting the first two interviews, I was of the opinion that the richness of the transcriptions and the subtlety of the information would not best be captured by such means and decided to analyse the transcripts manually.

The transcriptions from the interviews revealed very rich, complex information on the experiences of participants and their patients. The language used in them was of great interest and Discourse Analysis or Narrative Analysis might have been appropriate. However the intention to look at the ontology and epistemology of spirituality made it less appropriate (Hurwitz, et al.). The interviews certainly considered the ways in which spirituality was involved in the relationships of general practitioners and patients. This meant that the understanding and meaning of spirituality, its embodied experience and its effects, were central to the interviews. For this Grounded Theory could have been appropriate (Strauss, et al., 1990; Maykut, et al., 1994).

The interviews contained both information and explanations about the participants themselves and information and interpretations by the participants about patients and others. This latter information is what Morse calls ‘shadowed data’ (Morse, 2001). She suggests that such information is important as it provides another perspective on the topic under discussion. This may help the researcher to understand the topic faster and validate the analysis faster as well. In a sense she is suggesting research that includes shadowed data is really about both the participant and the person they are describing – and the descriptions of the patients certainly also revealed aspects of the doctors as well as the mirroring discussed above.

Collection of the data and analysis were conducted concurrently. Data was not only collected from interviews but also from the various group sessions along the journey of the thesis. The transcripts were analysed using a pragmatic generic qualitative method (Crabtree, et al., 1999; Thomas, 2006).

The process of analysis started with the transcription by the author. Being a four-finger typist was for once an advantage as it gave plenty of time to let the information sink in. Listening and re-listening to the tapes certainly enabled an ever-deepening engagement with their contents and familiarity with the reflections and styles of participants. It also identified the most emotionally challenging parts of the transcripts by the tone of voice, the words used, or the restlessness of the participant.
The data was analysed in a reiterative manner, using a constant comparative method. Categories are derived from content analysis in which like segments of text are grouped together (Morse, 2008). Initially large numbers of categories emerged which were then reduced by further cycles of analysis into a small number of categories and themes (Miles, et al., 1994; Thomas, 2006; Starks, et al., 2007). This reiterative method of analysis is also used in immersion crystallization described by Crabtree and Miller in which the researcher reflects on the transcripts until a process of crystallization of the content occurs (Crabtree, et al., 1999). This happens as a result of using both intuitive skills and analytical ones and is analogous to the process of making a diagnosis.

The initial process produced more than fifty categories. These were put on a chart and then reduced in number by repeated analysis and clustering. This takes the information out of the context of the interview, and therefore the individual story. However as a result of further reflective analysis themes emerged which suggested the meaning of spirituality both for individuals and as an overarching aspect of all participants.

The themes of self, other, natural world and transcendent emerged together with connection and disconnection. An overarching theme of connection and disconnection emerged that reflected the conclusion of the literature review. This was then divided into two main sections, connection with self and connection with other.

Connection with self looked at understanding and experience of spirituality. It considered practices of the participants that sustain self and spirituality and values and meaning in relation to spirituality. It also considered the education received about spirituality in families and during undergraduate or postgraduate training.

Connection with others looked at connection and disconnection within their family, with patients, with the natural world and the transcendent. It considered connection and disconnection from birth to death in the family. It looked at the ways these impinged on the participants. In addition it contains reports of patient spiritual experiences and issues (shadowed data). It also looked at ways in which doctors dealt with and supported their patient’s spirituality and their connections and disconnections with patients. There were clearly connections between participant spirituality and that of others which are discussed in Chapter 8.
In New Zealand connection with the natural world emerged as a very important way in which participants experienced spirituality. It is also central to Maori spirituality. Experiences of connection with the transcendent were present in most transcripts. Some participants had many of these experiences, others only a few. They are further discussed in the results Chapters 4, 5 and 6.

This process of data analysis followed a pattern similar to the diagnostic process in General Practice. There the clinical history and other data (lab results, past history, Xrays etc) are reflected on by a combination of deductive thought and intuition and experience, or tacit knowledge, and formed into a diagnosis (Nettleton, et al., 2008). This tacit, embodied knowledge is where ‘we know more than we can tell’ and is important in making a diagnosis (Polanyi, 1967). It is the basis of empathy.

I was aware it was also important in analysing the results as the information from groups, literature and interviews were brought into conversation (Polanyi, 1967). This combination of tacit and articulated knowledge is the way in which qualitative research analysis proceeds (Maykut, et al., 1994 pp 18, 123).

Some participants commented that they felt like patients, who came in expecting to talk about one thing and ended up saying something quite different, much to their surprise. I noted at times the temptation to move into ‘doctor’ mode rather than interviewer mode. I also, on occasion, got into quite deep discussion with participants, because conversation with dialogue encouraged a deeper exploration of the issues. I thought this an appropriate addition to the interview and part of being an ethical interviewer discussing topics of deep human significance.

All participants thanked me for interviewing them. They appreciated being able to think about spirituality and its connection to their work. Three said they agreed to be interviewed so that they could increase their understanding about spirituality. Some also expressed an interest in continuing to pursue the topic of spirituality after the interview.

I had the impression that being listened to about their understanding and perception of themselves and their spirituality was not a common experience for most participants. I found the interviews a privilege in the same way that participants talked of the privilege of looking
after patients. After reflecting on their transcripts for two years or more I feel a sense of connection to the participants. I also found they, like the patients in their narratives, were a spur to my own spiritual reflection and growth.

Participants were all given the opportunity to check their transcripts and comment on them.

9 Quality measures
1 Personal bias
From the start of this project it was clear that I came with my own biases. I was raised in a middle class family where my parents came from two very different European cultures. The values and focus of the family was on being open and caring, working hard at what was believed in and continuing to pursue knowledge throughout life. While we moved place every three years, it was a secure and stimulating environment in which to grow up. I was educated at convent schools and Edinburgh medical school.

I moved culture for the first time at the age of five, going to live for three years in Sri Lanka. Later we moved to Wales and then to Scotland. As a clinical medical student I worked briefly in the USA and then in Algeria. Since graduating I have continued to work in a number of different cultures in Tanzania, Bangladesh and New Zealand. This has helped to make me aware of the subtle intra-cultural differences between individuals as well as the yawning gaps that can occur between and sometimes within cultures. It also sharpened my awareness and understanding of the importance of spirituality in healing, health and sickness.

Attendance at medical school in Edinburgh coincided with the second wave of feminism, and major social changes in the 1960s. At that time the number of female doctors was small. It was also a time when the medical system was rapidly becoming biomedical and losing its connection with spirituality. It was the end of an era during which the art and science of medicine had been seen as complementary. My first clinical teachers were educated in liberal humanities as well as medicine. An oligarchy of biomedicine then emerged and became the dominant paradigm in the West.

I have been a practicing Catholic Christian all my life. Growing up in a church with a strong tendency to authoritarianism has sensitised me to the misuse of role power and made me
adept at finding strategies to deal with it. It has also made me aware of religious or secular dogmatic and fundamentalist attitudes. I have been interested in and investigated other religions and had a long-term interest in the intersections of theology, spirituality and health. I spent over thirty years working in the area of spirituality, health and human growth and development with adult groups.

Forty years of medical practice in six different cultures certainly confirmed the need to be aware of medical role power and cultural difference. It also affirmed the impression that spirituality was important in all cultures in relation to health, illness and the journey of life from birth to death. The reality therapy of raising children and grandchildren and remaining in a marriage for more than forty years provided an antidote, in terms of tacit knowledge and recognising the need to enter into dialogue.

2 Trustworthiness
While it is important to check that the process of data collection and analysis is rigorous and trustworthy, it is clear that lists of ways of doing qualitative research will not in themselves make good research (Barbour, 2001). The use of purposive sampling allowed the inclusion of people who are different from the majority – in this case those with no religious attachment or interest. I accept that the collection and analysis of data by a single researcher is open to criticism but think this is offset by the checks listed and below.

Four common methods of checking the data are described: multiple methods of collecting data, building an audit trail, working with a team and member checks (Lincoln, et al., 1985; Maykut, et al., 1994).

The data for this research was collected from a number of sources. The original information about spirituality came from 30 years of work in this area. This was compared with the information emerging from the group sessions outlined above and the emerging data from interviews. Using several methods of collecting data enables the validity of the data to be checked. In addition the literature search confirmed the presence of similar spiritual issues in other research. This was then considered with the data emerging from the interviews. The interview transcripts were all returned to the participants for checking. Eighteen had a follow up discussion and four sent written comments and additional material.
The audit trail also exists in previous papers, workshops, the group sessions above and the recordings, transcripts and notes about the interviews.

At all stages of its development this work has been checked against the responses of supervisors and advisor. This was particularly so in the early stages of coding. It has also been taken to meeting of peers and other researchers as outlined above. In addition to these during 2009 I gave the following papers which all presented some of the preliminary findings. The responses to these papers affirmed the emerging themes from the interviews.

- The Hidden Dimension of General Practice at the RNZCGP conference in Wellington. (Appendix 9)
- Spiritual self-care: Healing the Healer at a conference for Alternative Health Practitioners in Queenstown. (Appendix 10)
- From Noun to Verb: Is Hope an Ethical Issue for the AABA conference in Queenstown. (Appendix 11)
- Spirituality in a Secular Age at the International Conference on Spirituality and Ageing in Auckland. (Appendix 12)
- Bearing Witness to Suffering – Letting Go of Control at the Psycho Oncology NZ Conference. (Appendix 13)

During the duration of this thesis I also ran three workshops for General Practitioners: First Cry - Last Breath - Care of the whole person in General practice, From Cure to Healing and Doctor’s Health Matters. In addition for the Hospice Education Programme for GPs and nurses I ran workshops on Spirituality in Palliative Care and Hope. Once again the responses were all confirming of the emerging themes.

10 Summary

This chapter has looked at the aims of the research and the research question. It has looked at research design and methodology. It has traced the research from its roots in past group work on spirituality and health. It then considered the three group sessions undertaken before and during the interviews. All of these affirmed the question being asked and the scope of the enquiry being undertaken in the semi-structured interviews.
It then described the method and the reasons for choosing a pragmatic generic qualitative method. It considered selection of participants, their variety and background. It also looked at participant validation in that section. It then looked at the process of data analysis. It concluded by considering possible issues of personal bias in the researcher and the trustworthiness of the data.
Chapter 4  

Participant Spirituality

1 Introduction

When I started to work on this section I experienced a sense of impasse. Every time I seemed to have a usable outline it fell apart. I realised that I had a very deep resistance to dissecting the wonderful, multi-layered stories that I had been told. It seemed like sacrilege. Those stories, on long contemplation, revealed, like Monet’s waterlily paintings, deeper and deeper layers. Fragmenting them into little crumbs labelled ‘self’ or ‘other’, ‘natural world’ or ‘transcendent’ felt like sacrilege.

It was not easy to classify these divisions tidily since the resonance of the deep inner immanent transcendence with the other or outer transcendent often moved from one to the other and back again in a sinuous dance.23 As result sometimes I have noted that a particular passage could belong in several places.

So how do general practitioners understand and experience spirituality in their work and for themselves. How do they deal with the spiritual issues brought to them by patients? Clearly these are intimately connected with their self and other awareness, acceptance, communication and understanding as well as their acknowledgement of transformations as part of normal human growth from birth to death.

In Chapter 2 the meaning of spirituality was discussed in detail. The final conclusion was that spirituality is primarily about the deepest part of self, and connection and disconnection with that, with other people, the natural world and the transcendent. It is also about meaning and

23 I realised as I wrote this that the spirituality was seen as a dance, a perichoresis, in the Christian church many centuries ago. In fact religious dances have emerged in many religions as ways of revealing the spirit.
purpose, which involves a journey throughout life. This enables growth and development from birth to death through a series of normal life transitions. Some of these are about life stages; others are about life events like moving place of residence, illness and healing. Participants were asked what they understood by spirituality. This stimulated responses both about meaning and the experience of spirituality.

I have therefore decided to use three sections for this chapter. The first will deal with what participants said they understood by spirituality – their description of their own spirituality. This is formed by their culture, which shapes both language and social imaginary.

The second will deal with their experience of spirituality. It also includes the relationship between religion and spirituality.

The final section will deal with spirituality and emotions. This connects with the section in the Literature Review on the neurophysiology of spirituality.

2 Understanding of spirituality

1 Culture and spirituality
Language about spirituality presented the first problem as discussed at length in Chapter 2:7. Participants struggled with words to describe spirituality as has been observed by others (Hay, 2006). Some of the difficulty was about cultural background and some about their attitude to religion. Many participants rejected religious attachment and much language about spirituality originally came from religious sources.

Participants came from a number of different cultures and more than half identified with two or more cultures. As mentioned in the literature review, culture shapes spirituality and is both a common human characteristic and uniquely developed in each person.

Pakeha New Zealander. And very much pakeha - I like that term. (1)

My culture? Well in the broadest aspect of it I’m Western, white, middle class, male, professional, doctor. (4)

I think I class myself as a New Zealander. The question is do we have our own culture – I think we do. (16)
Some identified the ‘social imaginary’ of Pakeha New Zealand very well. This concept identifies the common ground within society carried in images, stories and legends (Taylor, 2007a p 172). It includes the expectations that we have of each other and an understanding of the common practices we share which make up our social life. Thus it contains both the expectation of behaviour and the underlying demand of particular behaviour as identifying ‘normal’ social action for that particular culture. It encompasses the embedded values of a society and the connections within it that underlie spirituality. This is well illustrated by the quote below.

My own culture – I see it as probably European but very, with a Kiwi, a unique Kiwiness I think I realized that from living with a Scot how different our cultures were. It’s quite an independent culture. We celebrate independence and hard work. Yeah - hard work and hard play. (17)

Participants with a strong sense of indigenous culture were also present. These participants were clear not only about their own culture but of their connection to particular places, people and tribes. There is a sense here of spirituality being embedded in the culture in a way that Europeans for the most part do not describe.

I was born in (Pacific Island) and grew up there for the first 19 years of my life. I had all my schooling there. It’s a changing culture. It’s still very strong when I go back to (Pacific Island), there are very strict protocols on how you do things and that hasn’t changed. …We spent all our school holidays with … the grandparents, two other cousins of Mum’s, Mum’s sister’s children… and these cousins… are still very close, would all be there at grandfather’s place. (14)

In New Zealand there are a number of social imaginarie. Maori and Pakeha are the principal ones, but this is changing rapidly as more immigrants arrive from Pacific Island and Asian backgrounds. The Asian population in New Zealand now exceeds that of Pacific Islanders and has increased 50% between the last two censuses. It was 8.6% in 2006 when the Maori population at 14.6%.25

Since the social imaginary identifies clearly what is normal and what should happen in a particular culture, when people have origins in more that one culture, there may be

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24 I well remember being very puzzled when I came to New Zealand at how long it took for me to feel at home. I had moved cultures a number of times with no problems previously. This continued until I realised that, contrary to the expectations based on people in the UK saying New Zealand was very like England, in fact it was not. I was hanging on to my social imaginary and it did not fit New Zealand. Going to live on the Chatham Islands which was very different from England, enabled me to see this.

25 NZ census 2006. Statistics New Zealand
disjunctions and conflicts between them. On the other hand, given the strength of medical culture as distinct from patient culture, learning to understand and identify cultural difference is a valuable skill for doctors.

Well I see myself as a New Zealander and I guess I was brought up in a house where things that were Irish were highly valued. (3)

I think I probably identify with, um, I was going to say, with a New Zealand culture, in that New Zealand seems to typify quite a melting pot of Polynesian and European and that’s my cultural heritage. (5)

So I grew up in Fiji. Then I went to boarding school in Auckland for a couple of years. My father came from Fiji. My mother was a Kiwi. (20)

I am a New Zealander. With a background of English, Scottish and Jewish. (19)

The participants acknowledged the contributions each culture had made. There were comments that the changing or experiencing different cultures sometimes helped in making good empathic relationships with patients and understanding their spiritual pain. They also helped in reflecting on their own culture and spirituality.

Being confronted with cultural difference, particularly from a young age, broadens the understanding of what human beings are about. It brings up the infinite variety of the human race in an unavoidable way. This may enable the development of tolerance of difference in culture and world-view. The experience of having their own cultural expectations, indeed their social imaginary, challenged by a different culture is well described.

Was it helpful? Yeah. I think and vice-versa too. It wasn’t a huge shift in culture. I came to med school from Fiji but my mother was a Kiwi so NZ culture was part of our lives too. But I like to think that my exposure to other cultures – I’ve benefited heaps from it really… It’s hard to define…They’re just things you pick up through living and experiencing and specifically – I’m not sure about that really…What specifically changes the way you think. (2)

We are a mixed marriage and come from very diverse backgrounds, and so I think in some ways, you know, I’ve had experience in plenty of life close by (in three different cultures)...so I feel it’s sort of given me a good background for recognising spiritual and that sort of pain. (11)
Many of the participants who had originated in another culture were very clear that their culture was modified by living a long time in New Zealand. Those who came to New Zealand in childhood tended to identify as New Zealanders.26

I am a New Zealander with quite a strong Chinese background. (12)

I think, um, when I came to NZ, I was very aware of my differences…So I fell over backwards to try to become a Kiwi as quickly as I could. I don’t recall the language particularly but I remember I never wore shoes. I went around bare-foot to school and everywhere because that was doing a bit more than everybody else. And in the winter I can remember breaking the ice in puddles with my bare feet. (20)

Several also commented they did not fit back in their original culture. This is because cultures, like spirituality, are dynamic, growing and changing continually.27 This means that those leaving their culture of birth for long periods come back changed people to a culture that has changed. Not only are they at a different point in their life journey, but the culture and the family and friends still in the original culture have changed as well.

I would see myself very clearly in the half and half…. Just like you I suspect. Most people in New Zealand, it doesn’t take them long to work out that I’m English, and yet virtually all of my working life has been in New Zealand and I feel very comfortable with that culture. I feel more comfortable with the culture in New Zealand than when I go back to the UK, which feels uncomfortable there. (13)

Well it’s quite complex because my mother is English, my father is Irish and they emigrated to Australia. I feel more akin to New Zealanders in the person I am, but I don’t feel I’m a New Zealander. Stranded somewhere in the middle of the Tasman perhaps. (18)

And some even found fitting into their own New Zealand culture a struggle, due to changes in it that they were not comfortable with, or the fact that they had changed in their spiritual understanding and perception.

Well, I see myself increasingly fitting less in into the culture in which I now live. I think that relates mainly to my age, it relates to the rapidity of change in the culture, it relates to the whole secularisation of our culture… NZ culture has gone from being a Christian based culture to a secular based culture. Because I choose not to move on in that direction I become more, not exactly isolated, but increasingly different from the culture in which I am living. (21)

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26 I can remember my own children coming home bare-foot from school when we returned to New Zealand and lived in Northland where many children went bare foot. They also spoke English English at home and Northland Kiwi English at school.

27 After living in New Zealand for more than forty years I no longer feel at home in English culture. I resonate to some aspects of it but it is no longer my culture.
It was suggested by this participant that aging may be responsible for this disjunction, but also the loss of religiosity and secularisation of New Zealand, is also thought to be a factor. The spiritual change has been very difficult for this participant to accept.

2 Sacred places

The idea of a therapeutic landscape, a healing place, is very ancient. Cos was such a place in pre-common era times (Williams, 2010). There have been many places of spiritual connection and healing since, in all religious traditions. Some participants identified their spirituality with sacred places. Others identified sacred places when away from home. Interestingly the sacred places had connections with the dead as well as with the sacred or transcendent for both Pakeha and Maori.

So I was born in this place here. Under this mountain, that’s our spiritual home. Our connection to this place is embraced in that Titirangi….And the river that comes down here is Uawanui-Atumumatua. So the tribal people are the Hauiti who are descendents of an ancestor called Hauti related to Pororangi. And so from Pororangi comes Ngati Poro – the people all the descendents. Ngati meaning all the descendents of Pororangi. Pororangi’s wife was called Hamotirangi and when Pororangi died his younger brother, Taupotiki took Hamotirangi to be his wife and took her down to the South island. And so that’s the relationship between the East Coast and down south. The people of the south island, the Ngai Tahu people is through her… So, yes, I was born here, a long story about that birth, and I’m from here and not surprisingly I’m still here. (laughs). (7)

The next participant had a sense of sacred energy in some places in England and elsewhere although raised in New Zealand and includes the experience of laying on of hands as a transfer of that energy.

At one time I felt far more attuned to the world of energy and spiritual connection outside myself. I’m always reluctant to say some of these things, but even when I worked in England I really felt quite able to use the energy of some of the places I visited. I could have a tangible sense of it in my body as if I could feel it between my hands, and use that working with people, through touch and through an extended compassionate feeling. I don’t have that here nearly as much. The energy of NZ is really much lighter and it’s less easy to sense or feel or channel than in Britain. And I just kind of drifted away from all those practices. Not particularly because I stopped believing in them, but lack of usage, lack of familiarity, lack of being around other people who feel like that. There were other places that I believe in things like ley-lines but there were certainly places that had a special quality of peace and vitality that was well beyond the physical beauty of the place…It all sounds very flaky and fey when you talk about it but it’s quite a real sense isn’t it. (10)
The participant below identifies very clearly both the place and the connection with those who have died as something that adds depth to human spirituality.

I think there’s this … the whole idea of people, the children seeing the virgin Mary at Fatima, wherever it was, or Lourdes. I’ve been to those places as a child and there’s some dimension to that which is, there’s a dimension there that we don’t really have in a secular society, which is like the sort of relationship between the living and the dead. In our sort of conception of it as a secular society, it is very separate. You’re either alive or you’re dead. And that the idea that you might communicate with the dead or see them is, or whatever, there’s sort of something in that depth. (3)

Certainly the next example also implies a presence of the sacred and immediately mentions connection to a dead father, which for this participant is in the mountains. Here the different domains of spirituality connect: the self, other, natural world and the transcendent.

Go up there! Mountaineering is where I, when I get up there, I get into a sort of transported state, which is spiritually much higher than when I think about it… And interestingly, when I’m there, I’m probably connecting with Dad, because he was at his happiest, most peaceful when he was up on the hills, and in the mountains or in the woods. He was in his element. (6)

3 Uniqueness and Centre of Self

The extracts in this section and sections 4 and 5 were all in response to a question about how the participants understood spirituality. Many gave a number of ways of understanding it. In Chapter 2:1 I considered the difference between individual development of spirituality, which is a life-long process of growth, and an underlying universal human spirituality.

There seemed to be a clear and general understanding of spirituality in both these ways. However participants tended to focus on the uniqueness of individual spirituality both for themselves and in their patients. Even those who were religious tended to avoid using religious definitions of spirituality and struggled to express the immensity of their concepts of spirituality.

That’s a hard one to answer really. What is it about. It’s those things we’ve just talked about – spirituality varies from person to person. (2)

Now that’s another hard question. I believe everyone has their own spirituality…. (16)

But everyone’s definition of spirituality is going to be different, and spirituality in a sense is anything to do with the spirit. So that that inner consciousness, if you
like. Anything that’s not materialistic. And it’s a huge subject and there’s a huge area. (21)

For a number of participants there was also a sense of spirituality as the core or depth of human beings, the essential self. Some struggled to put into words what they thought about spirituality as a connection to the centre of self.

Each of us have something unique and that has maybe it’s a spiritual element that’s a real core self and at the end of the day that’s what is the most important and being true to that is the most important thing. …I certainly think it is about respecting the uniqueness. The most important thing I can do in general practice is to acknowledge everybody’s good and bad aspects. And there’s always something that’s good there and the uniqueness. And when I can find that, I actually find I’m involved with them in a very meaningful way…. It’s very difficult to come up with a tidy definition. . It’s about the core, the centre of you. (19)

I guess according to my beliefs, that we are spiritual beings experiencing a human existence. …. and to me that is quite significant that the kind of the little essence of yourself …the eternal part of you that is there for ever and incarnates into human beings from time to time for the human experience.. Yes. So it’s not very coherent but just a few little comments on that. (22)

Some talked about this centre as the soul, the eternal part of a person, the life force or essence which persists after a person has died.

I sometimes say something like – something being hard on your spirit or hard on your soul; sometimes I use the word soul – and um I don’t know what that means. I think that sort of.. It’s the same as your spirit really it’s a sort of... (essentialness) (3)

Because to me the spirit of a person is the essence of a person, it’s their life force, and I think after a person dies the body is there but the life force leaves that person. (9)

And being around the dead. The absence of the, there’s so much more that’s gone from the body than breath and pulse, have definitely convinced me of the existence of a soul. (10)

The next participant linked the sense of soul as the best self with the need to strive for moral goodness and to give something back to the world.

And yet I know there is more than just being a person. I sort of believe that matter is something indestructible. And I am part of the matter of this world. And when I go whether it’s ashes or burial, or through earthworms I will still be there somewhere. And so I have to lead a good life, because that matter will carry, in essence, my contribution to the world. (11)
This essential self and the best self that strives towards what is perceived as good, is in a way self-less or altruistic in caring for others. However altruism is an intellectual concept and this caring self certainly involves the whole person and their deep feeling of connection to the other. Such caring needed to be freely given not done out of a sense of duty. The essential self certainly does not seem to be egoistical, possibly because at this level the sense of connection to ‘other’ is paramount. It is agapeic in its connection of care with others.

And, but true goodness is you’re giving without a price tag of any sort attached. So you’re not making a martyr of yourself which is sort of making yourself a victim and putting a price on in reverse, in a way. (16)

It's the best part of me, that wants to care for others. It’s also about using your talents for the good of others… We can only do what – each of us has been given something and we have to find from which we’re at – the better self I suppose… (19)

4 Beyond the rational and religious

One of the problems both with the language and the concept of spirituality is its dynamic nature, forever changing and growing. Another is that spiritual language has nearly all developed in a religious context. This language is sometimes unacceptable to those who have walked away from their religious affiliation or who possess a secular spirituality.

Some participants certainly thought that spirituality had an aspect that is essentially unknowable and beyond the limits of rational thought. This corresponds to the mystic understanding (James, 1985; Suckiel, 2002). What comes through clearly in the reflections of participants on spirituality is that there are limits to the scientific paradigm and to the language for describing human existence and spirituality.

Spirituality is belief in things we can’t rationalise. That’s the way I’d look at it. When we go to medical school …we’re taught there’s physics and biology to explain things but we can’t rationalise other things we believe in and I think that’s part of our spiritualism. (2).

It’s a difficult thing. (11)

Some participants struggled because they believed spirituality went beyond the religious and they felt constrained by both secular and religious language and its past and present connections. Once again there is a sense of spirituality without boundaries.
I knew you’d ask that question. To me it’s separate from religion. It’s believing in things, something a bit higher than yourself. Not necessarily tangible or visible but can be. (15)

I don’t think, for me I don’t think going to church or having an affiliation for one …I think a spiritual view of life is much bigger than attending church. (22)

This participant clearly believed there was a community aspect to spirituality as well as an individual one.

What is spirituality? I don’t actually have the language about it .. there aren’t any words to, that aren’t (religious)… I don’t really know what it means …Because it’s really problematic … it’s an idea that has been so linked to organised religion… And more recently it’s been associated with the New Age spirituality which doesn’t really appeal to me. Because it’s very focussed on almost self-development, which I’m not sure, is really quite what it’s about. … (3)

On the other hand the next one was certain that the language of the modern world and biomedicine was inadequate for the reality of spiritual life for human beings.

Given that we’ve impoverished by the language that we’re using, to consider whether or not we do things, or in what way we do things. So I guess that would probably come close to maybe, my take on what spirituality is about. Because it seems to be about humanity. And humanity has probably being replaced a little by economic theory… And the scientific model – you know I think there’s quite strong connections between those two. (5)

For others spirituality was essentially unknowable, in the sense of their intellect being unable to grasp and understand it. For the first participant this had an element of the magnitude of the subject.

Well, I sort of think it is highly possible that our brains are actually too limited to encompass some things and that we arrogantly think that we do understand the whole thing but actually we might just be understanding a miniscule part of it. And it made me think about the whole idea of our perception of size or importance, that’s really just a perception. I’m not sure, I think that to start to label it is a bit arrogant. Because as soon as you start to label it, you are putting some confines on it, it is confined by your perception of the world. I don’t know. (3)

The next one seemed to be talking spirituality beyond understanding but clearly accepted and lived with this as an ongoing process. For this participant spirituality was persistently sought in the mountains.
And... so there is something about spirit which is essentially unknowable for me. And probably, maybe that’s just the essence that is unknowable. And will forever be. I’ve no expectation of ever understanding it, or even a desire to. I mean it is so, its like trying to imagine the end of the universe. I’m never going to try. I don’t think its even worth bothering about because its almost by definition unknowable. I feel like that about the spirit. We’re aware of it. We know there is a universe that goes on and on, we know there is spirit, but ... I don’t even struggle to come to terms with it (6)

The last participant in this group seemed to be comfortable with a life long search for perception and understanding rather than struggling to come to terms with it.

Oh goodness. Spirituality to me I suppose it means all those aspects of my life which aren’t in the reality based, concrete here and now of reality that we live with. It’s all of the things that are to do with what affects our lives that you can’t actually touch and see and feel and so on…. But I think it behoves us to continue to think about this because it’s unlikely that we’re ever going to understand this and I’m not sure we’re meant to...(8)

5 Perception of the transcendent

The transcendent was perceived in a number of ways. I discussed the perception of the transcendent in five ways in Chapter 2:2:5.

1. Theistic transcendence is about the presence of God or Gods.
2. Pantheistic spirituality believes that all that is is part of the divine being.
3. A panentheistic spirituality accepts that the transcendent is both within and beyond all that is.
4. Atheistic spirituality denies the presence of a supreme being or God.
5. It may be a sense of transcendence in the natural world which is so much bigger than human limits.

Participants also saw the transcendent in all these ways. Some had a clear sense of the presence of God. For others there appeared to be a changing image of God throughout life, which is appropriate if spirituality develops throughout life. Some seemed to have a pantheistic sense of God in everything. Others had a real sense of spirituality penetrating all that is – God within and without. These rejected the fragmentation that occurs when dualist ideas of separation of body and spirit are accepted.

A further group envisaged transcendence as a greater power in atheistic terms. One of these understandings was of the transcendent as the natural world in its immensity and
interconnectedness. This was usually linked with the idea of the smallness and insignificance of human beings.

1 God immanent and transcendent
Some of the participants were quite clear that their spirituality was religious, theistic, and the transcendent meant the Christian God. Others had a sense of God that was not Christian.

With regarding spirituality, which has been, is a very important part of my life… I’m on the margins. And then during early teenage years I had a couple of experiences that had a major impact on me in terms of realising God was real.… So it gave me, … a profound sense, in a small way but actually in a profound way, that … God is interested in me. You know, I’m not just a blob in the universe, just a nothing. (4)

However for these participants, there was also a clear understanding that in our present era the meaning of spirituality could not be confined to Christianity or religious spirituality.

Well to me personally it means my relationship with God, and Jesus Christ but I accept that’s not what it is to a lot of people. That it doesn’t have to have any connection to any religious affiliations, necessarily, but for me it does… (20)

Well, I knew you were going to be asking me that question and I thought – well that’s interesting, because again it’s part of our culture and the whole post-modern era that spirituality has become a big thing…... And, um, for me in terms of spirituality I think in terms of my Christian faith and therefore I think of spirituality in those terms. (21)

The participant below almost seems to be proposing a pantheistic approach, or perhaps a Celtic understanding of a world infused with spirit.

And I have problems with dualism for all sorts of reasons. And I have problems with a triple-ism as well. Well you know, people have mind and body, and mind, body and spirit. …I go with the Celt’s view that matter is spirit seen from the outside. I like that sort of definition.… There can’t be anything outside God: God is infinite by definition. So everything is in God and…, so with that proviso… you know my background was evangelical charismatic that wouldn’t be the way they would understand it, …but it’s very much the way I see it. (4)

For others the sense of God within and without was very strong. This was not necessarily a Christian God. This ‘something there’ (analogous to the Egyptian concept of Ba) was raised by a number of participants.

There’s a Samoan concept called, which is sort of like….Well I guess some of the things that are coming more into the fore….It’s God within, really. Isn’t it. I really know how to describe it, it’s called Va, and it means, it’s like God, but I suspect
it’s a pre-John Williams God. It’s more of an ether. And it’s within and without. And it’s everywhere. And it’s a God concept. (5)

I believe, I don’t know, I believe in something, I’m not entirely sure what it is I believe. I don’t necessarily believe in the Christian God the way he is worshipped. But I do believe there is something there…is it without of me – or is it within me. I’m not entirely sure I can answer that. But, um, I don’t know…(16)

There was also a clear process of development, of the understanding of the transcendent God throughout life, which meant that the idea of who God is becomes less clear as the person matures and accepts human limits. There appeared to be a sense of comfort in living with or entering in to this mystery.

It, it governs another dimension. It’s a dimension that, for me I grew up when there was the dimension, it was a very Christian household believing in God and that was spirituality…. In the last ten, fifteen years that has evolved a bit for me and rightly or wrongly I still believe in that dimension. I am not so clear whether there is – I am not so clear in my mind about the God and what that involves. But I still believe that there is a God and I feel very comfortable with that thought and I use it in my practice…. Even though that God figure is not as clear in my mind or shaky, I will still tune in with a someone. (14)

2 Higher power
Another group believed there was a higher power, something greater than humans, but had no sense of a personal God, as described in any of the major religions, more just a sense of something there. This ‘something’ varies in intensity for different people and causes awe and wonder for some.

It appears to be both within and without the person. There is also a sense of the smallness and limits of humans in the natural world as well as a human need to seek for answers to the fundamental existential questions of life. Spiritual understanding varies from person to person. There are limits that are physical, psychological and spiritual.

And the concept of something great out there is much more concrete for some and much more nebulous for others. I think that for all of us there is something. (8)

So it’s an unformed sense of spirit, but an optimistic one. There is no feel of a divine hand controlling the chaos but there is something more that the obvious that does in some way form or govern or protect or determine what happens. But not in a sense I could ask for it to intervene in my life. (10)

I think it’s functioning from an inherent need within us all, whether we recognise it or not, to know and accept that there is something bigger than ourselves. (20)
Some participants linked spiritual experiences with the natural world. Those who were religious linked their love of and wonder at the natural world to God. Others had a sense of their own human smallness in relation to something greater than themselves that transcended them. For others the sense of intimate and enduring connection with the natural world itself was striking. It suggested that Maori spirituality, that sense of connection to land, has permeated New Zealand spirituality. I will return to this in Chapter 5.

Probably only in relation to the earth, really. In the sort of, that sort of idea that there’s something bigger than us which you sort of experience when you are out in the world seeing huge mountains or whatever that go far beyond us and longer than us. And then there’s the extension of that there are other things bigger than us even bigger than that …Well and also about relationship to the earth. That’s quite important. We don’t just exist as a community independent of our environment. And that if there’s anything bigger than us it’s the earth or the universe. (3)

If I have got a system it’s a natural one…. Acknowledge if my grandmother heard me saying this she’d string me up!...Ooh, we’ve been there Nan, we’ve been there Mum, OK, and we’re well aware it’s had a very powerful influence. But I will step back from that and say well, there are other parts to it, eh, of one’s beliefs and if there’s a word I’d use it would be a naturalist one. (7)

… you can’t help but wonder at the awe of God’s creation. I mean from here every morning at 8o’clock the sky over there changes from blue to pink and it’s just an amazing palette of colours. What an amazing thing – why would that happen just out of chance – what’s the point. Something has put us here and given us the ability to appreciate all that. And at night just looking up at the sky studded with stars, or getting to the top of the mountain range and looking out and seeing all the mountains around there. So there are physical occasions where you feel very close to God. Just in what you’re looking at and the environment you’re at. …. I think it’s more seeing the magnificence. And you just can’t help but be amazed and in awe at it – I can’t. So that’s one aspect of it.(20)

But if you look at it in terms of society as a whole…. And people are much more willing to talk about spirituality and spiritual things in very broad terms… I think it means there are an increasing number of people who appreciate that the good life and materialism is not really fulfilling all their desires and therefore they are looking for something else and this whole spiritual side of life has become something that people are beginning to look at, not necessarily in terms of religious spirituality but in terms of a spirituality of nature. (21)

When asked to talk about the meaning of spirituality some participants spoke of spiritual experiences. Experiences of spirituality were very varied and unique to each participant.
Some had a number of spiritual experiences they talked about; others thought they did not have any experiences. This group often did have spiritual experiences but they were mostly in relation to patients rather than for the participants themselves. I have included these below as deep human connection.

Participants who did not mention spiritual experiences were asked if they had ever had what they would call a spiritual experience.

Those whose sense of the transcendent was in the natural world are also listed in the chart.

Seventy-seven per cent of participants describe a mystical experience, using the criteria of Greeley, Hay and Kacela (Chapter 2:2:6) (Greeley, 1975; Hay, et al., 1978; Kacela, 2006). This is even higher than the figure of 55% quoted by Thalbourne in a recent study that replicated the work of Greeley in 1975 (Thalbourne, 2004).

Spiritual experiences were both about the presence of the transcendent and about the absence. In other words these too explored the processes of connection and disconnection.
### Table 9: Participant Spiritual Experiences

<table>
<thead>
<tr>
<th>Transcendent presence</th>
<th>God</th>
<th>Mystic experience</th>
<th>Deep human connection</th>
<th>Natural world</th>
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<td>22</td>
<td>Y</td>
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Y=Yes
A=absence of God/transcendent
An=involved an animal
Hs=Healing of self
Ho=Healing of other

Only one participant had experiences in all these domains. Five had experiences affecting four domains, ten had experiences in three and five in two aspects and one in one. I found it interesting that all participants had at least one spiritual experience, even those who were ambivalent about spirituality.

### 1 Mystery

The concept of mystery came up frequently, although the word itself was not always used. It was used both in the sense of inexplicable and in the sense of something awesome beyond our rational understanding. When experienced in this way it also gave rise to strong, positive emotions of awe and wonder.

Birth and death both very deep, Life changing. To, to hear that first cry and last breath. (1)
But on the other way things that you believe maybe you won’t see or you can’t see currently but you still believe in them. That’s also another meaning of my life I find. Yes. That’s why I mean because of my religion or my belief there are a lot of things that people won’t see with their eyes, actually, but I do believe that that happens. (12)

When used in the sense of not knowing why things happen there was less emotion attached to it. These participants had more to say about the process of healing in section 6 of this section.

I guess there’s a certain amount of mystery in it. You go to the doctor with some problem and he would say “You’ve got this and there a certain mysterious manner in which people can make a diagnosis and fix people really…. So there is that sense of mystery and then people get better and you don’t have an answer. (2)

I suppose it’s a mystery. What is this about? How does that happen to a human being. (3)

What I realise from doing my own research…is how many stories there are out there that sit below the radar, that are common…Yes, mystery and marginal phenomena. (4)

The last participant in this group recognised the complexity of consultations and felt pressured by the lack of time available to explore the spiritual aspect of patient concerns.

I’m not sure… Well really are there any straight lines? … if I’m aware I’ve got a whole room of people to clear, I don’t want to elicit the mystery… (5)

2 A quest

The concept of spirituality as a quest or journey, a seeking and re-seeking connection, was discussed above. It was also a seeking a right path and was experienced as a life long journey. For participants below it was a life long process central to their spirituality.

For me it’s about reality. You know - How is the universe? What is the nature of it? And about living in accordance with that. (4)

The other things, Anna, are parts of that journey and we can talk about beginnings, and I suppose there is no ending to the journey. (7)

To me it’s almost like a fourth dimension to a person. Perhaps it’s your subconscious encouraging you to point in a certain direction or giving you guidance. (9)

I think some of it is finding the path through life in whatever way you do that. (16)
There certainly were some participants who saw it almost as a yearning, a seeking for that which was not yet found.

I was generalising from my own personal need. Sometimes I would think of myself as an atheist in search of conversion. So I think we all need some source of meaning in the sense often supplied by religion. (18)

And that life’s part of kind of a path of initiation in becoming more human and in showing each of us along the way what is truly human and what is good … I also see spirituality as being connected to, it definitely comes more into, working in medicine, into the life path... (22)

I guess it’s what I believe and also what I think… I guess spirituality contains lots of different things, for example experiences, which actually build up what you believe. And also experience can form what you think about particular matters. Or events or whatever, so that’s my understanding …. (12)

Spiritual experiences emerged more strongly at times of transition, when disconnection and connection are taking place. Sometimes this was as a result of deaths or difficulties in family or professional life. One of the striking aspects of some participant stories was the way in which problems could be synchronous, with a number of events forcing the participant to change their understanding. Synchronicity was a major feature of Hay’s findings (Hay, 2006).

And then suddenly the bottom fell out of our world and we realised it wasn’t things that make you complete. So that started us on a quest looking for something greater than us. And exploring various options. I can’t remember how long it went on exactly… (20)

And I remember walking round the – the place … you look out over the water – and the hills. It’s magic too. I remember walking round the house thinking – … at 43 years of age thinking for the first time in my life – gosh I think that life is really a spiritual journey not a physical one. So that was a bit of a turning point for me. A realisation. (22)

Some participants recognised that their own growth was sometimes a response to patients.

Helping people at work still seems important. Enabling them to grow and they helping me to grow too. (19)

3 Meaning and purpose
Participants were asked what gave their lives meaning and purpose. This understanding of spirituality had a sense of seeking and journey. It was also connected to beliefs and values, some of which were inherited from their families and some of which they developed
themselves. The first group all spoke of the legacy of their father’s values on their own values.

Probably doing and making a difference. And that comes from my father. Which is very big headed. But I need to be able to do what I can… (1)

The third thing is that…a sense of fairness and equity and desire to make the world a better place. It’s sounds terrible, but that’s why I go into battle with politicians all the time… But that drives me. (13)

For the next group the internal pressure to care seemed to come from their own journey and need to connect.

If we go back to the beginning and say it’s about the essence of being human, having purpose and your relationships… And…. There’s something about purpose,….. And that’s probably given some direction in terms of work. D’you know what I mean? (3)

I mean I don’t have a religion per se, but I do believe that there is a reason for us being here. (9)

I have a strong sense of life purpose or obligation to anything. I don’t have a defined faith that says this is what you are supposed to do but if there’s one thing that I’ve been given, or do well, or love doing it’s, that is what my passion. (10)

There was a strong sense of being in the right place at the right time in some responses, as well as having the right purpose in mind. This sense of direction was passionate and deep.

I could say that some of my self-exploration and spiritual exploration is around finding out what is your core purpose, I suppose. Or what really, … pulling together ideas and then sharing them with other people is what for me, when I’m doing it I feel like I’m completely in line with where I should be and who I should be and what I am about, if that makes sense…. (10)

I think that’s a big part because also for some of the people the meaning of life means things to sustain their life… working for money and that kind of thing. But on the other hand the meaning of life is more spiritual like what they think and what they believe… I think its what I am actually contributing. Because if you actually give a contribution that actually gives a lot of meaning in your life (12)

Some participants had chosen medicine because they wanted to help people and make the world a better place. While this was the family value it was also a personal value lived out in a commitment to medicine. One aspect of spirituality was indeed living out deeply held values in relation to the well-being of other people, the focus on the ‘other’.
On the one hand is, um, when I think about it is a direct way to help people. Because I do believe that contributing or helping out is really important... But I think alleviating people’s suffering is the most direct way of helping people. So that’s the reason I chose medicine....And I can be honest... like my Dad, I won’t say he actually pushed me towards that direction but he suggested like, you know. (12)

I wanted to change the world and make it a better place.(laughs)... A little idealistic..... Right from the time I remember the things I wanted to do were always medically orientated....Um, what stage did I decide I wanted to be a doctor, I don’t know – mid teens. (16)

In some the rational wish to be in control and orderly was defeated by the moral imperative to seek the truth. They had difficulty putting that seeking into words.

.... I am hugely aware of how we all need some source of meaning in our lives and I think that whole notion is best captured by the term spirituality – seeking for meaning. And I find it very hard to articulate beyond that.... it’s that we all have this burning need to try and separate ourselves from the rest of matter because we have insight, because we have consciousness, then our birth is the need to find meaning and that’s what causes us to think about spirituality. (18)

For others life was much more straightforward. They were clear about what gave their lives meaning and purpose.

My faith, …my wife, the kids and my role as a GP (give my life meaning). That has been a significant role for me. And I think when I was …spending a lot of …time and energy in the church there that was quite a significant role as well. (21)

4 Growth and transition
A number of participants reflected on the process of growth in their lives, spiritually as well as physically, emotionally and psychologically. Growth was seen as lifelong, from birth to death. The impetus for it sometimes came from deeply held values within the person. It also came from their life experiences both positive and negative.

In undergoing spiritual transitions the process of growth followed that of birth. It happens in four stages. The first was a process of unfolding, reaching a sense of the limits recognising the need to change; this was followed by a painful process of letting go of the past and allowing the new self to emerge; at some point there was a time of impasse, when it is impossible to take action to change but the change simply has to be awaited; finally the transition occurs and there was a new stage of being welcomed with joy. The sense of struggle in this process came through clearly in the examples below.
It’s very much an internal personal challenge because you’re confronted with yourself the whole time... You’re confronted with your own emotions that come up about it as a response to someone else; and you’re confronted with your need to fix things when you can’t. (3)

And I think, I like to think, that all of us are striving for growth – to be a better person, so that sort of personal development and growth... And I think that’s basically what my idea of spirituality... is. It is growing within me as a person so I can be the best that I can be. And by the best I don’t mean materialistically the best or whatever, but the best person that I can be.... (16)

The next participants spoke about the need for continual development.

...and continuing to develop new talents all your life. Growing.... And accepting change you have to leave aside and move on in an appropriate fashion that is, well perhaps graceful, I don’t quite know what the word is. At the moment there’s a lot of things happening in the surgery and I’m not sure I’m coping very gracefully. (19)

I’m I guess according to my beliefs, that we are spiritual beings experiencing a human existence. And that life’s part of kind of a path of initiation in becoming more human and in showing each of us along the way what is truly human and what is good...I also see spirituality as being connected to, working in medicine, into the life path. (22)

While for those above this seemed to be a gentle process, for others below there was a sense of being driven, of passion. The trigger for this attitude sometimes seems to be a passionate sense of justice for all, but perhaps especially for those unable to defend themselves.

I wanted to work with people. And I was brought up with a sense of helping the underdog. My father was a great socialist. And also a great sense to ever changing; that anything is possible... he was a doctor as well, so he had an influence on it. (3)

Being driven by a wish to make the world a better place was clearly a demanding journey. There is a striking ambivalence in the wish to believe in science and its limits.

So there are inner things that drive people and you can see that there are different levels of emotion and enjoyment that people get out of life... For me it would be that inner driving thing. But in terms of belief, I practiced belief in science to a certain point, except that there’s masses of uncertainty. (13)

5 Impasse
Transitions often contained an experience of impasse - a sense of being stuck and unable to move by will power. In an impasse the person can only wait until it passes.
I’ve come close to very bad times. And I sort of thank whoever it is out there that I survived. I could’ve died many times...And I’ve considered taking my life, during that phase...Because it seems ...when you get to option reduction stage, sometimes suicide becomes a viable option...I did many times think it would be easier to be out of it than dealing with this. (8)

In a spiritual impasse there was often a sense of waiting in darkness, of helplessness and inability to move forward by rational effort. This may be recognised by the participant, as in the cases below or sometimes only in retrospect. (Wardell, et al., 2006).

And I went through quite a process of black despair, feeling trapped. ... And then I kind of burst through that and suddenly moved to a new (stage) (10)

6 Healing vs cure

Healing is a particular form of transition that is central to medicine. This was discussed with fourteen participants. As discussed in the Chapter 2:3:3 the emergence of biomedicine tended to focus doctors on cure and not healing. Participants were very clear that there was a difference. Cure was something done to patients – healing was a process of relationship that enabled patients to move towards a sense of wholeness or harmony. Healing was about the whole person and cure about a particular bit of the anatomy or physiological function.

No, healing is about the whole person. About coming to peace...Yeah. Coming to terms with the diseases. (1)

Well they’re quite different. They’re often quite different trajectories really. You can be cured without being healed – and healed without being cured. And curing is a biomedical idea diagnosis and treatment. And healing is a restoration of your sense of self as a human being with purpose...(3)

Healing to me implies, a bit like the difference between teaching and learning, healing is something the patient does with the help of the physician, I think, as opposed to curing which implies the external agent did it. I have cured you, but in a sense I have just been involved in your healing yourself. But maybe that’s just a personal point of view. (13)

For me healing is more about the state of mind and how people perceive their illness, and how they are supported through that. And so I think it’s more about people than illness or physical unwellness.... Cure...It’s the absence of disease, which I think is why you like palliative care. There’s probably a lot more healing involved. (15)

Participants also talked about healing in chronic or terminal illness. Here it was seen as being able to live with a disease but not being controlled by it.
I think a cure obviously is – a cure – you recover it’s gone, never to be a problem again. I think healing is once more a spiritual thing, where you may not necessarily have cured the physical problem but you have healed within to live with or deal with the problem. (16)

There was also a clear understanding of the importance of a healing relationship, not necessarily with a doctor. Part of the healing relationship was about bearing witness to the suffering of the patient.

I think there’s an interesting idea – can you actually heal outside a relationship? …we talk about healing happening in a relationship and it might not be with the doctor; most of the time it isn’t. But some sort of witness. I think the witness is quite important actually. I think for those people the witness is quite important….And that your focus is on trying to understand, rather than trying to fix or something (3)

The next participant pointed out the doctor must be aware of their own need for healing in order to be able to enter a healing relationship.

Healing. Cure. Cure. Healing is to make better. Healing is an ongoing process of keeping well, keeping better. OK. Is cure an end in itself? Cure a pain. I don’t know….You say that curative medicine cures pain. Absolutely. Heal thyself, O doctor. (laughs) (7)

Laying on of hands was also important in enabling healing, and as a way of transferring compassion. It is always striking to see photographs or films of disasters or sudden death when people can be seen laying hands on one another, holding one another.

I think there is something, there is an aspect of healing in the literal laying on of hands. And whether that is examining a chest, or taking a blood pressure or feeling a pulse, there is something that occurs in that interaction which is more than just in their physical action. A transfer of compassion as well in crucial times. (10)

The next participant suggested healing was about coherence both within the patient and in the community. It is about being in the right place at the right time. Since it has been thought about and struggled with for thirty years it had clearly made a great impression.

And I believe that that kind of healing ability is often not recognised by the person who does it. And I think that even the people who get involved in the healing process for others are often edgy about talking about it because they are afraid if they talk about it, it might disappear. And so he was blissfully unaware. If he was aware of his ability to heal himself he didn’t show it at any stage….I’ve been thinking about that and struggling with it for thirty years and I still don’t think I’m any further ahead…Yes. And I think he had a sense of coherence. He felt that he
was in the right place and there was no doubt in his mind this was where he belonged and he was important to the people around him. Not important in an ‘importance’ sense but important for being there...And I think it had something to do, you said what do I think of this healing process business, I think that has something to do with the healing process between two people... I don’t know if (he) healed himself, I don’t know if the whole community healed (him) because they didn’t think he should die of his cancer, or whatever. (8)

This participant also said patients could be healed, even while dying, and may become a healing event for family, community and perhaps, doctor.

That’s a huge example of that because we did not cure her. The cancer ended up taking her...The conversion, ... from the person she was to the person she became was a healing event even though we didn’t cure her. Nothing could cure her. (8)

Healing can occur even in the process of dying. Well we’re all going to die. And if medicine sees death as the enemy and the ultimate negative outcome they’ve got it all wrong. (10)

As well as the connection with healing spirituality can be a support for resilience and fortitude during a difficult and stressful time.

With this dreadful thing I’m going through at the moment, which is really, really awful, the spiritual part of it is really helpful. It’s also not easy. And I’m not praying that God will draw it to a close, I don’t even pray down that line. It’s up to him. Be a man...Stand up! Handle this! You know. This is difficult but you’re going to learn from it, be expanded by it, strengthened by it. Go through it. Why should I be asking for God to make it all easy. It’s bloody hell not easy. But it is also spiritual. And it’s part of my walk with God and He’s working something out here. It’s sure, certainly not comfortable. (4)

Resilience was also mentioned by another participant as an important function of spirituality in patients. The ability to face the trials of life is enabled by an understanding of a spiritual dimension that transcends the human.

And I see patients who have a spiritual dimension in their life as usually very lucky, in that they have a protection that has some way of explaining the world that works for them. And a sense of being held through disaster by something they believe in that seems bigger than the events of the day. They are not as battered by random events. (10)

7 Spirituality and Religious beliefs

I have considered the relationship between spirituality and religious beliefs and found it to be complex and changing (Chapter 2:3:5). Participants described the three states of relating to the institution that Hay refers to: believing and not belonging; not believing and not
belonging; untouched by church (Hay, 2006, p. p 211). His sample was drawn from those who did not attend church. In my sample there were two further categories – those who believed and belonged and those who yearned to belong but could not believe.

The consensus seemed to be that spirituality is a universal aspect of human beings and for some this is ordered by religious beliefs and attachment. There was also a sense of spirituality as being more than religion as emerged in the previous sections of this chapter.

I would pretty much accept the formal distinction that’s made there between the religious practices that are involved in religious behaviour, and the essence of what that’s really about. (4)

Spirituality is to religion as the Telecom network is to paying your phone bill. Religion is like paying your bill, but it doesn’t have much to do with the enormity of the wonderful system that connects us to every other person on the planet. (8)

So…for me it’s not a religion thing, it’s a fourth dimension. Yeah. I think everybody does have a body and a spirit. (9)

Seven participants said they were attached to a religion, but only four of these were currently regular in their religious observance. These tended to identify faith and mystery as important.

That’s why I mean because of my religion or my belief there are a lot of things that people won’t see with their eyes, actually, but I do believe that that happens. For example, in my religion we believe in re-incarnation which you don’t see, you can’t see in front of your eyes, but I still believe in that concept. (12)

Eighteen participants had been attached to religions in the past and some clearly showed the traces of this past connection. Four had never been attached to any religion. Eleven participants said they occasionally went to religious services for social reasons. These are shown in detail in the table in Chapter 3:6:5.

For some the connection was clear from childhood but others came to a sense of spirituality through an adult religious conversion and had felt increasingly attached. These participants identified spirituality with their religious beliefs which they felt had focussed their own spirituality. They did not necessarily think that everyone had to have that religious spirituality.

Well a lot of it comes out of the Steiner philosophy. Because …encountering that was what woke me up to crystallising my own belief system …And passion is the other thing that comes up…I know that’s why you asked me what I do in my spare time. But passion comes up too. People connect with what their passion is
and their eyes light up and you know that this is what they are meant to be here for. Yes. So it’s not very coherent but just a few little comments on that. (22)

For some participants spirituality was about religion. This participant is clearly thinking about religion while talking about spirituality with this response to the question: How do you understand spirituality?

Spirituality – getting to a tricky question. Well, it’s not something I’ve thought a lot about. OK I’m not religious. It has never, never, I got confirmed in the Church of England and never really thought deeply about it and it never seemed to me something that I personally needed. … (13)

I Reasons for religious detachment
A number of participants discussed reasons why they had left religions. These were many and varied.

And I grew up in a Presbyterian church which was pretty dead really, but gave me the notion that God was real. I mean why would you go to church if God wasn’t, and all this talk about him. (4)

Some acknowledged the aspects of belief, moral understanding or ritual that were helpful from their churches of origin, even though they have left them.

That’s an in term – culturally catholic – a good term though. Does it leave an impression. Oh, absolutely. I think it’s quite a socialist tradition in a way – very much caring for the underdog and valuing community. And there’s a lot of kind of morals and values tied up in that – most of which are fantastic. And a sort of sense of ritual, and a sort of sense of being part of something that’s been going for a very long time. That’s quite powerful…. (3)

Others had a sense that their religion was merely ritual and had lost its connection with the real world.

Because I got away from religion very early in life. You know I had a dose of Islam from my parents, who were not strict or anything they were very good people. And then I had a dose of Catholicism in convent school. And in some ways that was similar. You know there were so many similarities of organised prayer and fasting – Ramadan and Lent. And you know having a ceremony that had gone on for hundreds of years. I sort of didn’t find solace in it. (11)

There was also the idea that dogma limits freedom to explore ideas. This could be within a childhood experience of religion or when exploring in adolescence and early adulthood. It stops the pursuit of truth by providing closed answers for questions that continue to develop as our humans grow and develop.
… Truth is a sacred thing. And I know philosophically that truth is something that you never really pin down. But the pursuit of truth is one of the sacred commitments of our time. And I suppose my objection to religion is that it is ultimately a destroyer of truth because it gives you a set of beliefs (18)

For some the human imperfections within churches caused a loss of faith. For some the relationship had been close in the past but was no longer so. Some of the reasons why they left are considered below. Some left disenchanted by the behaviour of religious groups. They particularly took exception to a rigid and controlling aspect of religions. Many considered that religious belief did not cover all of what they considered to be spiritual.

Well, I think a lot of people, their spirituality, no their religion, which I think is different from spirituality, is that they go to church on Sunday and pray to God and have all their sins absolved and the rest of the time don’t put a lot of effort into it, or anyone else, or following the Christian beliefs …. Too easy….. …As far as I was concerned a lot of the religions out there are saying very similar things and certainly have very similar values and moral standing and all the rest. And yet they are so exclusive of each other and that’s what I struggled with. So it wasn’t the idea of a God, or Higher Power, or whatever, it was ‘our way or no way’ the infighting, the politics. (16)

When I left school…fundamentalism … was the prevailing creed at university. I found it awful – appalling the social manipulation and lack of intellectual rigor that went with the beliefs that you weren’t allowed to question anything…I found it negative and ridiculous and it put me off organised religion in a lot of ways – in the way it was used to control people. I hated that. And it seemed to have very little to do with true love and compassion and faith and any of the things that seemed to be valuable out of believing. (10)

Why don’t people have religion in their life any more? …Because I think people have reacted to dogma, actually. They have reacted to this idea that you can be told how to live your life without you engaging in any thought about it. And I think in medieval societies you could probably do that but I just think that people want more than that. (3)

Some participants had clearly spent much time and energy reflecting on why they left their religion. This participant had left in adolescence.

You take those (dogmas) as givens and you build up a world-view from that. And you are almost certainly mistaken in your world-view because of that…. If you don’t believe those, then there is a good chance you will fall outside the church or be outside the church in one way or another…Yes, they got rid of him(Jesus) because he was a troublemaker. And in that sense he is a wonderful model to follow. But as the church became more institutionalised I think it has forgotten that aspect of his life and has set up structures to protect human power and one aspect of doing that insists on a certain set of beliefs. (18)
For some any continued relationship with religion was about their relationship to parents.

No. I go along to church with (my father)… Interestingly, my father had a crisis of faith when he was about my age or probably a bit older, about 50. He decided the (church) was completely hypocritical and there was a bit of, I guess some more unpleasant sides of humanity in the church… they still tithe, and a lot of it seems a bit greedy. So I don’t actively go along to church. For me, like I think, in terms of an organised religion, I think that there’s huge strength in it for society, for Samoan society, but I’m not strident advocate of it, I just accept it and I’m happy to be involved with it but I’m not. (5)

For this participant, as a child at a Christian school, formal morning and night prayer did not meet the spiritual needs of Maori children away from home.

I was sent away to an Anglican school. Very Christian, morning and at night, and they said they took care of our spiritual needs….. (7)

For others it was both about their parents and upbringing.

I considered myself a Christian. Not particularly, my family were Christmas and Easter – C and E Anglican…. And I drifted from being a Christian into being an agnostic. (10)

A number had left their childhood churches when they were adolescent and at the stage of questioning everything. There was also a sense of outrage in discovering that some religious people in no way lived up to their religious ideals of goodness. The next participant also left their church in adolescence both because of hypocrisy and because of a theological objection to a partisan God.

My parents were Baptists. They were caring people. They taught me to be very aware of doing to others as I would want them to do to me. … I went along with the Baptist church until adolescence. Then I found myself unable to accept the people who went to church and said they believed in the principle of caring but behaved in exactly the opposite way in their everyday life. I could not believe in a God who only saved some and the rest of the world was abandoned. I could not accept the idea of a small number who were saved….(19)

Some participants went to church to fulfil community responsibilities. For the next one while the community aspect of church was enjoyable it was not essential to their own spirituality.

And so if, and I still have, and I have to be honest, my faith isn’t going to church and things like that, that’s non-existent. I would go to church – last Saturday I went to church … there was a combined church service in the afternoon with the health seminar…. But I really enjoyed the church service. I enjoyed it more for
the singing, the meeting people. Sure there is that spiritual side which I think I can take or leave. I don’t feel I need it in that formal setting. (14)

For others leaving seemed to feel like exile that may be self-imposed.

I was brought up a Catholic and for a long time bought the whole thing but in fact as a teenager it ceased to make any sense to me and I now don’t see spirituality as anything to do with formal religion but I am hugely aware of how we all need some source of meaning in our lives and I think that whole notion is best captured by the term spirituality – seeking for meaning…. (18)

Others wanted to believe but found their own beliefs were at odds with their church.

Now that’s another hard question. I was brought up Anglican….I really sort of wanted to believe and fit in except my beliefs weren’t the same. (16)

I was brought up in a Christian home. My parents were very hospitable. We had lots of … evangelical Christian speakers that came … So I absorbed an awful lot of stuff just by osmosis, being in that situation…. And I went through a fairly rebellious stage. … And so we put on our Christian face and we were the proper Christian children of a proper Christian family. And in my mind I was anything but proper and Christian…. (21)

The response of the next participant was clearly still strongly influenced by what he had heard from his father.

I’m not religious. It has never… seemed to me something that I personally needed. And I come from long line of agnostics, I would say. My father … I was sent to Sunday school, he said go and find out about it. I can’t speak for him, he’s not here any more, the view, and it was not rammed down our throats, but if on the subject he was, he was an avid reader, he read lots and lots and lots. I think he probably had the view that religion had more to answer for than it offered. That’s my summary of what his belief was. (13)

The participant below still seemed to be trying to find a path to follow and rightly pointed out that religion by itself does not make good human beings. Neither does a lack of religion necessarily make bad ones.

I was thinking that one of the advantages of being brought up in a religious house is that you are brought up with a shared set of values, beliefs, rules in that sort of lifestyle…. And in that sense I regret the loss of presence of religion…in all our lives…People do not suddenly become bad because religion is no longer there. Actually my own experience seems to be that people who can come of their own accord to a values of life found in religion tend to be much better people than those who just take them as a set of rules because they belong to a church.(18)
2 Religious attachment

Some also talked about how they became involved in religion and why they stayed. Interestingly for this one the connection happened during adolescence, running counter to the family culture and mirroring the departures of others during adolescence.

… my mother gave me a book to read – the Cross and the Switchblade by David Wilkison. And reading it I thought – this sounds like the real thing! …And at the end of reading the book I said to my mother ‘It’s a great book and I really enjoyed it’ and she said ‘Oh, you don’t really believe all that do you?’ ….And around the same time… we were given a Gideon Bible at school….And they said if you don’t understand it pray and ask God to help you understand it. …. It was an issue with my family, you know, I’d go out to a Youth for Christ rally, and my mother would burst into tears as I went out of the door, because I was different and changing and taking it all far too seriously…. And then, um, probably late teenage years I got involved with Apostolic (church) mainly because quite a few of people of Youth for Christ had this background. (4)

For others the connection was a bit later in their development. Maori culture is permeated by spirituality and religion. Prayer (karakea) is an integral part of all Maori community gatherings. This participant was struggling with Christianity as part of the colonisation of New Zealand. It is a patient who enables an adult religious commitment and conversion.

… I was always convinced that Christianity is so ingrained with the Maori culture in like, any Maori thing you go to there is going to be a prayer to God… And, um, so I was having this tussle within me a bit…. I was actually getting to the point where I was actively refusing to do Christian prayers or I’d frown on people when they stood up…. And … I had this patient. he revealed he was an Anglican minister and that his life’s research was looking at… all the different Christian faiths, studied them, all their Bibles… and then a really in depth study around Te Ao Maori (The Maori World) and our creation stories … So he kind of put it all together so that it just was one. And it was really awesome. (15)

For the next participant connection to community was also part of the reason for being attached to religion.

I’ve been involved… with the local Buddhist community. Mainly through the Chinese Temple… We used to have a broadcasting programme, a radio programme so I was helping out… And then they set up a sort of youth group so I was involved with the youth group quite heavily as well. I ran the camps and activities and that kind of thing…. Compassion is a really important concept as well … I guess balance is important in all kinds of religion and also what we do every day as well…. I don’t do prayer that often compared to others, really devoted ones… (12)

For two participants their adult transformation was mediated by a seminar that enabled an immediate mystical experience of God. This changed their religious experience from a
marginal or intellectual one to a heart felt commitment. Once again for these two participants the community aspect of church was very important.

And we went to the Presbyterian church up there once or twice. But …we had no commitment whatsoever. … Nevertheless we had that in our upbringing and I always had it in my mind I must actually look into this .. and see whether there’s any validity or whether Christianity is just a myth …. And we ended up going to this thing called a Life in the Spirit seminar…. you know it was a turning point in our lives. And we have some very close friends now in the church. And … they come and visit and pray with us and that’s a very important part of our support system. Which we never had before. (20)

And going to Dunedin in a sense I kicked over the traces and individuated and then I had to come to my own situation of faith not just a family faith. But really it was the Life in the Spirit seminar, in a way that was the transforming time. For me. Yes, We were very much …involved in the church and preaching and so on. I mean it was still a head thing rather than a heart thing, I believe. (21)

This section has looked at the detachment, attachment and practice of religion. It has considered why people leave the churches of their childhood and what attaches them to churches in their adulthood. It is striking how important major life transitions, adolescence and mid life, seem to be both in attachment and detachment to religion. It also appears that other major life events like death or illness may play a role in this as they confront individuals with existential questions about the meaning and purpose of human life.

One participant had no religious belief, and defined their philosophy as rationalist. What is interesting here is the sense of an ongoing search.

I believe in rational explanations even though we don’t know the whole story – cause and effect, I’m a firm believer in evidence, you know, things like randomised controlled trials and so on. I think they have limitations. As opposed to believing something just because. I’m looking for something that convinces me …. I think, and I say to the students, what we understand as truth has got a half life of about 6 months in terms of our understanding of things changes as we sometimes realise that in fact the opposite may be true. True as in at this point in time. The things we now consider true would have been completely fanciful 100 yrs ago and I am sure that’s the same now. Because of our great but still incomplete understanding of the physical universe. (13)

Another also reflected on the incompleteness of human knowledge and the way in which institutional religions sometimes capture and distort the message of their founders. This participant shows a deep spiritual understanding that is not limited by dogma. There is a radical humility in accepting the mystery at the heart of human spirituality.
And … apart from Buddhism, the people who have got in charge of the religions have kind of messed them around …And we haven’t actually seen the whole thing yet. That’s one of the big problems, when people believe that they have seen the whole orders. And the orders are actually written in invisible ink. … I think some of those sensitives have actually been able to get a glimmer. Certainly Jesus would, Mohammed, even people like Ghandi in their own way…. They all were sensitives and they were all able to see what we couldn’t see. But I don’t believe anybody has got the answer this year.(If you say you know God) You don’t know anything about God. (8)

The last comment reflects the belief of mystics from the early church to the present.

3 Religious practice
The table of religious attachment and practice in Chapter 3:6:5 shows some interesting facts. Seven participants had a religious attachment. Four of these were regular attendees at services. Three were occasional attendees. Another eleven went occasionally to religious services, usually to support patients or their families. They saw this as part of their caring for the ‘other’.

Five had had no religious attachment during their lives. Fifteen had no current religious attachment. Seven never went to any religious service. Seventeen participants said they prayed either for self or patients or both. Five said they did not pray.

4 Spirituality and emotions

The sections above look at some aspects of connection with the self where they describe the understanding of spirituality. Some authors also suggest that the feelings of spirituality evolved in the limbic system in the brain and are closely linked with the positive emotions, as discussed in the literature review. These were love, joy, forgiveness, compassion, faith, hope, awe and thankfulness (Vaillant, 2008). Negative emotions are also associated with spiritual experiences, classically in the ‘dark night of the soul’ described by St John of the Cross (John of the Cross, et al., 1976).

1 Positive emotions
Certainly the participants spoke more of positive than negative emotions for themselves and for their patients. It is perhaps easier for people to talk of that which is joyful than that which
is sad or overwhelming. These experiences provide many of the reasons why they stay in medicine.

1 Joy

Joy is an under-researched emotion, yet according to Vaillant it is the primary emotion of connection (Vaillant, 2008). This is well illustrated in the gaze of love shown in the statue of mother and child (Chapter 2:2:2). Because it is so intense, it is an embarrassment to adults who wish to be in control. Children have no qualms about expressing joy. People are often unwilling to talk about it and tend to play it down, as this participant does about a spiritual experience during adolescence which is remembered.

In fourth form I went to a Bible Class Camp. We had daily readings. Everything was different. But I wonder how real it was. Yes. Yes - we went camping everything was more intense and brighter. Yes. Mm. I have remembered it. (1)

It was very clear that some participants found it easier to talk of joyful experiences than others.

Oh – I love listening to wonderful music. And that’s an experience at its best of entering and enjoying the transcendent and the mystery of life which music does. And I love the earthy grounded strong bass notes in music, combined with the other stuff on top which is open to the transcendent and mystical in some way. (4)

I think it’s when something spiritual is going on, there’s something transcendent, beyond the material facts. And I talked to you about materially I could put on my boots and go and walk up there (gestures to hills) and walk among the rocks and enjoy the view. Which is the fundamental of it, but actually there’s something more. There’s something totally transcendent in my spirit, I feel elevated, I feel joy. (6)

This participant also links joy with sorrow, an association that Vaillant makes when he suggests that the joy in sorrow at funerals was in remembering the person who has died (Vaillant, 2008 p 133). This concept is certainly picked up below. The joy is about love and connection remembered, along with the sadness about those who have died, but who are in a sense resurrected, as can be seen from the comment below.

So, that sense of huge joy and privilege that I’ve had from those relationships, which hopefully I pass bits of Mum and Dad on to my family and my dearest friends as well… And that’s wonderful connection. I think what do I live for, what is meaning? Moments like that of human connection are meaning for me. At its highest point. (6)
2 Love

Some participants talked about loving their patients – and then added ‘but not really’ having been trained in biomedicine to maintain an emotional distance from them. Yet the characteristics of this love were an attachment that was selective, enduring and remarkably unselfish – all of which applied to the care they described of their patients. There was a clear link between trust and affection or love that both transformed and permeated a good clinical relationship. This selfless love was called agape in the early Christian church. Participants talked about it as a reason why they stay in medicine.

It’s like, I remember the registrars saying to me …‘Look from the way you are talking you expect us to love everybody’ and I say – yes – and…You don’t have to like everybody’….and I say you can not like somebody and still love them because it’s a different process…I can’t like them, but I still love them and I’m connected to them because I care about them. And that’s what it’s about.(8)

But I do love the patients. I loved the fact that I had two or three generations of the same family there… It’s those sort of things that keep you interested. (9)

I think I love the people. You know what I mean? I love my patients, well (laughing) the majority of my patients to be realistic (both laugh) (17)

3 Compassion

There was often a blurring of the distinction between love and compassion. Empathy was the expression of compassion in feeling with patients. One participant certainly discussed this.

So I’ve got a compassion; it moves me when I know people are doing the hard stuff with the spiritual thing, - and I can normalise it, this is normal, it’s good, it fells bad but it’s OK. I guess what sort of strikes me, is as far as the spiritual side of things is concerned, there’s often so much more there than kind of appears on the outside. And once you, sort of, get into it, with people, people often have some kind of faith or some kind of anchoring spirituality in some way that helps. (4)

Compassion is a really important concept as well. Because people usually say love and usually we think compassion more in a broader spectrum. Covering lots of things rather than just love…You love your family, you love your friends, but to other people you won’t say you love them. However in terms of compassion you can actually have compassion when you are dealing with other people, and you also can have compassion dealing with family members and also friends as well, so I guess compassion means you can cover more people into this goal rather than love …I won’t say I love my patient but I will say I’ll have compassion…and also to try to help them as much as you can within your ability. (12)

In Maori communities the awareness that comes with compassion and connection was noted.
That’s what we mean by spirituality…it’s global. You know, and the words we use are words like ahua, you know, there’s I suppose people might call it vibes, where you get a funny feeling. There’s always this notion – Oh there’s something going on here. That sixth sense, is another word we might use, so there’s that, that affective or emotional component. (7)

The last three sections have looked at the positive emotions of joy, love and compassion which enable human connection.

4 Faith and trust
Several participants commented on the satisfaction of having ongoing relationships with patients and their families. This ongoing relationship built up a trust that was irreplaceable and valued by both doctor and patient as mentioned. It is a particular feature of general practices where patients were able to see the same doctor over extended periods of their lives.

People will come …. because they just want to talk about an issue and they know its safe. (1)

To have this job where there’s given this level of trust and the opportunity to be part of people’s lives at critical times in their lives. You know I say I don’t cry much but that sometimes makes me feel a bit tearful. (6)

Some participants also linked trust to the issues of role power, and the lack of mutuality when the power was unequal.

It’s a great mystery to me, trust … I’m not sure that I know what trust means, actually. There are different elements to it. There’s this idea that you won’t hurt someone. But then there’s this idea that you have a level of technical competence…. Well I mean on one level you can say someone has to trust you because of the power that you have … because that person is exposing their body and their secrets to you and you’re not doing the same thing. (3)

Others linked it clearly with spirituality and saw this as a sacred trust.

I think within medicine at times you are trusted with a lot really. You’re trusted with people’s greatest thoughts and their greatest fears. Birth and death – people trust you to do invasive things or things that aren’t normally socially acceptable so I thinks there’s a trust there- has to be between the patient and the doctor and I think with that there is a certain amount of spirituality. (16)

The other aspect of mutual affection and trust was that it can be a cause of joy.

I spend quite a lot of time teasing patients. And that’s based on a high level of trust. You can’t tease someone when there’s no level of trust. And if I’m going to tease them that’s an indication I’m putting a lot of trust on them to not come back
and bite me…And of course they then all tease me back relentlessly. It’s a joy.

(6)

The thing that is most satisfying and keeps you going in medicine is that relationship and rapport that you build up with people. They trust you.(2)

I loved, the fact that I had two or three generations of the same family there. And also I love watching people grow up. You know, diagnosing a positive pregnancy test and then seeing them at school, and now seeing them at secondary school…and seeing where they are in their life, and having serious partners and buying houses. Just following them. (9)

Some doctors trusted patients enough to give them cell-phone numbers, particularly in terminal care. So that trust is a two way process, the doctor trusting the patient not to abuse their trust.

Yes. Giving them your cell phone number and … they don’t have to talk to … a stranger, and they can get help. I think that is a memorable thing is when you see how important that bond is and people travel a long way to see you….She just appeared one day and she said … I think I’m pregnant. I wanted you to do the pregnancy test. So she’d come down …. so I could do the pregnancy test … and I hadn’t seen her for three years. (13)

For others giving trust to patients is a way of letting go.

Actually something just came into my head about trust. And a couple of times when I’ve been really kind of worried about someone I’ve told them that I trust them to do the right thing …. I think that’s worked quite well. It’s partly a handing over of responsibility, partly a sort of – you know when people are teetering towards recovery a kind of letting them go in a way. Which is very hard to do. But I think that’s sort of empowering isn’t it. (3)

For some this faithful relationship was difficult. This participant described going with on house visits with a GP father.

So I used to accompany him on house visits. It was quite fun… He was there for 25 years. (5)

This idyllic memory of the devoted, interconnected rural GP left the participant with ambivalence about their own career. What is interesting is that this participant clearly recognises the spiritual element in the love and trust of patients.

I got to know that family over a period of time, and it seems to me, that the, what would you call it, the affection and I guess almost adulation, that was showered upon me seems completely undeserved and ridiculous, but it also felt ungracious not to allow it to continue….I felt a bit conflicted about it as you can see. And I
think that’s probably, that example is probably an example where I’ve seen maybe, the realm of spirituality in practice more clearly. (5)

And I was reminded by lots of resonating experiences of me imagining what it might have been like for him (father) because there was quite a symmetry there ending up in semi-rural general practice. …So of course there were those echoes there. Which were nice…. I think feeling a bit tied down to a group of patients…I wasn’t prepared to commit to being the GP for this community for a long period of time. (5)

Another GP, a long term locum, commented on the need not to allow patients to get too attached, while at the same time valuing having regular patients.

I like the people. I think in general practice you get to know the people in a way you can’t possibly do in the hospital system…I’m down to 2 practices that I locum at…. I think it’s important from the patient’s point of view they have continuity of care. One of the nice things though with being a locum sometimes is that you know ultimately the patient is not your responsibility but is someone else’s…And I think that is the thing I dislike about that dependency is patients look on you as their doctor, a commodity, and if they need you they want you to be there and available at their beck and call. And that’s hard. (16)

Having been in a rural practice for many years, the next participant now also a locum, felt quite differently about this. Their long-term patients and multi-generational families were precious.

And then I nursed her through the next couple of years or so…dealing with her husband and her three girls going through all that stage (until she died) and afterwards…And having those three girls eventually come to me and say they were engaged and then two of the three asking me to deliver their children. So in a sense I was involved in that family right through and you know that was a good experience ….Something which you don’t get as a locum. (21)

Some participants expressed concern at the loss of ongoing relationships because of changes in the way general practice is organised. They also commented on the biomedical model.

Sometimes I think we’re losing that a bit because we don’t have the same continuity of care. … If we’ve known a patient for a long period of time, we know how they think, we know what their anxieties are, how they rationalise them, it’s easy to manage them and they trust you…Because a lot of hospital medicine now is just pure technology. Doing tests and making sure things are negative …I think people like to know what is going on. They like to be reassured… but for a lot of people if there isn’t a label at least to be reassured by someone that you’ve got a good relationship with is more satisfying than the cardiologist saying, ‘No it’s not a heart attack. Go away.’ (2)

Because of all that’s gone before, what people understand about the respect and confidentiality and all those sorts of things in a consultation … We have to be
very careful to protect that. If you lose that everyone would be much worse off, if you don’t have that kind of mutual trust. (13)

It’s not without reason that we regard continuity as being one of the essential qualities of general practice. The one that we’re at risk of losing. Why GP’s are prepared to accept some poor remuneration because they are getting that sort of really meaningful payoff. (18)

Two participants describe the experience of religious conversion. These would have fitted equally well in the section on connection with the transcendent. Both had attended a Charismatic Life in The Spirit seminar. The search for a spiritual home in the first case was precipitated by a deep personal loss.

Over the next six months we spent all of that time exploring and trying to find things out, and we ended up going to this thing called a Life in the Spirit seminar…. And I went along as a total cynic and sort of rubbished everything everybody said and so on and so forth. But what it did do was it brought us to a point of having to say…Really it was like walking along this path and getting to a stile at the end of it and getting up on it and saying – now I’m actually going to have to turn around and go back or I’m going to have to jump over and accept it. So it brought us both to a point of decision. And I had a very good friend …, who I spoke to about all of this. And he said – look at the end of the day you are going to have to make a decision of faith and see where it goes. And you’re not going to have a bolt come out of the sky and tell you that God is real. You are going to have to look at the evidence and decide – is there enough evidence to go for this or not. Make a decision in faith and see what happens. So, you know, it wasn’t a lot he said but it was quite wise words. So we went through this thing in this particular day after some weeks where they give you a chance to be prayed for and saying well that was it – on balance God does exist and Jesus is who He said He was, and let’s go for it and see what happens. And that was in response to the loss …. Yes … although we would never have wished for that to happen, you know it was a turning point in our lives. And the good that came out of it. (20)

The next participant was very surprised at this event which came out of the blue.

I’ve had a number of occasions when I’ve had quite a significant experience within the charismatic renewal….someone wanted to go up and be prayed for and she was very anxious so I went up with her…I don’t like Americans and all my most significant spiritual experiences have been with Americans…. And she sort of started prophesying over me. And I went down like a ton of bricks. A very significant experience for me at the time….Prior to that I was your average … Anglican, I suspect. Who’d been brought up in a Christian family and absorbed a lot of stuff by osmosis, and therefore knew all the jargon but didn’t necessarily believe it. And live to it. (21)

5 Hope
There are many ways of looking at hope – its origin, meaning, intensity and changing focus. It refers both to internal dynamics and external ones. It comes from the depths of individuals as
well as emerging in relationships with others, and for some with the transcendent. Hope unfolds throughout human life. It has been a concept from early history. The hope in a clinical relationship resonated between the patient, patient’s family and health carer. It is an important aspect of healing and was also linked with trust and ongoing care or faith.

Just connecting with them is part of the process. Connecting and showing a willingness to reconnect. So that you become a sustaining thread. (18)

And our job, I believe, is always to try and sieve through and find the glimmer of hope. Find the small bit of flame that, the small ember that might be fanned back to life to give hope again.(8)

Some participants were very aware that it was possible to take away hope as well as to give it, so nourishing hope was extremely important in the healing relationship.

But she really woke me up to how we as doctors can remove hope, and remove a sense of wellness and autonomy from people so easily. And try to be careful …to be realistic with people and give them information, so that they have the opportunity to choose their own path. But to really value wellness and what it does for people. (10)

Symbols of hope were seen as very important. These were extremely varied.

People from all over sent cards and letters and we hung them on the nylon line we had up for Christmas cards. She said these are like the prayer wheels and flags. They’re all the good thoughts and wishes…(1)

6 Forgiveness
Discussion about forgiveness certainly formed part of the discourse. Most of the comments about forgiveness were in relation to patient situations. Participants recognised patients who were stuck in an impasse of unforgiveness that prevented them from healing and being able to be self-caring.

It does involve a lot of forgiveness. And forgiveness is so powerful in terms of healing… I think it’s a large part of our job in General Practice.(6)

she was diabetic…and she stopped coming back for her 3 monthly reviews …she had been gang raped when she was a teenager …had bumped into one … in the supermarket….which had brought it all back to her…And she felt so bad about herself she said “Actually I guess I was really trying to let myself die.” …So she ended up coming round to the possibility of actually forgiveness….And that was her breakthrough. It wasn’t saying that it was right, it was simply saying that despite what he had done… she was prepared to offer forgiveness…And then she was able to start looking after herself again. (20)
Well very often there is a lack of forgiveness in relation to depression. And the whole business of the inability to forgive, things have happened in relationship with parents or spouse and they are depressed and they’re angry and they are frustrated and they have despair. (21)

Only one participant talked about self-forgiveness. This participant also makes the connection between forgiveness and healing. It was clear that forgiveness was not an event but a process. It related well to the comments above.

And self-forgiveness. Some things are still, have not fully healed about, in terms of things which I find it hard to forgive myself. Having made poor decisions, behaved in a way I was not, looking back on, was not happy about. And I don’t know, sometimes we just have to wall those things off, and hope they don’t erupt. (8)

7 Thankfulness

Participants often mentioned thankfulness, gratitude or luck as part of their experiences both in relation to themselves and of patients.

And she was so uncomplaining and grateful no matter what happened to her. And bore it and carried it. …I think it was her family. They were always there, they were there all the time taking it in turns. For this little deformed old lady. And when things weren't going well. And she had every reason to complain. (1)

The participant below linked it with grace, which comes from the same Latin root as thanks.

And he had cancer. He had heart failure and lung failure. But was forever mindful, didn’t want to be a bother to anyone. Very thankful and gracious, for any help or assistance that had been provided. Non complaining. (7)

This participant also expressed it in relation to self and the gift of life and connection to others.

And I said, yeah, thankful for the earth mother. And so the primary belief system I have is around earth mother/sky father and the environment. Saying that living things out there, treasure them, they’re all living things, you know.(7)

I come from a big family, so very fortunate…. So in the end I suppose I am very fortunate. And it’s something that’s not taken for granted and I suppose if there is a learning that comes out of it, one of the learning things that comes out of our experience is not taking anything for granted.(7)

My wife always says how fortunate the kids are here, it’s a safe environment. Everyone knows everyone else. Where else can you walk out of your gate a hundred yards down the road, there’s the sea, fresh air, food is abundant, sunshine is rampant. So you look at the environment. It brings for them, OK, wellness and
wholeness, wellbeing. There’s no pollution around, no buzzing lights, no high-rise buildings. (7)

There is certainly a sense of thankfulness that is about the reciprocal connection for other participants as well. The connection may be to family, patients, the natural world or the transcendent.

We are extremely lucky being in this sort of a job. (13)

And I’ve practiced medicine in very comfortable circumstances, where everything is laid out for me, there have been no difficulties, So that’s my other luck. You know many people haven’t got the chance to practice the way they would like to practice. So I’ve been fortunate in every way and I haven’t forgotten that for a minute.(11)

So very lucky… I think we’ve got so much to be grateful for and I think we do need to appreciate it otherwise. We live in a very materialistic and throw out world and unless we’re grateful and appreciate things, the world is not going to be around for the next generation (9)

One participant, having recovered from a life-threatening illness, had a reason for thankfulness.

I think certainly after my … diagnosis … Every morning I can wake up and give thanks for this, for another day, and the blessings we have. It makes you very aware. Because it’s so easy otherwise to just drift through life and a day passes and another and you don’t notice it. It certainly made me a great awareness of all the blessings that come day by day.(20)

8 Awe

Participants often described the experience of awe. This one became tearful at the remembered sense of awe and wonder.

… both very deep, Life changing. To, to hear that first cry and last breath. Although after a time it doesn't (looks tearful) touch you as much as much as it did. Yes yes. Very easy weeper (laughs) (1)

The response of the participant below, who was at that time in early adolescence, also showed deep emotion. The transition from childhood to adulthood is often accompanied by spiritual transitions.

And they said if you don’t understand it pray and ask God to help you understand it. I came across a word that I didn’t understand, that was leviathan, and this particular day it occurred to me to ask God what it meant … and in a moment this word came into my mind ‘dragon’…and leviathan was a creature with smoke
coming out of his mouth and fire coming out of his mouth, and I thought ‘Oh - the dragon!’ …And at that point I thought – well, maybe God did speak to me yesterday. I had no idea how God was meant to speak to you and I remember wondering at the time ‘I wonder what happens now?’ …(4)

Some experiences were not in a religious context at all but were very significant for the participant.

An experience in another Greek museum of just wandering round on a hot tired day looking at little statues from the Cyclades …And I’d seen several of these things and ‘they don’t know what they were for’ was the caption and then standing in front of one that looked just like all the others and being completely overwhelmed by the experience of awe, which is not a 21st century emotion. Just knowing to my core that this thing was something that some part of me or memory of me had venerated, had been terrified of.(10)

2 Negative emotions

Some participants spoke of the negative emotions associated with spirituality. Just as positive emotions are about connection, negative ones are about disconnection. These came from a sense of the loss of connection with God or a higher power, family, or meaning and purpose. For some it was an experience of both. Just as positive emotions promote and enable connection, negative ones disrupt it.

The feeling of despair and loss came to the participant below for a number of different reasons. But they also had a sense of breaking through after a time of impasse as part of the transition.

I think adversity sometimes does that. Not quite the dark night of the soul but it was pretty close. I remember it as a very dark time. And I came through that to what I discovered was a place of relaxed maturity with medicine. (10)

Inability to connect within families when one party wished to connect was a cause of great pain and hurt.

Although my family cause me quite a lot of grief as well….Because for some reason she has found total dissatisfaction with me. … She said ‘I don’t think I can talk to you, you’re so different. …So it’s a sorrow that is very deep but I can’t resolve it. (11)

For the next participant facing mortality, in spite of a strong faith, was very difficult.

I reached a point of – a really black hole – and felt I can’t go on, I can’t get out of this. (20)
For the participant below family and peer disapproval were clearly a deeply wounding process.

So … during the modernistic, reductionistic scientism that was …the dominant discourse at the time, and the whole flavour of my context growing up, believing in God was marginal, deviant in many people’s eyes…. It was an issue with my family, … I’d go out to a Youth for Christ rally, and my mother would burst into tears … because I was different and changing and taking it all far too seriously. The problems I had, … growing up as a teenager, which were fairly minimal, all got blamed onto the fact of spirituality. And I felt quite wounded by that. And kids at school, they looked at me like I had two heads and three ears, so I had quite a strong sense of, this might even get a bit emotional (looked tearful) being behind the eight ball, and of being less than, and of something wrong with me because of that. And so there’s quite a bit of emotional injury really from that. (4)

This participant also had an experience of being cut off from God.

I had…about fifteen years ago … four and a half years where God seemed like He was on the other side of the universe. And I felt like He and I had really parted company. … And my own spiritual map had run out. …. So somebody suggested I go and have a chat with (an Anglican Priest) which I did. And… he said, (laughs) he wasn’t chuckling but it makes me chuckle now, ‘You might be going through a dark night of the soul’ and that meant nothing at all to me, I felt like that was far too spiritual for the way this felt. … And that was part of the darkness of it, that I couldn’t see that. There was no consolation. (4)

At the end of this painful time of alienation, in what might be called the wilderness, this participant felt moved to go to a new church and was reconnected to religion. A sense of impasse is very much part of negative emotion in relation to spirituality. It is interesting that the participant recognises being in the right place. The final comment, that in retrospect it was a rich time of growth although it felt like total impasse, is also telling.

And I felt, ..church was a pain in the neck for me at that point. It was like salt in my wound…but one day I felt like going to church….so I looked through the paper to see what I could find. I thought ‘Oh. Check it out’. I walked in the door and there were only about eight people up the front…But the priest had written the order of service, … and the opening paragraph of the service was a summation of my journey over the last four and a half years so I thought that I was really in the right place. That was the turning point and things just all came right. I mean I don’t know how to put it into words. It wasn’t at all an intellectual thing…And now I look back on it, and a bizarre sense of what that time did for me, was in retrospect so rich, there were so many good things happening for me, and I couldn’t feel it or sense it in any way at the time. (4)
5 Summary

After a brief introduction, section 2 in this chapter started by looking at the understanding of spirituality. It found spirituality has both immanent and transcendent aspects and developed throughout life in a continuing search for depth of self and transcendence. Spirituality had a boundlessness that went beyond rational understanding. For some the transcendent was understood and experienced as theistic for others as agnostic or atheistic.

Section 3 went on to look at the various ways in which spirituality was experienced and the connections between spirituality and religion. The process of religious detachment, attachment and practice for the participants was explored.

The final section 4 examined the connection between spirituality and emotions in the light of the neuro-physiological understanding of spirituality. While positive emotions enable connection to others, the natural world and the transcendent, forming community, the negative emotions disrupt both connection and community.

The next chapter will consider the connection of doctors and others in greater depth. This covers the reasons for choosing and staying in medicine based on the values and spirituality of the participants. It then looks at spirituality as connection with family, community, the natural world and the transcendent. This includes dealing with family illness and deaths.
Chapter 5

Connection with others

1 Introduction

The last chapter considered the spirituality of participants. This chapter looks at spirituality as connection with others – patients, family, community, the natural world and the transcendent. As discussed in Chapter 2 community is what makes us spiritual because, as humans it is in connection that we find our fullest and deepest self. Radcliffe suggests human freedom is to belong to community, be that of family, wider community or even the interrelated community of our universe (Radcliffe, 1999). Connection with others was explored throughout the interviews.

In order to understand what motivated the participants they were asked both about why they chose medicine and what was it that made them stay in medicine. This gave information about their values and what gave their lives meaning and purpose. Their accounts of memorable patients and doctors were very revealing. This chapter then goes on to explore connection with their family through the experience of disease and death in the family. Finally it looks at connection with the community the natural world and the transcendent.

2 Reason for choosing medicine

The life choices made by adolescents about their future careers are clearly affected by a number of issues that are central to their life story and provide a context in which to appreciate their thoughts about spirituality. There was no doubt that some participants chose medicine as an idealistic and ethical decision. Others fell into medicine as an option suggested for them by parents and schools. At least four did medicine because it was implied they were
not up to it, or it was unsuitable for them. With few exceptions the choice of medicine was
made in late adolescence when participants were well into one of the major life transitions.
Two participants did other degrees immediately before medicine – one an MA in English
Literature and one a BSc. Another participant started in medicine, did a BSc, then teacher
training and only returned to medicine in mid life.

1 Parent died
Two had had parents who died when they were adolescent and both felt that this influenced
their career choice in medicine.

Table 10: Reasons for choosing medicine

<table>
<thead>
<tr>
<th>Why medicine</th>
<th>Female participant</th>
<th>Male participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent died</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Make world better place</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Medical father</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Community expectation</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parent expectation</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>School expectation</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Told not bright enough</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Father discouraged</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

I will look later at the important spiritual effects of death or serious illness in the family. This
is because death challenges and confronts the meaning and purpose of life. When it coincides
with a major life transition, as it does in the two cases below, it may also influence life
choices that are made.\(^{28}\)

About that time I was thinking that veterinary medicine would become quite
repetitive… and I was sort of questioning whether I actually wanted to do
that…And I can actually remember the week before Mum died, because I was
really annoyed that she was dying, saying to her, ‘Don’t worry I think I might do
medicine Mum, I might be able to help somebody.’ So probably it was Mum and
her illness that put me in that direction. (9)

I had a cousin … who chose to study medicine…. And I thought what a terrible
job…Then Dad ended up … having a heart attack. And I went into this place and
there was something about what was going on there that I suddenly thought, yes
this is the place for me….. I did enjoy science but I was much more of a people
person for God knows what reasons….And I thought maybe that’s where I’ll
head. And from then on every subsequent possible choice or circumstance
reaffirmed that. (6)

\(^{28}\) For many years I puzzled at my own choice of medicine, which originated when I was five years old. There
were no doctors in my family. Then I remembered that my mother was ill and in hospital for weeks when I was
five and I really wanted to make her better.
2 Parents encouraged them

Seven participants were encouraged to do medicine by their parents, although only three of these felt a strong expectation from them to do medicine. Six had medical fathers, and four also had siblings or cousins in medicine. While the three below felt their fathers wished them to do medicine most said they were not pressured but that it was pleasing to their fathers when they chose it as a career. Four male participants had children currently doing medicine and all said they did not pressure them into it.

Father joined a solo practitioner… So I used to accompany him on house visits. It was quite fun. …Well, there was a very strong feeling from him that that would be quite a good thing for me to do. (5)

I used to go on Dad’s ward rounds when I was a kid, with him. On Saturday morning he would go round the private hospital and I used to go round. (17)

He started off as a teacher and then went into university. But he wanted to be a doctor in fact so that may have been an influence on me…. I think I was very aware while growing up that my father would very much like me to be a doctor … I didn’t really know what I wanted to do but the options seemed to be architecture, engineering or medicine… And medicine in a way seemed to offer the most freedom of choice in life. (18)

Some were definitely encouraged by their schools. This was particularly so for high-achieving girls.

School were very pushy. That’s where most of the influence came from. They were quite adamant right from the start they kept saying to me – Oh, you’ll be doing medicine – were the words that came from the headmistress. … And no doubt my father had an influence on that, although he never actually said anything. He wasn’t pushy himself for it. (17)

This participant was ambivalent about medicine and until mid life, had a career in a different profession.

So I grew up in that sort of medical family where father was at work and absent all the time…. And I guess what happened in the 7th form when you are doing UE the teachers said why don’t you apply for medicine, you’ll probably get good enough marks to get in. So I did, not being particularly committed to it but at the same time quite interested in the broader concepts of healing and wellness.(22)
3 Community encouraged them

In two participants the expectation from their community was very strong that they would do medicine and it was decided and arranged by the community leaders in one case and an influential mother in the other.

Well, that’s when I was at school, it was again one of my elders, the principle then was tono (command). I was sent away. I didn’t have a choice. I was told to go off and do medicine… Wasn’t an issue. You know. Brought up in an environment where you know, pathways were clearly defined by those around. By one’s elders. (7)

And so being a doctor was never really an option. …And it wasn’t until 6th form that my Mum… said … take this into school and see if any of your friends would be interested in going to med school. Why don’t you have a look at it while you’re on the train.” … So I had a look at it and thought it sounded OK … And so … first of all I talked …to a tohunga (Maori healer) … and he said – yes we want a doctor that’s centred on the marae… So my principal got a Maori doctor in to see me almost the next week…and that’s how it happened. (laughs) It wasn’t really any passion to be a doctor – I had no idea what doctors did. (15)

In a third case it was definitely a family decision. In all these cases the cultures of the participants were such that decisions about careers were usually taken by elders or senior family members.

Medicine was actually a 3rd choice…Mum and Dad started having conversations with me… ‘So what about medicine that seems quite good.’ When the 6th form exams came out I’d passed but marks were not high enough to do medicine …So I went to teacher’s college – kind of just accepted it. My third day there…Dad rings up and says …we think you should go and do 6th form again and … then get into Med School. And I said “OK”(14)

4 Discouraged from trying medicine

One was strongly discouraged from doing medicine by father, who was a doctor. It made them determined to do medicine.

In fact my father tried to talk me out of it. That’s probably why I did it. It’s not a great time to tell your 17-year-old daughter, that she shouldn’t do it, because it’s not a good job for a woman. Emerging independence and stubbornness – I’ll show him, I’ll do it anyway. …But he said, and ironically he was quite wrong…’You’ll use up so much of your life qualifying for what is a very difficult and challenging job and demanding.’ … But as it’s turned out it is a perfect job… and it pays well and its flexible and there are lots of different corners of it that you can choose. (10)
Three were told by careers advisors at school they were not bright enough, or medicine was too hard, which made them determined to prove the careers advisor wrong. In one of these the participant had a desire to do medicine from early childhood. Their personal determination to do medicine seems to reflect a wish, or perhaps a vocation, to heal. All three of these participants were passionate about their involvement with patients who needed care and support.

(The careers advisor) looked at me and said pure and applied physics, that wasn’t you know, a question, it was more of a statement. And I said no, biology, chemistry and physics, I want to be a doctor. And he said, ‘Too hard’. That was it. That was my careers advice. ‘Too hard’ and so I thought, ‘Well, that’s it, I’ll go with it now.’ (13)

But right from quite early in my childhood I wanted to be a doctor. But I didn’t talk about it or tell anyone till I was about 16...It was confirmed for me when … we had a careers adviser who asked me what I wanted to do. I said I wanted to be a doctor. She looked at my marks and said – I think nursing would suit you better. That was it. I was determined that I would do medicine. (19)

One thing I do remember was at high school the careers advisory people said – You’ll never manage medicine, you’re not bright enough, so that determined me to do medicine. (20)

5 Chance decision

For some the decision seems to have been almost by chance.

I don’t know if I could answer that question. I’d always been interested in what makes people well again from when they’re sick from when I was young…. But it wasn’t until the end of sixth form, …I was sitting with a classmate of mine ...And I said ‘Have you figured out what you’re going to do yet, you know with your life?’ And he said ‘I think I’m going to do law. Have you?’ And I said ‘I’m going to be a doctor.’ And it was just like that – and I suppose that’s the way my life has been really. (8)

I don’t think I wanted to do anything else. The fact that I’m still enjoying it is a sign it was the right choice. But the reasons I went in to medicine are pretty sort of flimsy… A lot of other people in my last year at school were going to do medicine and whether that influenced me….I’d had a little to do with a GP. And I think he’d influenced me because he was very nice. I felt he was really caring …for me it was really quite significant. And I thought well, I’d quite like to be that sort of person. (21)

It is interesting to look at these choices in the light of why doctors stay in practice in section 3 below. What is intriguing is that the reason they went into medicine does not seem to have a great bearing on how they practiced. While only two spoke of feeling called to medicine as a vocation, many of the others went into medicine because of their personal, family, community
or school connections and because it enabled them to live out their own values. It also enabled them to make close connections with their patients as is evident in the next section. Having made the choice, or had it made for them, twenty out of twenty-two have continued to practice and enjoy it. One is retiring at the age of 70 and the other is considering a mainly non-clinical career.

3 Reasons for staying in medicine

When participants were asked why they remained in practice, many said it was because of their fascination with patients. The unending variety of the lives and journeys of each person interested the doctors. Their relationship with the patients was treasured, particularly when they were patients over a long period of time and the experience included births and deaths in that family. Relationships were not always positive and sometimes a challenge for both doctor and patient.

I was impressed by the level of commitment and job satisfaction, the sense that participants had of being part of their patients’ families and sometimes of making the patients part of their families. This connection seemed to touch into the depths of both patients and doctors and was identified in Chapter 4:2:3 as one aspect of spirituality.

1 Privilege of practice

The sense of privilege in practice was very clear and nine participants used the word in describing their work. The privilege is in the close and deep connection with patients and their families, sometimes from birth until death. This enriched and expanded the life experience of doctors, making them grow as human beings. This was another aspect of spirituality identified in Chapter 4:3:4. Birth and death seemed to be times of particularly close human and spiritual connection.

... you feel privileged to be part of their life…There’s that sort of privilege that keeps you going. (2)

You used the word privilege and it’s an incredible privilege to be allowed into people’s lives, as the book The Fortunate Man says, to be treated as an honorary member of the family. And that’s even more intense in rural areas where you just walk into a house… and they’ll probably try to feed you as well… What a

29 Two have died unexpectedly between being interviewed and writing this thesis.
privilege to walk in and have that immediate sense of connection with someone. (6)

There is a depth of commitment and compassion in the last sentence of this participant.

The participant below commented how this connection continued long after the incident that has formed it. It is a good example of how the emotional response to a spiritual event, discussed in Chapter 2:2:3, may persist and be a positive aspect of lives for many years.

I think the privilege of being there and the enormous support that you seem to be able to provide for the families that remains long after. They are still, you know close… you see them in the supermarket and there’s a bond … you were there at the end – for a period you were an integral part of their lives. … That’s what doctoring is all about really. (13)

Some of the privilege was about what participants occasionally referred to as priestly roles in medicine. This was about access to intimate life details, holding secrets safely and listening to and bearing witness to suffering.

I think there is an incredible privilege to being part of birth and death. That doctors have a privileged role to be witness to birth, death and other forms, other times of jeopardy for people, when they’re right out on the edge of despair as well. (10)

This participant was immensely touched and humbled, by being thanked for listening to the patient.30

‘Thank you for talking with me’ … it always hits me when someone says that. I think, really that is my job and I feel privileged that you would share with me the really painful … thoughts. (14)

It is interesting that the sense of privilege gives rise to gratitude and wonder in the participants that they have been allowed in to the lives of patients and their families. It is not a self-centred gratitude but recognition that a deep human bond has been made that touches into the spiritual centre of doctor and patient. I have to say I felt the same about listening to the participants.

2 Knowing and caring for the whole person

It was endearing to see how doctors attached to their patients. They treated them almost like family, listening to them and providing them with support and nurture when they needed it,

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30 I shared a similar sense of privilege listening to the stories of the participants. I was also moved when they thanked me for listening to them, at the conclusion of their interviews.
just as patients also incorporate doctors into their lives. 

Connecting was central to good care and good patient relationships and was what the doctors found satisfying. They also needed to recognise appropriate boundaries. The majority of the participants recognised the importance of the human connection as well as clinical competence in good care of patients.

That’s what keeps me in medicine. It’s meeting all these people. And connected-making those connections…From then on I think our medical encounter, our human interaction, having made that strand of connection, will be more effective. (6)

The thing that is most satisfying and keeps you going in medicine is that relationship and rapport that you build up with people....So I think that’s a significant part of enjoying medicine. Hearing, interacting with people. Talking to them. That’s why I run so late all the time. (2)

So in fact I think that’s a very, very important spiritual role. And it’s one of the taonga (treasures) that we work with all the time. It’s just re-recognising, rebuilding the person, where illness or social circumstances particularly have undermined them. (18)

The next two participants worked part-time in clinical medicine and part time in administrative or advisory roles. They recognised the importance of being grounded in patient care.

I think if I stopped seeing patients face to face I would very quickly lose interest in the other things that I do. It actually provides the stimulus to do the other stuff. (8)

And I think that … really I don’t think I’ll ever stop learning about the richness of humankind, the diversity. …if I ever go more into policy work…I think that the only thing I can draw on and that really grounds me is that contact with people. (14)

For some there was ambivalence about the variety and challenge of daily practice. But even for these there was also a fascination with the richness and variety of people and the value of knowing them as other human beings, not just as patients.

I think it’s the breadth of what I see on a day-to-day basis. You can’t predict. Some days that’s what I hate most about it as well…I think in GP you get to know the people in a way you can’t possibly do in the hospital system. (16)

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31 Some years ago I made a radio programme about patients about their doctors for the Christchurch School of Medicine. One family had had the same GP for three generations and had most definitely incorporated him into the family. They were grieving his retirement. Doctors were also interviewed about patients leaving and they too grieved the loss of long-term patients.
And what’s challenging you is not just the diagnostic process and the need to know about a wide variety of areas, it’s about the need to continually respond to the person as a person, who you know as a person. (18)

Some described how important the caring for the whole person until death was for them and the patients.

In the hospice I find it very gratifying being able to help people with their symptoms and being able to help them in some small way to face their death more easily. (20)

I discussed the question of love and patients (Chapter 4:4:2). Listening to stories and hearing different chapters certainly came through as a delight for many participants. Some of the participants identified their interview with me as being like a patient consultation, as indeed in some ways it was. They were surprised at some of the things that emerged. It was a reminder that patients too are sometimes surprised where the conversation with their doctor takes them.

Mm. I love stories. (laughs delightedly) Yeah. Yeah. And its great when you've got the patient to come for-they think they've just come for a prescription and then they tell you a new story just like I'm doing now. (1)

And the other thing is of course, the human story that people are willing to share with you. And it’s like going to a play. And all from person to person, just like - I feel very much like a patient, you asking me questions and me answering to the best of my ability. And coming out with things I didn’t know I would come out with. (11)

The next participant was very clear that the patient encounter was not only a human connection but a spiritual one.

So in working with patients that comes around their ability to engage and develop a rapport, develop a relationship both at a professional and clinical level. But where’s the boundary between that and that other dimension, the spiritual one. And I suppose people will bring their own spirituality, however they might define it, into that encounter, into that relationship, for whatever reason. (7)

For some looking after whole families had a complexity and completeness that made such practice more interesting. The connections and information carried by the doctor in long and ongoing relationships get richer over time (Chapter 4:4:4).

I guess I’m seeing it more…because I’ve been in the same job for nearly 7 years now….The longer I’m in the same job, the more satisfying, you get to know the whole family and how important they are, and how important my knowledge of the family is. (17)
So what is it that keeps you in medicine – it’s …not something as concrete as oesophagitis, but something much more subtle about what is life like for this person. I say to all my students…I want you to ask two questions.. Who is this person I’m meeting. And what is life like for them? (6)

They also commented that as the relationship deepened over time it allowed better care to be given because the trust between doctor and patient also increased. One even suggested jokingly that altruism was selfish.

Many things. I might even be in medicine from a selfish point of view. The warm fuzzies you get from helping people, and that’s got to be selfish too…the ultimate selfish act, altruism. (13)

This participant expressed a strong commitment to the biomedical model, but practiced with tacit awareness and a deep, affectionate care for patients as the following account shows.

The other day, a chap arrived, who I see very rarely, in his eighties. So I said to him, and I don’t know why, “How did you get here?” He said “I drove” And I said “That’s interesting, I don’t think I’ve done any medicals on you for a while.” “Ah, no” he said ”no”. His eyesight was 6/36 and he had a car out there. He was a mechanic and he’d done the thing up. And … at 5 o’clock at night he was happily going to drive home, turning right … onto the bypass. So anyway I drove him home. I got into the car and just about managed to work this old jalopy he’d put together and the receptionist followed with my car. As I was going there it was going through my mind … when I first arrived …I had a collection of rotor arms that I’d taken out of old people’s cars who wouldn’t stop driving…. You wouldn’t get away with it now, you can’t do that any more. (13)

This participant clearly regretted the passing of the ‘paternalistic’ doctor – yet I find endearing the way in which the welfare of others takes precedence over the doctor getting home on time.

3 Being transformed by patients

A number of participants remarked on how patients enriched their lives and made them grow into better human beings. Most were very grateful to their patients for this and it was one of the things that kept doctors in practice. In being transformed by patients, doctors seem to become more aware of their own ongoing transformation through life.

And so you have this understanding of the kind of layers that people hold in their lives and that makes you much less quick to judge people. (3)
And I just love being able to wonder together. Yeah. And to honour and appreciate it as something special and important… that’s lovely and it’s special for me. (4)

There might be pain. It could be physical pain, it could be a psychological and emotional pain. Could be a spiritual pain. I think that’s something. So it’s being able to appreciate how does one engage in a narrative round their story. And I’d like to acknowledge that it works both ways. (7)

Oh, you can just learn so much from your patients. (17)

The way my patients make me grow. (19)

Finally there was one participant who was very aware of the effect patients had on doctor vulnerability.

Are you asking whether the patient’s illness exposes my vulnerabilities? I like that. (laughs) I guess so, yeah. (3)

The participants appreciated the intensity and challenge of their work and the depth of connection. It is interesting how the link between joy and sadness is picked up in the next quote (Chapter 4:4:1 and 4:4:2). As the doctor went to comfort the patient, the patient comforts the doctor.

I’d gone round to her house because her husband had just that morning committed suicide…I’d only seen her a few times as a patient. And she came and gave me a big hug of comfort and connection, and all the rest of it. I mean, that is, as a human experience, completely sublime. Terribly sad, but in a way, I hate to say it, enormously joyful… it was non-possessive, and it was non-judgmental, and genuine and totally empathic. It was all in there. It was as therapeutic as a hug could be for me…But as she had initiated it, I suspect it was for her too. Now what spiritual events are going on there? (6)

One, after saying how much the intensity was important, even speculated what it would be like to be someone else.

I sometimes wonder what it would be like to be an accountant, because you just get used to having an intense human interaction. All day, every day. So it becomes normal. (3)

The final comment sums up the complexity of spiritual connection with others, when the participant is not only deeply connected to the patient but also to the transcendent in such a way that ‘everything stops’. This seems to be an example of being ‘outside time’ (Chapter 2:2:6).
And I think that is a deeper form of empathy really…But when you can truly sit in the patients shoes and get drawn in I think there are times when that happens and everything stops for a moment…you’ve got to shake yourself out of when the patient has gone. But I can’t get any closer to it than that unfortunately. (8)

4 Teaching students
The majority of participants enjoyed teaching students. They drew parallels between the connections made in teaching and the connections made in healing. Some, like the participants below, were passionate about it, finding it gave life meaning.

And I’d been really keen on teaching the students in Dunedin …Seeing young people getting the hang of it and getting excited was very good…It’s either about helping learners or helping patients. And I have to say that the processes have become astonishingly similar over the years. Those are the things that give life meaning. (8)

It’s quite nice with the medical students because… we spend hours and hours driving together between clinics. And … the students, most of them, open up more and more as we go along. And we learn a lot about their personal life their past life and their present relationships, and all the rest of it. That’s a lovely privilege… (6)

Later this participant talked about the response of the student coordinator. This comment really identified the importance of greeting and saying goodbye as a human event, as well as the role of the doctor to train healers.

‘You know I can see what you give to those students by the way they greet you and part from you.’ …. And maybe it reaffirmed the sense – don’t worry if you’re not teaching them fine clinical medicine, then maybe I’m teaching them to be healers. … Connection again. (6)

The last participant was delighted with a student comment at a conference. Here, too there is a sense of teaching healing in the communication between doctor and patient.

Absolutely it’s a two-way thing. (13)

4 Memorable patients
Whenever doctors gather for peer groups, conferences and clinical meetings they talk about memorable patients. It is almost as if they are imprinted on the doctor’s mind or perhaps soul.
In the transcripts there were stories of seventy-seven memorable patients, some given in response to asking about memorable patients and others spontaneously. The largest number of stories about patients from a participant was eight, and four only talked about one patient.

There were major differences between the stories told by male and female participants. The most striking was in the satisfaction of the participant about the outcome, whether they were being a ‘good doctor’. Sixty-seven per cent of the stories from male participants showed a good outcome for the participant in terms of therapeutic satisfaction, while only 41% of the stories from female participants showed this. Female participants talked about more than twice as many female patients as male patients while male participants talked about almost equal numbers of male and female patients.

Table 11: Stories about memorable patients

<table>
<thead>
<tr>
<th></th>
<th>Female participants</th>
<th>Male participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total patient stories</td>
<td>37</td>
<td>40</td>
</tr>
<tr>
<td>Average/participant</td>
<td>3.4</td>
<td>3.6</td>
</tr>
<tr>
<td>Range/participant</td>
<td>1-5</td>
<td>1-8</td>
</tr>
<tr>
<td>Male patients</td>
<td>11 (30%)</td>
<td>19 (48%)</td>
</tr>
<tr>
<td>Female patients</td>
<td>26 (70%)</td>
<td>21 (52%)</td>
</tr>
<tr>
<td>Dying patients</td>
<td>19 (51%)</td>
<td>15 (37%)</td>
</tr>
<tr>
<td>Outcome good for participant</td>
<td>16 (41%)</td>
<td>27 (67%)</td>
</tr>
</tbody>
</table>

The largest number of stories were about dying patients. The female participants contributed thirty-seven stories of which nineteen (51%) were about dying patients. This is perhaps not surprising since death is the last major transition of human beings and doctors were often involved with patients and families at that time. The male participants told forty stories of which fifteen (37%) were about dying patients. Many stories were also about the early clinical contacts of the participant. The early contacts appeared to imprint more deeply than later ones.

The connections of these memorable patients were extremely complex. They included not only the relationships of the patient with their families and communities, but also the relationships with the doctor, other health care providers and other community agencies. Some even contained relationships with animals. They also illustrated spiritual connections with the transcendent as well.

The example below of a patient from 20 years previously showed this very well. Being there was important for both doctor and patient.
And one in particular ... the specialness was just being able to be with him for this period of time. I knew he was going to die. And being able to care for him ... and learning, learning through that whole process. I think it was about being available and being able to explain what was going on. To alleviate his suffering really. And that was very satisfying. And then after he died ... being able to say I think I did a good job. (2)

The next one was also a dying patient in a very connected context. The patient wanted to die in his own place with his family around him. The doctor observed with a compassionate eye both the joy of remembering and connecting and the sadness of leaving the family.

I just marvelled at him. I suppose in one way I marvelled at facing the inevitability of death and dying. Maintaining his dignity and independence ....He made it very clear – just keep me comfortable at home...Well that’s quite a spiritual environment and family environment ...his family around him, and his mokopuna put themselves onto a roster to care for their Grandad, eh. So that’s what I say, they loved him dearly....He was an old wise, seer, talking to his grandson ... and his granddaughter there who was at high school ...They were reflecting on the good times they had together. They had had a lot of fun. (7)

One participant talked of a memorable patient who communicated very clearly to the doctor without saying a word. The understanding of courage, presence and connection in this story is palpable. Facing suffering is not easy when you are ‘just one human being to another.’

So I went into her room and just sat there. And I didn’t say anything and she didn’t say anything and I don’t know how much time passed but she just started to weep and weep and sob and sob and I didn’t say anything and she didn’t say anything and that was quite powerful for me....The power of that? It was sort of well, that in the end you are just one human being to another really... Well. Maybe I was just facing her suffering. Yeah. Without walking away from it or being distracted about what sort of medication I was going to give her. Things you had to do. And I think that’s sort of powerful to acknowledge someone’s suffering I ...But maybe a witness is a very important thing in people’s recovery as it were... It is quite brave to go into a room like that – but then that’s an acknowledgement of how brave the other person is too, in a way. (3)

Other memorable patients were those who the doctor had cared for in their pregnancies. Several talked about the uniqueness of that relationship. There was a sense of deep connection. The first participant responded with eyes filled with tears when asked what was spirituality.

Birth and death both very deep, life changing. To hear that first cry, last breath. (1)
A number of others also commented on the close relationships they had with maternity patients and the satisfaction that delivering babies gave them.

They were all very special people you felt you had this bond. (2)

The cradle to the grave approach. …Lovely to see new life. (7)

One participant was so deeply involved with maternity patients they intuitively knew when the patients went into labour. Another spoke of the satisfaction of delivering two generations of a family. Keeping tight control of emotions was impossible in these cases.

I enjoyed getting to know the girls really well. When you’ve taken a girl through the pregnancy and all the hassles and the anxieties of labour and then the joy of the baby, you know, that brought tears to my eyes. (21)

One also talked about the spiritual implications from the patient’s perspective when they were considering an abortion. There is a very clear sense of awareness of the patient’s sense of connection.

I seem to see more people who are terminating pregnancies than people who are dying. And… that would be the situation where that language of spirits and souls comes up, from the patient…And…a need to … in some way honour or acknowledge that life even though you are actually going to terminate it….And how are they going to incorporate that into their sense of who they are. Can they do that? (3)

Another group of memorable patients were those that were depressed. Participants were clear that depressions had spiritual as well as material reasons for existing and treating them just with pills was not always the appropriate way.

It’s one of my pet subjects that maybe we do load the diagnosis of depression, or mismanage despair, peoples’ unhappiness, by labelling it as depression and treating them with drugs like SSRI’s. (2)

Some of the counselling and psychotherapy, that I’ve done has certainly related to spiritual issues. And seeing people through spiritual transitions with a depression, but the actual issue is a spiritual one. Underneath that, where they’re at with God, and where they’re at with their church, and where they’re at with themselves. (4)

The next participant was still in training when this consultation occurred. It shows how good listening reveals the complexity of a story, and how satisfying that is for the doctor as well as the patient.
And… she’s got anxiety problems, depression, stress from work, from boyfriend. Which, you know, I was quite surprised, I thought it was … just a follow up of the tonsillitis. …. After that consultation she didn’t want to take medication and she said, I’ll think about it, but I’ll start counselling. And then she made another appointment … and she actually brought her parents in….I feel really good having that particular patient. (12)

Some participants were clear that the reasons were often mixed, lack of social support, financial and spiritual.

And it’s really hard. They often look to their doctor to fill that gap. And a doctor just can’t. They can’t be a family to someone. (16)

And when you started exploring their lives and their life styles they were on a treadmill… (9)

5 Dying patients

The death of patients affected doctors more deeply when they have known the patients a long time. They also found it hard when newly graduated looking after people of their own age who were dying.

It was the difficulty of looking after someone of our age. (1)

Given that most of the participants had been trained in emotionally detached biomedicine, I specifically asked if they grieved for their patients. Five said they did grieve and some spoke of hugging patients or their families. Several also spoke of weeping with patients. Grief for some participants was proportional to the length and depth of the doctor-patient relationship. Most agreed that long term patients, needed to be grieved. Several talked of sending cards to bereaved families, or calling in to see them.

Yes of course you do. I mean … we were talking about the anniversary effect that her family are going through I am as well and you don’t often have an anniversary effect from a patient. …. You can’t disconnect from it. (8)

Yes. In different ways. I usually go and sit with them. Nice to really talk to them. … There are a few, not many, I’ve actually been to their funeral. (14)

Oh yes at times with them, and occasionally I think of them. But basically I grieve with them and then shut off. But … if a person is grieving I’ll go and put my arm round them. Talk to the younger doctors, they won’t do it these days. (21)
One participant regretted not being able to say goodbye to a long-term patient who went into hospital and died there. One participant was unable to cry even though sad at the death of a patient.

I don’t do much grief… I always wish that some tears might come. They don’t… Even though I’m feeling sad. And that’s something I regret… It doesn’t mean I don’t actually grieve. (6)

Three said they went to funerals often, while others went occasionally, usually to long-term patients. Some specifically said they went to support the bereaved family. One wished to go but felt funerals were not for the doctor but the family. In rural areas, where patients are also neighbours and friends, attending funerals is common, but less so in urban practice. Three participants realised it was important for them to say goodbye.

And those special patients who die – I will go to their funeral. … For me it’s not so much grieving as saying goodbye. Perhaps that’s the other word for it – grieving. (11)

You can’t disconnect from it. I go to as many funerals as I can of patients, if I’m there. And I think that’s really important too, because it’s part of the grieving process for yourself. (8)

One participant learned how important messages were from having a personal bereavement.

And going through the grieving … has influenced my practice too. It’s the little things that you really appreciate … just how important it is to make a point of ringing or writing a wee card saying sorry to hear about your death … Or calling in on the way from home. (2)

6 Memorable doctors

There were a number of stories about positive relationships with memorable doctors who cared for the whole person. Some of these were about tutors in the training programme, others about the care given to participants.

The final comment in this quote is about hopeful holding. This involves listening well to the patients and enabling hope giving them some new possibilities.

Well in the GP training I found (teacher) invaluable. I guess getting the most out of the consultation with a patient centred approach. Listening to the patient.
Letting them tell you what they want. And taking it from there. … Of, um, bearing witness to someone. Partly that, but also giving them a bit of hope, because although you might not have been there before, you have seen people who have been there before. (3)

The next quote was about a GP who had cared for the participant as a child, who seemed to have been a model for the participant.

I’d injured my arm 2 or 3 days before the sports. He’d strapped it up for me so that I could carry on. He actually came and watched me. (21)

One observed the respectful, almost reverent way that the hospital consultant dealt with patient as human beings, not as clinical cases.

I saw people like (doctor) kneeling down by the patient’s bedside and holding the patient’s hand in his two – big beefy hands he had as a physician. And I saw that and there was a sort of an intercession in his approach to the patient. I saw that. (8)

The last participant was told by the consultant to just be present to the patient in pain. The participants wanted to avoid the pain of the patient.

So it was very interesting because I spoke to the consultant about how I didn’t want to go into the room. And she said to me, ‘You just go into the room. You don’t have to say anything. You don’t have to do anything. You just sit there’. (3)

In all these cases the connection with the other doctor was a human one rather than a professional one.

There were also twelve stories about memorable doctors from training days that were negative. Eight were from women and four from men. Many of these stories also reflect the predominance of biomedicine and the conflict between that paradigm and the practice of whole person medicine. Participants had been taught that medicine was an exact science as students, then found that real life as a GP was not like that at all.

I think there was a real mismatch between what was taught pre-clinically and the reality of clinical medicine, which is that medicine is a true science, that you can be perfect. If you know enough and do enough you can get the true answer. But in reality medicine is nothing like that. If there is a true answer it’s usually only determined by the pathologists. And most things are just a best guess. And even when you apply quite exact science to the best guess, the way in which the person reacts to that science is individual. (10)
I see myself as something of a medical dissident and am not and never have been particularly enamoured with the clinical classifications that we use. …It sort of feels limiting to me. Well …it seems to me that our training and the perception of what a doctor is what a doctor does, the social perceptions tend to constrain, and the economic models around the rationing of time, tend to constrain the nature of the interaction. … I’m not saying it’s not useful, but I’m just saying it does, it creates a tension and it creates a certain predictability and in the end I’ve found it to be a little bit arid. (5)

For this participant being expected to live with uncertainty was difficult.

I didn’t enjoy it actually…I think the thing that troubled me most was the poor quality of the facts that we worked with. The softness of them all the time. (18)

For the eight women there was a lack of female role models. They complained about entrenched sexism, and a culture of detached toughness. Several described clinical teaching in hospitals as arrogant and brutal. Three participants identified the same surgeon as aggressively sexist towards female students, including one male participant.

I thought it was really brutal….And a very masculine world…there weren’t any female consultants. But it was more than that, the people who taught us, they were the peak of biomedicine at its unchallenged, really. And they had a terrible arrogance really. I think patients were treated with no respect at all and no regard for them as human beings…Well there was a culture of being tough – you’ve got to tough it out, not show emotion… The whole teaching method was this …most bizarre form of education. Interrogate the student to the extent of their knowledge and then humiliate them…Well maybe suffering is quite good for being a doctor you see. (laughs) (3)

The way medicine was taught was: you are inadequate if you do not know the answer. And I think that was a very punishing culture, especially for GP’s because we live with uncertainty, and it was as if uncertainty is a crime … And there is a lot of hidden and unspoken anti-feminism around…. There was a lot of shaming at medical school…. (10)

I remember in a paediatrics tutorial being put down in front of a patient... And in front of the other medical students standing round the bed. (17)

Most of the teachers were good. Some put women down. Some took a delight in being nasty. … I learned to stay in the background. (19)

Students who were in a cultural minority also had very real challenges in terms of medical language and cultural ignorance.

Difficult to start with… the language was challenging to people like me. But difficult. When one is the only brown one amongst a whole lot of other people. I
struggled for the first three years...I suddenly learnt the rules of the game, what to do and how to go about doing things... It became much easier. (7)

You know it was really hard... there were only thirty-six women to a hundred and thirty odd boys, so we were definitely in a minority. And among the girls there was only me who was...non European... (11)

I found it quite hard. And you were left to your own, there was no one telling you - you must do this... I think I lacked the confidence. I thought, oh, English is my second language – people know it much better than I do. (14)

The culture of medical school suppressed the idealism, the dreaming and thinking of students. This was a recent graduate.

Well I always maintain... that you start med school with a fantastic idea, ... And you come out the other end ... and you're very clinical with that, that was not that nice. The culture of it... And now I’m starting that again. You do regain it, but you just get so focused on just getting through that you... stop dreaming and thinking. (15)

There was clear evidence that the quality of life of medical students tended to deteriorate as they progress. Survival takes precedence over care of either self or patients. This is a recipe for burnout (Henning, et al., 2009). This will be discussed further in Chapter 8.

One participant was so appalled by the medical culture they left in 4th year and did not return to finish for many years. In all of these examples there is a failure of the medical teachers to connect with patients or students as other human beings. It was a long way from the tender respect and sense of privilege that shines through the accounts of participants and their patients in section 3 of this chapter.

I didn’t like it at all. I found it very dehumanising – quite brutal by the time you got into the clinical bit in the hospital....Um, well to give you one example, in the 4th year we went into the wards ...And the physician – maybe it was a surgeon ... walked in and he said, “I’m just going to find out where it hurts Mr Smith” Prod, prod, prod till the man yelped. Then he got each of the nine students to do the same thing... (22)
Families formed the spirituality of their members. For some this was religious formation as well. Children seemed to be a potent precipitators of spiritual growth, both in the feelings and in the psychological and spiritual process around their arrival, growth and well being.

Well I guess I think … having children gives you focus and purpose. And it’s satisfying. ….. Well of course that means joyful things like when the children were born. (were you there) Oh yes. (felt) Elated really (laughs) I used to do obstetrics and people would say Oh did you deliver the baby? And I would say No Way. Laughs. Certainly those were very exciting times. Life is a whole lot of very exciting times that give you a lot of elation. Just little things such as seeing the children achieve in different things. It gives you a great thrill. And when children play loud music playing the drums and guitars and things. I think it’s hard to determine specific major events but there’s been lots and lots and lots of joy.(2)

They also challenge their parents with the ideas they have and their questions and their unfolding understanding of their world.

It’s interesting how having children challenges you because they ask you who God is? You know. You have to sort of think about it. (3)

I think all of that, you know, …, raising children for instance, I’m sure I’m a better or a different father from when they were first born. I’ve learnt a lot. I would say that has had quite a dramatic impact on my expectations and what I feel is appropriate to offer in a consultation. That would be one significant thing. That’s really aside from the experience of seeing people and working clinically, it is that life experience, which informs how we work. I work so differently now, if I think of myself ten years ago, it’s just completely different. (growing) Yes, that’s right.(5)

The innate spirituality of children was sometimes particularly challenging.

I was having a discussion last night with (my son) about what happens after death…And here’s my nine year old saying to me – But … you can’t tell me there isn’t a fire God out there…And then he referred to the fire god as he. So I said – Is it a he - and he said well, it doesn’t have to be a he or a she…And I was sitting there thinking – you’re challenging me here…. We have a friend who is a Buddhist monk who’s been staying a bit recently and …(my son) has thoroughly enjoyed grilling him on reincarnation and meditation. So he’s got a whole lot of information there which I think is great because at school they do Christianity and so it’s good for him to get another perspective…. he takes himself off to the trampoline and will jump on the trampoline and after a while you’ll see him lying on his back just looking at the sky. Just chatting away. Nobody else out there…I came into his bedroom one night and he said – excuse me Mum, but I’m just meditating. (both laugh) (17)
For some the cultural process of learning had a very different emphasis.

It used to be interesting. About learning. I went to school, brought up in an environment … I suppose you could say schooling and learning, was with one’s – I was brought up by my grandparents. OK. So that’s the first and most important school that you’re nurtured in. So that schooling is embraced within the bosom of ones grandparents. In the Maori setting that’s important, the influence of extended family, of whangai, so in understanding that one is nurtured and then learning within that sort of environment. On the other side you have this system that says you go to school at five, …(at) the local school here, Maori was the first language, yes…My family is here (immediate family) No they’re scattered. In New Zealand. They’re still in the country. My brothers and sisters, I come from a family of ten, eleven and there are only one, two three of us here …. I’ve got a couple in Australia, the rest are scattered around the country. Yeah So our four children, we’ve got two in Auckland and one in Dunedin. And we’ve got one of our sons is with us here. So, yeah. (7)

For others there was a close connection between their family and their spirituality.

I think also, for me its, its, how I would imagine my mother to guide me. Because she died when I was sixteen….. And I, in my mind, talk to her. So that’s my spirituality.(9)

He started life, after the war, as a bricklayer, he ended up as chief surveyor …. So over a lifetime he did pretty well for himself. Pretty much all within the building industry. Oh, he was very grounded. He definitely inherited a number of traits, not all of which were attractive, including not suffering fools gladly. And that’s why he did so well because … he had to be strong, when he … got to the point of organising stuff that was important…. He was a cockney, Both my Mum and Dad were …. but they spent a lot of time in the Dales and in the Lake District. A great walker. That’s where I learned to go tramping. Every year we used to go up to the Lake District. In the spring there was still snow on the hills. And walk and walk and walk. (13)

1 Family illness

Spiritual issues emerged during life transitions. Participants were asked if they had to deal with illness in their family. The illnesses referred to included both family members and the participants themselves.

For doctors, dealing with family illness was complicated, by having multiple roles. They were often consulted for opinions when family members are ill and have to be very clear about not treating them. It was also difficult for doctors to deal with peers as normal ‘patients’ even though they have the same needs and anxieties as other patients. It was also hard to advocate well for family members when there is a fear of upsetting colleagues by being demanding.
1 Participant danger of death

The first two participants talked about their own experience of facing death. The first participant’s father had died many years before. It is interesting how the possibility of death immediately linked this participant and father.

So let’s go back to what must have been a spiritual experience, the two occasions I’ve been up in…the mountains and wondered – am I going to get out of this. And my motivation was not please someone look after me. It was what do I have to do now? What is the right thing to do? How do I keep alive? What are the decisions I have to make? And I mightn’t get out of this. But I wasn’t afraid of dying, though I thought I could end up just getting colder and colder and just slipping away. Which …is not a bad way to go, actually, you know. And no fear of what lay beyond. I think I might have thought briefly – this’ll be interesting!….but it’ll probably just be the long sleep. The long dreamless sleep. Dad used to say that.

(6)

So that very much made me aware of facing one’s mortality, at the time. Because that was metastatic, and the prognosis wasn’t particularly good. …So again it certainly made me more aware of how people feel when they get a diagnosis of cancer. …Every morning I can wake up and give thanks for this, for another day, and the blessings we have. It makes you very aware. Because it’s so easy otherwise to just drift through life and a day passes and another and you don’t notice it. (20)

2 Family illness

Many of the participants talked about being consulted by family members about their illnesses. There was sometimes a very clear conflict of interest between being a good doctor/good patient and advocating for good treatment for family members. There were about equal numbers of stories of good and bad treatment of family members but some of the accounts were heart rending in the anguish and inability of the participant to enable good treatment for their family member.

For some families confronted with a serious illness, the way peers dealt with them was very unsatisfactory.

. …And I have to say, that the worst part of it, Anna, has been dealing with my medical colleagues. They have been the, they’ve doubled it (the suffering)….It’s about treating people as biological machines. It’s about limited ways of being able to handle a narrow range of relationships. It’s about paternalism. It’s about their own psychological limitations. And it’s about a lack of generosity. It’s about arrogance. It’s about the ordinary human condition, really….But bringing that, without having done much work on it, to situations which have huge emotional

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32 I could certainly empathise with this group, having had the very unpleasant experience of being handed my mother’s pathological diagnosis by the registrar on her ward and told curtly, ‘The cancer has spread. There’s nothing we can do’. I then had to go out and face my parents waiting anxiously for the report.
impact in people’s lives and just not having the skills or the insight to deal with it, really….Their illness and the way it was attended to there was this dark pall over it (life) the whole time. (4)

The next participant clearly felt abandoned by the hospital consultants.

And then (partner) developed a rare…tumour…… The hospital doctors (said) it was benign …and not to worry. So …, they took out … the tumours …. Which was huge…And (partner) couldn’t … work any more… really got quite depressed over the whole thing….a…. psychiatrist sent him … to visit one of her friends who did a laying on of hands …… just before we came down I came across (Ian Gawler’s) book on – You can Conquer Cancer. So, um, we actually did go to Melbourne and visit him briefly. So … the hospital doctor said, ‘Go away, you know, we can’t do anything for you.’ As people often do we started to get into complementary bit. (22)

There were some good stories of care of participant families. Participants learned a lot from their family illnesses about caring for patients.

Mum had a hip replacement… It’s given me a real wake up call, I have to say…In my head I’ve always known that at some stage I would lose my parents. Deep down I can’t believe I ever will. They’ve always been there, they’ve been my support. And Mum after the operation looked so awful. And then she turned into a cranky old lady that I didn’t know. And it was a real eye opener. To see her so helpless was horrible. Absolutely horrible….Dad had a TIA at the end of last year …So those two episodes have certainly changed the way I’ve had to start coming to terms, going into the grieving process, even though they are both fit, healthy and still alive, I’ve had to start working through that process which is good for me. But the people it has changed my relating with are the people who have just lost one of their parents …. Because I now really understand what they are potentially going through. (16)

2 Family deaths

The issues raised by death in the doctor’s family are complex. Most participants had some experience of death in the family. Only three said they did not. Two talked about deaths of close friends and I have included these under family. The most difficult deaths to come to terms with were those that were unexpected and the struggle is well described in the accounts below.
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The first participant was a medical student at the time and found fellow students were embarrassed by death. The body language of those deeply grieving often shows the weight of sorrow that is described here. The other important issue here was that families often find it difficult to support each other when they are all grieving and need some outside help. The loneliness of grief also came through here.

I had a brother that died… when he was twenty-eight … And I was 21. That had a very profound effect on my life actually. …. Well it was about age. The sudden death of a young person is crippling. And it’s about the suddenness as well …. I was a third year medical student and I suppose it’s that sort of you don’t realise that, how, big an experience can be until you experience it. I think … the sheer size of it, is what you get out of it. … I was surprised that people of my age, at 21, couldn’t deal with it and that was really difficult for me. Oh, they would cross the road or not say anything… Well, like you’re walking round with a skyscraper on your head and no one else can see it they’re just walking past you. It’s like you’re completely weighted down and completely absorbed in holding this thing up, and balancing it and dealing with the weight of it. And you’re so absorbed in it you can hardly carry on a normal conversation and no one’s actually can see that. But I sort of worked out that if I …. brought it up and talked for about one minute that would give them a chance to gather their thoughts, (laughs) and then the conversation would work quite well and they would think of some response. … I think you do have to share that with people … Otherwise it’s quite lonely, isn’t it? And in some ways I think that the other thing that happened is that you have to get you support outside the family. Because … I don’t think we were able to support each other. It was too hard dealing with your own stuff, without dealing with your sisters’ or your mothers’, you couldn’t take on their skyscrapers as well. Which is kind of interesting isn’t it. (3)

The next participant described the difference when there was time to say goodbye.

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33 I have certainly had patients who describe this avoidance by friends. One said to me, “You would think cancer was an infectious disease, the way people avoid me.”
My father died last year. It’s just coming up a year in June. … What was hugely different – losing my mother 20 years ago. I dealt with it far less well than my father last year. For two reasons it was very sudden and there was no preparation for it but also 20 years later you feel better prepared to deal with the grieving process. You’re able to deal with it. It’s still very hard. And better organised too – and put in place things that help you. You go through a grieving process and say goodbye - that sort of thing. Whereas 20 years ago with my mother. Looking back on it the whole process of funeral and all that sort of thing was pretty badly done, I think really. It was wrong. It was done through standard Catholic church way of doing things and that was the way it was done at the time. (2)

The next participant seemed to have more sympathy for the person who found the grandfather than for the grandfather.

I had grandfather die suddenly. He lived on his own. He died in the shower and was not found for hours. The shower was still going. Poor person who found him. (1)

The other sudden deaths were of close friends who died in accidents. I have included them as family because in a sense they are. The next quote described a close friendship that was so imprinted on the participant that death would mean losing ‘a huge chunk’ of self. This really underlines the way that a loving relationship expands the sense of self for both parties, rendering them vulnerable to loss.

The other person I haven’t told you about losing was my dear friend … And he died …. about four years ago now. And that was really devastating. He and I had a connection in the mountains… but we loved each other. It was just wonderful and we had that same sense of being there. …. And losing (him) was absolutely devastating. The only thing that carried me through that was having my … dearest friend since early university days … And knowing there was still (him) to have that unquestioned loving connection between each other and the mountains at the same time, was the one thing that got me through. If something should happen to him I would lose a huge chunk of me. Because I don’t actually imagine having a relationship again like that …. I think I have a huge vulnerability there. (6)

The way in which death disrupted not just the connection with the person who has died but sometimes also with others, is well shown below.

It wasn’t till the next day that we discovered … he died as well. It took me a year to deal with it. I … had no one … to talk to. No NZ friends there. I mean they … all knew the risks they were taking. (She) would not talk to me and when I left messages she did not reply. I think it would have been easier if I had been back in NZ. When I came back I visited her…. It took two days before we were really able to talk. Then … we … were able to grieve and move on. (17)
Finally there was one participant who talked of suicide in the family. It was still painful after twenty years.

And my mother had taken her life…I was 33 (when mother died). That was a huge barrier for me to get over. (22)

Dealing with expected death can also be difficult, particularly if the person was very young. Two participants talked about losing a parent in adolescence. In the first case the participant had plenty of time to connect and say goodbye. There is a paradox in the fact that human connections often deepen as people are dying. It is almost as if the deepening is a preparation for departure.

He had lung cancer. …. And he spent a long time lying out in the garden under the trees. And during those months he’d stopped going to work. He hadn’t quite retired …. And he spent a lot of time talking about his life and things which he hadn’t talked with us much before. He was not remote, not emotionally remote but he was not around a lot because he used to work late and come home late in the evenings. He was quite tired a lot. We had most connection with him on holidays. He got really relaxed. It was a lovely time. And I had another friend at that stage …and we… re-met in recent years because she’s … in Melbourne… that’s a connection of that special type. So we were talking about people passing on and their heavens and hells and if you’ve has a bitter relationship with difficult parents and they leave behind memories of a tortured childhood. They’re leaving a little bit of hell behind and you and I know what that does to people’s relationships and lives. (6)

In the example below the participant was also adolescent and had to grow up very quickly. There is here a sense of loss of childhood. There was also a reason for a later career choice to work in a hospice..

…she had cancer and it just kept coming back. So I kind of lost my childhood. Because my parents had emigrated from England … were older parents anyways. … we were isolated some ways . There was quite a good expat community who were very supportive. But we had no family here and Mum was sick. So … from a very young age … I was helping with big washing, cleaning, cooking, all those sorts of things. … I’m not saying this because I feel cheated, or I missed out, but I didn’t have the usual typical childhood. Friends dropping round and going on what they called play backs and things like that, …. I sort of grew up very quickly. …I think probably the main reason why I became involved in hospice was because when Mum was sick … there was no hospice and she had a lot of pain and I don’t think it was handled well at all. …. And at no time was any support offered for the family. I can still remember the … last time Mum was in hospital, …the consultant ringing up and saying that we could come and collect Mum and she probably had three weeks to live. And that was my only contact with medical professions, that one phone call. …. So … because I thought it wasn’t good. I didn’t want people to go through what we went through. And I’ve
always been very careful in practice, when there’s been a family member dying, talking to the children, talking to the adolescents, seeing how they are. Checking to make sure the children aren’t having to take on too many responsibilities and they are actually getting out with their friends and having a life a well… When Mum got really sick the last time, we started going as day pupils. And then I was home after she died for a year … as a day pupil so I could look after Dad. In fact probably getting back to your first question, I’ve done all my looking after my parents. (laughs) And perhaps I feel subconsciously I don’t want to go there again, because I’ve done it. … The community was great. … They all helped with food in the freezer. There’d be people dropping in…That was rural New Zealand, there was always a roster of ladies who could be called on. (9)

When there was time to say goodbye properly other deaths, although sad, had a real sense of completion and ongoing connection. There was also, in the account below a very clear message from participant to the hospital that the family thought it was time to prepare for death, not keep pushing the high technology. This participant learnt much that was useful in patient care.

He died in the States … where it was interesting to see how much technology and how driven the American medical system is in terms of investigations. And he was 77 and … I remember being grateful that they were able to offer him all this high technology stuff but when it became apparent that it was not of much use. But I think the thing that I was most struck by … there is a line you really have to draw when you say, no, this person is going to die and lets get ready to help the person through that period when they are ready to die. And I was very pleasantly surprised that American hospital staff were able to do that. Well we made it quite clear we thought that they were over reacting a little bit and over investigating and it was time to pull back and they were able to do that. And it was great to see and certainly I think that influenced my practice back here too. That you need to make it clear early that if something happens to someone…the family need to let the clinicians know how they want things managed. So I think that influenced me a bit, when I see the older people here now, I tend to broach that subject a bit more than I used to. (2)

Interestingly, in a very different situation in New Zealand, the same issue of knowing when the time has come to prepare for death, learning to let go, rather than seeking cure, comes up in the quote below. It highlights the problem of having a medical system that is death denying.

Just earlier this year my Dad died when he was 84. But he a, it was only a short illness, He had a lymphoma. We had him over the road. We looked after him. My sister and we took turns. Yeah. But again it was that process of coming to terms. A planning process and acknowledging that and him acknowledging that hey, his time was up. It’s OK. Really calm. You know we’re pretty pragmatic. Lets all pull together, eh, just have him here. It’s OK. The old body is dying. So it’s about, when you’re dealing with death and dying all the time, there comes a point in time when you say hey, and as a clinician, you’re well aware of that, eh, death that all
the time about how to, um. Not so much facilitate as to just acknowledge and try to understand and be there in a supportive way and honest with people…Dignity is the only thing they have got left. In terms of their personal care, whatever their wishes are is part of their dignity and their spirituality. So that’s about peace within themselves and with others, eh. It’s the least we can do, eh…The other thing is in terms of pain and suffering to alleviate or to lessen the pain. Certainly we can manage the pain but the down side of managing the pain might be that Dad will become less and less communicative. Coming to terms with letting go. (7)

In some cases it was the dying person who comforted and healed those who were left behind. This has been touched on in Chapter 4:3:6.

Because my father had an illness where he knew he was going to die and he sort of made it all right that he was going to die. You know, it was sort of all right. My mother six months after his death, said ‘Well it’s not alright!’ (laughs) It’s quite a different experience of dying. And he was very philosophical about his life, my father, and quite contented with his lot really, he didn’t struggle with it at all. And he, he was a scientist. I said to him did he believe in any after life. And he said ‘Well, I’m a scientist and I’m not sure there’s anything there, but I’ll take it if it is’ (laughs) Quite a rationalist. So that felt relatively easy. (3)

For others there was a reconnection with the dying person before they died, which in the case below was extraordinary and healing for the family. I found it interesting that the words privilege, presence, witness and grace came up here as well as a clear sense of love and connection.

It’s something I noticed when my father died… he had a fall at the rest home…and went into hospital … He was in the dementia unit. Pretty far gone. And I’ll never know if it was being on oxygen that gave him a bit of a new lease of life in his brain but he was far more present in his dying than he had been for two or three years. He knew who we were. He said goodbye. He told us he was proud of us. I remember him hugging me and telling me how much he loved me. And for the last two years I would have sworn he didn’t know who I was…And he hadn’t called me by name in two years. And he was incredibly present and lucid and peaceful and completely aware that he was dying. It was lovely. And he needed badly to die…he had gangrene…and he had three or four days to make his peace with people and tell my mother how much he loved her. I was witness to that. I was there when he said goodbye to my mother and telling her how much he loved her and what a wonderful privilege it had been to be her husband. She was trying to turn away from it all and I made her stay and listen and take it in because she was so upset. But yes, it was an extraordinary privilege. Although he sent us all away before he died, which was interesting…. So it was a special process, a privilege, given where he had got to, ashamed and confused. It’s intriguing isn’t it. That final burst of adrenalin or grace allows people to do that. I’d like to see it as grace. (10)
This participant also commented on the way in which doctors and other health professionals were able to accommodate comfortably with death.

That two of my brothers are doctors and one of their partners is, and another partner is a physio…. And our comfort and the simple acceptance of my father’s death and being around a dead body was in such intense contrast to my mother and sister, neither of whom had ever seen a dead person. Their fear of the process of dying, their fear of death their fear of the dead. That we had somehow travelled to a completely different place with accommodation with death. (10)

A number of participants talked about the privilege of looking after or being with the dying person, as they did earlier about caring for patients. It raised the idea that deep care of another as they move towards death was humanly satisfying and fulfilling and enabled positive emotions in those who do it. It was a spiritual connection.

Just last year my mother died. … And so we took her home and looked after her for six weeks till she died. And we didn’t have to get a palliative care nurse. We slept with her and toileted her and gave her the morphine and all the rest of it. …It was a continuation and I was very glad that I had done palliative care for patients like that at home. Because I pretty much did treat her as a patient but as a mother as well….and she was so light I could carry her. So we took it in turns, my sister and I. And it was a hard decision to make to stop her feeding and stuff like that. You know my sister was very ambivalent and at one stage we were giving her morphine and my sister would force-feed her. And I said to her – we have to stop this, you know, just give her fluids. And then she stopped taking fluids. And … she very peacefully died…Yes she was ready. And she was in the best place. (11)

The next participant had come from Europe so had to fly round the world to see a dying father. Once again the sense of privilege came through very clearly.

(tapping) Well, my father. He died of bladder cancer. Four trips … in eight months. Three weeks here, three weeks there. I looked after him. I was with him for three weeks continuously and twenty-four hours in hospital. It was a very unpleasant experience medically. Not medically, physically it was very unpleasant. Dying from cancer, it was very unpleasant. But he was a very special character and I was very lucky, I was very privileged to have several weeks of talking to him, debriefing him in a sense, which most people don’t get. Dictating his last story for the children. That was good. Sent them all letters. So, yes, dealing with the hospital who were very good I have to say, but you know you can’t spend – he appreciated having me there and my mother who is a bit deaf, it was good for her. (13)

This participant, whose mother became terminally ill, was also in a different country. Again there was a sense of gratitude at being there when she was dying.
It happened with my mother. It was Easter, we were on holiday. I talked to her on the Thursday. ‘How are you’ and she said, ‘Not well’. So I said, ‘Well I’ll ring you after the weekend and come and see you if you’re not well.’ Next day Dad called to say she had had another stroke and is not talking at all. ‘Put the phone to her ear, I said, ‘We’re in Adelaide. We are leaving here on Monday. I’ll catch the flight on Monday night and come over to see you.’ … She went into a coma on Sunday, wasn’t eating. … I arrived at 1 o’clock in the morning on Monday night. So I sat with her all night just massaging her, talking to her….I said, ‘Look I’ll just go and lie down in my brother’s room next door.’ I had just fallen asleep, when…the woman came in and said ‘Wake up! Your Mum’s awake.’ ‘What’ and I came in and here was Mum looking at me, staring at me. I said, ‘It’s me. Don’t be afraid, I am here. Whatever we talked about is going to happen. Everything’s in place. It’s going to happen…she died later that day. And I believe she was waiting. (tearful)….I think Mum and I had a great relationship and I felt I had been there for her….In fact I was just looking at it again tonight and …I was so pleased with being able to do it. (14)

For some participants the experience of death in the family was very distressing and remained so even years after the event. There was a sense of double bind in the account below where the participant knew what needed to be done but was unable to make it happen. There was also a sense of déjà vu in relation to the mother’s experience with her own father.

The other time was when my mother died. And that’s probably more traumatic to me than probably the rest of my family. …This is about 4 or 5 years ago. … Mum …was frail … I had gone down to look after her…while my sister was away at a family wedding…I heard this noise …and then I realised it was coming from my mother’s room…and she’d broken her arm …So I called the ambulance …and she went into hospital …I would have liked her to have gone into a hospital care bed out in the community for her GP to look after her. But no, they decided to rehabilitate in the….hospital geriatric unit. What I didn’t know is that the doctor who was looking after the geriatric unit wasn’t even registered in NZ as a medical practitioner….. But anyway she…put her on thyroxine and…four days later my Mum had a heart attack and died. I rang and I talked to her …to say thank you for a gift…And shortly after she got this angina pain …. But I rang back and heard her… moaning in the background and…I said for goodness sake give her some morphine – “Oh we can’t give her morphine because it will drop her BP too much” And I said ‘Well the ambulance guys had a BP of about 60/20 …do it the same way.’ And…obviously it still rankles. And I put it behind me because I do know also that for her she’d always said – well when my time is up I’ll go to your father we’re going to be together. …And it was sad. …I just blame the system that allowed that to happen. So I put in a complaint to them about … ensuring the junior staff could get hold of somebody to tell them how to manage pain. (19)

For this participant, the need for families to be listened to became paramount and the conflict of interests and power imbalance clearly identified. Advocating strongly for a family member may irritate the colleague looking after them.
I think it just made me more aware of listening to relatives. Listening to the people that are around. I mean …being aware that you feel so powerless. I think that’s the hard thing….And… because you can’t be objective and also you feel like if you say too much you’re going to make it worse for them, if you say too little you’re not supporting them, what do you do?. And so I actually feel very strongly for patients and listen to their stories when they are sad about somebody and will actually intervene if I think it’s necessary. And it’s not often that they want much more, it’s just to be not treated like a nobody. (19)

Some participants showed the bleak loneliness of suffering very clearly.

But we had a series of miscarriages and then… a stillbirth…about 24 weeks. And that happened early in the morning one morning, and I can remember leaving and walking out of the hospital …thinking – who can I go to. Where can I go. And I had nobody that I could actually go to, to share my grief. Not a soul…So it was a very destitute time. (20)

Others firmly detach themselves from the dying person, using the techniques they have been taught in biomedicine.

But I think I’ve always been able to be quite divorced from the emotional side in terms of illness. Perhaps more so – I sometimes wonder if I’m perhaps too divorced. …When my father had his stroke…And then we had a scan which showed that he had a major infarct and was not going to get better. And then I was just glad that he died soon afterwards. The same with my mother. I wished, I prayed that she would go. Because … she didn’t have much quality of life. …Well, I think I treated my family like I treated my patients. There’s a degree of involvement but also being able to step back from it so it doesn’t tie me up in knots. I don’t think I’ve allowed myself to be emotionally involved in my families illnesses. And I think sometimes my sister thinks I may be a bit cold in that respect and she may be right. I don’t know. (21)

This participant had the family example of a very stoical, uncomplaining father and found expressing grief difficult.

The only time I have actually broken down were when our lovely dog Kerry died. I was absolutely devastated. It was quite an extraordinary experience…Whereas with other people, Mum was 86 when she died. I was going to tell you about that. It’s much more the part of me that tells me ‘This is what happens’ and you kind of deal with what happens and pass on, and all the rest of it….She became more and more difficult to manage in a practical sense. She’d become more sedentary and it looked as though it would become quite troublesome dementia. And one night she died of viral pneumonia. And it was such a relief. (6)

The participants showed very many ways of dealing with death in their families from being emotionally overwhelmed ‘ a skyscraper on their head’ to being very stoical and unable to cry. What is striking is the number who had experienced poor care and lack of empathy from
other doctors, for their family members. This put them in a double bind of trying to be ‘good
doctors’, polite to their peers, and at the same time advocating effectively for their family
member.

8 Connection to community

Community involvement varied greatly from one participant to another. Some were greatly
involved and others minimally. The idea of being involved in caring for the community was
clearly linked to the sense of ‘the other’ which comes through in the quotes below.

Well, I'm involved with scouts, which is sort of a social group….Then there's all
the school stuff. Boards of trustees….I have a need to walk down the main street
and see faces I know. I don't even have to know their names. It's probably about
being a small town (person) you know, and knowing everybody… to see that
same community. (1)

It was about belonging and caring, which came through very clearly in the next quote. Below
there was also an interesting idea of a ‘real’ community born out of tragedy. This connects
back to the idea of people ‘holding’ each other after disasters (Chapter 4:3:6).

(Patient’s sister)… committed suicide in the bathroom. … she could not bring
herself to use the bathroom again. It needed doing anyway. … So we and our
neighbours organised to redo the bathroom so it looked quite different. Some
people gave money and others gave time or skills and so it got done. Everyone
gave something. This wasn't a fake community…Or, you know. It was born out of
that tragedy really….Yes. And I guess there's something in that everything that I
make, when I am making things, is often for other people as well as us. So there's
an element of giving as well. …so when I'm cooking a fancy dinner I'll often plate
up some for her as well. In fact our neighbours - we are all backwards and
forwards with muffins and biscuits and cakes. It's that sharing thing. (1)

Discovering a new sense of community could also happen when participants stop being too
busy, by taking a sabbatical. Having time to write was important to this participant.

I stayed home being neighbourly, actually. Quite interesting, this whole culture of
women, in communities that bake cakes for people, look after people who’ve had
babies or who are sick, that you’re not really aware of when you work. Well I
remember being amazed, when I came here that people did voluntary work.
People of my generation don’t do voluntary work….But that’s what keeps rural
communities functioning really. You sort of need that…When you have children
you often belong to groups of people who have children. And I belong to a book

34 While writing this up Christchurch suffered a severe earthquake. The sense of new community built out of
shared disaster has been very evident there.
club and I live in quite a small community….that’s quite a close network of people…I’m in a drama group…And it’s very sporty here. Everyone bikes and skis. We went to this…wedding anniversary yesterday. I think occasions are quite important. Because they’re sort of, they are about community and they are opportunities for you to say things to people that you don’t normally say, because they have a certain ritual to them, or purpose to them. (3)

This participant chose to practice in an area that was familiar, with many connections of people and places.

It was interesting that I was … brought up in this area … and suddenly I’m back in my old stomping ground. Lots of people that I knew and it really did feel like grace. At the time jobs were hard to get and I got a really good job in a well established practice with a whole lot of people I already knew but didn’t know well enough so that it was a problem. So that today I still have some of my primary school mates as patients, just a couple and … teachers and things so it feels like, life feels quite integrated really. And the other key thing about it was that the … church was starting out at that time, and I really wanted to be involved with that and so it all, all the bits of the jigsaw suddenly slotted into place. (4)

For the next participant the links are all with culture, family and place.

(There) is the whole weekend at the Marae based round things like history and language linked specifically to our area. My cousin runs a Maori language group once a week…Where the parents want their children to be exposed to Maori but don’t speak Maori themselves or are just learning…We take the kids…to play games and sing songs in Maori…I also belong to another group called Te Paneikitanga O te Reo which is a national group which meets … once a month for a weekend. I’m a member of the Maori Doctors association, I’m one of the Executive members…I’m on the steering committee for the Pacific Rim Indigenous Doctor's conference …(15)

9 Connection to natural world

I discussed the experience of spirituality in the natural world (Chapter 4:2:5:3) and speculated that the Maori spirituality of place has touched all who settle in New Zealand. This connection was quite marked for a number of participants who literally delighted in the natural world and wondered at its rich complexity and wanted to protect and nurture it.

And I think especially for us as Maori it’s being in touch with the environment and respect for it, basically for the land and for everything. And being aware that you’re not the ruler of this place and that there is a kind of give and take in all aspects of it. You need to be respectful and mindful of all that. (15)
And I love, I’ve got a thing about the sea and fish, and the seashore and I love that…And what I love about it is the counter-intuitive nature of it. And again its the mystery of life. So a barnacle is a crustacean like a crab or a crayfish, stuck by it’s tentacles onto a rock…. So it’s attached by it’s tentacles, and builds a shell around itself. And when the tide comes up it opens up and lets its feet dangle in the water and lets it filter feed like that. How wonderful is that. And that’s part of the way I connect to the natural environment. (4)

But also you’ve climbed up there … but there’s just so much more to it in the world than just climbing up that mountain. ….I think maybe if I think of connectedness I think of how do we relate to our planet. How does the human race relate to our planet and I think … everyone’s got great qualities. But the human race I think is quite selfish and … I don’t think we are connected to our planet …I don’t think we are treating it well at all. And our own self. And I think we’re all part of that. …To me I think we’re just tiny specks in the whole universe. And I think – I was having a discussion last night … about what happens after death. And to me I just had this – you get cremated or buried or whatever and that’s it that’s the end of it. (17)

The next participant had already made a connection with the beauty of nature related to God, then talked about those who do not relate it to God.

And then beyond that, yes I think people do – they go into the mountains and they sit on a mountaintop and see the sun rise and that gives them some sense of spirituality. Of something greater than themselves. (20)

Experience of Um, well I wouldn’t have known that I was particularly connected to nature, but I sure hate it now when I’m in one of those great big hotels with those whatever they are – pillars of iron. And I think you have a greater sense of wellbeing from being in the bush or by the water and these sorts of things. (22)

10 Connection with the transcendent

Connection with the transcendent emerged in all the participant accounts. This included the two who had specifically rejected religion and spirituality. Modes of perceiving the transcendent were discussed in detail earlier (Chapter 2:2:5). The participants certainly expressed theistic and atheistic ways of experiencing the transcendent. Some seemed to experience a pantheistic world where all things constitute the divine and others a panentheistic one where all things are in the transcendent but the transcendent transcends all things. There were certainly a number who had a natural spirituality, a sense of the transcendent greatness of the natural world and the smallness of human beings.
I was surprised at the number and range of stories of spiritual experiences. These were also
discussed previously. The experiences ranged from a sense of connection to everything ‘I was
in a different world’ (11) and ‘everything was different’ (1) to a sense of total absence ‘God
seemed … on the other side of the universe… and my own spiritual map had run out.’ (4)

Some happened when the participants were alone, quite unexpectedly. Others were in
connection with patients or family. Some were very definitely linked to the natural world.
The interpretation of the experience depended on the culture and religious connection of the
participant.

I have included in this section both the participant’s own experiences and patient experiences
described by them. It is sometimes difficult to decide where to classify a particular account
that may fit equally well into two categories. I have used the classification of Greeley for the
extraordinary human experiences (Chapter 2:2:6).

1 Extraordinary Human Experiences

1 Déjà vu

Déjà vu is a sense of having previously been in a place or experienced something. Both
participants were Pakeha New Zealanders with Celtic ancestors.

Travelling in Greece was a very powerful thing for me and I kept stumbling into
odd, odd things… Like entering a place and knowing my way round places I had
never been in before. When we were in the old part of the city I’d know exactly
where to go and navigation is not my strength I read a map every second corner. I
could lead my friend around that because it felt as if I had been there before. …
(10)

In the second quote the participant’s mother was the subject. It started with a premonition and
ends with déjà vu.

I think the interesting thing though was that it was almost like she’d had a
premonition because 2 days before she fell, or it might have been the day before,
when I was caring for her, she told me the story of sitting watching her father die
from an angina attack. He was out in the country and she’d given him one lot of
anginine under the tongue and she’d rung the doctor and the doctor had said – Oh
you’ll have to wait 20 minutes – and she said – I waited for 20 minutes and he
died. Because she wasn’t allowed to give him another one. And she’d been in
agony and to hear her on the phone in agony was like, it was kind of like déjà vu.
It’s happening again. (19)
2 Extra sensory perception

Extra-sensory perception covers knowing events at a distance or clairvoyance and being aware of another person’s thoughts or telepathy.

1 Clairvoyance

Clairvoyance, or knowing at a distance, comes up a number of times. The first quote was from a Pacific Island participant who talks about it as a gift.

My mother came from a family that was very, I think very spiritual. …But my grandfather had this special gift. … We spent all our school holidays with them…And grandad would say… tomorrow morning you’d better hang around, don’t go to the river until the second bus has gone. And I’d say – Why? There’ll be, I think there’s something coming on the bus. You know he had this sense… he’d tell my grandmother ‘You’d better cook more taro because we’ll have visitors tomorrow’. He had this, we always used to say, gift. But that gift he said will travel through the family … and one of you will have it. Of the three of us I think my brother has it, but I’m really aware of that and probably very comfortable with that extra dimension. (14)

This participant was a Pakeha New Zealander with Celtic forebears.

I’ve got a very modest degree of second sight, I’ve had premonitions and ignored them to my cost. There’s a little voice that says ‘don’t do this’ and it’s ridiculous I always do it this way, and I’ve gone ahead and done it this way and disastrous things have happened. And I’ve learned to recognise that. Yes, I do listen now and it hasn’t happened for a while. (10)

The last quote was about a patient who reported it to the doctor.35

One of my Maori patients…was living in London and he was in Hyde Park and one day he saw a morepork …And he suddenly had this knowing that his grandmother in New Zealand had died…. The morepork is associated…with death of a person in that tribe….He rang home to ask if anybody had seen grandma for a while, and nobody had so he said ring her to see how she is. And she didn’t answer the phone and they went round and sure enough she’d died. (4)

2 Telepathy

Being aware of another’s thoughts has already come up in relation to tacit awareness used to make diagnoses. The examples below come from a study on twins

Nineteen out of twenty of the interviews,(of twins) …showed this knowing something was wrong with the other twin, they couldn’t understand how they knew. They just knew. And all of them without question remarked how accurate it

35 A morepork is a New Zealand owl.
was. They said it was never wrong, and I doubt that, but they certainly experienced it as very accurate. And you know I think it’s fascinating to think what it really means about the nature of our reality, and what the nature of human being is. The nature of connectedness and community, and empathy, and it is clear that the dynamic by which it tends to greatly facilitate connectedness, there’s not much doubt about that. …The twin up a telegraph pole who is working away as a linesman and suddenly knows that his brother has died and they’re all miles away. And the interesting thing is that in the last 5 or 6 years, the physicists who previously thought non-mortality only occurred at a sub-atomic level they have now come up a number of orders of magnitude and know it occurs at a molecular level. (4)

The last quote could involve both clairvoyance and telepathy in a participant who had been caring for her mother.

Nothing obvious comes to mind straight away…I mean I knew the moment my mother had died. I was coming back on the school bus and at 4 o’clock I said “Oh, I think she’s died.” Which seems an odd thing for a sixteen year old to say and when I got off the bus I found subsequently at four o’clock she had died. So for me that was quite powerful at the time. (9)

3 Mystical experiences

1 Awareness of patterning of events or synchronicity

A number of participants talked about patterns of events, of being in the right place at the right time. This could also perhaps have been classified under clairvoyance.

The first quote came from a participant for whose Christian faith was a daily source of support.

But … the day … (our child) had died… the Minister from the church turned up here that night. And like he just knew he had to come. We hadn’t told him and he didn’t know. He turned up at our door uninvited. And he said – I needed to come and see you tonight. He knew something had happened. And so again I think God directed him to be there, to come to us. He knew we needed some comfort. (20)

This right time event was mirrored for the same participant with a patient. The participant felt compelled to go and see this patient and offered an explanation for what occurred.

I had a gap … So I went to see her and she was dying, She’d probably had a PE or something, and … she’d always talked about trying to get home… We got her home later that same day … where she died quite shortly afterwards. … so she died where she wanted to be, with her husband beside her in her own home. I have no doubt that something directs us to do certain things at certain times like that morning. … And so, you know, it’s not that infrequent that those circumstances all come together and seem to be at the right moment….I have a Christian faith and I personally believe that there is a guiding hand… not a big
deal or anything miraculous but it’s just a guiding hand or voice that leads us too
do certain things at certain times, so that it’s right. (20)

There is another example of this phenomenon below. Again it was unexpected that the doctor
had time to go and see the patient. What was unusual about this many-layered story was that
the connections involve not just the doctor, the patient and the transcendent, but the cat as
well. The other interesting aspect of this story is that it provides a sense of connection, of not
being alone, for the doctor who had connected so well with this patient.

And she lived alone and she used to say, ‘My cat is my friend’. She loved her cat
and would stroke it and say, ‘She and I will go together.’ And you know I never
go out for lunch because it’s always busy. It was a beautiful day and I thought –
I’ll go for a wee walk. And I went for a walk... and so I went past her house and
her roses were beautiful so I just lingered to sniff one of the roses and I saw the
cat lying on the driveway. And it was very still and I thought – is that cat
alright!? And you know when I got there it was dead. And I thought – Oh God –
this is Mrs D’s house. I’d better just go and check. And when do you do that? So
I went in and called her. There was no reply and the doors were open and I knew
her bedroom and there she was in her bedroom gasping and Cheyne-Stoking. And
so I just held her and she died… So you know, things like that. You are left with
thinking that you are not alone. (11)

2 Awareness of the presence of God
Participants involved in religious practice described a number of experiences of the presence
of God. The first two quotes above, of synchronicity, were also about the presence of God.

Where you feel life is chugging along and you’ve reached, something happens, or
particularly a time of need and it’s like. God’s hand reaches down and touches
you, and makes you very aware of his presence. (20)

In some cases the sense of the presence of God was very clear and dramatic and happened in a
religious context. This event below happened about thirty years ago. There was a powerful
sense of God breaking in unexpectedly and transforming the life of the participant, when the
participant was not intending it. There was also a sense of indignation that ‘an American’
facilitated this event and others, and an unawareness of the irony in this. This event is
transient, noetic, passive and ineffable, fulfilling the criteria of a mystic experience (James,
1985).

And I’ve had a number of occasions when I’ve had quite a significant spiritual
experience within the charismatic renewal...It really irritates me. I don’t like
Americans and all my most significant spiritual experiences have been with
Americans. ...it was the first time I had – well they said slain in the Spirit – I
prefer rested because I think it’s a more appropriate term...I was going up to talk
about somebody else and it was not about me at all and it just came out of the blue
...I just went down ...I didn’t hurt myself, it was just one of those things I find really strange. I mean she prophesied over me a whole lot of rather surprising things. But it was totally out of the blue ...I didn’t lose my sense of hearing ...And quite happy just to rest there and not being worried that people saw me lying on the floor...But very conscious of everything going on ...just resting. Literally resting. And thinking through what she’d said and just letting it absorb into my being. So it was ..., a very transforming occasion for me. ...And ... it was totally unexpected and therefore I couldn’t really say there was any sort of sense in which there was an expectation and I did what I was meant to do – you know. (21)

Another participant also described an ineffable spiritual experience beyond human words, when they had a dark night of the soul, when God appeared to be absent. This was also an experience of impasse discussed earlier that moved the participant to tears (Chapter 4:3:5).

And I got to the end of praying so all I had was my inner, kind of groans of emotion to let go. ...I feel slightly, there’s a ...bit of anxiety working for me here, a bit of emotion as well, telling you about it. Because, (became tearful) because it’s important. So its kind of prayer beyond words. And the words, Hm, I’ve always been full of them. I think a lot and try and put things fairly, but Hmm, that’s all good, that’s all important, but I know now what’s behind all that and ...so it’s certainly changed my, um, understanding of prayer and of connection with God. I don’t think I can say anything more about that at the moment. (4)

3 Awareness of a presence not named

For some participants a spiritual experience was linked to an unnamed presence. These experiences happened in both religious and secular environments. The first quote below came from a participant who was ambivalent about religion and spirituality.

Well that question has me; have I had an epiphany? No. Well I guess there must be something, but I can’t really point to a discrete moment. But since we’ve been talking about this I’ve needed to clarify what I’ve been talking about. I can see I haven’t been that clear. What we were just talking about in terms of an essence that’s within and without. There must be some sort of experience that reinforces that, mustn’t there. But I can’t give you an example. (5)

It was interesting that the next participant echoed a sense of the unexpected and also uses the phrase ‘out of the blue’ and linked the experience to a previous one in a religious setting. This experience was in a non-religious context.

Reaching out and touching a statue in the museum and getting a bolt of energy off the statue – it was like an electric shock without the unpleasantness.... But it was something way beyond. And the nearest I’ve been to that, to this experience was looking up the spires of York Minster. It felt like a completely primitive, ...totally alien emotion I’ve never experienced before or since. And it came completely out of the blue.... And admittedly at that time I was quite invested in the whole idea of past lives but I wasn’t going around looking for it. (10)
The next example was really about a sense of deep prayer and connection, again in a non-familiar place. There was here a sense of global connection as well as yearning from the participant to be able to pray and connect.

Well we went to a monastery when we went to Nepal and got to Tengboche which is up 15-16 thousand feet. And all those monks had totally devoted their lives. I did feel that they prayed for the world, they didn’t pray for themselves. I sort of envied them I wished I had that sort of vocation or calling so that I could do that. But I haven’t got it. And yet I know there is more than just being a person. I sort of believe that matter is something indestructible. And I am part of the matter of this world. And when I go whether it’s ashes or burial, or through earthworms I will still be there somewhere. And so I have to lead a good life, because that matter will carry, in essence, my contribution to the world. (11)

4 Prayer answered
There were a number of examples given, of prayer being answered in the interviews. Some have been included in the section on healing.

This next participant was an adolescent when this event happened. It was clearly an important one and remembered in detail. This event and another marked the beginning of a life long spiritual journey. The sense of ‘things being different’ was one of the identifying aspects of connection with the transcendent (Chapter 2:2:6). This event could also have been classified under clairvoyance.

So I prayed and I said, ‘Lord, help me find it, my rugby shorts and rugby socks’. And this particular day I had some odd state of consciousness, is how I would describe it now…. And something happened. And it was kind of like a switch got flicked, and just suddenly things were different… I was aware of what I was doing, but it was almost like I was an observer of what was going on, there was something going on and my mind was just noticing it… I found myself walking off down one of the aisles of lockers and turning to a bay of lockers…And hoisted myself up on top …And switch went back on. And there in front of me all covered with dust were my rugby shorts and rugby socks…I had never been to that locker bay, never had lockers in that locker bay before and never afterwards either, in the five years I was there…I thought, ‘I wonder what the criteria are for a miracle? And I wonder if that was one? And if it was, Lord, thank you very much.’ (4)

5 Healing
Healing is a recognised aspect of mysticism (Chapter 2:4:9) (Wardell, et al., 2006). There are four accounts of patients being healed, three of participants being healed and one healing of a
family member. What is interesting were the explanations why healing might have happened, and the close connection of some of these healings with positive emotions.

The first account was about a patient whom the participant thought might have been healed by the whole community from cancer that had already spread. The participant, who had thought about this for thirty years, suggests it might be about the spirituality and sense of coherence of the patient and the wish of the community to heal him (Chapter 4:3:6).

Another patient of this participant was transformed, from an unhappy tense person, into one whom everybody wanted to be near. This patient became a healing event. In this example the positive emotions emerge strongly.

But the thing that I wanted to say was that (she) had been a rather tense, rather unhappy, non-trusting person….And …it didn’t help any of us who were left behind, including her husband and her family and even me, that she became almost a saint like figure. That’s strong words but she became the sort of person that everybody wanted to be around. Everyone wanted to look after her …. And they just found her such a calming influence. And she developed an aura … of calm and contentment around … and happiness and … that sense of coherence that we talked about before. And she became a special person. She was not cured … The cancer ended up taking her….The conversion, if you like … from the person she was to the person she became was … a healing event healing event even though we didn’t cure her.(8)

The next participant, who struggled with the idea of religion and spirituality, also saw a dying patient as a healing presence. Again this patient spreads a sense of peace and love to her family and the clinical carers.

In fact they were a religious couple. I don’t know what religion they were… she was largely confined to her bed because of the burden of tumour. And they’d set up a room as a kind of a shrine. It had wonderful bedspreads and sheets and mounds of pillows and family things all around her and she just maintained a serene peacefulness… And this went on for about two years. Far longer than we all expected her to live….she was wonderful… to her young family who came and jumped on the bed to feel her love and warmth. Even though she had no energy left. You know she had an extraordinary presence. (18)

In the last two cases the sense of connection and the process of healing while dying was very clear, as was the sense of peace and serenity coming from the patients. I find it intriguing that the doctor comments on the ‘presence’ of the patient as in previous sections doctors have discussed the need to ‘be present’ to patients.
A number of participants prayed for patients but the next one is the only time an immediate,
dramatic healing occurs. An interesting aspect of this account was the sense of helplessness
and indeed almost hopelessness of the doctor. However in spite of this the doctor prays for the
patient. Other participants also talked about the “help” prayer as discussed previously
(Chapter 6:5:3).

I can’t remember what the circumstances were, but he refused to eat anything
whatevsoever. . . . And the ward rang me this day. . . . and said – look we’re really
stuck. . . . we think we’re going to have to send him down to the medical ward. . . .
Would you be able to come up and maybe have a talk to him. All my thoughts
said – no this is ridiculous and a waste of time. . . . After work I went up and went
into the ward . . . I sat on his bed and put my hand on his arm. . . . And the door was
open and there were people running about. So it was quite noisy. Not a very nice
environment. . . . And I thought – this is just a total waste of time, being here. So
I. . . prayed (silently) . . . Lord, there’s nothing I can do about this, but if there’s
anything to be done maybe you can. And as I finished saying that . . . he propped
himself on the bed and he leaned over and he took a banana from the bowl beside
the bed and peeled it and ate it. . . . So out of helplessness if you like. You could
say it was a coincidence, you could say whatever you like, but the fact of the
matter was that’s what I did and that was the immediate response while I was
there. Which was very reassuring to think that my beliefs as such, that there is a
higher authority there that sometimes intervenes. . . . I went out and said – he’s just
had something to eat, that’s the best I can do for you today. . . . he didn’t get
transferred, and then he went back to his accommodation. That was quite
dramatic. (20)

This same participant was later in hospital after surgery and felt in ‘a black hole’ and totally
unable to eat. The family and some members of the church came and prayed at just the right
time. I was fascinated at the way this story mirrors the healing of the young man above.

I reached a point of – a really black hole – and felt I can’t go on, I can’t get out of
this. . . . And our minister and a couple of others picked up on that and they came
down to the hospital and actually came and prayed with me and that, the next
morning I woke up and I had an appetite and I ate for the first time. . . . And how do you crawl your
way out (of a deep hole) unless you have people that can help you do it. (20)

In the next participant spoke of the healing was of a family member in response to prayer by
the mother. This convinced the participant of the power of prayer.

One example is my brother. To become a pilot . . . he. . . needed to go through the
medical examination . . . and there was a problem with his vestibular system . . . so
he didn’t pass that particular test. . . . He went to lots of (doctors) and the doctors say
to him – maybe it’s a congenital thing so we can’t do anything about it. So he was
quite upset and depressed. And then my Mum just kept praying for him because
Mums always looks after their children. (laughs) So she prayed for him every day,
prayed to the Medicine Buddha and I don’t know whether it’s a miracle or we didn’t actually find the cause of it. Then next time he actually passed the medical examination. So I do believe this is a really strong power…. So when someone is sick, or someone has physical problems or whatever, that is the one we pray to.

(12)

The next example was a participant who was prayed for by the church community. There was a change in physical state as a result of the prayer. Again this was a rather dramatic response that has some parallels with the first case above.

It was about three or four months after I’d had angina (and an angiogram showing blocks) and went to (cardiology centre in another city) and I’d been prayed for. Anyway the blocks that were in my heart in the angiogram…had disappeared …I had a perfectly clear set of arteries. And I said to myself, I saw that as a miracle. And I could remember thinking – well if God has chosen to do that to my arteries He must want me to hang around a bit longer, and I wonder why. …Because I felt in a way that was God putting an extra call on my life at that time, a call I think to be just a bit more obedient. (21)

A Maori tohunga healed the next participant.36 He not only prayed for the participant but also blessed the land on which the school was being built. The participant and the tohunga are both sure the unsettled land is causing the illnesses.

Actually…when I was at high school…I had visited the tohunga…he was involved with blessing the land where the new high school was going to be and there’d been something, it was pretty disturbed land, he said it was really difficult to bless. And during that time my legs were covered in eczema, …and they were like massive elephant’s legs, red and hot and inflamed and he blessed me at the time. And he said there were a few students that were really picking up on what was going on either physically or in other ways and once he’d finished all that my legs cleared up. (15)

6 Awareness of a sacred presence in nature

I looked briefly at the presence of the transcendent in nature (Chapter 2:2:5). I have also commented on how the transcendent in nature seems to have an effect on many people in New Zealand. For some participants the sacred in nature is also about connecting with their loved family members who have died, as it is in the first account. It is a multilayered story connecting with past people and places.

Mountaineering is where I, when I get up there, I get into a sort of transported state, which is spiritually much higher than when I think about it. I can think – wouldn’t it be fantastic up there – and yet when I get there, its even more. And that happens every time I go into the mountains… And interestingly, when I’m

36 A Tohunga is a traditional Maori healer.
there, I’m probably connecting with Dad, because he was at his happiest, most peaceful when he was up on the hills, and in the mountains or in the woods. He was in his element. (6)

I was very struck by the connections with mountains, which for religious people have a long history as being a place of encountering the transcendent. It may also have something to do with the fact that the majority of the participants were in the South Island and it is difficult to avoid mountains there. What is interesting in the both extracts is the positive emotions.

I think the, to me it’s more a feeling I get. I guess I don’t have any religious affiliations. And I guess to me I get that feeling when I’m, if I’m on a crisp clear day in the mountains and you can see for miles and the place is covered in snow and it’s sparkling and I think it’s a feeling of how small we are in the world compared to the size of it. A feeling of wonderment and.. – I had a few other words this morning that described it and they’ve left me now. It’s a feeling of contentment as well and sometimes it also comes with a feeling of achievement. (17)

The next participant was deeply religious, but it is interesting how similar the language is with the previous one.

… you can’t help but wonder at the awe of God’s creation. I mean from here every morning at 8o’clock the sky over there changes from blue to pink and it’s just an amazing palette of colours. What an amazing thing – why would that happen just out of chance – what’s the point. Something has put us here and given us the ability to appreciate all that. And at night just looking up at the sky studded with stars, or getting to the top of the mountain range and looking out and seeing all the mountains around there. So there are physical occasions where you feel very close to God, just in what you’re looking at and the environment you’re at. … I think it’s more seeing the magnificence. And you just can’t help but be amazed and in awe at it – I can’t (20)

The participant below not only found a sense of the transcendent in nature but was aware of the connectedness of it, indeed of an almost global connectedness and unity in spite of being alone in a lonely and foreign place.

Being up in India in the Himalayas was pretty amazing. …I’ve never been in a more remote place in my life. It was just amazing just being on the path. Sometimes in the afternoons I’d go for a walk just by myself. Just being up on a path and you wouldn’t see anybody and there’d be this vast expanse of nothingness. And that to me was pretty amazing. And although it was desolate you felt connected with it, which is a very odd thing to say. (9)

In a different part of the globe this participant was again aware of the transcendent in nature and feels an immense sense of gratitude in response.
Similar to watching the sun rise and the sun set in Tanzania. To me that was just really amazing. Even though I had no roots there that I know of I felt quite comfortable and at home. Sitting out in Tanzania watching the sun and listening to the animals. All by myself. Yes. Yes. Yes. It’s just so special just sitting there, this enormous sun is dropping down, and you can hear the giraffes and the elephants and the birds, thinking – I’m so lucky. So very lucky. I think we’ve got so much to be grateful for and I think we do need to appreciate it. (9)

The participant below replied to a question about having a spiritual experience. There is a strong sense of inner peace and oneness, or unity of everything, in this response.

I feel most at peace, most spiritual. I can actually see the day. It was one day when I was skiing up on a ski field.…. And being a club field I was on my own – there was absolutely no one around – just me and the snow and the mountain. And blue sky and sun… That to me would be that feeling of deep inner peace. And I can get a similar thing walking down …the beach….. Somehow that peak for me it comes from nature. (16)

For Maori participants, there is always a connection with the land of their ancestors, it’s mountain, and river. They believe that being separated from their land is spiritually damaging. There is also a connection there with generations past, present and future.

Well, you might have heard me talk about being connected, connected to the landscape, connected to the past, to stories, connected to generations beyond mine. Connected, you know interesting from the Maori perspective and the Maori paradigm, in all our talk, so we talk it, and we try and walk it and we try and live it. So it’s a real tangible perspective, really, so it becomes a belief. (7)

For some participants the connection with nature was sometimes about its capacity to grow things. Gardening was a very popular way of relaxing and finding spiritual space and nurture.

And sometimes it can be as simple as finding that something you put in the ground is actually growing… Gardenning is I think, one of the most important occupations for everybody to do, all those of us that like it. I’ve never been very good at it. I can’t get flowers to grow very well, but I’ve grown a lot of big trees. (8)

For others the experience in the natural world was a form of ritual, prayer or meditation. This really seemed to be space to be in the presence of the transcendent, to wonder at the beauty and order of it. Some participants related it to their religious beliefs. It again raises the issue whether spiritual wonder and awe is an inbuilt human characteristic. In the quotes below one of these participants one remains marginally attached to religion, the other has detached from it.
I need to be outside. In the depths of winter when it's dark the stars are incredible. And most times, there's only that little time, it is very important. Yeah I walk that same route every day and its always different –new… I used to walk with a friend but recently I have been walking on my own. It is a very good sorting out time. (1)

I thought that solace for me is to go on a tramp. You know I found for a while I was running every morning and I was training. And every runner wants to do a marathon once or twice so I did that. And being out in the morning and seeing the stars and seeing the sun come up, for me was almost like putting out your prayer mat or going to Mass. (11)

7 Awareness of the presence of the dead or spirits
These participants are of course a very selected group who are likely to have heard about death and after death experiences from their patients. There were twenty-six accounts of spirits or the presence of the dead in seventeen transcripts. Eighteen accounts of these referred to patient experiences and eight referred to doctor experiences. I have included in this category those who talked about spirits as well. Awareness of a dead person is one of the commoner categories of mystical experience (Greeley, 1975, 1987; Hay, 2006; Wardell, et al., 2006).

Two participants were convinced a sense of the person who had died was a delusion caused by the grief, loss of sleep and yearning of patients. They both tried to normalise it for patients as can be seen below.

Oh yes. Often. And I tell them it’s going to happen. I do. I mean someone, a classic example, someone whose husband died, a 70 year old woman, I said look it’s entirely likely that in the next month or so you will see Fred standing in the door… Well, it depends how often you ask. Common. I don’t really ask people but there’s a lot of this when you’ve got broken sleep, … when they are dozing and see him in the door, were they awake or were they asleep. (13)

Indeed – so much so that if someone has lost somebody they are intimately involved with it is part of my routine talk to say – you will experience this person, you may see this person and that will go on for a while. It implies that our mind has a wonderful way of recreating past experience so that we can continually work through it. It doesn’t evoke a spiritual existence for me. I just treat it as normal….No. I’m not saying it’s a dream. But you can be doing something and see someone out of the corner of your eye and look and they’re not there. (18)

The other fifteen participants thought that it was a real, and common experience. Four accounts referred specifically to Maori patients and participants.
We have this interesting relationship – he’s an older Maori man …I don’t know what I’m offering. …he comes to me because he trusts me….When he’s unwell he speaks about spirits and says he’s visited by people in his house. (2)

There was an account in the section on ESP about a Maori patient who told a story of seeing a morepork in London when his grandmother died. One Maori participant explained the Maori understanding of death and the progress of the spirit after death. This was both in relation to patients and the participant. Having a process to send the spirit on its way, a place for it to go where there is a meeting with the ancestors, seemed helpful for families and patients.

And there’s a pathway along that, you know, so and it’s, the most vivid and most tangible way that is manifest is shown within Maoridom is when people die. You know the whole processes of our, we say while the body of a person may have died, life is extinct, the spirit hangs around for a while. (7)

So we say, so there’s a process to send the spirit on a spiritual journey. So there are words we use when we say farewell. We say Haere kio tupuna. Go to your ancestors. Haere kea ratou ko whitu rangitea. Go to those who are now stars in the sky. Kei tua dar, kei tua paerau. Beyond the veil, beyong the horizon. OK? So there’s a space and place for spirits….So there’s the part when you say farewell. Haere, kiterere nga wairua to the departing place of spirits too. You know geographically, it’s a real place. (7)

It also expanded the role of doctor into what might be called a priestly role, in which the spiritual care offers peace of mind.

So I’m not only the doctor who confirms the death, but if it’s a Maori they will ask me to help the spirit to begin the spiritual part of the journey, eh. So I have to do karakia or awatia as we call it. And to nurture the spirit and the soul on its way. So those rituals that …ensure that the tapu process has been made noa….And that’s about peace of mind for others. (7)

It was very clear that the spiritual nature of the Maori world was very different from that of the European. In some ways it resembles the spirit filled enchanted world discussed by Taylor (Taylor, 2007a). The next three quotes bear this out.

Not necessarily tangible or visible, but can be. And I do believe in being able to see spirits and seeing ancestors. And as a child having experience with that. And I know lots of people that have…. I also remember other spirit people in my bedroom….the Maori tohunga…came and blessed our house, and things settled down after that. (15)

And in France I definitely saw one. We had a very grand staircase that came down in a spiral and I was just going to walk up the staircase and this man, with a ringlet like … wig …and little blue pants and bloomers was walking down the staircase and that freaked me out. (15)
In the account below this participant was on ancestral land. The participant thought the voice was that of the ancestor.

Last year we were paddling across lake ...me, and one other girl, we both realized afterwards, could hear a karanga (a call)...off in the distance. So whether it was some kind of ancestor calling or whether it was the people who met us at the end stopping off and calling us there and we couldn’t see them, I don’t know. But we both, we were the only two that heard it...And so our leader, ...said do a karanga to Waitaiki (an ancestor)...So I stood there and started doing the karanga and it wasn’t my voice coming out of my mouth. Like, it was like this old voice and although I had an idea of what I was saying I didn’t really have much control over that. And my friend was a bit ‘Ooh, that wasn’t you was it’ and I said ‘No that was definitely not me.’ (15)

In the follow up conversation this participant talked about seeing spirits of the dead.

I’ve heard from other people but not from patients., interestingly the week after this interview I did have a woman who spoke about her son’s spirit (he had died) being at her old house more than at her new one and that that worried her a bit. (15)

Many of the other participants simply took it as a matter of course that their patients sensed the presence of those who had died. For some there were cultural aspects.

I didn’t think about it in the context of hope, but I think about it in the context of connection. In the context of connection eh. Until we connect again. That’s the spiritual connection. Until our spirits meet, your spirit is there waiting. And so we say words like whanganga or tatarianga. We say Haere ke ratou ke tititangi mo koutou – go to the one’s who are waiting. So that’s in the ritual is about death and dying in particular. Its about - go to those who are already there ke ratou, OK. Beyond the veil. Waiti So there’s a spiritual waiting place. So within Maoridom that’s a very, you know real concept. So they’re all really up there. So kio tipo and kio matua to your parents and to your ancestors. So there is a place. (7)

Even for those who were European there was a sense of connection between the living and the dead.

I mean, often with the hospice patients, particularly when they were close to death, they would, I noticed, they would start talking about relatives or friends who had gone before them. Almost as if they were thinking about dying themselves or the other people’s spirits were actually coming back to help them in the next phase of their journey. Recently I can think of one lady whose husband died about six months ago. And she’s feels that he does come back to her in the evenings and at night time. She’s grieving tremendously for him and she is a

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37 Karanga is a formal calling.
person who is socially isolated because she has a congenital hearing problem and she’s waiting to have an operation on her ears…So I don’t know whether or not he is actually coming back or whether she’s ruminating about him. (9)

The next three participants were Pakeha New Zealanders. Both were sure that there was a contact with the dead.

I think after a person dies you can still be, particularly with people you’ve been close to or connected to, you can still be in contact with that person. Yes. (9)

There’s some dimension there, a dimension there that we don’t really have in a secular society which is a sort of, like the relationship between the living and the dead. In our conception of it as a secular society it is very separate. You’re either alive or you’re dead. And that the idea that you might communicate with the dead or see them is, there’s something in that …I’m sure I have. (heard patients talking about dead) I think there’s something in the Catholic tradition – it’s possibly the Irish tradition which is open to those possibilities. And in the Maori and Polynesian tradition. (3)

The awareness of a lost one, a dead close person being present is a common experience for people who are in the early stage of grieving. And I’m not sure that that stuff is an entirely imaginary brain playing tricks. I think there is a presence of the person that we don’t understand at this stage. And I don’t know how long it hangs around for…But there’s something, there is a part of the person, whether it’s consciousness as Rupert Sheldrake would say, that’s just floating around in the region or what I don’t know. It seems to me to be more than just imagination. (8)

The next participant certainly thought that the presence of the dead was normal.

And she said after (he) died she was doing that and she passed (his) room and she’d do a double take, because she actually felt she saw him. Oh, he’s not there. She came in and said ‘I’m going mad, you know’ No. No you’re not. … it’s so comforting. (14)

And one of those was telling me about still feeling the presence of her mother around. That’s just bad. And I said I don’t think so. So I think you should, I don’t know how to explain it. But I think it’s very nice that you can have that presence, and it wasn’t a scared of it, it was comforting, stabilising. (14)

There was one account from a participant about the presence of a spirit in the room of a patient. The figure seen resembled a previous inhabitant of the house who had died.

One participant described a patient and a community experience involving angels.38

38 While I was writing up I was tutoring a group of 2nd year medical students. When they had their first clinical contact one pair described a patient’s wife telling them about seeing an angel in the ED which reassured her that everything was going to be alright for her husband. They were very startled.
I did my house jobs here and did a short stint on a Mission station in Papua New Guinea at the end of fifth year or sixth year….So culture shock for a few weeks. (laughs) It was interesting. What was interesting … was they had…a … revival there, over the previous two or three years, so people would see angels in church services and lots of people had become Christian, so it was pretty lively from that point of view. But I think, there wasn’t anything major that changed in my view of the world, by doing that. (4)

Angels are another quite commonly described mystic experience. A patient gave this account to a participant who had an interest in marginal phenomena. The participant then suggested this might be an angel although in this case the patient seems unconvinced.

She … said ‘I saw this figure. It was about seven feet high and had light pouring out of it’s eyes towards me.’ I don’t know whether she said towards me or into me. ‘And holding some sort of lantern or light in one hand, and light was pouring out of that.’ I said ‘That’s amazing, how did you feel about that?’ and she said … ‘I felt pretty uncomfortable. My darkness was being exposed.’ I said, ‘It sounds as if you might have seen an angel’. And she … wasn’t quite sure how to frame it up. (4)

8 Awareness that all things are one (unity)

A number of participants above describe a spiritual feeling of unity within and without that they had experienced and remembered with a sense of wonder and joy. Many were in the natural world, but others are listed under positive emotions in Chapter 4:1:1. There is a striking connection between solitude and a sense of unity. Such an experience is unforgettable.

Suddenly everything comes together- the light, the background, the time. It all comes together and you feel whole, complete. You do remember it. (19)

The most striking description of this feeling of oneness seems to run out of words to describe it. It is often difficult to disentangle the layers of a spiritual experience which covers more than one of the types of spiritual experience. This is so for the example below, in which the embodied experience and the sense of transcendent connection with and beyond the natural world was clear. It involved the senses of sight, smell, hearing, the emotions and an internal sense of integration.

I used to run … And I had just been given a present of a walkman so I thought I’d try it. And I had Holst’s Planets playing. And I just went up the hill, and just got up to the top and was thinking – Oh! this is beautiful.- all the gorse was in flower and we had the fragrance. And there were the yellow-headed finches, you know. And they flew with me as I got up and I was listening to this music and it was utter, utter, I was in a different world. You know my endorphins were good
enough, the finches were with me, the music was with me, and the gorse smelt beautiful and the clouds were beautiful, and it was truly a spiritual experience and I think that people who can pray properly probably feel that (reflective silence) …But it was right. And I was in the right time and the right place. (11)

9 Other spiritual experiences
There were a few other experiences that did not quite fit in the categories above. There were three interesting stories about animals and death. One is told in section 10:3:1 of this Chapter of the doctor, the woman, and her cat. The other two were told by participants.

My children tell me a story. My father died last year. It’s just coming up a year in June. …. He died in the US. I had to go over and see him, he was there on holiday at the time he died. My daughter’s friend has a dog that spends a lot of time at our place. But at the time he died the dog got very distressed and started barking. And I can’t (explain) A very spiritual thing. That certainly touched me. There was something spiritual going on, the dog was barking at the time. (Participant looked distressed) (2)

The next account was from a participant who was sceptical about spirituality and was given in response to the question about having had a spiritual experience. The event would have been maybe 20 years ago, so it had definitely been remembered.

Before I do, can I go back to the spirituality thing? One thing, it’s a story really, it’s a story that did make me think… I was a house surgeon … We were looking after … this person… he had a terminal cardiomyopathy. And his heart started to fail, and one night … pretty clearly he wasn’t going to make it. And we pulled out all stops…. And we spend virtually all night working on the second floor of the … hospital. …. I don’t know if you know the hospital, big square windows, and I noticed early on in the evening that sitting outside on the window ledge was a big pigeon, looking in. Most peculiar. And it just kept there the whole time. And about five in the morning it was clear we were not going to succeed. You know, so with great trepidation we turned off the machines and the thing was going down to nothing and the bird flew away. And I thought well, that’s interesting. That always stuck in my mind. (13)

10 No spiritual experience
There were three participants who thought they had never had a spiritual experience. Yet they all described spiritual experiences with patients or family.

This participant was clear that spiritual experiences occurred but seeks to label them as psychological, following the humanist strand of Carl Rogers.

Well, I’m absolutely flawed in my strong sense of evolutionary belief about what is it that makes me me. You know, puts my consciousness into this (gestures) particular bag of bones… So those points of leverage and I’m thinking back to the
level at which I operate in consultations, the points of leverage I feel are in the psychological area, um, and the behavioural area where we can actually do something. As a result of that I might experience an emotional or a spiritual change … You can only do things differently so that you’re available for spiritual experience. (6)

One participant firmly believed in the power of prayer and connection and described changes as a result of prayer. However, when asked about spirituality felt they had not experienced it. One was uncertain of personal experience, but described it very clearly in relation to patients.

11 Conclusions

This chapter has looked at spirituality as connection to others. This follows the understanding of spirituality as connection outlined in the preceding chapter. First it considered the reasons why doctors choose medicine and what keeps them there, something that reflects their own values both in choosing medicine and persisting in practice. This section also looked at the negative experiences some participants had while training which they were able to overcome. It then went on to look at ways of connecting with patients and how complex and valued these connections are.

The community connections of doctors and the ways in which they connect with the natural world are important spiritually. It then looked at ways of connection with the transcendent. These concluded with a collection of anecdotes about extraordinary human experiences and the ways these affected both doctors and patients. It finished by identifying three participants who thought they had not had any spiritual experiences. Despite that disclaimer all of these had described spiritual experiences in other parts of their interviews and in relation to their patients.

The next chapter will deal with ways of sustaining spirituality for both participants and patients.
Chapter 6

Sustaining Spirituality

Practices that sustain spirituality

Introduction

The last two chapters have dealt with participant spirituality and spirituality as connection with patients, family, natural world and the transcendent. They have also shown how the various aspects of spirituality interconnect. This chapter moves on to look at practices that sustain spirituality. Since spirituality is embodied in human beings, practices that sustain human beings also sustain spirituality.

The sustenance of spirituality requires a reconnection with at least one level of human being - with self, others, the natural world and the transcendent. This chapter will start with self-awareness and self-care that recognises the need for reflective space. It then looks at creative activities that tap into the spiritual level of participants. It finishes with a section on rituals and prayer, some of which involve religious attachment.

1 Self Awareness

Many participants talked about the stresses in their practice and their lives and the times when they had suffered from burnout. In almost all cases there were a number of things going on for the person in various parts of their lives, all at the same time. It appears that while doctors theoretically know about multiple life events having a stressful effect they often fail to notice in their own lives. This is in part due to the lack of encouragement in medical education to take time to reflect and be self-aware. It is also a feature of the stoical biomedical model. This has improved in recent times, but still in hospital medicine the tendency is to think of
problems and feelings as being attached to patients not doctors. Somehow the effect of the emotions a doctor feels in relation to patients is often still not reflected on. I think it was well put by the following participants.

However I also have to say that I believe that if you want to be the best GP you can be, you have to have some degree of involvement, emotional involvement with the patient, and there is no way you can have an emotional involvement without paying a price. (16)

And I’ll sometimes unwind by just reviewing the day. Again I’ve always thought the difference between as good doctor and a bad doctor was that a good doctor learns from his mistakes, a bad doctor keeps making the same ones… (21)

The doctor patient relationship, if you live in a post-modern society, with breakdown of subject and object distinctions, the doctor is part of this relationship. It’s not the objective patient out there. And so it’s you. You bring yourself to this. You do yourself a favour by recognising when you’ve got some issues. (4)

Self-care is proportional to self-awareness and self-acceptance. Apart from one recent graduate and Maori participants, none were trained in self-care. In fact they were highly critical of the put downs and lack of support they received both as undergraduates and graduates. They were expected to tough it out and not be affected by the patients they were dealing with. They complained about the suppression of feelings that the medical culture encouraged. 39

The women on the whole found this more difficult than the men, with the added stress of sexism. Because they were criticized so much in training I suspect they tended to be self deprecating and hypercritical. One, when asked if they were tearful because of the deep level of connection with patients, responded as follows.

Although it doesn't touch you as much as much after a time….You mean letting it be overwhelming? I'm good at boxes. You know how we have a quarter of an hour slot. Parcel it up and move on to the next one. And then at the end of the day you leave, you leave that there. And you move on…Sometimes there's sort of a spill over. (1)

1 Choice of practice
Female participants were rather more self reflective than male ones. They recognised the emotional and spiritual attrition that can occur in certain types of institutions or work

39 I certainly had that experience as a second year medical student, led into a dissecting room with rows of corpses with no preparation whatever and even worse, no debriefing afterwards. This experience was repeated later with compulsory attendance at a port mortem.
practices. Choosing to practice in a way that protected the doctor from stress was commoner in female participants than male ones. Some made positive choices, to practice in such a way that they could satisfy the need to be connected with patients and look after them well, but not get overwhelmed. They recognised their empathy and compassion discussed previously (Chapter 4:3:6), as ways of spiritual connection. They were very clear that empathy has limits.

I didn’t want to be part of a big institution. I could see that that was crippling. Well, the whole thing about you had to create your own culture and that control over your environment. … You know the basic things that make you content in your work like being respected, or being able to do the job in the way you see as the best way to do it without being hampered by a whole lot of other agendas….So I think, … if I’m going to put that much energy into other people and my work, then that’s only sustainable for a certain amount of time…..So I consult, probably between 5 and 6 tenths. And that’s way enough. (3)

I don’t know if you’ve ever done the Myers-Briggs stuff- I score zero for sensate, I’m completely intuitive. And it is a burden as well as an advantage because I’m incredibly sensitive to other people’s pain and energy, which is why I’m not a clinical psychologist and I don’t do palliative care, and why I don’t work in psychiatry either, because after a while, being around the pain and scatteredness of the psychiatric hospital, I start taking it on. I have to be careful with that stuff. I’ve less trouble with it as I get older….Sometimes just that pressure of everybody needing something from you becomes too much….. 5/10 is my absolute maximum or I would be at risk of burnout because I just find it stressful….I feel like I have ‘tell me about your deepest darkest secrets and traumas’ tattooed on my forehead at times…But I’ve actually deliberately chosen my current job because it’s a lot less stressful. (10)

The next participant was very clear that there are limits to commitment and ambivalent about the need for continuing relationships and the potential for dependence by patients.

I’m down to 2 practices that I locum at. And I probably work 35-40 weeks of the year…. It makes it easier from my point of view…I think it’s important from the patient’s point of view they have continuity of care. One of the nice things though with being a locum sometimes is that you know ultimately the patient is not your responsibility but is someone else’s. Although being more of a long term locum I am picking up responsibility for the patients which is nice and not nice, depending on – advantages and disadvantages…And I think that the thing I dislike about that dependency is patients look on you as their doctor, a commodity, and if they need you, they want you to be there and available at their beck and call. And that’s hard. I can understand it from their point of view but from the doctor’s point of view that’s hard. (16)

This younger participant found general practice less stressful than hospital medicine in spite of the uncertainty. Not the episode of burnout dismissed as ‘feeling really tired.’
I think the main thing in general practice now is uncertainty….So that’s the main worry…. I felt really tired at one point, so that’s why I had three months off at the end of the second year and then I went back to do the third year and I felt really tired…..I thought you know, working in hospital is not really my cup of tea but I don’t really know what else I can do…..And …one of my friends did the GP training the year before I did and she highly recommended it. She said there’s a lot of flexibility of your working hours. And also it’s more like a job where you go to work at 9 and finish at 5 or 6 in the day…. (12)

Few male participants admitted they adjusted their work because of empathy fatigue or limits. The interesting aspect of the next comment is that for this participant is aware that being compassionate to fewer patients is workable without burnout. Certainly the literature about burnout in medical practitioners suggests a lot of them suffer from it, at least in part because of a culture of endurance (Chapter 2:4:10). They ignore their own needs and as a result are unable to meet the needs of patients. This is because the healing support needed by the patient feels to the doctor like an unreasonable demand or burden. Work practices that fail to support doctors are a major reason for burnout. Only one mentioned altering clinical work to lessen emotional and spiritual stress.

These days I’ll do three to four sessions a week, which is less than I have done previously. The less I do the more sensitive or the more sensitised or perceptive I am about the impact of burnout, or the impact of exhaustion on consulting. You know when I was doing 8 or 9 tenths it always felt like a bit of a given (laughs) (5)

Another participant certainly spoke of a work style being imposed by the practice. Note the tone of endurance – ‘it’s the job, really’.

And one of the down sides of General Practice and this practice is that you do do pretty long hours and at the end of the day you don’t feel like doing anything else really….I think in a way it’s the job really. It’s a sort of tradition in this practice – I do know where it’s come from. I tend to come to work at 8.30 and I don’t get home till about 6.30 and then at the moment in the weekends I spend a bit of time doing paper work. (2)

Male participants proposed a different strategy for avoiding compassion exhaustion. They tended to work part-time in clinical general practice and do another job as well. Some did teaching and research, others worked in a managerial or advisory capacity. They did not acknowledge the emotional and spiritual strain that made this advisable. They were, however,
conscious of the need to be grounded in patient care to maintain their own interest and connection.\textsuperscript{40}

I’m full time in the programme but I do a half day which turns out to be about two hours … at the medical centre just to try and get a little semblance of knowing what the hell is going on out there. I think if I stopped seeing patients I would very quickly lose interest in the other things that I do. It actually provides the stimulus to do the other stuff.\footnote{I was also aware of this when I started doing this thesis and continued to do some clinical work throughout.}

On several things. The Committee I was talking about before … We meet once a month in Wellington … I guess I should, I hope I will still be practicing some clinical medicine, but I want to do more policy work.\footnote{I was also aware of this when I started doing this thesis and continued to do some clinical work throughout.}

I have no wish to give up the clinical practice which I like. It would be really nice between now and that time to go overseas and perhaps work in a third world country or something, but quite in what sphere it would probably be setting up education programme … the administration which I absolutely loathe and detest … actually takes up about 40\% of my time which is running a bit high. It’s very sapping of research. The university system, very sapping … and if I could free up more time, which I was going to and hopefully I will, then I would just weight the balance a bit more towards research.\footnote{I was also aware of this when I started doing this thesis and continued to do some clinical work throughout. (8)}

In the past there seems to have been very little constructive advice about career choices. The interesting differences between men and women in making choices about how they practice suggests that perhaps men in particular need attention to the balance of body, mind and spirit early in their careers. The lack of help in making choices and the lack of self-reflection are striking. Without continuing self-reflection, spiritual growth tends to occur only as a result of crises. These unmet spiritual needs of doctors may disturb good communication with and care of patients and with families. While some of the women made positive choices about careers to enable a sense of integration with self and family needs, many of the men complained about the over-demanding styles of the practices in terms of time and commitment. They tended to ‘tough it out’ and feel thereby deprived of a life style that matched their needs and stage of life.

2 Recognising stress

The central issue in recognising stress was self-awareness. Most participants admitted they had stress symptoms or signs. Sometimes they described these or demonstrated them without being aware they were doing so. For example becoming restless or tapping the table when under emotional pressure. Stress signs could be physical, emotional, psychological or
spiritual. Sometimes it was others who recognised participants were stressed - their family, friends, patients or even animals.  

A feeling of stress is the result of an imbalance in the life of the participant, where demands are greater than the participant can cope with. Given the diagram on spirituality, the imbalance can be personal, in the work life or in relational life. One of the very clear findings was that burnout tends to happen when there are stresses in several areas of life at once.

There were a number of physical symptoms of stress. Some were about muscle tension others about the physical effect of stress on gut or skin. Some participants do become aware of their physical stress symptom and act on this awareness.

Yes. I get a sore back. (laughs). Um. I think, mainly, and that’s not always something I’ve been able to recognise, but probably over the last five to six years, it’s become less of a body thing and more of a – the lights actually turn on in terms of being stressed sufficiently often and enough for it actually to come up to a conscious level. Previously I think I would have …(wondered why) Very slow learner! (5)

I know what my capabilities are there. It’s always work. And I don’t always appreciate that it might be happening but since my surgery here I’ve got some contractions in the side of my neck. That usually starts getting tight when I’m under extreme pressure. (20)

Oh yes. My eczema breaks out on my face. And I get more palpitations. (13)

…getting brassed off and irritated ….having irritable bowel 90% of the time, including weekends (4)

The next participant noted restlessness as a symptom. In fact several participants became restless when the interviews were stressful for them.

Also I find I wiggle and jiggle. …The thing that’s stresses me is getting later and later and later and things getting beyond my control, I find I wiggle and jiggle and that will do it. But I can feel it. I hold it through my shoulders, in my jaw. (16)

Anger was a common way in which stress presented. The deflection of anger onto family perhaps reflects the training of the doctors not to show emotion to their patients. Often it was focussed on the wrong area of life and against those emotionally closest to the participant.

41 Signals from others and animals are common in medicine. I once had a patient who told me she knew when her bipolar disorder was getting out of hand by the behaviour of her cat. When the cat died I was concerned that she would no longer know but she had learnt to recognise the signals herself.
Participants recognised the need to ask for help but often hesitated to do so. They also became less competent and unfocussed.

I get noisy and crash around and cuss and swear and become rather dysfunctional getting stuff done. Actual burnout, lost the plot, I don’t think that’s ever really happened. I know when I’m stressed. I recognise it, I have wonderful supports, I am able to ask for help, though I tend not to but if I really need it I will. And I’m learning to be better at that. (6)

Yes. I get cross with the kids and I know that it’s unreasonable, then I know I’m stressed. And sometimes when there’s a patient that I’m thinking about more than I need to. (17)

I get angry. When I’m stressed, the thing I get most angry about is when I’ve been incompetent in the surgery or out of the surgery. If I’ve messed up and I know it I get really angry with myself. (21)

The next participant was aware about stress signs of tearfulness and anger and suggested that a peer group was useful in identifying and acknowledging stress.

I think I tend to be angry more easily or tearful more easily. Though most of the time I will be calm. If the pressure’s on at work and there’s a lot of things to do I can deal with 2 or 3 things at once. I don’t get angry at the start but if something is starting to go wrong and I’m constantly niggling about things then I think it’s time I took a break. As one of our peer group said, like the time he really wanted to slap somebody’s face and he just didn’t do it. (Both laugh) It’s time to have a break…(19)

Unfocussed anxiety and inability to concentrate was also a stress symptom as was disturbed sleep. Both these suggest a loss of the integration, harmony and balance in life that is an important aspect of spirituality.

I can get quite anxious. I have speed wobbles. Stuff racing round in my head. It’s hard to stop racing round. You can get this sense of urgency. …(3)

Um, when I’m really, really, really stressed that’s when I can no longer think. That’s when I’ll say to the person ‘Look I’m really sorry I’ve asked you this before, but what dose of paracetamol did you say you were giving the child?’ And I know if I have to ask the same question and haven’t listened to the answer, then I know that I am. (16)

I start waking up in the middle of the night. Or start having odd dreams because as a rule I don’t dream. I try and work out, if it’s a dream, I try and work through the dream to find out what’s caused it. (9)

I don’t sleep, so that’s a signal. I have patches of eczema that come up with a bad day. Overnight, you know. I do have quite a few signals. (11)
Needing alcohol or a cigarette was also a clear signal for some participants.

I know when I’m feeling tense and things are stressful, I think I need to watch my alcohol consumption, because I think I drink more, …I’ll have that extra glass of red wine, because I feel I need to. (14)

Oh yes, I feel like having a cigarette or a stiff gin. Then I know I’m stressed. (22)

Sometimes it was others who alerted the participant to their stress, which in this case was actually being dealt with creatively.

My cleaner can tell if I’m stressed depending on how many fruit cakes there are on the bench. … We had a notebook and she’d always make a comment – (you) must have been stressed there’s so much baking on the bench. (laughs) (1)

3 Burnout

In this condition doctors may feel unable to continue to work. They often were exhausted and disconnected, or overwhelmed by work. There was a loss of joy and energy in work and living. This loss of the positive emotions that connected to spirituality is very clear. The other thing that emerged was the denial by the participant it was happening. Seventeen participants admitted to feeling burnt out at some stage in their careers. Some had plans of dealing with burnout, which suggest that it was an issue.

Yeah. I don’t know what burnout is but if it means throwing your hands up in the air and saying I can’t do anything. I could never see myself doing that….But if it got that bad I’d change career. I could do many things. I could do many things but I couldn’t necessarily earn the same amount of money…. (13)

The first quote about burnout was a result of illness of the participant, not work.

No, not from the work point of view. The weekend after I had my operation this time, I reached a point of – a really black hole – and felt I can’t go on, I can’t get out of this. (20)

When feeling burnt out the next participant felt disconnected from patients and self, which was a profoundly spiritual feeling. Note the use of religious language ‘a secular piosity’ to describe this.

Because that’s why I said it was time for me to stop doing general practice. Because my general practice was becoming a secular piosity. There was an element of pretending to patients that didn’t feel right. It’s another important spiritual theme, I think….I thought I was pretending to be what I perceived them to need me to be….But if that feeling starts to come on every day, then you either
need a holiday or another job. …But also the sort of feeling like the patient who is complex and you think – I don’t want to hear this. They’d be the strongest signals for me. It’s time for a break. (18)

The next participants also suffered from compassion fatigue as a form of selective deafness, again a spiritual disconnection. The need to parent, a spiritual connection, provided a valid excuse for re-balancing work and self-care in the first case.

And I’ve certainly been close to just giving up and not coping with it all and getting quite cynical. And there are times when I’ve thought – well don’t tell me your problem, you should have my problems or something. I always know that means I need a holiday, or I need to take stock and cut back or I need to change what I do. But much less of a problem in recent years …I put less into my work because I need to be a parent. (10)

What was happening I didn’t realise but in fact, patients would come in and I just couldn’t be bothered. Just get through it and get you out the door, you know. Not really wanting to intake, not really wanting to actually meet them. (21)

Burnout was frequently brought on by a lack of awareness or self-care by the doctor and number of stresses happening at the same time in work and family. Insensitive supervision with a total lack of connection or discussion may make this much worse, as in the case below.

I think there were two times that I’ve, although I’m not sure I’d say burn out. My partner struggled with (work). …I can’t see how I could do all that other stuff and increase my hours of work, so I do find that stressful at times. Then the other time was during the GP training programme … The GP … trainer thought that I hadn’t done enough hospital medicine and told me I had to go back to the hospital, and that he’d actually arranged a job for me. I turned up for work one day and he told me this. And that knocked me for six. I’d only been there a month. I guess my assumption was I was there to learn as much as I could so I was asking him as much as I could. And it came at the same time that my father had had (major surgery) so there were a number of things going on. (17)

Yes. Yes. (when sister was terminally ill, practice was in conflict, parents refusing to communicate) That’s probably the worst time of my life. . (18)

I got depressed towards the end of my time (in practice). There were a lot of issues between the doctors and nursing staff. …at the same time I was working quite hard in the Church and various things like that. Yes (spouse) got sick and… took weeks to diagnose and months to come right. (21)

Sometimes burnout was attributed to family stresses alone.

And you know, I think I felt close to burnout, not generally to do with work. It’s been when things have been difficult at home, because you were charged
emotionally …And sometimes you feel – maybe if you left home, you know that would be good. And you’re almost on the verge of walking out… (11)

Feeling unsupported and overworked was a potent cause of burnout and was a common experience both for medical students and doctors, particularly in their early years.

I think I did in my medical registrar year. Yeah. I did definitely. That was about feeling inadequate and unsupported and out of my depth. (9)

Yes I did. At the later stage of my hospital working life. Because in hospital you’re on call at least once a week which is at least 15 hours a day so if you on call at the weekends it is like ten days in a row. (12)

The sense of impasse, of being trapped in burnout also came through very clearly (Chapter 2:2:4).

Certainly in a lot of my 30’s …I tried to sell my practice. I thought, I can’t do this any more. It’s too hard. It’s too burdensome. It’s dragging me down. I don’t have enough stuffing left in me to enjoy my life…And I couldn’t sell my practice. And I went through quite a process of black despair, feeling trapped. Because at that stage nobody had got round to the idea that you could just give up and walk away. (10)

A conflict of practice style and personal commitment was also important in the next example. Note the deflection of anger onto self ‘I hated me’.

Oh Yes (sigh)…oh god, I can remember it so vividly… I was the associate there and I guess was a conflict of my beliefs and the practice politics I guess you’d call it. I honestly believe that a person is paying for a 15 minute appointment and during that 15 minutes I’m going to do my best for them…I was seeing up to 40 patients a day and at the end of the day it was like – I don’t care what’s wrong with you I just want you out of my room. And I hated me. I hated the way I was practicing…I think the worst case scenario was that they booked one adult and five children in one half hour appointment – all the same family…And I really do think I did burn out at that point in time. (16)

It is interesting how participants struggled to allow themselves to admit burnout and stress, as if it was shameful. Perhaps this was the idea coming through again that doctors were invulnerable and must tough it out (Chapter 2:4:9).

To be truthful, I probably last year was quite a big year. In fact I’m probably guilty of biting off more that I can chew. …Not burnout in terms of – I think empathy burn out, sure. But in terms of how it affects work. (5)
And I kind of get the speed wobbles and I’m always trying to do too much and my partner says “You’re about to hit the wall” and I go “Wahwahwah! I’m fine I’m fine! Fine, in control” (laughs) (3)

We were talking about burnout. Physically burnt out, yes (I) got very, very tired.. Emotional burn out. I get very tired sometimes….and its very difficult when I’m having to do practice and look after the animals, particularly when we’ve got so many young ones needing feeding and all the rest of it. (6)

Resolving burnout used a number of strategies. Becoming aware of what was happening was the first step. Taking time to reflect was crucial.

I think when I took the time off it helped me to prioritise what I wanted to put energy into and what I didn’t want to. (3)

Choosing a different career path was one way of dealing with it. It is interesting that this participant describes being stuck in a ‘hole’.

By taking a different career path. (laughs) Running away!...so I guess when I get close to it, I look for other options and follow another little path. Rather than staying in the one hole. (9)

Self-medication was a less effective strategy, since it did not address the real issues but merely looked for a ‘cure’. Self-treatment with pharmaceuticals for a spiritual issue was no more effective for doctors than it is for patients.

I got chest pain…I took some Panadol after that. In the afternoon and I thought maybe it’s indigestion, because it felt like that, so had some omeprazole. And in the end I said I’ve got to be reasonable, ring the 24-hour surgery …they transferred me by ambulance to hospital. (14)

I started myself on Prozac… couldn’t get in to see my GP for about 5 days, couldn’t get in to a counsellor for about the same length of time… I felt bad enough starting myself on medication rather than starting and stopping, I let my GP stop me …I’ve felt little bits of that again but never ever has it got that bad. Partly I think because I recognise it a lot earlier. (16)

It is fascinating how the doctor in the next case was diagnosed and ‘treated’ by a colleague’s mother.

One of the other doctors’ mothers decided I was (depressed) and said, “You should be on antidepressants” …And so I thought – I haven’t even thought about that….So I went onto Prozac – I’ll try it and see what it’s like. And about 3 or 4 weeks later I thought – oh I’m really quite enjoying medicine again. (21)
Sometimes it was simply about waiting for the impasse to move on. This was hard for participants when they felt trapped (Chapter 4:3:5).

And I came through that to what I discovered was a place of relaxed maturity with medicine. That I suddenly accepted competence and confidence. (10)

And then, of course nothing is solved by walking out. You know, you just persevere with it and then things come right. (11)

2 Dealing with stress

In order to deal with stress it is necessary to be aware of your own inner state of harmony or discord and act on it. This will involve a re-connecting with self and sources of support and nurture. This spiritual awareness is critical to dealing with stress. Denying disharmony or negative emotions may lead to burnout as well as misdirected anger and frustration at family or friends. Recognising and dealing with stress was acted on in four main ways. These were – self-care, support, exercise and creative activities.

1 Self

1 Family and friends

The most important way of caring for self was spending time with family and friends. This connecting with others had a spiritual as well as psychological aspect. It is both about being accepted as a unique self and being loved and nurtured, as some of the responses suggest. The importance of having family and friends certainly seemed clear as a means of enabling resilience. Being with family and friends sometimes included taking exercise and being out in the natural world.

I think I can just switch off and get back into the family milieu when I get home. (2)

So I have a number of friends that I go for walks or runs or cycles with, and we usually just go one to one and we chat and we philosophise and talk about God and life and I love that, that’s energising…. (4)

I have wonderful friends who I can talk to my closest friends about absolutely anything and I’ve been through some very deep experiences with them in their lives and they with mine. I think that one of the great wonders of life is true friendship. And I didn’t have that particularly as a child or a teenager, it’s been very much an adult experience for me. So, although I had that with my family… I found it hard access that with strangers. (10)
The last example identified very well the sense of being held in relationship and nurtured while the one below is thankful for a home that is a haven.

I was going out every night, you know, meetings and things all day, and up all night. And as I was driving home I thought – it must be terrible for those people who are driving home to stress and anguish and harsh words and I would never cope if it wasn’t that home became a haven where I could just be myself and relax and know that I was loved unconditionally whatever happened. (21)

Finally a Maori participant talked of the importance of spiritual and psychological care by family, or kaitiaki, which is the responsibility of some elders.

My wife, my kids, my brothers and sisters, and my aunties. Someone is supposed to be a kaitiaki, eh. The word we use is kaitiaki. The family provide kaitiaki and contact and are there...and they know and are always thinking about and caring about and that’s the moku (for me) that expresses wairua (spirit). (7)

2 Setting boundaries

Another aspect of self-care was setting boundaries to work and to patients. Because medical work can take over families and lives it is particularly important to have times of complete leisure. In the past this was not always possible. Some participants talked about fathers who were absent, at work, all their childhoods. There certainly was an expectation in the past that doctors were available to their patients whenever they were needed, and their families should support this.42

I didn’t particularly want to be like my father because his life was incredibly busy. ... He’d had his heart attack at 50 and realised that life was too short to work as hard as he did. (10)

Some participants were very good at completing the consultation and moving on, using the notes as a symbol of connection.

I'm good at boxes. You know how we have a quarter of an hour slot. Parcel it up and move on to the next one (1)

Basically you open their folder. They come in and talk to you about whatever it is. They leave and you close their folder and you put it in one of the cabinets and bring out the next one out. You don’t mechanically do that any more but you have to categorise your patients and deal with their issues and close that and start the next one. (20)

42 I recall a woman saying to me, “I hope you get your husband a nice cup of tea when he has been out at night.” She looked rather shocked when I replied cheerfully, “No, he gets me one.”
Sometimes this process was not quite as easy as imagining boxes or closing a folder. When the connection was deep it took a conscious effort to let it go and move on. (This quote also appears in Chapter 5:3:3 but I think it also belongs here.)

But when you can truly sit in the patient’s shoes and get drawn in … everything stops for a moment, and…you’ve got to shake yourself out of when the patient’s gone.(8)

Setting clear boundaries for patients seemed particularly important in small rural communities where patients were also neighbours and friends. In these situations making it very clear to patients and their families that out of the surgery the doctor is a different person.

But taking on board people’s problems and feeling weighed down by that, and vulnerable to it, generally not. Some personalities who may be a bit more compassionate than I am…And I’m reasonably clear with boundaries, thank goodness. (4)

Because he does have a habit of just rolling up “Oh could I just have a quick word?” I’ll change his name. “John have you made an appointment?” And then – “There’s no such thing as just a word.” ‘Could I just ask you about something?’ ‘Yes that’s called a consultation. Would you like to book yourself in.’ I’ve learned that relatively recently…I’ve really focussed on the word ‘just’. (6)

Another way of setting boundaries was to leave work at work and not take it home. Some participants took time out between work and home for exercise.

Well, I think 44 minutes time out, cycling, is quite good! It’s interesting how much better that is than fifteen minutes in a car. I’m not quite sure why. It’s partly time and maybe there’s something about using your body as well which is quite cathartic. (3)

One part of the week’s relaxation. As I said …I bike now, I mountain bike because it’s quicker and we live on the hill anyway. (13)

I don’t take work home. And I try and have my boundaries. That’s the first thing. And I always have a policy that at the end of each day I want to have completed all the paperwork, or at the end of the week I have to … not carry anything over to the next week. (9)

Another strategy was to do forward planning for patients so that they could find additional help if they needed it out of hours.

I think I’ve, well I’d like to think I’ve gotten really good at not taking on, leaving it there at work… I tend to make sure there is a follow up plan or here is a letter to present to the 24 hour surgery if things get worse. (14)
3 Regular holidays

Half the participants mentioned taking regular holidays as a way of self-care. Only one doctor had taken a sabbatical. Others took shorter times away from their practices.

Well actually last year I took off seven months because we had a new partner in the practice and we had another guy who wanted to come and work, and there wasn’t quite enough work. It suddenly flashed a light one day, I could just not be there. So I just stayed home. I didn’t do any study either. I didn’t do any medical things… (3)

Things like, I quite enjoy travelling so I spend quite a lot of time in travelling... (12)

The next participant talks about taking holidays as if they are self indulgent – ‘spoiling myself’.

And like, I have holidays as much as I can. And I found when I was in hospital you get six weeks a year, I have at least one week every quarter and somewhere I have 2 and 2 and just having time to myself. I’m quite good at spoiling myself. (15)

We also travel and enjoy that together. We had six weeks last year travelling when we just explored and had good conversations. We have always been quite good at taking holidays. (19)

Taking holidays also seems to mean re-adjusting when you get back so that having disconnected from work and patients it is then necessary to re-connect.

I can remember coming back from a holiday where you’ve been doing nothing and relaxing and being quiet and so on and the first two or three days you think – how could I cope with this- and then after a week you’re back into it and you aren’t even aware of it. But when you first come back into it you just realise the sort of ongoing pressure that you put yourself under. (21)

4 Taking time for self

A number mentioned taking time out when they finished work in order to let go of the day and to centre themselves. Taking time to reflect is one of the ways of supporting spirituality. Solitude in the natural world seemed to enable reflection at a deeper level. Some participants were very good at recognising their need for solitude and quiet.

Hm. Walking down the beach, those things that allows one to reflect. (7)

For me it’s about being outside. Being away from people. During your working day you’re inside. You’re talking to people, so I’m having to be neat and tidy and polite. So I actually like being outside being rough. By myself. Getting all the fresh air and getting away from everyone. Yes, that’s relaxing…But what do I do
I enjoy having some time to myself – just going for a run and sitting…just looking down, to me puts things back into perspective again. It shows us how insignificant we really are. (9)

If it’s been a particularly heavy day in terms of the problems, I need a quiet time … (14)

So you need silence, I think. I need silence. (21)

5 Music
Music was another way of relaxing but as can been seen participants often had several ways in which they relaxed. The order and beauty of music refocusses the mind and the harmony in it enabled harmony in the person listening. Some participants listened to music others played it or sang.

Oh – I love listening to wonderful music. And that’s an experience at it’s best of entering and enjoying the transcendent and the mystery of life which music does…I just got some Brian Eno this week and some of that music has got lots of that in it. (4)

A lot of it is that- the movies, the opera, the shows. I like travelling …(14)

I really love listening to opera…I belong to (an opera group) and we meet every so often and have talks and things. I went to the Ring cycle in Adelaide.(22)

6 Reading or watching TV, DVDs or films
A number of participants mentioned passive entertainment as a way of relaxing. Reading was used by a number of participants as an unwinding activity. For this participant it was the best way of relaxing.

Really I enjoy, that’s why I do everything quickly, so that I can have time to read. … So my greatest relaxation is reading…So my greatest relaxation is reading. You know going off to bed at 9 o’clock and knowing I’ve got two hours uninterrupted to read is my greatest pleasure… It is omnivorous but now I read very few novels as such…I sort of mainly read travel or biography or something that will change my world. (11)

Other participants watched comedy shows or films or DVDs as a way of switching off from their work. It is clear from the extracts above that there was a need to be able to switch off from the suffering and focus on the other that was part of most work for GPs. Finding something that suited them was important for self-care.
2 Support

Table 13: Support

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Seeking support was another way of avoiding or dealing with stress. The table shows methods used by participants. Some of the supports were professional, like supervision, mentoring, psychotherapy or peer support groups. Others were personal like church support, meditation or yoga. The professional supports also supplied some spiritual support. There is a real sense of connectedness in well functioning peer support and Balint groups. Some participants suggested that supervision should be mandatory, as it would protect doctors (and patients) from compassion fatigue.

1 Supervision/mentoring

Supervision involved a regular meeting with a supervisor. Mentoring was usually an irregular contact with a mentor. Some participants also chose to go to short courses on psychotherapy that they found personally helpful.

(When you have issues) going and having some therapy or supervision or both and get it sorted, and come back. Life’s going to be better for you, better for the patient, fewer complaints, more job satisfaction, win, win, win all round. It’s so obvious why don’t we do it?... (4)

And then I started doing some communication skill courses and learning some psychotherapy, psychodynamic skill through regular supervision. So I’ve had fortnightly supervision more or less for the last fourteen or fifteen years and the more I got into that, the more obvious it became how important it was.... Supervision needs to become a normal part of general practice. (4)

I have a weekly clinical supervision… I’ve been doing that for about eight or nine years. (5)

Supervision focussed the attention of participants onto important issues of good communication and on their own inner harmony or absence of it.
I think my supervision…was wonderful…Because he again and again would come back to the issue, the enormous difficulty of being totally present in the room and completely listening. And how it’s almost impossible to achieve but we try and we try. And the other thing he used to say to me was … all I want to hear about is change… so that they can move on. (6)

I actually had, … I may not have mentioned it, (supervision) for the palliative care … And that was very useful… And just talking it out, often as I see it, makes the whole thing disappear. (19)

Two participants also used mentoring. The most telling comment about this is that when the participant is stressed they are less likely to seek support.

I’ve got a mentor, though the problem with my mentor is I see him when I’m less busy and can fit it in, which is often not when I need to see the mentor. (laughs) I do find it helpful. (16)

And I did actually have a couple of sessions with a mentor. Just to give me some new strategies. (9)

2 Peer groups
Participants talked about how important peer support was for them. This was about the emotional and spiritual connection that may happen in these groups. For some it was being part of peer groups and for others it was the informal support from peers in their practice, or friends they could call. Balint groups were also mentioned. These are psychotherapist led groups of GP’s  that reflect on the doctor-patient relationship.

But in a way I’m probably a bit privileged…I’ve got colleagues to support me. (2)

I certainly have people I speak to but it’s not official supervision. And… in a small practice in a small town, you have to have a colleague you can go to, sit in his room and say I need to talk. But I think it would be really good for those who wanted to make it a formal arrangement that it should be really encouraged. (8)

I find my practice very supportive in terms of discussing patients. And that’s what I love about group practices, where there is communication. They’re not just doing it for me. (15)

For the next two participants their peer group is also an important social support as well as a spiritual and emotional one. It is certainly often true that Balint and peer groups can become close friends. 43 The first participant is in the process of winding down from clinical practice.

43 I was part of a Balint group for about 12 years. The group became so close knit that new members found it impossible to break into it. The thing that struck me, though I did not bring it up at the time, was the depth of spiritual connection between the members.
It’s an interesting thing, from changing my role as a regular GP - will I suddenly be outside the herd. So my peer group remains quite an anchor point and very much friends. (18)

We have friends but no groups apart from my peer group. I did belong to a Balint group when we first came …Our peer group now functions a bit like a Balint group. It used to be very clinically focussed but now it is much more like a Balint group. (19)

3 Psychotherapy
A number of participants had personal psychotherapy when they were under particular stress and found this helpful. The first example talks about the shame of a doctor needing help. Even though it is well recognised that doctors need support in order to practice well, seeking support is still experienced as weakness and failure. Psychotherapy certainly enabled the self-acceptance that is a precursor to spiritual growth.

(Local PHO) …set up a system (that) funds three sessions with a counsellor. But the whole thing was to try and normalise this as being a part of what we need to nourish our roles rather than something you go to because you’re a bad doctor. Yes, not coping…I became aware of it with the break-up of the partnership…And I spent probably a year …going to see (counsellor). I suddenly realised how unburdening the whole thing was. And initially I felt that I was a failure going there. A very, really eye opening experience. The most enduring sense is unburdening, actually…. I hadn’t realised just how much I was carrying the burden of patients without having any means to offload it. (18)

This participant also talked about the threat psychotherapy may present to partners.

And it was fascinating. Initially (partner) was quite angry with me because … (they felt) they must have let me down. And then when (partner) was working as a medical officer … they funded … as part of the contract to go and see (a counsellor). And…(partner) suddenly realised what a wonderful thing this was to do. (18)

For the next participant, who admitted to over-empathising, psychotherapy enabled a letting go of personal responsibility for change in the patient and engaging as an enabler in the patient’s growth process.

Well I’ve felt less obliged to do something … as I’ve done more of my own work and learned more about psychodynamic processes and so on. I’m much more likely to go not – what can I do for you – but –what can we do together – or what can you do to change where you are at. That isn’t my problem. (10)
4 Meditation, yoga, mindfulness

Meditation and mindfulness focus the mind and discourage discursive thought. This process allows an awareness of the deeper layers of self to emerge. I have included these here although they equally well fit with spiritual self-care. As can be seen from the comments below these are sometimes only practiced intermittently, partly because they are quite hard work and they demand a regular allotment of time. Self-care practices often diminish when people are under stress.

I go to yoga actually at 7.15 in the morning. No. No. Only once a week… Well I’m actually going to go and learn some meditation. I’m going to go to the Gawler foundation … My mother shouted me a course in transcendental meditation but I was too busy to do it. (laughs) I’d like to get to slow down a little bit when I’ve got the speed wobbles! (3)

I’ve been doing some meditation for a while as well….which I find very helpful. It depends. It may drop off the radar for a while, and it has, actually, recently, since I’ve been running round like a chicken with his head cut off. I’ve just started to get back into it. Most of the time I’ll do just a yoga practice in the morning about six o’clock. (5)

I used to take myself off to retreats to lovely places where there were lots of people who did meditation or did massage, or walk on lonely beaches. Since I had a child that doesn’t really happen…I definitely at the moment feel a certain lack of – I think I need to get back into meditation or going on long walks. (10)

When meditation is practiced regularly it can be very helpful for both physical and emotional symptoms of stress as the account below shows.

I meditate about five or six days a week. And I’ve done that for about ten years. It was necessitated by getting brassed off … with irritable bowel syndrome. ….And it was really, really helpful …now I hardly have it at all. I’m going through some very stressful times at the moment, with a difficult patient…But mostly this is OK and I’ve really got the meditation to thank for that… (4)

A number of participants studied meditation or mindfulness but found it too demanding, even though they recommended it to patients.

Because meditation does take a lot of, you have to learn properly. And some, in the past I was really vexing with my legs tingling and numb after the meditation and so I do think I need to find a proper way to learn it and then do it, but I haven’t been doing the meditation regularly (12)

And I try and get into – I went to Ian Gawler’s course on mindfulness. I’m trying to practice that regularly because I see it as a really beneficial activity and I try to, I talk to patients about it as well. (22)
(grounding) Bringing yourself back into the present moment. So I’ll think – feet on floor. Of course when I’m stressed, that’s when that can fly out the door as well. And I can use breathing techniques and visualisation, things like that settle me as well. The problem is when I’m stressed which is usually a time pressure is it’s hard to remind yourself to take the time to study those things. (16)

The last comment is probably true of many of the participants – as one remarked ‘Doctor, heal thyself’.

3 Exercise

Table 14: Exercise

<table>
<thead>
<tr>
<th>Activity</th>
<th>Participants</th>
<th>Activity</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking</td>
<td>10</td>
<td>Sailing/kayaking</td>
<td>3</td>
</tr>
<tr>
<td>Tramping</td>
<td>8</td>
<td>Swimming</td>
<td>2</td>
</tr>
<tr>
<td>Running</td>
<td>4</td>
<td>Mountaineering</td>
<td>2</td>
</tr>
<tr>
<td>Biking</td>
<td>4</td>
<td>Fishing</td>
<td>2</td>
</tr>
<tr>
<td>Skiing</td>
<td>4</td>
<td>Gym</td>
<td>2</td>
</tr>
<tr>
<td>Diving/surfing</td>
<td>3</td>
<td></td>
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</tbody>
</table>

Exercise was a very common way of dealing with stress. Exercise was mentioned by all participants but not practiced by all. The table below shows the variety of ways of exercising shown. Some participants were very energetic, others less so.

While physical exercise does have physiological effects in promoting relaxation it also links into the other spiritual aspects of being. Often performing exercise also provided space to be alone and time out in the natural world, connecting there with spirituality. Sometimes it was done in company with family and friends with all the positive effects of spiritual connection with others.

For some participants it was essential, as a self-care and a way of connecting with family.

Well that’s exercise. I’m a very physical person. I like to, I don’t actually have a choice, I’m physically quite restless. My colleagues think I need Ritalin. (both laugh) … Most of the time these days, rather than go and do something for myself, I try and incorporate it for my growing sons. Like once or twice a week I’ll do athletic training with them. …But it’s quite interesting. There’s quite a
divide (daughter) seems to do all of her stuff…her swimming and the other things she does with (wife) and I have the boys. (5)

For the next participant, time to be alone was important in enabling balance and perspective.

Well all my non-work time is basically running, biking, kayaking. Competing in events. …But what do I do – I enjoy having some time to myself … puts things back into perspective again. (9)

Whereas for this one, it was the shared time with a partner and the challenge that is a focus.

We both do a moderate amount of exercise – in winter we ski, in summer we dive. Stuff like that – those are probably the main ones. …Over winter, which is the hardest time of the year because of course it’s the busiest, skiing can be the thing that gets me through the winter. …But I think on top of that, the physical activity, the challenge. (16)

For this participant the exercise was only one part of the spiritual nurture, and is often not done through busyness.

And you think – I’d really like to go for a climb but I’ve got this to do and that to do, and all the rest of it. And for weeks and months it doesn’t happen. And then you get up there and you think ‘What was I thinking about just delaying.’ So relaxation is complete up there….I talked about suffering from a condition called petrophilia. Which is love of rock. I touch a rock and I start to be transported. (6)

For others the physical exercise is very important.

For me it’s physical activity is an important part of that. And I find that if I up my physical activity somehow or other the stress gets back into balance. I swim twice a week and bike. And kayaking and sailing. All important de-stressors. (18)

I go to the Gym. That’s probably all. … Actually I surf. I would love to be a great surfer but I’m not. I thought moving here would be the ultimate opportunity to get lots of surfing but I’ve only been out about 4 times since I’ve been here. (15)

This participant used exercise as a means of connecting with friends as well as exercising and enjoying the natural world.

I’ve got a number of female GP friends that I do trips with in the hills. I try and get away at least once a year on a tramping trip with them. And I try and organize some day trips and try and get two tramping trips in a year. … I also do a bit of mountain biking….And walking. I try and get out for a walk in the morning.(17)

For these participants the link with the natural world was also clear.
I tramp. I go for a walk if I am feeling over worked. (19)

We used to ski quite a lot. …But certainly it’s important to have time out…Well, I couldn’t sit around and meditate for three hours a day, for sure (laughs) probably most often when I’m either walking or tramping or in the garden. Sort of just in nature and enjoying that.(20)

This participant connects with the natural world and the dog.

I’ve got a beautiful … dog and we walk at least once a day. I’ve got a gym membership. And certainly aerobic exercise is a really good way to offload all that stuff that you accumulate during the day and it’s just a matter of sort of self-discipline to get there a bit more often than I do. (22)

4 Creative activities

Table 15: Creative outlets

<table>
<thead>
<tr>
<th>Activity</th>
<th>Participants</th>
<th>Activity</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching</td>
<td>13</td>
<td>Photography</td>
<td>2</td>
</tr>
<tr>
<td>Parenting</td>
<td>8</td>
<td>Craft work</td>
<td>2</td>
</tr>
<tr>
<td>Cooking</td>
<td>4</td>
<td>Community work</td>
<td>2</td>
</tr>
<tr>
<td>Gardening</td>
<td>4</td>
<td>History</td>
<td>1</td>
</tr>
<tr>
<td>Writing</td>
<td>3 (+3)</td>
<td>Painting</td>
<td>1</td>
</tr>
<tr>
<td>Music</td>
<td>2 (+1)</td>
<td>Drama</td>
<td>1</td>
</tr>
<tr>
<td>Woodwork</td>
<td>3 (+2)</td>
<td>Building</td>
<td>1</td>
</tr>
</tbody>
</table>

(+ ) participants who wanted to do all these things but could not make time for them, or felt unable to start.

Creativity activity is closely connected with spirituality. This is what makes great art and great writing so unforgettable. It is also one of the ways that human beings express their deepest selves. The responses from the question enquiring about creative activities outside medicine were extremely variable.

Some participants poured all their efforts into one activity – others spread them across a large number. I have included both teaching and parenting as highly creative activities, enabling others to grow and develop.
1 Teaching

Participants nearly all taught – some medical students others in a different capacity. Some were passionate about teaching and spoke about the way it enriched their lives in a similar way to patient connections. Their students, like their children, connected with them and enabled them to grow spiritually and psychologically. The connections were deep and important and described as a privilege as the first participant shows so well.

… in my present set up we spend hours and hours driving together between clinics. And that’s a place where you start to meet someone and the students, most of them, open up more and more as we go along. And we learn a lot about their personal life their past life and their present relationships, and all the rest of it. That’s a lovely privilege… (6)

And when we had our final dinner…three students who’d been with me came up and gave me a hug and goodbye and all the rest of it….And (the organiser) said to me … when he came to visit, ‘You know I can see what you give to those students by the way they greet you and part from you. And I thought isn’t that interesting. As though they don’t greet and part with other teachers in the same way. Because I thought they probably would. …And maybe it reaffirmed the sense – don’t worry if you’re not teaching them fine clinical medicine, then maybe I’m teaching them to be healers. And they can sort out the rest….Connection again. (6)

The next participant explains very well how the connections were important to the teacher whether for students or patients.

And so that teaching always has been an appealing thing to do. And when …they actually came round and said can we send trainee interns…It was fantastic… Seeing young people getting the hang of it and getting excited was very good….It’s either about helping learners or helping patients. And I have to say that the processes have become astonishingly similar over the years. Those are the things that give life meaning. (8)

Being able to show students the richness and depth of good clinical relationships is clearly both important and satisfying both at a personal and professional level. This was about the intuitive and tacit connections mentioned in the understanding of spirituality in Chapter 2.

I think the main thing they are seeing is the interaction between two people, that physician patient interaction…and just how different that is … and … things people will spontaneously say. Or the openness with which people will share intimate bits of their lives. (13)

There was also something about the philosophical, moral and ethical aspects of medicine that can be taught to students in a clinical attachment in general practice the Art of medicine does
include spiritual care. The next participant was anxious to ensure the dignity of patients, not by prolonging dying but by accepting it as normal.

But there has to be a part where I think we have to understand the limitations of medicine and I don’t think that is dealt with enough. I have 4th year medical students every Tuesday sitting in with me. And I try and do that, and if there is a visit to the Rest Home I’ll take them. You know, some of them are just blown away. When I say look, she’s got a chest infection but I’m not going to treat it, because I discussed this with her when she was well….We talk about quality of life. (14)

My main job, in our health centre… mine’s been education of students. I have had registrars and have had students at all levels. But now I just have the registrars. …And first of all I start by saying when you practice medicine you have to really … practice for the good of your patient, with your own beliefs, spiritual and educational….So we do talk about philosophy in a way … I don’t think you can teach but you can show. (11)

Some participants specifically focus on meaning, purpose and the transitions of life – especially dying. All these are dealing with aspects of spirituality.

Well we’re all going to die….And I try to get this across to the medical students as well. Because this is a medical construct, as death is the endpoint and death is the arbiter of success or failure, that medicine has declared war on death. And ultimately all we can do is lose. But we don’t lose graciously and we don’t allow any dignity in the process of our losing. (10)

For Maori practitioners spirituality is central to their understanding of health care and is enabled by good mentoring from the Maori Medical Practitioner’s Association. This cultural aspect of spirituality was dealt with previously (Chapter 2:2:2 and 4:2:1).

First there are very important spiritual and personal cares that need to be taken care of before they can help others….That’s the function of the Maori Medical Practitioner’s Association to provide that cultural training and that personal support training,. And that’s what I’m involved in. What we call tikana looking after the professional, personal, pastoral needs of Maori medical students. And Maori doctors. So that provides longevity to deal with other issues, personal emotional, cultural and spiritual matters arise from time to time. (9)

2 Parenting

Eight participants talked about parenting as a spiritual activity. Some referred to being with children as challenging and renewing. It was clear that the process of growth and development of children triggered growth and development in parents. There was a notable presence of positive emotions in these accounts.
And our middle son…he’s had a very traumatic life and we would just love for him to find something. But he’s not there quite yet …It certainly makes you realise how precious life is, and how precious children are, especially to parents, so it gives you an insight into, I guess, how precious life is. (20)

Raising a family really does give you focus and purpose….Just little things such as seeing the children achieve in different things. It gives you a great thrill. (2)

I get a lot of my spiritual nourishment from being round a child. And the love and the wonder and seeing the world through his eyes. It’s a very special experience. (10)

The next participant made a clear connecting link between his learning as a parent and caring as a doctor.

Children. …seven…ten…and fourteen….That’s … the bedrock of my existence…. I think all of that…. raising children for instance, I’m sure I’m a better or a different father from when they were first born. I’ve learnt a lot. I would say that has had quite a dramatic impact on my expectations and what I feel is appropriate to offer in a consultation. That would be one significant thing. (5)

Children may, however, be a challenge and a stress. This was normal when they are adolescent. It was particularly difficult when parents struggle to agree on how they should be handled. The other challenge they presented to participants was having enough time available for self.

I have reached close to burnout when the boys were in their teens because things were extremely difficult with them and things were difficult for us because we didn’t agree on what should be done. (11)

Two were absolutely exhausting. …And … it always felt to me that the negatives far outweighed the positives. …Only now does it feel like the positives – there’s a lot more of those around than the negatives. (4)

Sometimes there was a conflict of interest between work and family needs.

The only time would be when my older daughter became very ill …and I had to work because I had this huge debt … and that was a very difficult time … But that things were hard then. (22)

Children certainly presented a challenge to the spiritual understanding of their parents.

I was having a discussion last night about what happens after death. And to me I just had this – you get cremated or buried or whatever and that’s it that’s the end of it. And here’s my nine year old saying to me – But Mum, you can’t tell me there isn’t a fire God out there - and I said – Look where would the fire god be- In
the sun. And then he referred to the fire god as he. So I said – Is it a he - and he said well, it doesn’t have to be a he or a she And I was sitting there thinking – you’re challenging me here. (17)

It’s interesting how having children challenges you because they ask you who God is? You know. You have to sort of think about it. (3)

This parent was quite ambivalent about the uncertainty of practice and felt this had affected the son.

But …well he did a year and a bit as a house surgeon. He actually decided, no he knew when he was a student, that he’d made a mistake, that it wasn’t the right career for him. You know it’s interesting, it’s the sins of the (parent)…He loved the science but as the science became more and more dealing with people he became less and less comfortable. He felt that it was wrong practicing on people. That was one of the things he was able to articulate. His level of confidence, he just didn’t feel it was right. But he too was greatly troubled by the uncertainty that you have to live with with people. (18)

3 Cooking
Cooking is a way of focussing on the needs of the other. It is a spiritual as well as a practical activity. It has a communal outreach as well as expressing individual creativity. It feeds and it connects people – in these cases family, friends and neighbours. This is a kind of community building that underpins spirituality.

Yes. It’s definitely a cooking mess…..Ah. I think it’s just the creating really - and I think that you can make something in a defined time… And I think it’s something the children can get involved in if they want to. They don’t get in my way too much (1)

I love cooking….Sometimes I make bread to relax…Not with a breadmaker, the proper way….It’s a weekend thing. The children, everybody loves fresh bread. (13)

I cook – I enjoy experimenting and coming up with new things. One of my son’s used to come and encourage me – tasting things and suggesting this or that or a bit more salt. One of our sons has a Turkish partner and I am learning Turkish cooking with her. She remembers her grandmother cooking but she never really learned when she was at home…. (partners) we have always cooked together … Yes I do enjoy feeding people.(19)
4 Gardening

Gardening was a way of being alone as well as being productive, feeding people and of having a sense of connection to the earth which is part of the understanding of spirituality (Chapter 2:5).

And sometimes it can be as simple as finding that something you put in the ground is actually growing. …Gardening is I think, one of the most important occupations for everybody to do all those us that like it. I’ve never been very good at it. I can’t get flowers to grow very well, but I’ve grown a lot of big trees. (8)

Gardening is. Escapism. I like growing things. We’ve got a big vege patch out there and we’ve got lots of fruit trees and I find it really satisfying to come in with a bucket of vegetables or fruit from the garden and to feed the family with it and so equally I find it really satisfying to weed my vege patch and to plant my vege patch because I know that what I’m going to reap at the end of the season – or not depending on how it goes. …And also I just find for me without the garden,… I would really miss the changing of the seasons. (17)

I garden. I have always had a vege garden full of things that are good for us. (19)

For the next two participants gardening was about creating an ordered space from paddock.

I enjoy gardening a lot. This was just a paddock when we built this house and developed the garden, which is about two acres. So we very much enjoy that. (20)

I enjoy gardening, but of course it’s a whole new ballgame here and we haven’t really started….I’ve got the view and I often actually go outside and do something away from people, get out in the garden for a while. (21)

5 Writing

A number of participants talked about writing as a creative activity. Some happily fiddled with words as a creative activity for the joy of others as well as themselves.

I like writing actually. I like words. …That’s why I like the Masters, because it’s writing….I was brought up with poetry, poetry and drama….I probably fiddle with words in my head quite a lot. We went to this 50th wedding anniversary yesterday…And so when we were driving over in the car I created this little, I wouldn’t call it a poem, it was just this constellation of words for this couple ….Well you see, some ideas, like fiddling with words, that feels quite restful, to fiddle around with words. (3)

And so I think I sort of enjoy anything I do really. And I quite like writing a bit. I mean I’ve not published anything but I am going to a course at university which is gifting your story, so I shall certainly leave a little booklet for the children to know what my life was like. (11)
The next three participants do not allow time for creativity. It seems to be swamped by work and busyness.

I’d love to write a few short stories and poetry but I don’t seem to find time really….I do joke with my friend – we talk about going and writing poetry but we haven’t quite got there yet. (2)

I love the idea of writing things and I’ve always enjoyed in the administrative role trying to get something down clearly on paper but I’m far too constipated to be able to write something that is enjoyably readable. (18)

I write in a journal, though that is intermittent as well. Good intentions but… (16)

6 Music
Making music was another creative outlet linked closely with spirituality. For the next participant it is a very important aspect of life.

Music is a big part of it, I feel in my singing lessons at the moment they really feed my soul, which is great. I don’t know, it’s something I’m aware of at the moment…. Yes. I’m starting to feel confident to sing in public and sing on my own as if at 48 I’m finding my voice. It’s a wonderful journey. (10)

Others hesitated to allow themselves the time, or the confidence to actually do it.

I have lots of plans to do creative things but I don’t do them. I play my guitar but my children tell me that’s not creative….And singing lessons. I do (sing) sometimes – not very well. I know a singing teacher and I asked her once and she said come and see me. She laughed – she thought I was joking. Well, playing the guitar it would be nice to be able to sing along better with it. Sorry, I’m holding you up. …(I was just thinking you have a lot of inclination to be creative but don’t indulge it) … I think in a way it’s the job really… it’s sort of finding the time and the energy really. It’s easier to just relax and socialise that to be creative really. (2)

Listening to music. I don’t play – well I play the guitar a little. But not well. (21)

7 Woodwork
Five participants talked about woodwork. Two had not found time for it at present due to the busyness of their lives.

It’s probably not a bad idea – I was thinking I’ve got a lot of recycled rimu and all the tools in my garage, I keep saying I’m going to start making furniture but I haven’t done that. It’s been there about five years (2)
I’ve always been interested in making things, so for a lot of my life building and joinery and woodwork have been interests. In fact I haven’t been active in them over the last few years because my time’s been too occupied a combination of GP and administrative work. (18)

The next three certainly did make time for creative woodworking. The first one dismisses it as ‘occupational therapy’.

Woodwork. Make furniture. Mm Sporadically. I do it with a class mate …. We’ve both got workshops and make things like dressers and beds and huge articles like desks. Large projects, each article taking several months and it’s Sunday evening occupational therapy really. Mm Gives you endless opportunities to buy tools. (13)

The next two see it as creative and satisfying.

I’m a very physical person I like, like I built this house. I like building things and making things. (20)

I enjoy woodworking and construction and things like that and I’ve got quite a good workshop now that we’ve got the garage there… And I’m doing quite a lot of big stuff at the moment – stuff in the house and stuff outside. But I’m hoping to actually do some more creative woodwork …incorporating, designs or stones into wood and cutting stone… even jewellery relating to wood. …. (21)

8 Photography
One of the interesting aspects of this creative activity was the expressed need to share it with others. The need to share a gift with others and have it accepted is a deep human need.

I do a lot of photography. …. But I’m not sure how relaxing it is. (laughs) It’s recreational. But I find I’m often quite tense with a camera. … Suddenly a picture, an image starts to grow and a possibility, and I’m, funny word to use, totally focussed… It’s really quite tense and as I look at an image I’ve got and delight in it, that’s lovely. I think I’m quite anxious about needing that image to go beyond being in my possession. It doesn’t really live until it exists out there and other people are enjoying it and appreciating it…. Yes there is a gifting. Wow, that’s interesting because it brings us in to gifts. One of the highest things we know as humans is the acceptance of a gift we give. (6)

I enjoy photography…I like photography and I’ve learnt digital with manipulation and all that. (11)

There were a number of other creative activities including dancing, drama, painting, craft work- scrapbooking, patchwork, jewellery making and Maori flax weaving. The number of creative activities for any one person varied from none to many. For some participants, work seemed to devour all their creative energy and they never quite got round to doing other
creative things they wanted to. Others spread themselves across a number of creative activities.

Well you know I was brought up in a place where you had to do all your own things. You know, sewing cooking, growing. And I enjoy painting, I enjoy photography, I enjoy craft work….I’ve learnt a lot about Renaissance music,…I like to explore different sounds and songs…so I think I sort of enjoy anything I do really. And I quite like writing a bit….I used to go to a painting class which I don’t any more. Because as I’ve grown older, work certainly takes it out of you. (11)

There have been over the years. I’ve done a lot of sewing during my time and after our wedding I made scrapbooks for all the kids of the wedding. Things like that but not so much at the moment. Yes Possibly. I mean I wasn’t quite so busy work-wise when I did that. (16)

And I like drama. So I’m in this drama group and last year we did a production…I like challenges you see…(3)

I like weaving, but I’d actually like to learn more. I can just do basic things. But I’ve always been a bit of a fiddly hands person. (15)

Sometimes participants dismissed their activity as not creative.

And other things are, not creative you know. Things like doing a bit of dancing, but it’s mainly because they need someone to perform in the functions as well. But I quite enjoy being a dancer. (12)

5 Rituals

1 Secular rituals

If rituals are defined as repeated behaviour patterns, secular rituals take many forms. I have already discussed taking space and time to be, as well as exercise. Some are about boundaries between work and home. Some are about shedding stress.

Even cups of tea may become soothing rituals.

So try to, also I try to drink herbal tea like chamomile, that kind of thing, is actually quite soothing for me as well. (12)

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Ritual: a series of actions or type of behaviour regularly and invariably followed by somebody.
I have a cup of tea. That’s a very healthy ritual…. It’s a routine and it just calms your mind down and gets you to see things in perspective….– turn the pot one way and turn it the other way. (17)

This participant also had a ritual for switching off from medicine and on to parenting.

Pre-children I used to go for a run after work.. or do some form of exercise. It’s harder now because … we usually get home at the same time …. Sometimes taking off the GP hat and putting on Mum’s hat can be tricky. But the kids are very good and usually when they come in we try and have a routine that’s calm …. So we put our bags away, put our lunch boxes away, have some afternoon tea and just talk about how their day’s been. Occasionally they ask me how my day was. I think it’s just having that time out before the demands. (17)

Another used both the ritual of a bath and reading as soothing after work.

A lot of escapism, which I guess is the reading in particular. You know, you escape from the real world, especially in a nice hot bath, that works wonders. (16)

Some developed rituals of relaxation that told them and others they were no longer in doctor mode. Two mentioned changing their clothes.

Work clothes come off and if it’s late enough …. then straight into the shower and into the sloppy clothes that don’t matter if you get tomato sauce on them. Straight away…It gives a message to everybody that now I’m not being doctor I’m being the other part of me. (1)

The first thing I would do is get out of all my clothes and put on other clothes. Somehow taking off your, taking off your work. And you’re putting on your comfy at home clothes you are physically doing something which you are psychologically doing. And then you can relax. (21)

Another used several psychological and physical rituals for letting go of patients and stress.

I can put into place the grounding…Bringing yourself back into the present moment. So I’ll think – feet on floor. And I’ll think of my feet literally walking on the floor as I go to get the next patient. 16)

Interesting comments about medical rituals were also made.

Clinical years I spent probably most of my time trying to avoid patients. Yes. That was exactly it. But I felt, it felt like being in a church and I didn't know the rules and when you need to stand and when you need to kneel - all that sort of stuff…. And I mean, there were difficulties with patients getting that whole role thing right. It was very hard not to be the granddaughter. Interestingly as soon as I was a TI and had a role I was fine from then on. But I needed a role and I didn't have one. (1)
There’s a lot of ritual in medicine. …It’s steeped in ritual isn’t it. If we didn’t have ritual how would someone I’ve never met before leap up on the bed open their legs and say – oh, look, what is that?. If it wasn’t for that ritual, even before we get the nurse in the door, they’re up there showing me. That sort of thing, maybe ritual is not the right word for that. And that whole ritual around the way that we work the system…. (13)

2 Religious rituals

Some participants found religious rituals useful in self-care.

I had a Nepalese girl working for me. And she was Buddhist and I was asking her about when she goes to the temple and stuff, and the prayer wheels … and incense. What was it all about. And she said ‘It’s like a meditation. The spinning the prayer wheels and lighting the incense. It’s a ritual….And so sometimes when I get a bit stressed just round the corner here we’ve got as Buddhist statue and a wee place for lighting incense. I’m not Buddhist but sometimes I go and light the incense and sometimes the kids say - Mum can we light the incense. And just the smell of it reminds me of being calm. (17)

We’ve had home groups of one sort or another. …we’ve had another one that has been going – it’s our tenth year this year (4)

But I try to actually literally take some time out during the day where I’ll actually read the Bible a little bit and think about that. (20)

I sometimes go to a thing called, since we’re going to get on to spirituality, a thing called sacred space. A sort of quite interesting meditation thing that goes in the local church … (3)

Some talked about the use of rituals in the care of others.

I said ‘I’m here now.’ Mum and I had talked about her funeral before. I said ‘Don’t be afraid I am here. Whatever we talked about is going to happen…Everything’s in place. It’s going to happen.‘…she died later that day. And I believe she was waiting. (14)

3 Prayer

In Chapter 3 there was a table of religious attachment, observance and prayer which I show again here.

The majority of participants had some past experience of religious attachment. What was very interesting was that seventeen participants said they prayed. Two of these had no religious background – two also said they did not pray but that they hoped for patients – I have
included these under agnostic prayer. Ten of those who prayed had no current religious affiliation.

Table 16: Religious attachment, religious attendance & prayer

<table>
<thead>
<tr>
<th>Past attachment</th>
<th>Current attachment</th>
<th>Religious attendance</th>
<th>Do you pray?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>R=regular</td>
<td>O=occasional</td>
</tr>
<tr>
<td>Yes</td>
<td>18#</td>
<td>Yes</td>
<td>7</td>
</tr>
<tr>
<td>Anglican</td>
<td>7</td>
<td>Anglican</td>
<td>3</td>
</tr>
<tr>
<td>Catholic</td>
<td>4</td>
<td>Catholic</td>
<td>1</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baptist</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Islam</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PIC*</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methodist</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buddhist</td>
<td>1</td>
<td>Buddhist</td>
<td>1</td>
</tr>
<tr>
<td>Evangelical</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Age</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>Indigenous</td>
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<td>CCC **</td>
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<tr>
<td>House church</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>No</td>
<td>15</td>
</tr>
</tbody>
</table>

\*Pacific Island Church
**Christian Community Church
##Attend various churches occasionally to support patients.
***15 prayed for both self and other; 1 for other, 1 used a prayer wheel. 10 of these had no current religious affiliation.
3 doctors prayed for patients in their surgery
3 said patients prayed for them

The form of prayer reflected the participants’ spirituality. Some prayed to God and others to a higher power.

1 Praying with patients
It was unusual for participants to pray out loud with patients. Some prayed in response to a request from the patients. Others felt moved to offer prayer. Four participants said they had
prayed with patients at their request. Two of these did not belong to a religious community or church.

I have on one or two occasions. It felt uncomfortable…. (prayer in consultations)
Well I have. It might have been five or six occasions. Perhaps something like that. It wouldn’t have been any more that that…. (4)

I’m often asked, yes, particularly around times of stress or death or dying. …. So they look at me and say you’d better go in. …Yes, So, that’s just another function, another role, part of the spiritual healing process. (7)

Not very often…But occasionally. Sometimes they ask and sometimes I have a strong desire that I ought to. That is not common but there’s been one or two that I have……it would be very rare that I would pray for a patient with unless they ask me to. And probably not more than half a dozen times would I have offered to do that. And whenever I have they have accepted. And that is I’ve probably always known that they were Christians. Sometime it’s quite surprising – or it surprises me that people actually do ask. So I always pray for them. (20)

This participant, who did belong to a church, once offered to pray for a patient and got a very negative response and was very clear that prayer should not be offered unless asked for.

I can remember one particular patient who’s husband collapsed and we …sent him to hospital….I said “Would you like me to pray with you” ….It was quite interesting, and she often looked back and reported on the significance to her of that prayer but I think you’ve got to be very careful about using prayer like that, you can create issues sometimes if you make an expectation that people are going to want that and they don’t. It happened once with me and …that made me step back quite a bit so that I was more careful after that…. If they ask…Yes. I would pray for them and I would sometimes hold their hand while I was praying for them. (21)

Requests for prayer did happen but were not common unless the doctor was known to be religious. This participant was agnostic but agreed to ‘make a connection’ on behalf of patients because of her connection with them. She clearly feels ambivalent about it, being lodged in ‘the prosaic reality’.

I’ve never, no one’s ever asked me to pray with them, but a few people have asked me to pray for them, when they were going into major surgery or a trauma or something. And I think I said I didn’t have strong religious beliefs but that I did believe in a higher spirit and that I would make a connection with that, on their behalf, because I wanted to be with them in what they were doing… I think this was offering a bit more than that… I mean it’s a sense of the world that I feel quite disconnected from. I feel very lodged in a prosaic day-to-day reality.(10)
2 Praying for patients or self

A surprising number of participants prayed, seventeen out of twenty-two. Some prayed both for themselves and for patients others for one or the other. Some of these prayers were to God, others to higher power. It was sometimes difficult to know exactly where the prayers were directed but the compassionate care, the mindfulness, maybe even the tacit connection of those who prayed is clear. When the participants prayed for themselves, they were often stuck with a patient not knowing where to go or what would help.

I pray for – if I do pray for them it’s mostly not in a consultation and it’s my own prayer for them, and they would not know I was praying for them. (4)

And I do pray for them in a way. It would be not going to church because I don’t go to a formal church, but by thinking of them. (11)

But I do sometimes pray for patients. No. I don’t tell them. Afterwards if I’m totally stuck with someone I sometimes do that. There’s a really nice prayer that one of our doctors from England gave us when she came over to a big conference. It was really a prayer for a parent to say to a child that was troubled. And it’s ‘Lord put your hand upon – I’ll say her – her shoulder, speak to her ear and whisper to her heart so that she will know what she should do.’ So that might be a prayer, the sort of thing that I might use if I’m stuck and don’t know where to go. (22)

Participants also prayed for help in wisdom and understanding both for patients and situations affecting them.

(do you pray for yourself) Help! Yes, sometimes when I remember I’ll pray before I start the surgery just to give me wisdom and insight and understanding and empathy and sympathy and all the rest… and I still do that. (21)

If I’m having difficulty with something, I used to a lot, but I don’t so often now, I still do it and have no problems, just go somewhere quiet and probably pray. That’s the easiest thing I say. I’d almost be talking out loud to God. Even though that God figure is not as clear in my mind or shaky, I will still tune in with a someone. (14)

Sometimes they felt moved to pray and were puzzled at their own action. Certainly the first two below were ambivalent about religion, even while they clearly felt aware of the transcendent in their lives and work.

I’ve been in situations where I’ve felt really – oh I’ve just got to be able to get through this and do this. And I’ve prayed, you know and I’ve come through the end, and I’ve just felt this, I don’t know how you would describe it, like a leading or a guidance, not so much a presence, but I have certainly felt myself that it was because of that prayer that really helped me get through that situation. And
sometimes it’s really, that’s interesting because I didn’t think, well if that was really a help why am I not more… of a practicing Christian if you like. You know, practicing in terms of the spiritual things that I just used. But I’m getting more and more comfortable with that, that it’s there, something that I can call on. (14)

…but if someone specifically asked me to pray for them I probably would. And that’s not to say I don’t offer up the odd prayer because I actually do when I think about it. (laughs) Not perhaps as formalised as, yeah, but certainly not on a regular basis. (is it about you, the patient, or both) Probably both. (16)

The next three participants all express a sense of being nudged to pray at certain times, as did the one above.

And sometimes when I’m with a patient, particularly if they said something that just triggered at that level and I’ll just think – I need to get this right – Lord, help me. I think I make the assumption that if it’s gone right then I probably was helped. But, no writing on the walls. (21)

There’s been just a very small number of cases where I’ve had patients that I’ve felt very, very strongly that I should pray for, for something specific, basically for a healing, and on those very few occasions those prayers seem to have been answered. So it’s a very unusual occurrence. But it’s almost like I’m being triggered, I’m being nudged to do so. (20)

With this dreadful thing I’m going through at the moment, which is really, really awful, the spiritual part of it is really helpful. It’s also not easy. And I’m not praying that God will draw it to a close…You know. This is difficult but you’re going to learn from it, be expanded by it, strengthened by it…And it’s part of my walk with God and He’s working something out here. It’s sure, certainly not comfortable. (4)

3 Agnostic Prayer for patients and self

Some participants prayed even though they were not sure to whom. The sense of connection in prayer comes through both to the transcendent however it is perceived and to the other person.

I probably do. Yeah. Mm Not that I’m down on my knees. But in thought calling to whatever it is that’s bigger. (laughs) (1)

Not on an individual basis. It’s very much part of Maori karakia that we always, I think it’s probably a Christian thing as well, pray for people in hospitals, but I can’t say it’s something that I do. I think my prayers are more around the earth and the sky. (15)

I don’t know if you’ve heard of Peter Fenwick? He was a neurologist in London who did research on prayers and thinking about people and so on. …And so he did research like that and I really do believe that thinking of patients and wishing
them well, hoping that they will be alright, the same as you do with your friends. You know good thoughts do reach people in whatever way. (11)

Two spoke about ‘hoping for’ patients as an active process between them and the patient and seemed uncertain whether this was prayer or not.

Well you see prayer is such a loaded word, isn’t it. You see I, there’s this difficulty with prayer, is that it, always seems to be about asking for things. What was that about? So, do I pray for people? Well I hope for them. Is that the same thing? And I (long pause) hope that whatever mystery is enfolding them will translate into some sort of good outcome. (3)

I’ve never said any sort of secular equivalent of perhaps we should just pray. Or maybe I do, I just have to recognise it. May be I’ll say all we can do is hope. Or speculate that hope and kindness or whatever it is will eventually see us through this battle. I suppose that’s moving up, edging up. I’ve never, I don’t think I’ve ever prayed…In terms of asking, of entreating a higher power to keep an eye on things and make them all right. I don’t know whether that’s prayer but that is one form of prayer isn’t it. (6)

In a sense these two participants both offer hope or positive thoughts as did the participant above who talked of making a connection on behalf of patients.

4 Encouraging patients and families to pray

The next two participants always encouraged patients and others to pray because they believed in the power of prayer.

Mmm. Yeah, well I mean if we had any doubts about that the research has shown that it does help and I encourage patients to use a form of intercession, whatever that means to them, to this higher power. Or sometimes it can be other people interceding for the sick person. I definitely encourage that in families, extended families, communities, church groups. I mean the more the better. God gets so much stuff coming in all the time so many request, so the more focussing on this one person, the more he has to listen. She has to listen, sorry! (8)

I think when it’s appropriate. People talk about the power of prayer and I don’t pooh pooh that. I really actively encourage it because I believe it can really be helpful for people. I’ve probably mixed it up with faith as well and that’s reflecting my upbringing. Our faith and our belief… Its always with that and all those little bits I feel very comfortable with. It’s almost like it helps me hear that. (14)

5 Prayer for doctor

Patients, friends and family sometimes prayed for participants. Occasionally the doctor asked for prayer.
(On being asked by a patient to pray for them) Yeah. I say – you pray for us. (laughs) (7)

No, but a few have offered to pray for me. (laughs) (I say) Thank you very much. (13)

A lot of people have said they pray for me and that’s been a, sometimes a gratitude thing. Or when I had my baby a few of my patients said they were going to pray for me, which was lovely. (10)

I understand and know the spiritual dimension. Dad …He’s always, he’ll say that he prays for me, like he’ll end the conversation with “I’ll pray for you this week in your work” (14)

6 No prayer
Two participants were clear they had never prayed for patients or themselves.

There are more examples of prayer in Chapters 5:10:4 and 5:10:5 on prayer in the section on prayers answered and healing.

6 Conclusion

This chapter has looked at the ways in which participants were able to sustain their spirituality. It started by looking at self-awareness and response to stress, particularly by self-care.

The ways in which participants care for themselves are also the ways in which they find harmony between body, mind, spirit and environment. The supports that they seek for their spirituality are about connection with family, friends, peers and mentors or supervisors. In other words they are enabling connection at many levels and creating a community of care – what a Maori participant called kaitiaki.

It then went on to consider the ways participants realise their creativity and how this contributes to their sense of self and expressed their deepest self or spirituality. This is both in connection to other people and in the way that human creativity connects by offering something new and unique to others who then accept it. This connection happens whether the creativity is poured into words, photographs or making bread or food to share. Once more it seemed, spirituality created community.
The final section has looked at rituals, both religious and secular. These enable integration of life experiences and also made boundaries for work and relaxation. It then went on to consider the variety of ways prayer entered into the lives of participants and their patients. It showed how varied the ways of praying were and how widespread, even when there was a sense of not knowing to whom the prayers were addressed. Once again there was a sense of focussed connection with others – wishing well and hoping for them.

What emerges from this is that spiritual sustenance cannot be separated from physical, psychological and emotional sustenance as it is about embodied spirituality. Sustaining body and mind also sustains spirit. Each aspect of the human person is connected to the others. From the concept of spirituality as connection to self, others, natural world and the transcendent emerged the various aspects of spiritual sustenance discussed above.

The next chapter will consider education about spirituality and possible developments of this in the future.
Chapter 7

Education about spirituality

1 Introduction

Participants were asked about any education on spirituality that they had received during their medical careers. Nineteen had received no education about spirituality as undergraduates. It was never mentioned. Five talked about Maori spirituality being mentioned and three about the bio-psycho-social model of health. Otherwise any education about spirituality had been as a result of the participant seeking it or seeing it modelled by clinical teachers, or identified by patients.

Postgraduate education about spirituality was mainly through patients telling them about spiritual issues. These were usually about meaning and purpose, or about dying. Some had done palliative care training and had received specific training about spirituality. Others had been house surgeons on oncology wards and there the topic had also been raised. A few had specifically sought education sessions at conferences on spirituality or whole person care. Some thought that doing psychotherapy training or having supervision also helped raise their awareness of the importance of spirituality.

2 Undergraduate education in spirituality

Very few participants had any education about spirituality as undergraduates. Five mentioned the bio-psycho-social teaching that looked at the whole person but not at spirituality as a specific aspect. Spirituality is beyond the bio-psychosocial model. It is not about possessing knowledge, like a scientific fact but learning to see connections of which you are previously unaware.
The first participant below thought that the biomedical model meant that the doctor had to be detached from the patient. On the other hand, spirituality and connection was demonstrated by some clinical teachers.

I don’t think it was ever mentioned. I mean, I saw it happening in a role modelling way. I saw people …kneeling down by the patient’s bedside and holding the patient’s hand in his two – big beefy hands he had as a physician. And I saw that and there was a sort of intercession in his approach to the patient. I saw that. But no, there was no formal teaching. It would have been considered very strange for anyone to think about that. In our day we were meant to be objective. You don’t even get involved with the patient, Anna. (8)

The next four participants had teaching in behavioural science. However, they recognised it was the patients were the main teachers about suffering, resilience and compassion. For the first participant modelling of compassionate care by some teachers was also important.

In behavioural science we had a few texts to read, like Eric Cassell and a few others that touched on that. Often it was the patients themselves who taught us a lot. Their suffering but also their resilience and compassion for others and tolerance and all sorts of, I mean you do see humanity displayed at its best and worst in medicine. And certainly some of the people I saw were inspiring in their grace. But medically, I saw some physicians and a few surgeons, who really had a way of reaching out to people and understanding people. I remember working in a psychiatric hospital with … a psychiatric registrar at that time. And he came over and examined this completely inarticulate patient… and his stillness and compassion for this person and the art with which he examined him, it was like watching a piece of literal art to see him examine this person and try and find out what was wrong with them. I was only a TI at the time but I remember some of my mentors being extraordinary examples of wisdom and compassion. They seemed to have a deep connection and understanding of people which I wouldn’t have identified then as spiritual but I can look back and say some of those had real compassion. (10)

I think people talked about the bio-psychosocial model and added spirituality sort of tagged on the side. But … there was never any discussion about what spirituality was. (17)

I was very excited when they actually introduced social into the model bio-psycho-social model…. (22)

Some looked at the whole person as a result of personal interest in psychotherapy or the focus of their medical school. It was interesting that it was psychotherapy that showed them the need for spirituality just as it seemed to be psychotherapists who led to spirituality being re-introduced into bio-medicine.
I was interested in psychotherapy from a very early stage…thanks to my dear friend …a child psychiatrist….And my sister …who gave me two books of enormous importance and you know them both. Michael Balint, the Doctor, Patient and Illness, and A Fortunate Man….As a medical student, well, (mine) was one of the first universities to have a behavioural science course. And our course was only a very few years old it might have been as little as two years…So there was a lot of training there. But we’re talking psychiatry and behavioural science so I did mention to you yesterday my first essay in behavioural science was ‘The doctor is replacing the priest in modern society. Discuss.’ (6)

Most however said they had no formal teaching about spirituality, it was not mentioned. A conspiracy of silence seemed to have prevailed. One participant was aware of the gap and felt it emerged in the ‘fabric of life’ – a nice phrase to suggest interconnection.

I think you just pick up things as you go along. There certainly was no formal teaching. (2)

It wasn’t a subject within my training at all. As an undergraduate no, not at all. I can remember being a little bit horrified by how off the curriculum that was actually, at that stage. (18)

Nothing…I think the most important education as I said comes from the fabric of life, doesn’t it. (5)

One participant thought spirituality or religion was mentioned in care of the dying but clearly the focus was on religion rather than spirituality.

No. None at all …they may have said that as part of the plan around what is going to happen and where do you want to die. Probably it was mentioned around do you want a priest. (15)

This participant chose to be interviewed as an opportunity to discuss spirituality.

I’ve gone through med school and I guess that was one of my interests in doing this. Because I think it’s actually the first time I’ve had a chance to talk about spirituality at all. (17)

A number of participants mentioned the way in which Maori spirituality was discussed in Maori health. This reflects the embedded nature of spirituality in Maori culture. The Maori students certainly were educated about spirituality and well supported spiritually during their training. Perhaps the principle of kaitiaki (spiritual and emotional care by nominated elders) could be useful for all medical students and GPs. In the last few years mentoring was available for medical students in their last two years at medical school.
I think with Maori students …we have a different dimension there, eh? So it’s incumbent upon us to be able to understand, to participate, support. So that goes without saying. So you internalise alongside to their medical training. (7)

I don’t think we had any. We learnt a little bit – a few sessions on the Maori culture and spiritualism and Maori culture but other than that I can’t recall anything to be honest. (9)

This participant learned about suffering from patients and personal experience. The message that was given was that only Maori had spirituality and apparently Pakeha did not.

I learned about my own suffering while going through the training and I could see patients suffering at the hands of doctors, apart from their own suffering. But I think it was from experience. I don’t have any sense of being taught about spirituality….the only context where that was brought up was to do with Maori health. They had spirituality and we didn’t. (3)

The next two participants experienced spirituality in a cross-cultural context. Both had done electives in other cultures and reacted in totally different ways. The first seems to have been well buffered against any incursion from a different culture.

So I did my house jobs here and did a short stint on a Mission station in Papua New Guinea at the end of fifth year or sixth year…No it didn’t affect my understanding of (spirituality) What was interesting about it was it had, what was called at the time a revival there, over the previous two or three years, so people would see angels in church services and lots of people had become Christian, so it was pretty lively from that point of view….people would see angels in church services. (4)

The second was very open to the new experience and seems to have found it a life changing experience.

Yeah It did. But why should that be? Is it because they articulate those things? They have more of the language for it. Well I remember fully the first experience I had in another culture that was significant was my elective in Western Samoa. And what I remember from that was I was face to face with my own culture, which I think is quite interesting. It was all your own assumptions about the way the world should be. So I guess face to face with your own ideas about spirituality, so you get them challenged. The thing about the whole Polynesian thing is that it’s been colonised by Christianity whereas the Maori thing does not have that same, I don’t think it has been quite so colonised by Christianity. (3)

I think the comment on Maori not being colonised by Christianity is interesting because it certainly does not match the response of one of the Maori participants, who commented on the capture of the souls below. This records a cross-cultural experience of 150 years.
Baker was the missionary. Stack was the other one…They had a very powerful influence on capturing the souls of the local Maori people. And so we have this relationship between, particularly between the Anglican Church and the local Maori community, that’s been now for over 150 odd years. So it’s been well ingrained into the mind, into the soul of the local communities. (7)

3 Postgraduate education about spirituality

In terms of postgraduate learning about spirituality the major way participants learned was by listening to patients, as is abundantly clear from Chapter 5. Their life experience as family members was also mentioned. Four mentioned cross-cultural experience as a way of understanding spirituality. Exposure to Maori spirituality was also important for eight participants, like the one below.

I’ve never forgotten that she said, and she was talking about the four cornerstones of Maori health, and she was saying that she’d been in hospital and a doctor had come along to her and said “How are you doing” and she’d said “The body 0/10 but as for the spirit 10/10” you know. It was just that wonderful way of being able to acknowledge all parts of your being not just your physical body. (22)

A number mentioned spirituality being discussed in the GPTP.45 Eight talked about the influence of mentors and teachers demonstrating the presence of spirituality through connection and compassion rather than actually talking about it as a separate subject. Practicing palliative care and palliative care training enabled understanding of spirituality for six participants.

1 Palliative care

A number of participants talked about spirituality emerging in sessions on palliative care or grief.

(A palliative care tutor) alluded to it when he talked about pain. And being there as part of pain. But we haven't had anything since… (1)

I must admit one bit that really did stick in my mind was the grief (A clinical psychologist) was a fan of Kubler-Ross and the phases of grief. And it is something that I find. I say to a lot to people how you go through phases of grief. I must have picked up something …. So perhaps we did get taught some of those things. (2)

45 General Practitioner Training Programme
The next participant learned about spirituality from working in Maori communities and in palliative care as well as in cross-cultural contacts.

First of all I did a course at St Christopher’s Hospice….I just found out where you could go and went to one of their courses. I remember the chaplain was the first person who articulated this difference between religion and spirituality. That was well after I graduated. I didn’t have a sense of that before. And its not that I’m not interested. And in the hospice movement there’s a lot written about spirituality and I had worked in Maori communities as well. I worked a year in Whakatane and a year in Gisborne and then I worked up in Rawene for a bit and a bit on the East Cape and I worked in Niue for a bit as a volunteer for three months. (3)

The next participant learnt about spirituality while working in Oncology and Geriatrics, where teachers demonstrated how to give dignity and hope to their patients and accompany them on their journey towards death.

What I’ve picked up was from the incredible doctors that I’ve worked with. Some of them have really taught you skills. And the ones that stick out most in my mind are oncologists and geriatricians. I know an oncologist…I was her house surgeon, as green as anything. And just the way she talked to people about the diagnosis and the finality of that. And I still remember the strapping young 17-year-old rugby player that had an osteosarcoma and was going to have his leg off. …Just the skill. Then at the other end where she, when people were dying, coming in, chemotherapy, radiotherapy failed, just the keeping people comfortable. That was such an incredible thing to be able to do to have someone pain free and comfortable in the last few days. And I’ve always thought that is one thing I would love to do. And I enjoy that part of medicine in the Rest Homes, where someone has decided they just want to die or want things to be peaceful. And the geriatricians just talking to old people. They are the dignity of life and the end of it…And… palliative care training, I haven’t done the formal training, but there’ve been …sessions. And I find …I really admire the palliative care nurses for what they can do. (14)

Note the sense of innate dignity with age, culturally very different from the New Zealand pakeha attitude to the aged. The next one too, had learned much from doing palliative care training and from personal searching.

I think most of what I learned since I graduated would be through the palliative care course and apart from my own reading. And reading stuff about like Paulo Coehlo and Sheldon Kopp. So that’s probably where I’ve got any formal training about it. (19)

The next participant was unhappy with the way biomedical technology was being used to increase the suffering of patients, by not allowing them to die. This was justified by the
consultant on religious grounds and ‘put up a wall’ between doctor and suffering patient, stopping any communication from patient to doctor about their wishes. This illustrates both the biomedical conviction that death is the enemy and the reality that religious beliefs may be damaging when they are imposed on others without empathy.

But I have to say I saw some of my bosses abusing religion as a way of not seeing people. That … there was one ICU consultant I worked with who put people through extraordinary suffering because his beliefs would not allow him to let them die even by omission let alone commission. And that put up a wall between him and their suffering. I’ve heard some wonderful speakers like Patch Adams and Kieran Sweeney talking about the nature of suffering and they made a huge impression but that’s long after I graduated. (8)

2 General practice training
In spite of its absence in the medical school curriculum it was heartening to hear that spirituality did emerge in the GPTP. It was the antithesis of the ICU experience above, being very focussed on patient centred medicine.

So in the general practice training I felt we had a lot… I found (Tutor) invaluable. I guess getting the most out of the consultation with a patient centred approach. Listening to the patient. Letting them tell you what they want. And taking it from there. And being open to the fact that there is something they may present physically but it may actually be more of a mental disease rather than a physical disease. Otherwise it would be easy to miss all of that. …Again – I guess with the hospice. (9)

When the MRCGP, one of the medicine things was on it, (spirituality) but I was aware of Balint stuff that was going around in the 60’s and 70’s the patient and the illness stuff, so I was familiar with that. I read that. I’ve never been to a Balint group... I remember John Howie telling me to avoid encounter groups like the plague. (13)

The next participant comments that while in Maori health the topic of spirituality came up, in biomedicine it was too hard to discuss. It certainly came up in GP training.

Well, in the GP training, I mean you went through a lot of life cycle stuff and things like that. So you talked a lot about where people were at different stages and the spiritual aspects of those stages. And there was a certain cultural aspect, particularly Maori culture. Very little on anything else but… we talked about spirituality in relation to them. So there’s been quite a lot in the GPTP… I still think … medicine, not completely but largely is the biomedical model and I think we have … put a lot of the other stuff in the too hard basket. Which isn’t correct of course, but I think…we were taught very much in the biomedical mode. (16)

This participant also thought it had also been mentioned in the Diploma of Obstetrics course.
Probably next to nothing I would say offhand…Not through the formal teaching but certainly when I did my diploma in obstetrics, you know you’re faced with a few mishaps and upsets so you did, I guess there was exposure there to spiritual pain with the loss of babies and things like that. But certainly nothing formal (16)

3 Personal learning
There were a group of participants who went out and found the information they wanted at courses or in libraries. Some of these were not specifically about spirituality. Bioethics was one route for learning about spirituality for the next participant who describes spirituality as ‘a theme, always there’ giving a clear impression of being on a spiritual journey.

In various contexts we’d um, dealt with it there with the registrars and registrar training. John O’Hagan had also brought it up from time to time. I was on a bioethics working party and there were some workshops that came in that. And somewhere along there the issue was raised. I can’t remember any need being filled…. No. At one stage I actually set up a group of colleagues … to discuss issues around this area. That ran for a year or two – this was probably 85-86. That was interesting. It’s a theme that’s always there for me. (18)

Communication skills and psychological training was another area where spirituality seemed to creep in, as it did in supervision.

Basically it’s something which I’ve certainly done a few courses through the College basically on how to relate to patients, talking with patients, and that gives you spiritual issues in some respects. And I think the rest of it has just come from learning on the job. (21)

I’ve done psychodrama. And, um, I’m trying to think. On arrival in (rural practice) I found people with mental health problems and fairly quickly got into supervision. So I’ve had supervision. I’ve been to loads and loads of workshop type things on advanced counselling skills and things like that. I can’t even remember them now. I’ve just sought them out over time. (6)

The next two participants were both interested in spirituality. The first found the information in the medical literature a bit dull and prescriptive.

I’ve read, I’ve got some stuff there. I’ve read about some of the research that’s been done on handling those situations and I find it leaves me a bit flat….it’s not quite dynamic enough for me, or it’s a bit too prescriptive. (4)

This participant has trained in anthroposophical medicine that included attention to the spiritual in the context of the whole person.

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46 Anthroposophical medicine embraces the philosophical and spiritual principles of Rudolph Steiner.
So, kind of in answer to your question, I’m really interested in working that way, so the study that I do, and I did go to a course in Australia recently, is just consolidating all that sort of approach. Yes, that’s why I went back to medicine so that I could work this way. Yes. It’s just such a useful tool when people are coming in with functional things going on with their bodies that you know if you did a scan or this or that nothing would show and the blood tests were all normal. But its more the balance in the body and the body’s energy it’s just a functional thing. And we can help in quite a good way with those sorts of problems. (22)

4 Cross cultural experience

Several participants mentioned the impact of cross-cultural experience. It is interesting that the language to describe spirituality comes up here. What also emerges is the way in which communication between different cultures raises awareness about their own culture and spirituality.

4 Suggestions and possibilities

Participants were asked for suggestions how students and GP’s might be able to come to a greater understanding about spirituality and its place in healing and health. Many thought that the experience of patients in medical practice was the most common way of learning. Listening to the patient stories taught students a lot about suffering, courage, resilience and hope and bearing witness.

Working with vignettes and case studies was thought a good way for general practitioners to learn. There seemed to be general agreement that this topic needed to be discussed not just lectured about. Being interviewed about spirituality also seemed to raise awareness.

Stories are always useful…. I love stories. (laughs) …. And it’s great when you've got the patient to come for- they think they've just come for (a prescription) and then they tell you a new story just like I'm doing now. (1)

The obvious answer is case based discussion around difficult cases but I actually don’t think that students are often in the right place to actually value these questions. It comes later once you cease to be anxious about your knowledge for solving problems….. But, um, as I said at the start I think this is an incredibly valuable area to explore and I really encourage you to keep working on it. (18)

I think it would be helpful, you know in things like just what I’ve discussed in terms of understanding what relatives might be going through by using vignettes of examples of things. I don’t know whether if something is put down in
Theoretical terms I don’t think I can understand it. I need a vignette and GP’s work very well by those….I still remember reading that bit about not hearing the diagnosis. And it taking two or three times before he actually heard what his specialist had been saying to him. And I think if we understood that a little better we might then not feel so, um, upset or angry or irritated with patients who say no one told me. Because I think there are times when you know you’re in shock and you think that you’ve heard but you actually haven’t heard. … You’d be a bit more understanding of that and perhaps even ask them again what do you understand about your illness. (19)

The next participant was hopeful that stories might help students but somewhat gloomy that they would also help GPs.

But with students my gut feeling is that opening students up to it is, may well be mostly about telling stories, rather than theories and approaches, which sort of misses the human power and essence of it. So because I’ve got a few stories to tell, you know I tell those to my registrars, and I hope in telling them that, I mean mostly the ones I have these days, they seem to agree with them all, they don’t seem to have a problem….But wild facts challenge paradigms. … So if I was running a course in medical school, I’d certainly start with patient’s stories….Off the top of my head, what comes up for me is that it’s a lost cause (for GPs). Too much effort for no return. You’d probably get some but it’s very limited. And they’ve just been going too long, too socialised into one way of doing things which works for them. (4)

Reflective learning was also a way of absorbing and processing such emotionally laden material. It was important to distinguish between spirituality and religion so that the enquiry does not seem to be an exercise in evangelism.

The problem is that people confuse religion with spirituality and there’s a strong opposition to a Christian doctor or a Moslem doctor going in there and trying to evangelise or whatever. That’s not what it’s about. It’s about asking – does a person have spiritual needs and I think under the umbrella of holistic care in whole person medicine it should be introduced along with everything else that you’re teaching a young doctor to ask and enquire about. It should be part and parcel of all the other systems they’re enquiring about. You should have somebody teaching them, helping them to see the spiritual needs. It’s a bit hard to teach GP’s. Except for the things like the one you did last week. (20)

Being asked to examine spirituality, and listened to attentively seems to have been a very helpful process for participants. Such an exercise appears to challenge the spiritual status quo and enable it to develop. For the next participant, the question of language for spirituality comes up again as well as a sense of spiritual depths that can remain unconscious and unexamined.

47 This was an interactive session for GPs on spirituality in practice in which they worked in small groups and then shared their insights.
Well I’ve learned quite a lot through this interview. I think in a sense is what you’ve done is link spirituality to things that doctors come across every day in their world, which they might not call spiritual issues. Taking some idea that spiritual is about religion out of it and giving some sort of sense of suffering and healing and how that is a sort of spiritual process and how that links in. That’s quite powerful. It’s having the language you see. … I hadn’t actually, until the interview put all those ideas together in one place….Like it wasn’t preformatted information. Which I think is quite interesting in itself. They were ideas that I hadn’t placed in that particular relationship to each other….Well, often when you do an interview there’s a sense that you’re just retrieving information rather than putting new information through some sort of process, through the interviewer. Quite interesting. (3)

And helping them to understand the relationship between their own spiritual beliefs, especially when they have strong religious beliefs that may conflict with other people, understanding your own culture in that respect as well as others. It seems important to me but the challenge is to do that respectfully. Because we now have, with the GP registrars it’s a united nations. I had some wonderful discussion with the people in the registrar group who were Buddhist and Islamic, Christian and all sorts of different flavours of those, because they are all extremely broad. But Buddhism seems the most consistent in the way that beliefs affect lifestyle and compassion….I’ve really enjoyed being asked to think about these things and I certainly feel quite challenged to renegotiate my own spirituality after talking to you. (10)

The next three participants also felt it needed to be discussed in small groups with careful facilitation. There is a question of trust in even discussing the subject because it exposed deep emotions and existential anxiety in those discussing it, like the participant below.

I’ve seen things at conferences and I haven’t been to them. I guess I’ve tended to go to the sessions that are very cut and dried …I know. I think its probably fear of the unknown and feeling inadequate and not being able to say what I feel like – not knowing what I really feel about spirituality and not having the confidence to go and sit and listen and hear what other people had to say. (17)

So I think if anything that would be workshopping, along those lines. Smallish groups so that people don’t feel threatened and I think it could be done very successfully and with a lot of learning coming out. (19)

I think if it was to be done well it would need to be in small groups. With a facilitator where it was actually discussing people’s own views…People who are very staunch, then you get the disbelievers. ….Then it makes it unsafe for other people….I wouldn’t want to see it in a lecture theatre where there’s men down there and this whole big class where one person can play a complete nightmare. I think that if you believe in spirituality then you often find it difficult to believe that people couldn’t get that. Like, I find it difficult, but I do know that they do. (15)
This participant thought that trust had to be established before spirituality could be discussed, both for patients and for doctors. The conspiracy of silence was also important in New Zealand European culture as was a lack of awareness of Maori spirituality. The ethical issue of not imposing religious or spiritual beliefs on anyone was also raised. Interestingly, this participant also raises the possibility of a difference between men and women in discussing spirituality.

I think the difficulty with spiritual issues is that it comes down to a trust thing. It’s not something as you said, that is discussed much within our culture. It is within the Maori culture far more. But even the Maori culture is aware it’s not so much discussed among white New Zealanders. So like all those embarrassing problems, before a patient is going to bring them up, they have to trust the person on the receiving end and that takes time, takes time to form a bond. And then comfort that you could actually say something to this person. And not be judged for what you have said. Yes. The acceptance of different views be aware there’s no right views and wrong views and just acceptance of the different views …One thing, my gut feeling would be that female doctors would probably be better than male doctors in general. And I think that is probably because females as a group tend to talk about such things more than males—seem to tend not to talk about such spiritual and emotional – I think is still perhaps perceived as not manly not masculine to have emotions and things like that. I don’t know, I don’t know how you would help.(16)

Exposing students early to was thought to help them become aware of spirituality. Watching experienced GPs in consultation demonstrated the importance of empathy and compassion might also be helpful. Working in hospices might also be useful.

It is difficult. You can’t sort of teach someone. You pick up things the longer you are in practice. I think you absorb things by osmosis and pick up things by experience… How would you teach someone about those things – I don’t know – you’d have to get someone to come in and talk about their experiences and case study type things… You are exposed to the different ways in which people deal with death or imminent death so you guys are privileged working in the hospice because you deal with that a lot. (2)

You’ve got patients there who like having students, they’ve been there 20 years and they really like them It’s such a contrast to their sterile outpatient clinic. It is so different. And they can’t believe how good it can be. So exposure (13)

Well I think the first thing is, if I’d been a young doctor, the most important thing is it the other people who’ve worked at the work face. I think so often we get academics and they know it all and they might have it all nicely boxed and tied up but I can always recall as a 5th year student having a Christchurch GP come and talk with us about just being a GP. Which is a sort of spiritual issues type thing. And that had the greatest impact on me. Because in fact you felt he was talking from the heart, he was talking from on the job knowledge and it’s very different. (21)
Simply validating spirituality as part of care for students was thought to be very important. Exposure to experienced GPs who were prepared to talk ‘from the heart’ was very helpful.

It’s validating it for students is very important, …But for the majority of experienced general practitioners it would be, you know to talk to them about it, is to try and raise their awareness. …I suppose the only other thing I’d like to say is that it’s something that many of us struggle with and I struggle with understanding about it and there are times when you think – I think I’ve got the hang of this, the meaning of this, when you have one of these experiences with a patient …And they go out of the room and you think, wow that was just amazing. Wasn’t that clever….And then you realise, often when the patient comes back, that it was a much more wow phenomenon for you than it was for the patient. (8)

Acknowledging that spirituality is a normal part of being human and enquiring into this as part of taking a history was another way suggested for enabling students to acknowledge and explore this area.

I think that if it was more an everyday part of medicine rather than being an extra thing you can attend if you want to. That sets it apart whereas if it’s just the norm, if orthopaedic surgeons talked about it and …. If it was just normal and just like we all do a full blood count we talked about spirituality, then I think it would … make it easier.(17)

Might be quite helpful to have a – as I recall from my medical education it was quite they talked about bio-psycho-social model but it didn’t have much life in it. (laughs) They said well, there’s the biological and then there’s the psychological and then there’s the social. And so I thought OK. (A session on dying) … could be quite useful couldn’t it. (5)

The next participant was very clear it both needed to be a normal part of the history and integrated into the social fabric of the patient. The difficulty of broaching the subject in mainstream medicine is also referred to.

And there’s no reason why students shouldn’t be, they have a very clear protocol – these are the questions you should ask – have you any shortness of breath and so on. There are questions with spiritual and psychosocial aspects. But whether the students actually have that as part of their teaching…You know, what are a patient’s spiritual needs. Do they have any belief. … You need to know if your patients have spiritual needs and if they want a chaplain to come and see them, or do they have their own priest or whatever. But that’s important and part of a person. … Asking questions did I have a wife – did I have children – what impact that might have on that. But I think it needs to be emphasised that it is important it isn’t just data. It’s like is there going to be anybody there to help me, provide a loo for me and all those sorts of things, they are relevant to the management of this person. And are there spiritual needs that I might have, or not have and what supports. So I think it should be introduced right at the beginning when they are
starting their clinical year that this is part of the person. I think exactly the same as you teach them any other branch of medicine. You ask then to delve into the surgical issues and the medical issues, and you ask them to delve into the psychosocial and spiritual issues. To find out if there are any needs there. You see we’re in a unique situation at the hospice where we’re allowed to ask about spiritual things and it’s a recognised thing to talk about here but it’s not in mainstream medicine. (20)

Teaching and practicing whole person care with therapeutic listening skills and open questions enabled the process of hearing about spiritual issues. Both these participants were talking about entering into a dialogue of equals.

And if we grab onto this in case the moment is lost, when I’m with my students and talking about the nature of therapeutic relationships I usually refer to Carl Rogers. There were these four qualities of a therapeutic relationship…empathy, non-judgmentalism, non-possessive warmth and a genuineness. And if you’ve got those in a relationship it will be good. …Because it opens the door for people to feel free to say whatever they want with, and sharing things that are emotionally charged and therefore risky, because as soon as we show our emotions we are taking a risk, without fearing that they will be diminished in your eyes. (6)

I went to a course … and someone made the comment that the way they talked to a patient when they first come in ‘What are we talking about today?’ And I thought – what an idiot thing to say….. And I was fascinated because I found people stopped beating about the bush and told you what they wanted to talk about. … What are we talking about today is a very adult/adult. It means I’m not any better that you, we’re just here to talk about something. … I mean there’s a huge amount of wisdom in older GP’s that I think is not used. And … it’s much more about how you relate. …And if you can relate in an appropriate way then you are going to be so much more effective and do more effective work. (21)

The next participant believed that modelling the way in which spirituality can be discussed was important and refers to the need to ask the patient ‘how is life for them’ like the participant above. It is also about being open to their real suffering.

I don’t think you can give training about these things. No, I think you can talk…. And I can’t say I’m going to give you spiritual training because … you can’t. …I start by saying when you practice medicine you have to really practice …for the good of your patient, with your own beliefs, spiritual and educational. ….And first you have to do no harm … I think when you talk about philosophy, there is religion in your spiritual assets. So I don’t think you can teach, but you can show … well your patients can have all these things, but what worries them is something they have to find out. You … say ‘How are things. How are you doing. Where are you?’ and suddenly they’re in the midst of a divorce and they are unhappy and there are all sorts of amazing things happening, you know. That quite a lot is often revealed and you, they are away having left some of the burden that they came with. I mean, just like now, we could have had this interview but
I’ve ended up revealing what was slightly bothering me …. You know, I hadn’t meant to reveal that. (11)

Small group discussions on compassionate care might help students hang on to ideals. This participant felt that specialist training could be damaging for the students and for patients because it failed to support and nurture trainees. This allowed them to burn out and suffer severe compassion fatigue. Once again the difference between this and Maori students below, cared for with tikanga (Maori custom) comes to mind.

Well, I take a small group of medical students for professional development, its called. And often I find I’m talking about that with them. You know together we worked on being a doctor you need knowledge and skill but you also need humanity and that side as well. …. more about acknowledging the patient as another human being… It’s fine if you or I might think its important but I don’t think the people who write the medical student curriculum think it’s important. Do they? And the sad thing is that they have it all squeezed out of them….When I was …an oncology house surgeon (Another house surgeon) and I used to spend quite a lot of time in the evenings just going round talking to the patients and they had a chance to ask all those questions they never had a chance to talk to the consultants about, that were scaring them witless. And this young fellow was really good. I was sure he was going to be a Deepak Chopra he was so beautiful with the patients and so warm and caring…. And I met him about 5 years later and he was an orthopaedic registrar … I had a wee kiddie in hospital – a knee infection. And … he came in and looked absolutely haggard and I said, “Hi, … how are you”, and he said “Oh, I’m absolutely exhausted, I never see my family, I’m never at home. I’m here at 5 in the morning and I won’t be getting home till midnight.” Absolutely burnt out. And terrible with the patient. So peremptory and cursory with him. And I was so sad that he’d lost all that beautiful being that he could have brought into his work…..I talk to my students … about hanging on to compassion in their work. (22)

The next participant was deeply involved in enabling education about spirituality for Maori students and proposed that self-care was a precursor to good patient care. The suggestion of dealing with student and GP fear of mortality as a start is an interesting one. By inference this would also address the biomedical avoidance of care of the dying as well as broaching spirituality in terms of connection and meaning. Supporting the professional, cultural, pastoral and personal needs of the students and doctors was essential.

I think there’s both the, participation in about clarifying where the boundaries are. And dealing with the student or GP’s fear of their own mortality. Death and dying, death and pain and suffering. I think the sooner they come to the realisation that they aint (laughs) ironclad …. This whole notion they are driven by helping others….First of course doctor, help yourself. First there are very important spiritual and personal cares that need to be taken care of before they can help others. (How could this be approached?) With difficulty. (laughs) I’m not too sure. I think with Maori students we have a different dimension there, eh. It’s an
active process for us … because, you know… part of your Maori training, being Maori, is that you should be able to do these things. So it’s incumbent upon us to be able to understand, to participate, support. So that goes without saying. So you internalise alongside to their medical training. That’s the function of the Maori Medical Practitioner’s Association is to provide that cultural training and that personal support training,. And that’s what I’m involved in. What we call tikanga looking after the professional, personal, pastoral needs of Maori medical students. And Maori doctors. So that provides longevity to deal with other issues, personal emotional, cultural and spiritual matters arise from time to time. (7)

The other alternative would be to make spirituality care part of geriatrics and palliative care. The shared experience of death and grieving that occurs on a Marae over two or three days is a powerful lesson in experiencing and understanding spiritual connection.

Maybe it’s part and parcel of integration into care of the elderly. Because that’s where it’s more likely to happen. It’s part of geriatrics and also in terms of palliative care. So we have them for a week. And if, unfortunately, someone dies at that particular marae that’s part and parcel of the experience, that’s a shared experience. Yes, if someone has died we have an obligation there. …You know to actually have an experience of collective grieving, eh. Shared grieving, and not only right from the beginning to the end. …So it’s around that. And that’s something real, something that people participate in, and from within Maoridom, eh, it goes on for two or three days. If that’s not learning, tell me what is, eh. And that’s the best learning experience. In my view. …I think it can be integrated, though as part and parcel of their training, along their pathway, if it’s in general practice I think it can be integrated in palliative care as part and parcel of professional development. OK then. In dealing with that and putting this as part and parcel of geriatrics, palliative care, community care, of dealing with death and dying. As an important component, a module, that’s the word I wanted. For starters. (7)

Cross-cultural experience was affirmed as a good way of raising spiritual awareness by the participant below.

I guess you need to be aware that it exists in the first place in order to be able to be open to opportunity during a consultation. So, yeah, you can’t teach somebody spirituality, you van teach somebody there may be an element of spirituality and so I guess it comes back to education. And it doesn’t have to be in a religious sense… We spent some time, a day or so on Karitane marae just being immersed in Maori culture, And that was very spiritual but not in a religious sense. So actually spending time out of the classroom in another culture. The more exposure I think students have to different cultures, in themselves they become more aware that there is a spirituality that doesn’t have to be religious. It is cultural. (9)

The next participant, also involved in teaching, would like spirituality incorporated into teaching as a matter of course. He was anxious it did not become legislated for. Some
participants referred to a conspiracy of silence about spirituality and a discomfort with mystery, even among distinguished teachers.

For the students, just by being open about it. With the fact that we don’t understand at this stage how these things influence the health or ill health of our patients. But we know they do. And I think we need to tell them that. And if there is a way that we can influence that for a patient… then that is a valid thing for us to do. For the GP’s who have been practicing for more than ten years, I think they already know. I think that there is a huge silent majority out there … The astonishing thing to me was that meeting we had it’s coming up ten years now, (a conference) on the healing process, and it was amazing how many people came out of the closet at that meeting and said ‘yes of course I do this’ even Eric Cassell himself said at our dining room table said ‘Of course I see auras around patients’. I said ‘Well why didn’t you tell the audience’ he said ‘I wouldn’t say that in public for anything. Where would my credibility go if I said that. But you often see things about patients that tell you how they are.’… But getting back to your original question, I shouldn’t say that they all are aware, what I should say is that as you say there is a conspiracy of silence and I’m not sure that’s such a bad thing. Because if we start talking about it too much, they’ll start legislating about it and the medical council will decide who’s bloody competent. It’ll be like this whole euthanasia question … it used to be something that was between the doctor and the patient. Not now there’s too many legislators out there. (8)

Validating spiritual enquiry for students as a normal part of practice was important. As the next participant suggested, it was like dealing with other difficult areas such as sexual health. In other words, this participant too was raising the issue of embarrassment at this topic which is not talked about.

Some of it would be simply encouraging them in the same was as we try and get the registrars to talk openly about sexual matters, or about depression and asking people if they feel suicidal. They dance around some of these concepts but to be able openly to say to people what are your spiritual beliefs and do you have any beliefs that sustain you, when they’re in a crisis. That’s simply adding that to your battery of things that you can offer. Not necessarily a question, but teaching them that’s a valid line you can offer. And that they need to be as comfortable with that as they are with other awkward parts of the consultation. (10)

The final suggestion was that it be introduced in the clinical years and should be part of a compulsory course enabling students to understand their own and medicine’s limitations. The acceptance of mortality was seen as part of spirituality.

I think it needs to be introduced more so in the final year. Maybe in 5th or 6th year because that beginning 2, 3, 4 years it’s all about learning to get people better, alive and all that, But there has to be a part where I think we have to understand the limitations of medicine and I don’t think that is dealt with enough. I have 4th year medical students every Tuesday sitting in with me. And I try and do that, and if there is a visit to the Rest Home I’ll take them. You know, some of them are
just blown away. When I say look, she’s got a chest infection but I’m not going to treat it, because I discussed this with her when she was well. …. We talk about quality of life. Medicine’s not, you have to understand where your limitations are, and then you’ve got to stop. Because I don’t think we have the right to be shoving medicine into people… Yes I think it should be formally taught and whether it’s a course block or compulsory workshop of three days that they go to. (14)

5 Conclusions

This chapter first considered the way spirituality was dealt with in undergraduate education. There it was mostly absent, though some participants talked about it being demonstrated by compassionate behaviour of teachers and mentors rather than being explicitly taught. The only place where it was made explicit was in the Maori health attachment or in cross-cultural experiences. Maori students were well supported spiritually and emotionally and well trained in self-care.

Postgraduate education about spirituality was present in some specialties – GPTP, palliative care and geriatric care. In others, not only was it absent, but the unreflected beliefs of some consultants had detrimental effects on their patient care and on their trainees. The lack of self-care by doctors is also revealed in this.

Dealing with death and suffering, pushed doctors into spiritual growth by confronting them with the unresolved paradox of mortality. This raised the idea explored previously, that times of transition or transformation from whatever cause, lead to a thinning of the ego that makes the person feel fragile and vulnerable (Chapter 2:2:1). Being well supported enables this experience to be one of creative growth and development. Not being well supported may cause burnout and compassion fatigue to the doctor and poor care to patients.

There were a number of suggestions made about the way spirituality awareness could be raised at all levels. Many felt spiritual enquiry should be part of a normal medical history taking. Good patient care was paramount, and the ethical boundaries were important and need to be observed. The distinction between religion and spirituality needed to be clear. Focussed dialogue, which inspired trust, was identified as the best way of discussing spirituality.

Time for reflection, both individually and in small groups, was also thought to be useful in enabling spiritual understanding. Ongoing spiritual, social, pastoral and personal care was
also suggested as a way of enabling spiritual awareness and care. This was reinforced by the participants who commented on the value of being interviewed as an exercise in self-reflection.

The next chapter will deal with the discussion.
Chapter 8

Discussion

Research Questions

How do General Practitioners in New Zealand understand and experience spirituality?

How do they deal with spiritual issues for themselves and for their patients?

What education about spirituality did GPs have as undergraduates and postgraduates and how this might be improved?

1 Key findings

1 Understanding spirituality

- It is difficult to define and beyond the rational and religious.
- It is universal, embodied and inherent with unique aspects for each person
- It is culturally conditioned by language and social imaginaries
- It may be understood in religious terms but there are secular spiritualities
- Spirituality has three aspects: is about core self or soul, existential meaning in the face of mortality and transcendent search and connection

2 The heart of the matter: experiencing spirituality

- It is memorable and accompanied by emotions and feelings
- It grows throughout life in a series of transitions
- It connects to the transcendent within self, in others, in the natural world and beyond.
- Spiritual experiences are common and extremely varied and memorable
- They reflect the culture and religious affiliation of the person having them
• Such experiences may be mediated by religious ritual or prayer or sometimes they break in unexpectedly, with no mediating cause

3 Making meaning: spiritual issues for GPs and patients
• Spiritual journeys are universal and unique for all people
• Such journeys are always done in the company of others
• The central tasks of General Practice were to bear witness to suffering, to enable hope and to accompany healing.
• These all included connections and disconnections
• Paradigm conflicts in culture and world-views, health management, and medicine affect both patients and doctors

4 Sustaining and developing spirituality
• Sustaining and developing spirituality is essential for health
• It involves self, other, natural world and transcendent
• Self-care for doctors will enable better care for patients
• Currently this may not happen for undergraduates or graduates in New Zealand
• Ways of developing awareness and education about spirituality are proposed for the future

2 Discussion
Introduction to the discussion

I start with the diagram on spirituality to keep in mind the dynamic connectedness of spirituality, remembering that the space within and beyond the diagram signifies the transcendent within and without, and the leaves signify self, other and the natural world.

Throughout this thesis I have had to struggle with the need to dissect and define what is, in reality an integrated whole. At this stage it seemed appropriate to bring together the spiritual experiences of both participants and patients and connect them with the literature. Spirituality has continually emerged in the wonderful and moving stories narrated by the participants, who I am now going to call GPs to mark a change in focus.

The world of this thesis has moved from the layered cosmos in medieval time where God was considered in control of every material happening, to the totally interconnected, interrelated, expanding universe of quantum physics. In this quantum world even thinking about something far distant affects its physical being. At the same time the dimensions of the world have expanded as the technology to view both the smallest and the largest dimensions of it has developed. The simple cosmos of the ancients has grown to the many galaxies of today and it is now possible to view the smallest organisms on which all life depends. Yet this world is deeply interconnected. The stuff of life, the atoms and molecules are the same from the simplest organisms to the most complex humans.

We have seen from the literature how the pre-modern, spirit infused, enchanted world was replaced by the modernist one (Armstrong, 1993; Taylor, 2007a) This claimed that the scientific paradigm was the only one that made rational sense. In such a world it seemed as if spiritual things were unnecessary and irrelevant. These modernist scientific certainties, that humans had conquered creation and were in charge of their own destinies have now given way to a renewed searching, as a result of a changed understanding of the quantum world in which all is intimately related. Today even with the avalanche of information and knowledge now available through the Internet, human beings continue to seek meaning and the transcendent. Individualism and scientific materialism are no longer adequate as the way forward.

The last four chapters have recorded the journeys of the GPs and their patients. They demonstrate the depth of the human search for meaning, purpose and connection. This search
arises out of the paradox central to human existence that in being born we will also die. The GPs showed vividly and movingly that this journey is one that we do together.

Spirituality had different meanings for different people. It was about non-material spirits, both human and other. Some defined this as the soul, core or best self. It was about existential issues – the values, meaning and purpose in life. It was also about connection to the transcendent and was in a dynamic state of growth from birth until death.

In the narratives of GPs, spirituality emerged continually. Sometimes it burst out of the blue, at others it simply moved from one domain of their lives to another. Some GPs were unaware of the spiritual content of their stories. Spiritual experiences, connections with the transcendent, were always memorable though sometimes dismissed as ‘flaky and fey’ even though there was ‘a real sense of presence’.

The spiritual connections between humans and with the natural world and transcendent were ever present, complex, mysterious and dynamic. They lead seamlessly from one domain to another. The threads of connection wound back and forth, touching both the sufferer and the healer. Sometimes it seems as if they changed places. The healer is healed, in the relief of suffering of a well-attended patient. The sufferer is not cured, but becomes a healing event for the community. Both doctors and patients share pain and impasses on their spiritual journeys. As I reflected on these journeys, it became clear I was also engaging with them on a spiritual journey.

A preliminary consideration is the weaknesses and strengths of this research.

**Weaknesses**

This is a small qualitative study of twenty two GPs. While it attempted to obtain a wide spread of ages, types of practice and cultural and religious backgrounds it does not claim to be statistically representative of all GPs in New Zealand. The researcher selected the initial participant but thereafter other participants were nominated by the GPs being interviewed. Participants were occasionally asked to nominate GPs who did not have an interest in or belief in spirituality and those who were missing in terms of gender or age. While some of the participants were known to the interviewer, most were not. A single researcher conducted all the interviews and the initial coding.
**Strengths**

The transcripts were checked for accuracy by returning them to the participants for comment. At every point and particularly in the early part of the study the emerging material was discussed with supervisors, advisor and peer groups. The emerging themes were checked against other sources of information, the literature, workshops, papers and posters presented both in New Zealand and overseas. These measures ensured that the themes that were identified in the data were not merely a subjective construct generated by the researcher but adequately conveyed what was being communicated by the participants. In view of the conflation of religion and spirituality in some of the literature, a very clear attempt was made to distinguish between these. This was discussed with each participant. The interviews were conducted in a conversational manner that both interviewer and participants recognized as resembling clinical history taking in general practice.

The discussion will be presented in four sections.

The first will deal with spirituality as a universal, embodied and inherent aspect of human being. It is shaped by the world-view, culture and religious background of the GPs. This will be explored in the light of findings from the research and the literature. Much of this section is providing new information about GPs.

The next section, the heart of the matter, looks at the way embodied spirituality is experienced accompanied by emotions. It goes on to consider transitions from birth to death. It then considers experiences of the transcendent and explores these in relation to the literature. There is very little in the literature about the spiritual experiences of GPs so this too is new information.

The third section considers what gives meaning to general practice. It looks at spiritual journeys, connections and disconnections, bearing witness to suffering, enabling hope and healing. It then looks at the conflicts of paradigms in world-views, the practice of medicine and in medical management. This too adds new information, reflecting on the spiritual consequences of changes in management and work practices for GPs.
The final section will look at ways of sustaining spirituality and teaching and learning about spirituality. Self-care was largely absent from the training of the GPs. This section makes suggestions for its inclusion in the future.

1 Understanding spirituality

This section will explore the meaning of spirituality both in the literature and in the GP discourse. It starts with a consideration of the universal nature of embodied spirituality, then considers the way it connects.

1 Difficult to define

GPs found it hard to respond to the question: What does spirituality mean to you? Definition, by its very nature sets bounds to the concept and sees it as objectively distinct. However spirituality is experienced as a paradox, both an immanent and transcendent aspect of being. It also develops throughout life.

Chapter 2 explored the many meanings of spirituality used in health, where the struggle to define it has been intense (Vaillant, 2008). Some understandings were about personal spirituality, others about the relationships that arise as a result of spirituality and there is also a strand that attempts to describe the experience of that which is transcendent (Chapters 2:2 and 2:3).

GPs were certainly aware of the sacred and transcendent in so many ways, in themselves, their families, patients, in the natural world and beyond it. They were also very clear that ‘everyone has their own spirituality’ and this went beyond rational understanding and religious boundaries. Some struggled to find language about spirituality that was not religious.

2 Universal and unique

There are four main reasons to suggest spirituality is universal. First, a history of spiritual seeking seems to have accompanied humanity from the earliest time in human pre-history. Spirituality was an essential part of all human cultures as well as integral to healing in both East and West (Teilhard de Chardin, 1959; Harris, 2009). Spiritual understanding has evolved throughout human history (Nye, et al., 1996; Hay, 2006). There is also evidence that that genetic, cultural and developmental evolution all play their part in human spirituality (Vaillant, 2008). Spiritual evolution towards cosmic consciousness was first suggested by
psychiatrist Richard Bucke and further developed by De Chardin (Damasio, 2003). This sits well with the post-modern interrelated world-view. Several GPs referred to their own spiritual evolution throughout life (Chapter 4:3:4).

Second, evidence showed that spirituality developed spontaneously in children, and appears to be an inherent, biologically structured part of human beings. It emerges in the spiritual sensitivity of children to awareness, contemplation, mystery and values (Frankl, 1954; Csordas, 1994). These findings were certainly supported by the GPs. Children by their presence, growth and development enabled the emotional and spiritual growth of their parents (Chapter 5:6). They gave focus and meaning to life. They contemplated, asked difficult questions about God and told non-religious parents that God existed.

Further evidence for the universal nature of spirituality comes from its embodied reality. It is within the person, a deeply sensed aspect of being. Spiritual experiences caused physical and emotional sensations (Puchalski, et al., 2009), which produce changes that can be measured by brain scans (Levinas, 1990). While these identified areas of brain activity connected with spiritual experiences they did not explain the mystery (D'Souza, 2007).

Both Czordas and Frankl proposed that humans function as integrated beings, body mind and spirit in connection with the world about them, not as disembodied minds or unspirited bodies (Bardes, 2007). Csordas goes on to suggest that current Western attitudes to the body are as a ‘consumerist utility’ and ‘medical terrain’. This certainly matched the experience of the GPs both for themselves, their patients and families.

Tacit knowing – knowing more than we can tell - is important to doctors as the basis of empathy, part of the process of diagnosis and healing (Pesut, et al., 2008). This was discussed at length by GPs (Chapters 5:3 and 5:4).

Spirituality connects. Derived from the Latin spiritus meaning breath, it is literally the breath that we share that gives life. This is beautifully demonstrated by the Maori hongi, where visitors and hosts literally share breath by touching noses. Spirituality connects humans to their own deepest core, to others, to the natural world including time and to the transcendent however that is perceived (Sinclair, et al., 2006). Since it connects, by its very nature it also creates community. It does this by bringing forth the positive emotions, and tacit knowing (Klitzman, et al., 2005). The GPs also discussed this at length (Chapters 4, 5 and 6).
The final evidence for spiritual universality is in the spiritual experiences described. These were the same regardless of the culture or religious background. The interpretations were, of course, shaped by culture and religion. In all cultures spiritual experiences were accompanied by emotions both positive and negative.

Most GPs agreed with this understanding and were particularly clear about the connection of spiritual experience with positive emotions. GPs discussed experience of intuitive or tacit knowing about patients that was beyond normal cognition and in all cases it was a memorable experience. Some identified these as a spiritual connection.

This sense of a universal underlying spirituality was balanced by an understanding of the unique spirit in each person. GPs were very clear each person has their own unique spirituality.

3 Spirituality and world-view
In Chapter 2:3 I briefly discussed the way in which the world-views have changed in the past 2000 years, from pre-modern, to modern and then to post modern. These three ages overlap considerably. Indeed it could be said that they coexist, even if the predominant paradigm today is still the modernist one. As different world-views have developed in response to new understandings of the natural world, parts of the previous world-views seem to remain embedded in the culture and understanding of individuals. In this they resemble the DNA that persists in cells without apparent function. Some GPs and patients appeared to live in all three views, and used different world-views for different parts of their lives.

This understanding of a spirit filled world persists in traditional spiritualities, including Maori, Celtic and Pacific Island spirituality. These also have clearly recognized spiritual links to the land. Connecting with the natural world and the land seemed to be part of the social imaginary, the shared myths and world-view of New Zealand that give meaning to life for other GPs as well (Klitzman, et al., 2005).

The modernist scientific world-view is rational, deductive and empirical. It fails to address the transcendent needs of human beings (Espagnat, 2006; Puchalski, et al., 2009). It has been marked by a growth in individualism and a loss of community. It has created a ‘buffered self’,

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48 This is defined on page 109.
out of touch with the transcendent, because modernism only allowed a scientifically designed and measured context of meaning or significance (Dein, 2005; Cook, et al., 2009). Time became a secular utility and sacred time disappeared. Scientism claimed authority over all knowledge and religion and spirituality were private matters. This made belief in the transcendent increasingly difficult (Davies, 1995). The modernist world-view is predominant in New Zealand and has promoted reductive thinking in education, politics and economics and developed an individualistic, materialist and competitive culture. In this model, advertising promotes wants and the media drive consumer demands. Because the basis for this model was individual, free, competition there was little sense of the common good, or responsibility for others. The ‘face of the other’ was ignored unless they might be useful (Frankl, 1954; Levinas, 1990; Anandarajah, 2008).

The GP narratives suggested the extrusion of spirituality by modernism has led to a widespread loss of meaning and purpose in life and a sense of alienation and disconnection from self, others and the natural world. GPs discussed this particularly in relation to depressed patients and to families who worked endlessly to try and obtain happiness through material goods. They were critical that the biomedical treatment for loss of meaning was to offer an antidepressant or other mood-changing drug, rather than to spend time enabling patients to explore what gives life real meaning.

The post-modern age began when the ordered, law abiding world of Newton was overturned by Einstein’s theory of relativity and quantum physics. In this universe human beings were not in control, chaos and order existed side by side. Objective science as the only possible explanation of reality became untenable (Berry, 1977; Espagnat, 2006).

The GP who had reflected about the quantum world had investigated telesomatic connection in twins and thought that some of the findings were due to a quantum entanglement effect. Interestingly, this GP also gave examples of spiritual experience suggesting the direct action of God, appearing to hold both a post modern and premodern worldview at the same time.

Living with two or more world-views could be stressful and seemed to work best when the differences between the modernist and pre-modern world-views were clearly distinguished and accepted. Some GPs were clear that human reality transcended scientific limits and happy
to explore this with their patients. Others seemed to be almost yearning for a sense of intimate connection that was present in the pre-modern and traditional worlds, which had vanished with modernism. Some, reflecting their biomedical training, were unhappy with the uncertainty of general practice and seemed to want a perfect modernist world of absolute certainty.

4 Culture and spirituality
Cultures shape the ideas, language and spirituality of their people. As cultures develop and evolve so does their understanding of spirituality. In this group of GPs there was a great cultural diversity and the majority of GPs identified with two or more cultures (Chapter 3:6:1). Some GPs complained that their own culture had changed over time so they no longer felt at home in it. This suggests that as well as the individual spiritual evolution, there is also a cultural spiritual evolution.

One of the results of globalisation has been that medicine now pays attention to culture as part of the human individual. Part of culture is about spiritual and religious understanding and practice (Johnston, 1978). Although it is politically expedient to pay attention to the various cultures in a society, in many Western cultures paying attention to the spiritual is seen as unnecessary and its relationship to human wellbeing is dismissed (Johnston, 2000). The rise of secularity over the last two centuries has led to the ejection of spirituality from the public sphere.

New Zealand is unusual in having spirituality entrenched in law. However, this seems mainly understood as applicable to Maori rather than the whole culture. This was clearly stated by the Pakeha GP, speaking about spirituality education in medicine: ‘Maoris had spirituality, we didn’t’.

Traditional spirituality was described by both Pacific Island and Maori GPs and in relation to Maori patients. They lived in a world permeated by spirits and the spiritual. Some European and Pakeha GPs did refer to their Celtic roots and Celtic spirituality as holistic. This seemed to correspond to a traditional spirituality, in which the spiritual was palpable and pervasive.

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50 I use European to identify European-born GPs and Pakeha to identify New Zealand-born GPs of European origin.
The whakapapa (genealogy) was identified by a Maori GP as the intimate spiritual interconnection between person, land, ancestors, descendents, and the transcendent. This GP also reflected on the way Maori ritual helped the journey of the spirit of a dying person to the place ‘beyond the veil’ connecting them to ancestors who wait. So although Maori connecting spirituality was recognised as central to the Maori culture, Pakeha, but Jewish and Celtic GPs showing the same spiritual connections tended to ignore it. One did refer to the religious connections between the living and the dead and they certainly talked about patients who had visits from those who had died.

GP accounts of moving from one culture to another suggested it may enable a greater openness and awareness of the common spiritual ground. Being confronted with a different culture enabled people to see their own from the outside. Only one denied a cross-cultural experience had affected their spirituality. This was baffling since it involved a community seeing angels in church. It suggested a ‘buffering’ of the GPs spirituality from that of the indigenous culture.

GPs certainly experienced their spirituality in terms of their culture and world-view (Chapter 3:6:2 and in Chapter 4:2:2:1). Those who identified with more than one culture or religion often described a spirituality that combined aspects of all these. The most striking finding was that GPs who had moved to New Zealand seemed affected by the spirituality of the land embedded in traditional Maori culture.

5 Religion and spirituality
This is the first age that has attempted to live without religion and spirituality as a component of health. The earlier writings on spirituality and health focused on trying to define spirituality and religion. Some authors insisted spirituality only existed in a religious context (Vaillant, 2008). Others were equally certain that spirituality and religion were distinct (Ingersoll, 1994; Cook, et al., 2009). There was much confusion and blurring of the boundaries.

In setting out to do this research I was very clear that it was to be about spirituality, but discovered that for many people spirituality is equated with religion. In agreement with the literature, there was a lot of negativity about religion (Klitzman, et al., 2005). The majority of GPs had left the religious attachments of their childhood for a variety of reasons. Some had experienced religion that was exclusive and oppressive, limiting human freedom and growth.
None, though went as far as Sinclair and claimed spirituality is a concept ‘void of religion’ (Sinclair, et al., 2006).

At the beginning of each interview spirituality was defined as an inherent aspect of human beings which connects them to each other, the transcendent and the natural world whereas religion was a communal way of organizing shared spiritual beliefs and ritual. In so far as it was possible questions were put in non-religious language for those who had rejected religion.

GPs were clear that spirituality went beyond religion and rational human understanding. Their spiritual self-understanding was complex. I thought the diagram below helpful in showing the connections, which matched the range in Klitzman’s paper.

Some had moved between these categories of spirituality during their lives. A number commented that they had not thought of spirituality in the ways it was discussed in their interview. One said, ‘giving some sort of sense of suffering and healing and how that is a sort of spiritual process and how that links in. That’s quite powerful. It’s having the language you see’.

They were suspicious of religion in the same way as the doctors in the study by Klitzman (Klitzman, et al., 2005). On the other hand many of them valued what their religions had taught them about moral and ethical behaviour, ‘brought up with a shared set of values, belief …by which you conduct your life.’ They may have left the religious attachments of their childhood, but were quite clear that spirituality was important to their patients and themselves and considered they were on a spiritual journey.
Figure 9: Self-understanding of spirituality

For some GPs religion seemed to have no connection either with the real world or with the transcendent. They varied greatly in the amount of time and energy they had spent in reflecting on spiritual issues; for some this was an almost daily occurrence but for others agreeing to be interviewed was their first adult time of spiritual reflection.

Even GPs deeply involved in religious practice thought that spirituality was separate from religion. Though all people must confront the spiritual existential questions, only some choose to do so in a religious community. In New Zealand today organized religion has been rejected by many people. Secular spirituality, connected to the natural world or a higher power and not mediated through a religious connection is important in New Zealand (Breitbart, 2007). The word secular here means not religious, not non-spiritual.

The idea of a natural spirituality was widely accepted in New Zealand and connects with traditional Maori spirituality as discussed above. It may also be a response to the beauty of
nature that is present in full measure in New Zealand, confronting everyone with an encounter that transcends the self.

Two GPs identified themselves as ‘not spiritual’ although in both it was an antipathy to religion that emerged. They dismissed spirituality in religious terms and seemed unconscious of their own spirituality. Both clearly experienced spiritual connection in relation to patients, self and family. One expressed the sense of tacit knowledge doctors have about patients as a ‘connecting thread’ by which GP’s help the patient connect with different aspects of their lives. This GP also spoke of the sacred nature of a search for truth, which is certainly one aspect of searching for the transcendent.

6 Three strands of understanding
In discussing spirituality three main strands emerged. The first was the concept of soul, spirit or core self. Secondly, it was about the existential issues of finding meaning, purpose and values during the growth and transitions from birth to death and coming to terms with death. Finally it was about the experience of the transcendent, numinous, sacred and mysterious in self, others, the natural world and beyond (Klitzman, et al., 2005).

In addition, connection to the moment, to time was also important allowing lifelong spiritual growth (Greeley, 1975; Hay, et al., 1978). These many meanings of spirituality are often conflated, which makes a clear definition difficult. For the purposes of this discussion I will deal with these aspects separately. In reality they are experienced as a seamless whole, with the focus moving from one aspect to another.
GPs certainly talked about a non-material soul, spirit, or core self as being the essential indestructible part of self that persisted even after the death and dissolution of the physical body. They also reflected on this deepest self as the best self, linking it to the ethical aspects of spirituality. This self was an integrating life force, thought to grow throughout life. Some GPs also used the word spirit to refer to courage and fortitude in patients, in other words referring to human qualities that may arise from spirituality. They also talked about the spirit of places. Some saw it as an ‘ether’ within and without connecting all things.

These concepts affirmed those suggested by a number of authors (Johnston, 1978 p 104; 2000).

GPs discussed the persistence of human souls after death, as a sense of presence, or a viewed reality, for some grieving patients. There were a number of accounts of spirits appearing to patients and in one case to a GP.
2 Existential meaning in the face of mortality

The way humans seek meaning in the face of mortality is well documented in the literature (Black, 2005; Chochinov, Hack, et al., 2005). This search for meaning and a sense of self is life long and necessary for personal authenticity (Greeley, 1975; Hay, 2006). Spirituality develops throughout life and grows, moreover, in relationship with others, so this journey is not a solitary one. It is intimately linked to hope and healing and important at the end of life as emerged clearly in the GP narratives (Chapters 4:3 and 4:4).

GP narratives of family and patients discussed how these gave meaning to their lives and made them grow and develop into better people (Chapters 5:3:3, 5:4 and 5:6). The search for meaning was more intense at certain stages of life, particularly adolescence and mid life, which were also particular times of leaving and joining religions (Chapter 4:3:7).

3 Transcendent

The third aspect of spirituality is experience of the transcendent. The transcendent may be immanent in the depths of the self or emerge in connection with others or the natural world, or it may be beyond all of these. It is within, without and between. Spirituality was also a sense of the mysterious, numinous or sacred, which may be theistic or atheistic (Nouwen, 1979). It may also be an experience of nothingness beyond meaning (Ashley, 2007 p 109). The spiritual journey, in the face of mortality was also a search for the transcendent.

The concept of mystery was raised by GPs, both in the sense of being unknown and the sense of being beyond human capacity to know. This kind of spirituality implied a sense of the sacred or transcendent forever beyond human understanding and analysis – the Being of Espagnet that is a ‘veiled reality’ (Johnston, 2000; Espagnet, 2006). GPs referred to this with a sense of human inadequacy - ‘like trying to imagine the end of the universe’ and ‘our brains are actually too limited to encompass some things’. They also referred to spirituality as ‘within and without.’ This was beyond the material limits, the bounds of lived reality, reflecting the insights described in literature about mysticism (Wardell, et al., 2006).

For those with an active engagement in Christianity, there was a strong sense of the presence and action of God in their lives. This also emerged in other accounts where there was no religious connection. Here it was a ‘higher power’ or ‘something out there’ usually in a sense of a benign power. For others there was a sense of a presence of something greater that was
both within and without. For a Buddhist GP there was also a belief in the response of the Medicine Buddha to prayer.

It has been suggested spirituality is the ‘glue’ that holds everything together, but I think that is too static an image (Cook, et al., 2009 p 86). What emerged time and again is the fluid spread of spiritual connection: from doctor to patient to family to the natural world and to the transcendent, even to the interviewer. This spread is active and continually changing, moving back and forth more like a laser light show than glue. In many ways it resembles the flow of neuronal impulses in the brain on a PET scan forming patterns that light up different areas of the brain. I have great empathy with the GPs who said they had ‘run out of words’ to describe spirituality: ‘It was too hard.’

7 Summary
In this section I have discussed the multilayered meanings of spirituality described by this GP sample. It is difficult to define. It is a universal, embodied, human characteristic revealing itself in the emotions. Understanding of spirituality is shaped by the world-view, culture, life stage and religious attachment of the person. It appeared to change when people move from one culture to another.

Spirituality has three mains strands of meaning. The first is about the core, soul or spirit that is at the centre of self. This may be the integrating centre of the self as well as the source of ethical and moral behaviour. The second is the making of existential meaning in the face of human mortality. The third is about the transcendent. This may be perceived as within or immanent, in others, the natural world, or transcending all of these. This aspect of spirituality is numinous and beyond human rationality. The relationship of spirituality with religion was also examined. There is a secular spirituality.

2 The Heart of the Matter: Experiencing spirituality
Spiritual experiences connect people with their deepest self, others, the natural world and the transcendent (Dalrymple, 1997). They are common at times of transition. Such connections are memorable and often accompanied by strong positive emotions. Occasionally they are accompanied by strong negative emotions – a dark night of the soul.

When planning this thesis some doctors suggested, ‘GPs will not want to talk about spirituality. They certainly will not want to tell you about spiritual experiences’. What became
abundantly clear was that they did indeed want to talk about spirituality both as a concept and as an experience. I was made very conscious that, as James noted, spiritual experiences can only be described by the person who has them (Phelps, 2006).

1 Embodied and accompanied by emotions and feelings
In the interviews it emerged that a spiritual connections aroused strong emotions and were memorable, perhaps even unforgettable. This was so whether the connection was with others, the natural world, self or the transcendent. There was a surprising and vivid range of memories of events and connections from GPs with patients, family and the natural world, some of which happened many years ago. Some authors suggested these are biologically inbuilt responses, to which we resonate due to the presence of mirror neurons (Vaillant, 2008; Cattaneo, et al., 2009).

It appeared that positive emotions generated by spiritual connection not only help create human community, they also remain as sources of spiritual and psychological sustenance after the experience. These were discussed in detail previously (Chapter 2:4:6). This is so not only for the person having the experience but also for those who are told about it. Remembering past joyful spiritual events may engender hope and growth. This might explain why the GPs so enjoyed telling stories about memorable patients (Chapter 5:4). This process might also explain the strength of community and bonding in newly formed religions. It was well documented in Christian literature in Acts of The Apostles, written about the new Christian communities

Negative emotions experienced in spiritual encounters are equally memorable and in some cases remain unhealed as a burden of grief, forgiveness withheld or anguish remembered. They were sometimes described as casting a pall over the life of patients and GPs, a dark night of the soul. Negative emotions were always about losses and disconnections. In the interviews they were often about loss of personal and spiritual connections. In spite of this they were also described in retrospect as sources of great spiritual growth (Tilburt, 2006).

Spirituality emerged in the interviews connecting GPs, their families, their patients, the natural world, and the transcendent. This connection was about loving, caring and self-giving in community really focussed on the ‘face of the other’ I am well aware that love is not a

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51 A pall is the cloth covering a coffin, hearse or tomb. It is more usually used to mean a dark cloud.
word usually used about clinical relationships but this was not erotic love but an agapec52
one. According to the GPs, their training in biomedicine made it clear that doctor
relationships with patients should be detached in order to make good, objective, clinical
decisions. The New Zealand Medical Council document on Good Medical Practice even
states that ‘your personal beliefs should not affect your advice or treatment’ suggesting that
the doctor as doctor was somehow distinguishable from the doctor as person (MCNZ, 2008).
As might be expected this demand for objective distance became a source of paradigm
conflict for the GPs interviewed.

2 Spirituality is Experienced at Transitions

Midway this way of life we’re bound upon
I woke to find myself in a dark wood
Where the right road was wholly lost and gone (Alighieri, 1949 p 71).

When I started doing palliative care I was surprised at the number of ex-midwives in the
hospice. Yet in a sense birth and death belong together as major transitions and their process
is remarkably similar. Both go through the four stages of unfolding, moving out in pain, being
stuck in impasse and breaking through to a new way of being (Groopman, 2005). Indeed
these mark all the transitions of our lives, including writing a book or a thesis.

Spiritual and psychological transitions may be experienced as a loss of coherence, or a loss of
clarity of self-understanding that demands change. A dying patient put it very clearly ‘I’m not
myself any more’. It appeared that in transitions of any kind there is a loss of the false self,
and a need to seek a new self, adapted to the changed life circumstances. Transitions thin the
boundaries of the false self, allowing a new self to be born. GPs identified these transitions as
times of intense spiritual experiences (Chapter 4:3:4).

At times GPs described such transitions as forced on them, and felt overwhelmed and in
danger of burn out. It was striking that both for the doctors and their patients, several crises
happening at once precipitated major spiritual shifts. Sometimes, as the doctors struggled to
understand the transformations that had happened in a patient’s life, they were also forced to
grow (Chapter 5:3:3).

52 Agape is a deep cherishing care of another person as having intrinsic worth.
Transitions demand new answers to the existential questions. They are not usually sought but emerge as part of living in a dynamic world. The search for meaning was more intense at certain stages of life, particularly adolescence and mid life. In families these two stages tend to resonate with each other. The adolescent young are disconnecting from family, making life decisions about work, relationships and place of residence. At the same time the adults in mid life have to let go of their youthful dreams and their children and contemplate how they will age (Holmes, 1989 p 251).

One GP spoke of the pain and conflict that could erupt over family rules for adolescents. Another of their anguish when family and peers treated their religious attachment during adolescence as ‘pathological…as if I had two heads’. Several referred to patients who were struggling with adolescents and so finding it difficult to care for their own needs.

A major transition was often precipitated by serious illness. For the sufferer it presented a threat to life, health and personal integrity that required healing. For other family members it presented a threat to the integrity of the family. Such illness may demand a change from being a family member to becoming a carer. This was particularly important when children have parents who become ill and die. It reversed the normal parent – child relationship. As one GP said, ‘I lost my childhood’. Another GP, poorly supported by doctors during the final illness of a spouse, realised that this was a spiritual journey and actively searched for a spiritual home.

The most difficult illnesses for GPs were those in their own family because not only did they have more knowledge, they also had higher expectations. At the same time they became trapped between the role of doctor and that of family member. They knew the needs of their family member or themselves and wanted to see those met. If they were not met, they found it difficult to allow themselves to be angry with peers and complain, because they also knew doctors disliked families who complain. GPs tended to treat themselves or their family, but felt guilty when they did, as did those described in the literature (Cellarius, 2008). One GP felt so guilty at self-medicating they visited their own doctor to be taken off the medicine.

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53 Reflecting on this section I was surprised to find that the word transition only emerged in English in the 15th century where it was first used in astronomy. In the process of human growth and development some authors use transitions, others transformations. Transformation was not used until the 16th century and focuses on the material self, rather than the relationships.
GPs, like their patients, felt threatened by illness and feared disintegration. Facing illness and mortality inevitably brought up the existential questions: “What am I?”, “Where have I come from?” “Where am I going?” With the onset of illness the other question that came up was “Why me?” Seeking answers to these existential questions was what drove the human spiritual quest (Elliott, et al., 2002). Revisiting existential questions removed the protection that roles give, exposing the vulnerable inner self so that a new self has to be sought on a new spiritual journey.

A particular problem for GPs was that it was somehow shameful for doctors to be ill (Brody, 1992). Becoming a patient means letting go of their known role and authority and accepting vulnerability and neediness. But biomedical training encouraged them to think of themselves as in control and so distanced from patients, they could not easily be patients. It felt like a failure of competence.

The GPs certainly discussed the difficulty of becoming patients and of their peers not treating them like patients. Doctors often assumed their doctor-patients know the clinical details about their illness and treatment. This assumption is mistaken, and failed to take into account the personal fragmentation and anxiety that accompany serious illness. Since doctors know more about the pathological possibilities they also worry more. Many had a lurid clinical imagination, when it came to their own illness. Anxiety disrupts normal orderly thinking and attentiveness and interferes with short-term memory.

Klitzman and Daya’s paper looked at spirituality in doctors who become patients and affirmed the importance of spirituality in helping to cope with illness. It also identified the ways spiritual self-understanding during illness changed (see Figure 9). Some doctors were religious and spiritual, some were spiritual and not religious and some thought they were neither. There were those who were already spiritual, those who became more spiritual after illness, those who were spiritual but did not perceive it, and those who wanted to believe but could not. Others did not seek spirituality, but found it emerging in spite of themselves (Egnew, 2005). These certainly matched the GP narratives including the lack of awareness of two GPs who thought they were not spiritual, as well as those who dismissed their spiritual experience.

Spirituality certainly provided comfort and a meaning during ‘a very bleak time’ to a GP facing the possibility of dying when they had young children. However, their own religious
faith and the prayer support of family and church community helped them to cope and to heal. This experience left the GP with a profound gratitude for each new day. Another GP also discussed the support of prayer during illness. Once again it was the church community and family praying together that strengthened the GP’s faith and sense of belonging. Prayer in these two cases allowed the GP to feel more supported by the spiritual connections in the praying community.

3 Connecting with the transcendent

1 Introduction

This section considers the ways in which GPs and patients connected with the transcendent. These were accompanied by emotional responses. Once again it was clear that spiritual connections tended to resonate between people, the natural world and the transcendent as indicated in Figure 6. It is also important to keep in mind that the transcendent is both within the self, other and natural world and without or beyond it. These different aspects of transcendence also appeared to resonate with each other.

Spiritual experiences were remarkably common and extremely varied, with all GPs describing at least one such experience. Some happened in a religious setting, during prayer or rituals. Others came ‘out of the blue’ and happened in the secular world. Yet others were experienced during everyday life and work. Some happened when the GP was alone, others when they were with someone else. They closely followed the patterns of Extraordinary Human Experiences (Chapter 2:2:6) (Domash, 2009). The issue of how religion related to spirituality re-emerged as the GPs discussed their spiritual experiences.

2 Extraordinary human events (EHE)

Paranormal experiences and Extraordinary Human Events (EHE) are of great interest and fascination to people. The enduring popularity of films and books on these topics over the past half-century bears this out. There is an important distinction to be made between the paranormal human experiences of increased awareness, déjà vu, ESP, clairvoyance, and mystic experiences of a transcendent other. There is a long history of mystic and paranormal experiences in the religious literature of all major religions. Classical writers on spirituality in both Eastern and Western religions warned about paranormal experiences as diversions from the real purpose of spirituality, of seeking the sacred. James also described these as the lower rungs of his ladder of spiritual experiences (Nouwen, 1979). Warnings about the potential for evil in paranormal activities are still being given (Johnston, 2000). Certainly this seems
appropriate given the number of cults that have ended in mass suicides or mass murders in the past thirty years.

Paranormal experiences were common for both religious and non-religious GPs and their patients. This was in line with studies of the general population that found these experiences occurred in both religious and non-religious participants (Greeley, 1975; Hay, et al., 1978). This adds weight to the concept of spirituality as a universal human characteristic. Extraordinary human experiences emerged in the interviews, particularly at times of major transitions, in relation to GPs, patients, friends, family and the natural world.

Clairvoyance and ESP came up a number of times both for GPs and for patients. The amazing story of the woman, her cat and the doctor who arrived just in time to hold her as she died, is a particularly good example (Chapter 5:10:3:1). Once again there were many layers and movements of spiritual connection in this story, from patient to doctor, doctor to patient, even from cat to patient and patient to cat. Both doctor and patient seemed to have a tacit awareness.\(^54\) This unforgettable event left the GP profoundly thankful, ‘You are left thinking you are not alone’.

Another GP told of a Maori patient who ‘saw’ a morepork,\(^55\) his tribe’s bird, in London and knew immediately his grandmother had died. When he phoned New Zealand and asked after her, she was found dead. Other examples of clairvoyance were described by a GP in a study of telesomatic experiences in twins. One twin knew when the other twin was sick or had died before being told.\(^56\)

Near death experiences and seeing spirits were described by Greeley and Hay. One GP described a patient who had a near death experience, was resuscitated and completely lost his fear of dying. A Maori GP discussed the spirits of the dead seen as a child both in New Zealand and in Europe. A sense of presence of the dead was common in patient discussions with GPs. Sometimes they were seen or heard, sometimes only sensed as being present. Two GPs thought these were imagined but the others thought this was a real experience.

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\(^54\) I cannot speak for the cat, but stories of the tacit awareness of animals occurred in two more GP narratives, one about a dog and the other about a pigeon. It does seem that some cats and dogs do know when their human companions are dying and will stay beside them at that time.

\(^55\) A morepork is a New Zealand owl.

\(^56\) I have heard similar stories of bodily connection from breastfeeding mothers who were miles away and knew when their infants had woken because they had a let down of milk. When they phoned to check they were told their babies had just woken.
As can be seen from Chapters 4 and 5, and the previous section of this chapter, GPs experienced transcendence whenever they were drawn beyond themselves. They described experiences when they felt in touch with their soul, centre or core self. Transcendence was also experienced in relationships with others, patients, friends and relations. The natural world quite frequently promoted an experience of the transcendent.

A few GPs also had mystic experiences of direct connection with the transcendent, as something totally without and beyond the natural world (Greenhalgh, 1998; Hurwitz, et al., 2004). A sense of being ‘outside’ time was sometimes part of this. For some the ‘something beyond’ was God, for others a power or presence not named. Triggers for these experiences included music, the natural world and prayer. Just as spirituality was difficult to describe and define so, by its very nature was the transcendent, which literally means to climb over. Several GPs talked of running out of words to describe their experiences. The experiences are examined in detail in Chapters 2:2:6, 5:9 and 5:10. They were almost all linked to experiences of connection and disconnection, although there were a few occasions when they happened unexpectedly ‘out of the blue’. It was striking how the themes of birth, healing and death, joy and grief, kept coming up.

Four GPs spoke of being ‘vulnerable’ to their patients who triggered emotional and spiritual change in them, sometimes in a way that mirrored the patient experience. This vulnerability was well described by Kleinman using Picasso’s Head of a Medical Student (Figure 5, Chapter 2:4:9). The fact that nearly all GPs mentioned the need to shed the pains and stresses of their clinical encounters at the end of each day suggested that Picasso got it right. Nouwen also talks of the need to acknowledge the wounds that patients inflict on healers (Nouwen, 1979).

I discussed above the dominant paradigm of reality as rationalist, materialist and deductive leaving no room for the possibility of the immanent or transcendent reality Belief in the transcendent was difficult for some GPs who also doubted their own spiritual experiences, even when they remembered them clearly after many years. ‘Perhaps I imagined it when everything was changed, brighter.’ They did, however, admit it was odd they should remember so vividly.
Some GPs experienced the transcendent as a ‘breaking in’ without any warning. One GP had such an experience in a museum in Greece. Three others had a very strong sense of the presence of God, two who were in prayer meetings and the third was alone.

One GP described being overcome by the spirit of God at a Charismatic prayer service. This GP liked to remain in control of emotions and behaviour, and was merely accompanying someone else who wished to be prayed for. On being prayed over, the GP ‘Went down like a ton of bricks’. The experience was described as a feeling of calm, not being worried about lying on the floor, but just resting in the Holy Spirit encountered within. This event changed the direction and purpose of the GPs life and was entirely in keeping with descriptions of Christian charismatic experiences leading to transformation (Shilling, et al., 2007).

Six GPs described experiences of awe, joy, deep peace, or transcendent presence. In such peak experiences, the light, beauty of the place, time and sense of connection, were intense and memorable. It was almost as if the light without reflected the spiritual illumination within. They were all in beautiful and isolated places. For this group of GPs there was clearly a connection with the transcendent in the natural world and a sense of being outside time. This sense of changed time is well documented in mystic experiences (d'Aquili, et al., 1993; Kacela, 2006). Since these events happened in wild and isolated places they also matched the wilderness spirituality described by Ashley (Ashley, 2007). Such experiences tended to arouse a response of profound gratitude. Another GP described this sense of peace and being outside time in a deep connection with a patient (Chapter 5:3:3).

There was only one GP who had an experience of global unity with the world and transcendent which they found very difficult to put into words. In this experience the GP was running. The wonderful music being listened to, the light, the birds, the smell of gorse, the sense of physical well being and the beauty of the place all came together to give an ineffable and unforgettable sense of connection, unity and enlightenment. I found it difficult to know whether other experiences of deep connection described above were also of this type, but were played down by the GPs who had them.

4 Prayer and healing
One way of seeking self-transcendence, without which life has no meaning, is to pray (McCaffrey, et al., 2004). Prayer was discussed with the GPs. It seemed reasonable to assume that only those who were religious prayed but of the seventeen GPs who prayed, eleven were
not currently attached to any religion and two had never been attached to any religion. Some prayed to God, others to a greater power not a personal God. This finding seems to affirm again that a sense of the spiritual is inherent in human beings, is actively engaged with, and seeks transcendent connection. I have not found another paper that looked at prayer of GPs in this way. They prayed for themselves, (Help!) for wisdom, for spiritual sustenance and for help for patients. Most of the prayer by doctors was done silently and without telling the patient.

In New Zealand it is rare for doctors to pray in the surgery for their patients. (Monroe, et al., 2003). Occasionally patients asked their GPs to pray for them, and three said they had done this on request. Those who were not religious said, ‘I will hope for you.’ One GP had once prayed spontaneously for a patient and got a very negative response. Several GPs said their patients prayed for them (Daaleman, 1997).

Healings as a result of prayer are included in observable mystic phenomena (Ellis, 2002; Hay, 2006). GPs described a number of healings of GPs, patients and relatives, in response to prayer. These have previously been discussed in Chapters 2:4:9 and 5:10:3:4. An unusual case was prayer by a Maori Tohunga (healer) both to heal the GP (as a child) and to heal the land on which the event occurred. The Tohunga thought the disturbed land, on which a new school had been built, had caused physical and emotional symptoms for the students. This is in keeping with the embedded spirituality experienced in Maori culture in which land, people, ancestors and descendants are all intimately connected.

There were three cases when prayer seemed to have brought about an objective physical change. In one the GP had angiography that showed blocked coronary arteries. After prayer by their church community, a normal follow up angiogram was found prior to planned surgery. In a second case the GP described in Chapter 5:10:4:5, has a patient who refused to eat. This GP described a sense of being nudged into prayer by ‘the hand of God’ and prayed silently. The patient immediately took a banana and ate it. Prayer by the GPs mother to the Medicine Buddha, healed the GP’s brother in the third case. These were all recounted in full earlier (Chapter 5:10:4).
4 Summary
This section looked at the way in which spirituality enables emotions and the effects these had on GPs. It has considered the way in which transitions from birth to death make spiritual growth essential because they demand a change of self and a coming to terms with mortality.

It has also looked at the connection with the transcendent. These happened at various levels of intensity and included EHE and mystic experiences. The interpretation of these depended on the culture and religious adherence of the GP.

3 Making meaning: Spiritual issues for GPs and patients

Introduction
Spirituality seemed to have disappeared from medicine because for the last half century the biomedical model of health did not allow any other paradigm to challenge its hegemony. The biomedical paradigm could not include spirituality because it did not have tools that could measure it. Spirituality was simply ignored, and that created a great deal of internal and external conflict for GP’s and patients. In this thesis what has emerged is that spirituality is at the centre of health and healing as it always has been.

In both East and West the principles of compassionate care and healing have been the same for thousands of years (Chapter 2:4:1). They required wisdom and careful listening with both heart and ears to hear what the sufferer recounted. Being there, being trustworthy and offering hope are central to healing and may lead to reintegration of life or preparation for a peaceful death. Prayer for the sick, and preparation for death are still part of religious practice for all major religions. They are also central to healing in traditional spiritualities including Maori spirituality. This section has six parts, spiritual journeys, bearing witness, enabling hope, healing, connections and disconnections and paradigm conflicts.

1 Spiritual journeys
There is a very long history of going on pilgrimages or journeys to seek the sacred in both East and West. Religious life was and is seen by many as a spiritual journey with progress and backsliding along the way. Such journeys were always taken in the company of and enabled by others. Spiritual journeys were well described in the literature from ancient times to the present (Williams, 2010). Phelps gave a contemporary account of a spiritual journey for a doctor searching for meaning and integration (Phelps, 2006).
The GPs talked about spirituality as a quest, a journey for themselves and their patients (Vader, 2006). GPs sought to enable healing, to provide support and accurate information for patients and to make the world a fairer, better place (Chapter 5:3:2). Three specifically chose to be interviewed so that they would have an opportunity to reflect on their spirituality. They discussed their own spiritual growth and searching throughout life, and the way that both patients and family, particularly children enabled that growth.

They also reflected on the way spiritual journeys were often precipitated or re-started by life crises and transitions. They included a search for the sacred, but could also be striving for goodness, truth or the moral and ethical behaviour of the best or highest self. They could also be coming to terms with stresses in life and learning resilience. Following the journey enlarged the spiritual vision and self of GPs, for while the beginning and the ending define each journey, the ending was shaped by how the journey was done. It was fascinating to discover that the spiritual journeys of those who were religious followed a similar trajectory to those who were not, once again suggesting that spirituality is a universal human characteristic.

A spiritual journey needs a community in which to flourish. GPs who had left religious attachment seemed to feel their lack of companions on the journey. The other factor was the effect of the biomedical model of health ( Reece, 2000). Tilburt gave a moving account of how biomedicine detached him from his inner journey and sent him into a spiritual exile Some GPs, like Tilburt, also seemed to be detached by biomedicine and searching for a spiritual home ( Tilburt, 2006).

GPs almost seemed to suggest that taking time to be, a rare occurrence in modern life, is almost enough in itself to allow space for spiritual growth. Many recounted ordinary journeys that turned into spiritual ones. It was striking how many of the GP encounters with the transcendent happened on journeys in distant places. Exposure to the natural world and time to reflect seem to be potent promoters of spiritual growth ( Kaiser, 2000). Wilderness experiences, by taking the person beyond known boundaries into something new, may also precipitate growth.

It was almost as if the physical and social disconnection of being on a journey precipitated a spiritual searching, connection or reconnection. Journeys, like major transitions seemed to thin, reduce or threaten the false or superficial sense of self or ego, so that new spiritual
awareness can emerge. This may be because on a journey, among strangers, all the usual markers for self in terms of social role are left behind. This is perhaps a good reason for keeping the name holidays, which were originally holy days.

2 Bearing witness to suffering

It was moving and humbling to listen to GP comments on privilege and wonder as they discussed their relationships with patients. They spoke of joy, love and compassion for their patients and occasionally reflected on the need for these for themselves. All these positive emotions suggest the spiritual nature of such work. Two GPs did not think they offered spiritual care, but fulfilled all the criteria suggested by a number of authors (Craigie, et al., 1999). It was compassionate, offered presence, true listening, and real hope that gave patients a sense of their own meaning. The GPs also experienced strong positive emotions connecting with their patients.

Bearing witness to suffering is a central task of GPs. Bearing witness is not being an idle bystander. It is allowing yourself to be drawn in to the world of the ‘other’. This is exactly what was so well described by another author who talked of the courage needed to provide a bridge to the suffering person and the transforming and enriching encounter when this happened (Arman, 2007). There was a good example of this in Chapter 5:4 of a GP who simply sat with the patient in wordless empathy but did not run away, in spite of their own distress at the patient’s anguish.

Bearing witness makes meaning by acknowledging the reality of suffering, and not abandoning the sufferer. The sense of abandonment and loneliness in deep suffering was certainly described by a number of GPs both in relation to their own losses and in relation to patients. They were acutely aware of the patients’ need, when afraid or distressed, for a faithful, ongoing and trusting relationship and presence from their GP. This was the essence of spiritual connection, explored earlier.

In bearing witness the GPs became vulnerable to patients. They let go of the protective carapace of the ‘medical role’ central to biomedicine and allowed themselves to be ‘just one

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57 I once had a very unforgettable experience of this. I was travelling on a ferry in Bangladesh, with a companion. He disappeared and I suddenly realised I was not only rendered dumb, since I could not speak Bangla, but also deaf since I could not understand it. My professional role was irrelevant and in a Muslim country unattached women are a shocking anomaly. I felt as if ‘I’ had vanished, for in that context my markers of self did not exist.
human being to another’. Such connection could be painful and emotionally demanding particularly if the GP was suffering emotional pain in another area of their lives. The resonance of pain, like spirituality, tends to move from one area to another. For some GPs providing faithful ongoing care was a challenge, as it made them feel trapped, or possessed, by their patients.

GPs spoke of the impasses suffered by patients stuck in non-forgiveness or despair. They told stories of angry, anxious and fearful patients. One talked of the need to forgive self, to come to terms with one’s own shortcomings, as an essential part of spiritual and human growth. They also spoke of their own wilderness or dark night experiences when they felt stuck in an impasse and hopeless. Sometimes they talked of the resonance between their own experience and that of patients, ‘am I stuck or is the patient stuck?’ (Chapter 4:3:5). A number of the GPs discussed how their own experience of suffering made them more aware of and sensitive to the suffering of patients in a similar situation.

Such bearing witness, being present to suffering, may leave the doctor temporarily holding the suffering, demanding both courage and endurance. I am not here talking of over-empathising or identifying with patients but of what might be called hopeful holding. In this the doctor may ‘hold’ the suffering until the patient or the family member is able to deal with it effectively. One GP who over-identified with a patient was told in no uncertain terms, ‘It’s not your problem!’ Fear, anger, alienation and despair normally interrupt or fracture human connections and are uncomfortable to be with. I found it very interesting that such negative emotions stimulated a caring response in many GPs. They have, it seems, a will to make things better.

Making deep compassionate connection enabled a tacit awareness of the patient’s state to develop. GPs talked about an intuitive or tacit knowing about patients that is beyond intellectual knowledge and that they identify as a spiritual connection. One described it as ‘vibes’. In Figure 6, Chapter 2, the transcendent is envisaged within, without and between as the spaces at the centre and the surrounding space. Note there is no cut off between self, other and natural world. GPs exist in a seamless unity of being and perception, even if they are not usually aware of this.

Bearing witness was the centre of good clinical practice for many papers looking at family medicine Out of this total presence developed a healing relationship which the GPs pointed
out is very similar to a good teaching relationship. The healing relationship is an enabler of hope, which is essential for human flourishing in the face of mortality.

3 Enabling hope
From the moment of birth humans live with uncertainty because in being born they will also die. Such uncertainty would be intolerable if it were not for hope. One author suggested the absence of certainty provides a basis for hope. He goes on to suggest good clinical care captures the paradox of uncertainty. While being honest when death is close, hope can still be pursued as a future goal in spiritual wellbeing (Groopman, 2005; Emmett, 2008). Another author suggested hope is a way of living and also an aspiration (Scott, et al., 2008). This resembles the analysis of hope as a noun or possession, that can be given or taken away by doctors, and hope as a verb, inherent to the core self and meaning (Whitney, et al., 2008).

Hope was a topic that came up in most of the GP interviews, as did living with uncertainty (Chapter 4:4). Hope came out of deep compassionate relationships with GPs for which trust and continuity of care were essential. One spoke of connecting and reconnecting so that ‘you become a sustaining thread’ for patients. Hope comes from the depths of individuals as well as emerging in relationships with others, and for some with the transcendent. Hope, like spirituality, unfolded throughout human life and has been a concept from early human history.

Hope in this sense is in direct conflict with the biomedical model which demands objectivity and detachment. It also runs counter to management and regulatory practices that attempt to reduce the connections between GP and patient. The MCNZ statement on Good Medical Practice that suggests personal beliefs must not affect their clinical relationships is one of these (MCNZ, 2008).

The hope in a clinical relationship resonated between the patient, patient’s family and health carer and was an aspect of their spiritual connection. GPs were conscious of the need to bring even a tiny glimmer or spark of hope to those who were despairing. They were very aware how the actions of a doctor, coming from a position of biomedical role power, could take away hope, by focussing on a biomedical probability as if it was true.

It intrigued me that while the literature was full of discussions about not offering false hope, there was nothing about not offering false despair, by presenting probabilities as if they were true. Section (6) of The Health and Disability Commission Code of Health and Disability
Services demands that medical practitioners give a full disclosure of risks and possibilities to patients in discussing diagnoses and treatments. The problem with such detailed information is that patients and their families have great difficulty extracting relevant information from such a full disclosure. The angriest patients I see at the hospice are those who have been told, ‘You have three months to live. There is nothing more we can do for you. We are referring you to the hospice’. They feel abandoned and disconnected by their hospital specialists at a time when human connection is extremely important. They get even angrier if they are still alive six months later.

GPs talked about symbols of hope, like cards that were ‘prayer flags’ of good wishes from friends. For some people the natural world is a potent source of hope, particularly in the unfolding of the seasons. GPs were also very perceptive in their understanding of the patient’s need for connection that is part of hope. The ways in which this was done included enabling links with family, friends, and the transcendent. Sometimes hope was mediated by remembering past spiritual experiences and the positive emotions they aroused. This aspect of care may include reconnecting and healing rifts in the family, so forgiveness of self and others also becomes an important enabler of hope. Hopeful holding was one of the key issues in healing. GPs spoke of a need to search for the ‘embers’ of hope and fan it back to life. This suggests the holding of hope on behalf of despairing patients, as did the comments of those who did not pray for patients but told them they hoped for them. Trust and hope were closely connected to having continuing relationships with patients. GPs were concerned that such close relationships with patients would be more difficult to make and maintain if the styles of practice did not allow them. Particular worries were the increasing size of practices and the loss of 24-hour care and maternity care.

4 Healing
For most of human history suffering people have sought healing. Illness disintegrates the healthy self. Suffering is caused by separation from self, family, community and sometimes the transcendent. Because health and healing were originally seen as spiritual as well as physical matters, healing was originally the province of religious leaders, shamans or priests and only much later became the work of doctors (Chapter 2:4:1).

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58 I recall visiting a patient who had a large tussock in the corner of his room. I commented what a lovely plant it was. From being sad and withdrawn this patient sat up and talked for half an hour on the meaning, smell, texture, uses and place of tussock in high country farming. I had intuitively reconnected the patient with the life he had so enjoyed and the joy remembered illuminated the present moment. For this man tussock was a symbol of hope.
Healing restored the patient to a sense of wholeness, harmony, integrity and meaning in their life and reconnected them to their family and community. Healing, then, was the ability to transcend suffering and reconcile the meaning of the disease event with a sense of wholeness. There is a sense here of implicit spirituality, the deep human connection between patient and healer that GPs talked about in bearing witness.

Healing was about a re-integration within and without, where patients develop a new self not overwhelmed by disease. It may include cure but it does not have to, for alleviation of pain and learning to live with chronic illness are also healing. It was something that patient and healer enable together, for healing only happens in relationship. This illustrates the very important fact that healing demanded dialogue in order to happen, like both hope and bearing witness. It cannot simply be handed to a patient like a prescription. It is a process of seeking meaning and enabling empowerment for the sufferer. In that process the healer and sufferer connect deeply at a spiritual level.

This explains the wonderful collection of healing narratives from the GPs about their patients. It is also the basis of the wounded healer. Some GPs were certainly aware of the vulnerability of doctors to their patients and their need to pay attention to their own spiritual wellbeing in order to be able to enable healing. One GP also pointed out that in order to be a healing presence the doctor must ‘heal thyself’. Another suggested that healing may be about the coherence within the patient (who was in the right place) and in the community.

For people living in a traditional or pre-modern society illness still separates them from family and community, partly as a result of the threat of the spread of illness to others and partly because they may have transgressed a tapu or been cursed by an enemy. A spiritual illness can be as lethal as a physical one. In Tanzania patients who had been cursed died within four days, unless a local healer was brought in to lift the curse. In New Zealand a Maori patient presented with a sudden onset of hypertension as a result of violating a tapu. This also needed to be put right, or in Maori tradition made noa. The hypertension settled immediately when the tapu was lifted.

Healing while dying was also described. GPs looking after dying family members bear witness to suffering and hold the family member in meaning by remembering with them.

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59 Only once have I seen a European who thought he was cursed. He had just come to New Zealand from Africa. I listened to his story and the symptoms and reinterpreted them in the light of the psychological and biomedical understanding in European terms. He went away cured.
They find this as satisfying and privileged as looking after patients. One GP’s father had an astonishing reconnection with his family just before dying, after two years of being silenced by dementia (Chapter 5:7:2). He was able to tell them how much he loved them and say goodbye, which was a wonderfully healing experience for the whole family.

Healed patients, who were integrated within, at peace with themselves and their world, were unafraid to talk of dying. There are several examples in the interviews. Such patients continued to find meaning as they die and can ‘offer hope to others’. GPs commented on the way these patients were immensely attractive to others, giving out a sense of calm, peace, healing and love. They became a source of healing and hope for family, community and doctor as they moved towards death. Both the attraction of the positive emotions they radiated and the comfort they gave to those distressed about their imminent deaths were very plain. The healing here was a sense of wholeness or integration, a gift of the dying to the living.

5 Connections and disconnections
Connecting experiences for GPs were often accompanied by positive emotions, particularly joy, as discussed previously. The other striking thing about spiritual connections was the dynamic way they moved from one domain to another. While some GPs only discussed one domain of spirituality, for example the deepest self, many connected to all aspects (self, other, natural world and transcendent) either at the same time or sequentially. This tendency for spiritual connection to spread from one domain to another was common, shown in the winding back and forth of connections within the narratives.

I noted in myself a resonance with joy and peace when listening to positive stories and a sense of sadness or anguish when I heard painful ones. The spreading out of spiritual connections between people and the mirroring of emotions that occurs may reflect the neuro-physiological processes seen in mirror neurons in the brain. This mirroring confirms the witness of others to suffering. There is also some evidence of positive emotions, ‘happiness’, being both attractive to others and enabling of community (Nouwen, 1979; Vaillant, 2008; Cattaneo, et al., 2009).

1 Birth
Birth is the first connection. In many cultures there are special welcoming rituals, prayers and blessings for infants and special food for the new mother. This suggested the birth of a child was not just about the immediate family, but also about being made welcome and protected.

60 The experience of running a workshop in which people connect deeply tends to bear this out. They become more cheerful and connect more freely.
by the community, for in a very real way infants are signs of hope for the future. This highlights the reality that as humans we exist in a network of relationships, not as isolated individuals.

I recollect seeing a mother in Algeria swaddling her new baby; wrapping him tightly, then winding the swaddling string round and attaching it with an amulet until only his head was visible, with his beautifully painted eyes. She began with a blessing and ended with a blessing and the sight stays with me after more than forty years.

There are prayers and rituals in Maori culture for newborn babies and their mothers. A Maori GP told of being in the painful position of knowing a patient wanted these and feeling unable to offer them because they did not fit with either the position of a medical student or the biomedical model of health care offered in the hospital.

GPs who had practiced maternity care spoke of it with wistful remembrance as times of particularly close connection, not just to the woman giving birth but to the child and the rest of the family. This was another example of the way spiritual connections moved from person to person and often across years and between generations. I am thinking here of the GPs who remember and the patients who remember. One GP who claimed not to be spiritual said ‘you see how important that bond is …people travel a long way to see you’ about a patient who travelled the length of New Zealand for a pregnancy test, so that someone she knew and trusted could confirm it. This was, perhaps, the resonance of spiritual connection within both patient and doctor.

A GP near retirement, who had birthed three generations of a family remembered what an intense joy it was ‘it brought tears to my eyes’. This GP immediately went on to recall the suffering and death of the mother (and grandmother) in that family and the grieving and healing that followed as a result of being present for patient and family. Once again spiritual connections are revealed that wind backwards and forwards in time and between different people.

Another GP talked about the suffering and spiritual connections that were made when patients were considering abortion. The conversation in the interview had been about whether patients exposed the vulnerability of doctors. The GP agreed it did, and immediately went on to reflect that women considering abortion were very vulnerable and wanted to honour or acknowledge
the life of their child even though it was going to be terminated. A similar need is certainly expressed by women who have an early miscarriage, to have their lost child recognized and acknowledged. Once again the interconnectedness of spirituality is revealed, moving from one person to another.

2 Disconnections

The literature was very clear that continuity of care was valued by patients, and by GPs. It provided an ongoing witness to the narrative and the suffering of patients. Knowing patients over long periods built trust between GP and patients. It allowed GPs to help them find a new story when they were ill (Davidson, 2008).

When I considered the depth of human and spiritual connection that GPs described it was clear patients and doctors become attached to each other. As emerged in the interviews, they have affection for one another. For some GPs this affection feels claustrophobic and they tend to move work place to avoid it. Others find it the most satisfying aspect of their work, the thing that keeps them in practice.

When doctors move practice, or retire, they and their patients both feel a sense of loss. Some years ago I made a radio programme on Doctors and Patients for the Christchurch Clinical School. I interviewed doctors and patients about the experience of leaving each other. Both grieved after a change of doctor or the loss of a patient. One GP told of the sadness and depression suffered on retirement.

Conflict between doctors and patients that ends in the patient or doctor withdrawing is a painful experience for both (Boero, et al., 2005). A particularly painful disconnection occurs when a formal complaint is laid about a doctor (Considine, 2007). This not only negates the relationship between doctor and patient but also puts into question the self image and worth of the doctor, both of which touch into the spiritual life of the doctor. Two GPs reflected on how painful and wounding this is and one goes on to think through the healing needed after it.

61 Women suffer greatly if they are unable to give birth. This suffering is about the loss of potential connection and creates a sense of emptiness within. Many years ago I was involved in a weekend retreat in which the issues of grieving and letting go were considered. The participants were asked to think of something they were hanging on to, that prevented them from growing, and to demonstrate it by painting, clay modelling, poetry, or any other artistic medium. One woman came with a tiny pot in which there were three little seeds of clay. She reduced the whole gathering to tears: ‘This pot is my womb. These seeds are the children I did not have. I lost them in early pregnancy.’
Another painful disconnection is burnout. Burnt out doctors feel disconnected from their inner self, family and patients. They are emotionally exhausted and unable to carry on practicing competently (Hassed, 2005). More than two thirds of the GPs interviewed said that they had reached this point at some stage of their careers.

They felt as if they were being untrue to themselves and pretending a relationship they did not feel ‘a secular piosity’ and were not sure if they could carry on. In many of these cases it was a lack of awareness of their own emotional exhaustion and a cluster of transitions at the same time that led to burn out. They also often hesitated to look for help, and most workplaces were not supportive.

Negative emotions of sadness, anger, depression and frustration usually accompanied disconnections. Yet it was clear that these negative emotions in patients engage and challenge GPs to try and alleviate suffering. 62 GP interviews were full of accounts of attempts to engage suffering patients and enable them to move out of impasse into freedom but they seemed disempowered when it came to themselves.

3 Death

Death is the final disconnection for each person. It was identified by GPs as a critical time to be present, to accompany patients and support and explain the process and needs to their family and friends. The literature was clear about what constitutes good care in the dying. Being there, treating the whole patient as a person, being kind, maintaining hope and helping the patient find meaning are all critical in good care that includes spirituality (McKee, et al., 1992; Scott, et al., 2008). To these the GPs added helping the family grieve and let go of the dying person, resolving conflicts and enabling forgiveness. All these were well demonstrated by the GPs both in relation to patients and in their own families. One GP talked of (and specified the capitals for) ‘A Good Death’ as a job well done when patients were enabled to die with dignity, unafraid and without pain.

Two GPs spoke of facing their own death. In both cases it was connections to others and the transcendent that made their suffering bearable. When reflecting on their family deaths, it was the sudden deaths that were overwhelming. They were an immensely heavy burden for the bereft to carry: ‘like a skyscraper on your head’. It was not even possible to get comfort

62 I noted sadness and a wish to enable healing myself, as I listened to negative experiences and emotions from the GPs, particularly when they seemed stuck in an impasse.
within the family, for all the members were carting loads of grief at the same time. I find that image of skyscraper immensely touching – a literal reaching to heaven for help, while being flattened by the weight of grief. The hardest aspect of this was that other people seemed unaware of the burden of sadness being carried, and they avoided the bereft person. This suggests they were tacitly aware of the suffering but felt overwhelmed and unable to address it. That suffering felt contagious.63

Almost half of GP stories of memorable patients, were about patients who had died well, for whom they had been able to be present, care well and enable a peaceful death. I was very struck by the mirroring way patients absorbed doctors into their families, but doctors also carried their patients embedded in their memory. Stories of dying patients enabled these GPs to weave spiritual connections with family, place, community, doctor, other health carers, the transcendent and sometimes animals (Anandarajah, 2008). Carrying such memories was clearly helpful in coping with other similar situations. GPs grieved for patients, although some found this difficult to do, since biomedicine demands emotional detachment and gives no tools for dealing with grief when attachment has occurred. The GPs who admitted their own grief at the loss of long-term patients went to their funerals. GPs who found it difficult to grieve, tended to tell fewer stories about dead patients and did not attend funerals.

Dying patients and grieving families go through the stages of transition outlined above. There is realisation of impending death; sometimes a frantic searching for cure; the process of letting go and accepting death as part of life; and finally death itself. This can be an extended and painful journey if family members and patients cannot communicate and come to a place of peace. It can be particularly painful for GPs if they have experienced unhappy deaths in their own families. Their role is fluid and complex, acting as advocate for patients with the families and hospital specialists, enabling good care and supporting the family as well as the patient. The role of the doctor is to supply meaning and hope, which was discussed previously in this chapter.

GPs often remain with patients when ‘being there’ requires both courage and the ability to face their own grief and mortality. So that dying patients and their families will not have to ‘talk to strangers’, GPs gave their mobile phone numbers. What a depth of tacit awareness there is in that. They visit bereaved families and write cards of sympathy. When the GP has

63 I have certainly heard similar accounts from patients, ‘You would think cancer was catching, people cross the street to avoid me.’
been very present for patient and family, the grieving family feels connected to the GP and appreciate their presence at the funeral.

The sense of aloneness in dying was universal. It was increased by the way in hospital health carers tend to withdraw when someone dies, when what the dying and bereft need is a renewed sense of connection. Grieving was about re-weaving the networks of relationship, which is why it was better done in community. Some cultures cope well with the process of dying, providing community support when the family is feeling the loss. This was what made the Celtic wake, or Maori Tangi such an appropriate way of dealing with death. They celebrate life and death as a seamless whole, in which family and community gather to assure the bereaved that they are not alone and connections continue and can be re-made both by remembering and re-connecting.

6 Paradigm conflicts
The issue of paradigm conflicts has come up before. I would now like to give it some undivided attention. Three levels of paradigm conflict have emerged in the process of this thesis. The first is the conflict of cultures and world-views (Chapter 2:3). The second is the conflict of health management models (Chapter 2:4:3). The third is the conflict of medical paradigms between the biomedical and holistic that emerges particularly as the difference between cure and healing (Chapter 2:4:9).

1 Culture and community
Several papers explored community connection and cohesion as an important spiritual and health issue. Community support, religiosity and social capital were important factors for health (Lloyd, 2006; Schultz, et al., 2008). Two papers considered spirituality as being in a right relationship to all, based on an understanding of mutual equality and interdependence and suggested these principles should form the basis of good health care institutions as well as good human relationships (Kaiser, 2000; Reece, 2000). Connection to the community and social cohesion was clearly important for some GPs, particularly those in rural areas or small communities.

A number of urban GPs also spoke of the loss of community and subsequent loss of neighbourliness and support for those in need in urban areas. This urban loneliness is certainly in keeping with the findings of others (Cook, et al., 2009). One GP reinserted a lonely patient into the community by enabling her to join a church band. Another, when
taking a sabbatical, was surprised to find rural communities still practiced neighbourliness. Voluntary work, looking after the sick and frail and baking for new mothers were all part of this.

In 1960s New Zealand was a very egalitarian society in which the income gap between rich and poor was small and the focus was on the common good. The income gap is now sixth highest in the world and markers for children’s well being are poor. Imprisonment rates are second only to the USA, yet the incidence of violent crime has escalated (Yamey, et al., 2001). The impact of these changes on health and the practice of medicine has been very significant. Twenty per cent of the population have a mental illness and infant mortality is second worst in the western world.

Materialism and individualism have made acceptance of shared responsibility for the community difficult. It is striking how much this attitude has developed in the past forty years and what a huge impact it has had on individual and community health. GPs were aware of the impact of materialism and individualism on their patients. In working long hours to meet their material wants, patients suffered from social and family deprivation. Their unhappiness was labelled depression and antidepressants used to ‘treat’ it. One GP talked about their well functioning community, that could meet social and spiritual needs, but left material expectations unsatisfied because unemployment was high. Other GPs also talked of patients who felt empty, depressed and meaningless in spite of having an excess of material goods because their lives lacked real meaning and connection to others.

Maori GPs were well supported by their communities by kaitiaki, the care and guardianship they received from those with community responsibility for the spiritual and physical care of others. One spent time teaching Maori language at their home Marae, reinforcing for themselves and those they taught the central values and meaning of their culture. Another had returned to live and work in their birthplace, with all their connections with place, ancestors, descendants and wider family or whanau. Such principles formed the background to good care in the Maori world. They also provide an alternative model for the Pakeha world.

New Zealand is fortunate in having a strong traditional Maori culture to continually challenge the modernist world-view. The Maori renaissance has ensured that Maori traditional attitudes to spirituality and health are enshrined in law. Maori spirituality is recognised and acknowledged as an essential part of all community activities. There is however a tendency to
limit such spirituality to Maori alone and ignore its presence in other cultures, including Pakeha.

2a Conflict of medical paradigms

Biomedicine is the dominant medical paradigm at this time. Evidence Based Medicine (EBM) emerged from it twenty-five years ago, developing out of epidemiology, which is about population health not individual illness. It rapidly became preeminent because it complemented the political and economic reforms in health at that time, appearing to control costs, distribution of resources and quality by ‘rigorous objective scientific methods.’ However, as discussed previously, biomedicine fails to address individual health, and spiritual and social needs (Chapter 2:3:3).

The major medical advances came about as the human body was dissected in greater and greater detail and viewed as an object or series of objects. This distanced patients from doctors, and indeed from themselves as integrated people. The growth of more and more super-specialties that focussed on smaller parts of the person gave rise to increasing competition for scarce resources (Scadding, 2007; Miles, 2009b). I discussed the difference between the encompassing gaze of love that takes in the whole person and the fragmenting ‘clinical gaze’ of Foucault that focuses on the disease (Chapter 2:4:9). In fact technology has moved the fragmenting gaze even further into the patient. Scans and ultra microscopy divide the patient up into smaller and smaller bits. CT scans even reduce them to slices.64

The other technology that shifted the medical gaze away from the whole patients has been the computer. The time spent with patients has been reduced and the time spent looking at ‘virtual patients’ on computers increased, even when the real patients were present. Patients complain about doctors who stare into computers while consulting and some GPs also complain about the need to stare at computers rather than look at patients.

This change is detrimental to the care of patients and their connection with doctors. It has moved the body as text that needs to be carefully observed and repeatedly examined, to the body as icon, in the IT sense. All the technical information about the patient resides in the computer, hence its central place in modern medicine. But this is looking at the map, not the territory (Freeman, et al., 2003; Mainous, et al., 2004). Doctors are failing to relate to, look at

64 I once had an abdominal scan during which the radiologist solemnly introduced me to my various organs. “Anna, spleen, Spleen, Anna”. Well, maybe not quite so formally. I was both amused and appalled. This was he was talking about. I was already in those organs.
or examine the patient because the results are in the computer. This ignores the uniqueness and individuality of the patient, treating them as ‘disease units.’

This biomedical paradigm conflict first emerged when the GPs were medical students. Teacher attitudes towards patients and students were sometimes arrogant, dehumanising and elitist. Such teachers had failed to make human spiritual connections that are essential for good teaching or healing. Students were told that a fierce intellectual competitiveness between them would lead to good, detached, clinical medicine. Cure was the focus of biomedicine and inability to cure was a failure. Some teachers presented biomedicine in hospitals as simple and scientific when in the real world outside hospital, in general practice, it was often complex, imprecise and unpredictable. It was interesting to observe that when talking about curative medicine GPs often employed modernist, biomedical reductionist ideas, but when discussing disease or dying they used traditional, holistic pre-modern concepts and ideas. The medical paradigm conflict was also a conflict of world-views of the isolated individual versus the integrated community.

The impact of biomedicine on the good health of doctors was also a matter of concern. There was a very sad story from one GP of an empathic, caring, oncology house surgeon who listened to and connected with patients, being transformed over five years in hospital medicine. As an orthopaedic registrar he was burnt out, disconnected, exhausted and unable to connect or empathise. Several of the GPs talked about their own experiences of burnout as a result of the pressures of biomedicine, where they were unsupported and expected to tough it out.

2b Conflict of medical paradigms - Cure vs healing

For millennia human beings have sought healing from medicine. They sought meaning and reintegration with themselves and their communities, the wholeness that lies at the heart of healing. Occasionally they were cured. Over the last century, cure has become a real possibility for some but not all diseases. Medical advances in pharmacology, surgery and medicine have raised expectations that cure is the real purpose of medicine. The excessive focus on cure in biomedicine turned death into a failure, whereas prior to this it was seen as the normal end of life. EBM measures those who will most benefit from cure and politics then decides who can be treated. Since EBM tends to ignore chronic illnesses, ageing and dying, issues of justice distribution in health resources are also often ignored. The GPs often talked
of the need to advocate for their chronically sick patients whose needs were not being addressed by the health system.

Cure is the treatment or removal of a disease by medical or surgical means. It focuses on the pathology of individuals. This individual focus can further isolate patients from family and friends, since it often removes them from home and work and may admit them to hospital, where they are removed from all their normal human connections.

Cure also moved the focus, from the suffering patient, onto the doctor administering the treatment, and the technology that assists it. The more heroic and dramatic the treatment and complex the technology the more the focus is shifted. Thus, for example, the ability to perform heart transplants, or more recently face transplants, makes worldwide headlines. But it is the doctors who are in the limelight not the patients. The cost of these treatments for rare conditions is enormous and reduces available funds for care in the community.

This sort of biomedical cure disempowers the patient and empowers the doctor, because it fails to connect with the wider implications of illness and healing. The more technological the treatment, the more power is attached to it. Cure becomes a gift to be given or withheld at the behest of the doctor. In this it enables hope as a noun, also to be given or taken away. Since cure is costly it is also given or withheld at the behest of the health funders and politicians. Such over-emphasis on cure also disempowers GPs who are not high tech specialists and therefore do not merit financial support.

The difference between cure and healing is seldom reflected on. Biomedicine is unable to deal with the wider effect of disease on the patient’s life, social connections and work. Those who cannot be cured do not fit into this medical paradigm and tend to be ignored. This includes those with chronic illnesses, the aged and the dying. With current ageing populations in the Western world, this section of medicine is going to grow very fast in the next half century. Yet illness always has ramifications of disconnection from others including the transcendent that help to define the suffering experienced.

The change from care to cure crystallised when cardio-pulmonary resuscitation was introduced in 1960. Doctors were saving lives by defeating death. No one asked the patients if

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65 It is easy to forget how alienating and disempowering the experience of being admitted to hospital is. The patient is interrogated, labelled like a parcel, and may have their clothes removed and be made to wear hospital garments. They are then put into a room with strangers.
they wanted to be resuscitated. This problem had not disappeared. A very recent paper by Eisenberg suggested everyone should be trained to do CPR so the statistics of survival can be improved. One GP commented how destructive it was for students to be told death is a failure, not a normal part of life. One GP resuscitated a child, and spent weeks worrying whether the child would be brain damaged.

Biomedicine not only replaced healing with cure, in many ways it has confused it with cure. This resembles the blurring between spirituality and religion discussed previously, that also attempted to define and constrain a complex and interrelated aspect of human life (Chapters 2:3:5 and 4:3:7). This shows most clearly in the moral language used in prevention of disease, particularly the life style diseases. For these, being undisciplined and self-indulgent (sinning), leads to developing the disease (consequence of sin). Seldom is there a reflection on other social and indeed spiritual issues that may be involved which emerged frequently in the GP narratives of memorable patients (Chapter 5:4).

Biomedically-inclined doctors were often baffled when, after effective treatment, patients continue to complain because they are not healed. Holistic GPs, however, often spoke of the mystery of healing they recognised as happening in relationship. The conflict of medical paradigms affected patients as well. Some believed biomedical cure by the doctor alone was a right. They did not think that patients had to work at health and healing as well.

3 Health Management conflict

Community health has a spiritual dimension. Vader suggested that since the WHO recognised spirituality as important in 1981 individual and population indicators of spiritual health are equally important. While individual ones might include generosity, charity, solidarity, self abnegation, concern for others, self-sacrifice, self-discipline and self-restraint, social indicators would include equity, justice, sexual equality, unity in diversity, participative decision making and power sharing. He goes on to say that commitment to the transcendent was the most powerful motivator for human behaviour, so that ignoring the spiritual dimension deprives us of the means of empowering individuals and populations to achieve better physical, mental and social health.

The spiritual health of a health care facility is important and management practices affect the spiritual health of health workers. The way that clinicians are dealt with by managers will shape the way they manage patients. If managers ignore the human and spiritual need for
connection and community, and treat employees with a lack of respect, it was less likely the clinicians would be able to form healing relationships with patients. GPs certainly gave accounts of how poor management affected their ability to care well.

Belonging to a community is a fundamental aspect of human identity and Reece suggests that without belonging humans lack souls. If that is so spiritual connections in community and in health organisations, are not a luxury but a necessity.

Health management has changed rapidly in New Zealand. Prior to 1984, management in the Department of Health and in hospitals was by a team of Chief medical officer, Chief nursing officer and Chief Administrative and Financial officer. Hospital wards and clinical units reflected this model of professional involvement and cooperation. The model depended on cooperation and mutual trust. Communities of care in wards and specialist units of the hospital cooperated in the interests of best patient care. While the hours of work were long, junior staff were mentored, supported and felt part of the team and tended to return to the same institutions when they finished their specialist training.

A series of health reforms in New Zealand, starting in 1974, focussed very strongly on an economic and biomedical models that discounted the spiritual and relational in medicine. EBM appealed to health planners and economists because they thought it could measure use and costs accurately. This was an illusion, since EBM, the basis of biomedicine, depended on epidemiological estimates and did not take account of local and particular needs. It had no control over demand for services.

The health reforms had the specific political aim of weakening the status and power of health professions. Clinical managers were deliberately removed, on the grounds that they would resist change and there was a serious loss of institutional memory that could have prevented mistakes being repeated in the new system. Conflict intensified between managers and health professions as each followed their own agenda and the introduction of commercial management practices created enormous tensions and a lack of trust that persist to this day. Many of the GPs feel under valued. As young doctors they frequently felt unsupported and harassed by their seniors and their work conditions. This appeared to get worse after the health reforms.

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66 I worked as a manager for Rural Hospitals, GP liaison and Allied Health Services in the Canterbury Hospital and Area Health Boards from 1984-1992 and this section is based on that experience as well as the references.
67 EBM = Evidence Based Medicine
Subsequent changes in health management have continued to erode community and connection, fundamental spiritual aspects of health care. Shift work was introduced for junior doctors in order to reduce the wage bill. There does not appear to have been reflection on what this might do for the continuity of care for patients or the learning opportunities for junior staff. Burnout for medical staff is high as it was for this group of GPs (Cunningham, et al., 2009; Henning, et al., 2009; Linzer, 2009).

The same health management practices were introduced into general practice, with practices being encouraged to compete against each other and cooperation being reduced considerably. At the same time pressure increased to form larger group practices, where patients belong to the practice and were not always able to see their own doctor. It was less expensive to have management staff dealing with a large group than a small one. After hours work has been taken over by commercial after hours clinics, initially encouraged in the name of competition. A national health telephone information service was introduced to cut information seeking consultations in General Practice.

Such services may be convenient to some patients and doctors, but they fragment clinical care and erode the ongoing relationships that were so valued and important in the narratives of the GPs and patients, particularly for those with chronic illnesses and the elderly. There was a growing need for GPs to act as advocates for patients, in health services continually trimmed for economic reasons and often disrupted by strikes. One GP discussed the way in which a wedge was being driven between doctors and patients by restricting the concept of medical care to the physical ‘like having a car service’ when what is critical to healing is trust and continuity of care, both of which are spiritual aspects of care.68

Compulsory re-accreditation programmes and complex accounting processes for payments were also introduced, since there was no trust between the new managers and the professionals. These increased the bureaucratic burden and were a major stress for the GPs. It seems ironical this pointed lack of trust was being shown by health funders and planners as trust was being explored as an important part of the healing relationship. The idea that trust was important at all levels in health care, was not a concept financial managers were able to

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68 "Because of all that’s gone before…If you don’t have that kind of mutual trust….And there are external forces that are set to try and drive a wedge and say it’s just another service like having your car serviced. And if you destroy that slight, … aura around it…Things will get missed.” (13)
comprehend. Trust can only be developed by dialogue where the both parties listen to each other and pay attention to truth and justice. It cannot be developed when you tell the truth, but not the whole truth.

7 Summary
This section started by considering spiritual journeys. It looked at the central tasks in general practice of bearing witness to suffering, offering hope and enabling healing. It then looked at issues of connection and disconnection in clinical practice. While connections are enabled by positive emotions and disconnections tend to be accompanied by negative emotions and disrupt community. It went on to consider paradigm conflicts for GPs is three areas; culture and world-view; management of health services and in medical paradigms of biomedicine and holistic medicine. It considered the impact of science and technology in biomedicine as a source of fragmentation of holistic care and the devaluing and extrusion of spirituality in health care.

4 Sustaining and developing spirituality
If spirituality is central to human flourishing, then it needs to be developed and sustained. Sustaining spirituality is about sustaining the whole self, body, mind and spirit in its network of relationships. As already discussed, spirituality connects all these aspects of being as well as the natural world and the transcendent. Sustaining spirituality includes care of environment and community as well as body, mind and spirit. This total self-care is not something many doctors have been taught about.

Ways of sustaining and enabling spirituality are part of self-care. In the past the main ways of developing and sustaining spirituality were religious. Religious festivals, celebrations and markers of transitions or changes of state connected people to self, others, the natural world and the transcendent. These holy-days were not just individual practices but community ones, part of the fabric of society or the social imaginary (Taylor, 2007a pp 172-3).

This is the first age of human existence where there has been widespread rejection of religion. The reasons for this were discussed previously. In spite of these the search for the

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69 As a manager at that time, a defining moment came for me at yet another meeting about managing change. An American expert brought at great expense, told us how to manage change. ‘You tell the truth, but not the whole truth.’ I was outraged and asked quite politely but firmly, ‘Which bit of the truth do you tell?’ The meeting was brought to an abrupt end in order to avoid having to answer the question. I moved back into full-time general practice a short time later. I knew that being continually outraged by a system that violated my deeply held principles of care was not good for me.
transcendent persists and has increased over the past thirty years. It is therefore important to find ways of supporting and enabling both secular and religious spirituality.

According to the GPs ways of sustaining spirituality included close human relationships with family and friends, practicing self-reflection, connecting with the natural world, connecting with human creativity - art, literature, music, film, and being creative.

There are five aspects I will consider in relation to this. The first is about community and its erosion by changing social values, next is self-awareness, then self-care, including spiritual care, then creative activities and the last is on education about spirituality and suggestions for improving this.

1 Community and its erosion
It has become increasingly clear as this discussion has progressed that spirituality is not only central to human wellbeing but also to making and persisting in community. It enables human relationships with self, other, the natural world and the transcendent. Enabling the development of spirituality and its connection to wellbeing and healing seemed to be the basis of work in all aspects of health. The need for community and the maintenance of cultural engagement and connectedness is very clear for human flourishing. It is in community and through community that we grow as whole human beings. The problem of this post-modern age is a rapid loss of community.

There are a number of factors contributing to this. Rural people used to remain in traditional communities all their lives but this is no longer the case. Urbanisation has increased at a great rate and cities attract rural people because they provide opportunities for employment and education. In cities many of the inhabitants are newcomers, who do not belong to the established community and indeed are often rejected by it. This results in ghettos of new arrivals who have no connection with the original inhabitants and no common social imaginary of shared assumptions and beliefs. This situation is fraught with potential misunderstandings for talking past each other. Rural communities fragment and disintegrate when their young migrate to cities.

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70 I recall in 1969 being astonished to meet someone on the Chatham Islands in their mid-sixties who had never been away from the islands.
Cities crowd human beings into a small area where they have little personal space to call their own. In order to cope with this avalanche of humanity they have developed ways of avoiding human contact. They do not look at one another, or make eye contact in the street. They shut themselves off in buses and trains by working on computers, listening to personal music, reading books or talking on mobile phones.\footnote{Eavesdropping such conversation can be both fascinating and appalling since those who talk on mobiles assume they are having a private conversation even in a crowded public space.} It is impossible to go unnoticed in small communities, where people know one another, but in large cities where they do not, it is very easy to disappear.

Competition and individualism have made community more difficult. They have also greatly lessened human trust. If your worth is measured by your individual possessions, you do not lightly share your inner self or your resources with others who might take advantage of you. Materialism also contributed to this loss of community with the ubiquitous reach of the media, promoting materialist life styles as a route to ‘happiness’ reaching into every home. The ultimate effect of this aspect of culture was the economic recession in 2009, due to excessive borrowing to support unsustainable life styles.

Communication technologies paradoxically also contributed to social isolation. Young children are left in front of televisions or computers and lack connection and nurture within their families. Entertainment and education have become possible without leaving home.\footnote{I was very struck being a student now by the difference from when I did my first degree. Then I went to lectures and searched the library for books and papers. Now I did not have to go out to research and even supervisors’ comments were sent by email. All resources are available on my desk at the touch of a button.} In the virtual world of the Internet, food can be ordered, information obtained, and discussions held without ever looking at the face of another. It is even possible to create imaginary selves who have imaginary relationships in that virtual world. With that said, however, technologies are useful and can make clinical advice available from around the globe even to very isolated health professionals and may improve communication in families.\footnote{On the other hand I heard recently of a three-year-old who used Skype by himself to talk to his grandparents in Sweden.}

GPs talked about the loneliness and isolation of city life for their patients. The overriding media values of individualism and materialism ensure the relentless busyness of urban lives. People worked very long hours at the expense of their human relationships and connections. This allowed no time for quiet reflection, connecting with neighbours or the inner self. Children are also deprived in such environments.
2 Self awareness

Self-care has always been an interest for me because I find it puzzling that GPs whose work consists in trying to enable wellness, healing and cure could be so very unfocussed on their own care. It is almost as if they felt it was inappropriate to acknowledge and attempt to meet their own needs. Their efforts at cure and healing were all other-directed. I suspect this is in part due to the focus of biomedicine that expects cure and labels death or non-cure as failure. However, it must also be acknowledged that the stories GPs told of their doctor fathers working long hours and being almost entirely absent from their families, suggested the denial of vulnerability and the needs of doctors pre-dates biomedicine.

Being self-aware was the first aspect of good self-care. This runs counter to a culture that values objectivity and detachment. While current teaching of medical students does include aspects of self-awareness, the predominant paradigm described by the GPs interviewed was of ‘toughing it out’ and not paying attention to self. Biomedically trained doctors were expected to ‘do things’ to cure patients. They were not encouraged to be reflective, mindful and totally present. The practice of self-awareness, which is critical to developing spirituality, and indeed to listening attentively, was positively discouraged. They had neither time nor opportunity to reflect on their own journeys and responses to patients and were frequently physically exhausted by their volume of work.

Resilience enabled by spiritual reflection is important for human beings. It enables them to cope with the uncertainties and stresses of life. Burnout was common in the medical and other healing professions. There are suggestions in the literature that it may be becoming commoner for young practitioners. Seventeen of the GPs interviewed had suffered from burnout at some time in their careers (Chapter 6:1:3). Having supports in place to pre-empt and deal with it would therefore make sense.

Burnout was linked with a lack of awareness and self-care and a culture of endurance. The reasons for this were very varied but often included a cluster of family and workplace issues and management practices that ignored the humanity of the GP. It occurred at any stage of their careers from undergraduate to post graduate and when winding down to retirement and was usually heralded by stress symptoms. As mentioned previously the GPs interviewed were not very focused on their own needs and feelings.
The GPs were instructed during medical training to become detached and emotionally independent of their patients, because such space in the biomedical paradigm was thought to lead to better objective diagnosis and treatment. In so doing they also became detached from themselves. The reality, as they pointed out in no uncertain terms, was that they became deeply connected to their patients and healing was only enabled by such connections. They sometimes got wounded in the process and were not taught ways to heal such wounds. Thus there was an unmet need for training in self-awareness about body, emotions, spirituality and wholeness.

Meditation cultivates compassion and sensitive listening and focussed attention, in other words it raises self-awareness. Meditation, mindfulness and yoga were all recognised and used by GPs as ways of returning them to emotional and spiritual balance and reducing stress (Chapter 6:1:2). They were also ways to connect with the transcendent within.

Mindfulness, grounding and breathing were used as a way of disengaging from patients. One GP found that meditation treated their irritable bowel disease very effectively. GPs spoke of the struggle to continue the practice of meditation, starting and stopping throughout their lives. When they were most stressed they were least likely to meditate regularly.

GPs described the way comments from family, friends, colleagues, patients and even cleaners make them aware of their own stress. They recognized a wide variety of physical, psychological and spiritual symptoms relating to this. Restlessness, silence and tearfulness were certainly apparent during interviews as was empathic mirroring of positive and negative emotions. When asked to identify support for themselves they gave priority to family and friends – in other words their own community. In spite of this they often failed to allow time to be supported by any of these particularly when stressed.

3 Self-care
Practicing self-care was well understood by the GPs but they did not always actually do it, particularly when stressed. This was of course in keeping with normal response to stress which makes people less aware of their own responses and particularly makes them ignore their own spiritual needs for space and time out. It was almost as if GPs felt it was inappropriate to acknowledge they had needs. Their efforts at care, cure and healing were mostly other-directed.
Seeking a balance between the needs of patients and carers seemed difficult for some. One particularly good model of self-care included education, stress management, spirituality, exercise, nutrition, connectedness and environment (Hassed, 2005). This model can be used for health promotion, disease prevention and healing of doctor or patient. The GPs interviewed identified five main ways of supporting their spirituality: 1) human connections, 2) limits to work, 3) space to reflect, 4) creative activities and 5) religious or secular rituals.

1 Human connections

Having company on spiritual journeys was important. The top support identified by GPs was their human connections with family and friends. This required that they actually had time to spend with family and friends and some certainly struggled to find this. On the whole the GPs interviewed were good at seeking professional mentoring and supervision and ensuring company on their journeys. For some religious support was also important from ministers and church communities.

GPs occasionally worried about the burden they were putting on partners by using them as support people. This anxiety mirrored their anxiety about over demanding or dependent patients. Peer groups and Balint groups were mentioned as important supports, and these certainly did encourage mutual nurturing and self-reflection, building emotional and spiritual connections between the members. In this we see again the way spiritual connections move back and forth between people.

Spiritual self-care was about seeking self-understanding and enlargement of values and beliefs. Some work places provided professional supervision as part of their contracts, which enabled self-reflection and understanding. The GPs were very clear of the need to continue growing and developing throughout life. More than half the GPs sought professional support, either as clinical supervision, mentoring or personal therapy. Some did this as a result of being very stressed or burnt out, others as a way of preventing this from happening.

Participants also used music, reading, watching films and TV as a way of disconnecting and unwinding from their clinical work. They commented on the use of humour as a way of unwinding and found laughter a good way to do this. This is certainly supported by McKee. One GP also spoke of joking with patients as a way of connecting. Perhaps it relaxed the patients as well as the GP.
2 Limits to work

The next way of self-care was setting clear boundaries between work and private lives. This is in keeping with the findings of Lloyd. The reorganization of general practice and the development of after-hours cover by services or locums rather than individuals has changed out of hours work over the past ten years. However in smaller practices and rural practices there is still a considerable demand for out of hours attendance. GPs were often in a bind knowing that particular patients were in crisis but needing to have time off as well.

GPs told stories of heroic doctor fathers for whom patients took priority over spouses and children. Such fathers, several of whom had heart attacks from overwork, had high status in their communities. The attraction of such heroism made a deep impression on young sons: ‘that was the culture I grew up in ...being a doctor’ or ‘you know, it’s quite different, there’s more of the priesthood…the vocational…maybe it’s the lyric of a time gone by’. They both seemed to yearn for this and reject it as distancing them from their families.

They did not always consider the very different emotional and spiritual costs of patients. Writing a prescription for an antibiotic to cure an infection is far less demanding than entering into a healing relationship, or accompanying a long-term patient on their last journey to death. In the latter case it was essential that the GP cared for themselves in order to care for the other.

Yet GP styles of work diminish opportunities for self-care almost to vanishing point. Large practices rarely function as supportive communities, particularly when many partners are working part time. GPs have been encouraged to compete with one another for patients, and sometimes have to subscribe to a practice work ethic they do not agree with. A number of GPs interviewed complained about the way their workplace expected eight hours of consultation time a day and any paper work and telephoning was to be done in ‘spare’ time. They also struggled with balancing the needs of partners, children and other family members and the demands of work.

Some GPs consciously practiced leaving work at work, finishing all paperwork before leaving, which meant working long hours. Others struggled with the way work seeped into private lives or ate into leisure time. One GP regretted having no time to develop creativity in music, singing or writing, but seemed unable to change the practice culture or allow themself
to deviate from it. Another specifically set up a practice that allowed its members to work the hours that were comfortable and appropriate for them at their stage of life.

Taking regular holidays was one way that several GPs looked after themselves. Holidays were times of spiritual nurture and links with their original meaning as holy days. GPs identified these as times to counteract stress and improve life balance. Some were good at planning and taking holidays, others less so.

3 Space to reflect

GPs were very conscious of their need to have time on their own for reflection. Some took this as an early morning walk or cycle ride. Others made time to garden or sat quietly, collecting themselves. It was a process of recognizing their mind and spirit was overloaded with ‘stuff’ they were holding for patients. Being out in the natural world certainly seemed to be helpful for this, by reconnecting them to a greater reality. For some it was also a way of taking time with friends and family.

Nearly all participants mentioned exercise as a way of unwinding. It was also a way of connecting with the natural world, of having time to reflect and of setting themselves challenges. One described it as essential for their wellbeing and found it a way of being involved with their children. Once again this illustrated the way in which spirituality connected to all domains of life. A few thought they ought to exercise more but did not. They recognised the good effects of a balanced life psychologically and spiritually but somehow found it hard to achieve.

Travels into the wilderness, or pilgrimages, have been used for millennia to enable people to get in touch with their inner self or spirit. What wilderness experiences do is remind people of what one GP called ‘the smallness’ of humans in ‘the vastness of the universe’. Mountains were particularly prone to do this, which is very much in keeping with spiritual awareness in the past. Mountains have always, it seems, been seen as the dwelling place of the sacred.

Taking time may have been easier in the pre-modern age, when the seasons of the year and the seasons of life reflected each other. There was also something then about sacred and ordinary time that was important. In the very technological, connected world we live in seasons have become almost irrelevant. Today time just is a utility, valued as ‘money’ with no sense of sacred time or being outside time. Connection in the electronic sense has also made
reflection time more difficult. It demands a positive effort to switch off from work, connection with patients or the rest of the world. It is also unnerving to get messages about things that have ‘not yet happened’ in the hemisphere you are in. 

4 Creative activities
The link between spirituality and creativity is an interesting one. Creativity is linked to exploring and revealing the core self and building community or connectedness. What creative activity does is give to others something for their sustenance as well as touching into the centre of self. The balance in life gained through having a creative activity, in addition to medicine, was clear. GPs, when being creative, connected with their inner depths and others were drawn in, sharing the activity, benefiting from it, or being an audience for it. Offering a gift to others and having it appreciated was, as one GP said, ‘one of the most sublime ways of connecting.’

Medicine, because it involves deep human connection, needs to be balanced by some outside interest that is also creative. Creativity is an important way in which awareness of spirituality emerges. This explains the deep connection that may be made between people by works of art and literature. When human beings are creative they touch into their deepest selves, into their spiritual realm. Creative activities of GPs included parenting and teaching, both of which totally engaged the GPs. Children gave meaning and purpose to life and challenged and enabled the growth of their parents. They were also, at times, sources of pain and stress, and sometimes left parents with no free time for themselves.

Students also enabled the growth and development of GPs who also enjoyed seeing their students grow and develop, in a nice resonance of positive emotions. They delighted in the warm responses of students to being taught about the tacit aspects of medicine, of living and dying, not just the diagnostics, pharmacology and therapeutics of biomedicine. They wanted to share the variety and richness of their practices and patients and to encourage students to recognise and reflect on these. One GP was very clear that teaching students or healing patients involved similar processes and both demanded deep connection. Once again the spiritual connections wind back and forth.

This was brought home to me many years ago when our eldest daughter was born in New Zealand and we sent a telegram telling her grandparents. It arrived in Europe the day before she was born.
The GPs were very creative in other ways, painting, writing, singing, playing music, photographing, gardening, cooking, building, and woodworking (Chapter 6:4). All these forms of creativity enabled people to gather in community to share in that which was created. However there were also some GPs who yearned to be creative but could never quite find time in the continual demands of work and family.

Cooking was an important creative focus for GPs. It both fed others and enabled community. For some cooking was a way of caring for the needy and of involving children in the household process of care. One participant talked about making bread ‘to relax’ at weekends and draw in children and friends to be fed. Many religions, it must be noted, have aspects of feeding the hungry within them. Gardening, like cooking, produced food for the family and others too. It also linked GPs to the earth and seasons of the natural world, allowed them quiet reflective space, and gave them exercise. Once again the interconnections in spirituality were very clear between self, other, natural world and the transcendent.

Religious and secular rituals were also ways of sustaining spirituality. These were about boundaries between work and home or letting go of stress (Chapter 6:5). Prayer was the most widely used of these and has already been dealt with in section 2 of this chapter.

4 Summary
Ways of sustaining and enabling spirituality are part of self-care. While in the past these would largely have been mediated by religious attachment this is no longer the case. Sustaining spirituality needs to take into account all aspects of self, body mind, spirit and environment. It requires taking time for self-reflection and encouraging this by exposure to the natural world, as well as having close human relationships that enable self-awareness and spiritual growth. It also demands finding ways to connect with the transcendent. Spiritual awareness was encouraged by creativity, which often links people together. Once again it is clear that entering into one aspect of spirituality often leads to the others.

5 Education about spirituality
There has been discussion about the need to educate doctors about spirituality for twenty-five years. It was first proposed in the interests of good patient care, to enable healing and hope. Like the GPs interviewed, the research was patient focused not doctor focused. While there has been general agreement that spirituality is important for patients little attention has been given to doctors. For this reason the present study focussed on GPs.
Neither of the New Zealand medical schools has specific training about spirituality, apart from mention of it in Maori Health and palliative care. This is in contrast to the medical schools in the US and in the UK which have some training sessions about spirituality. More recently it has been mentioned in the Health in the Community part of the curriculum in Otago and also gets a mention in sessions on palliative care.

GPs reported they had no education about spirituality apart from the Maori health course. Some had consciously sought spiritual knowledge and understanding but most had not. They were aware it did present in teaching about end of life, both in care of the elderly and palliative care.

I have already discussed the way in which GPs tend to ignore their own needs. What became apparent is that just as they tend to care for the other not the self, so they feel patients, like Maoris, have spirituality and they do not. Perhaps the time has come to challenge that belief because what has emerged very clearly from this study was the universal presence and significance of spirituality as a dynamic interconnecting reality.

GPs thought there was a conspiracy of silence about spirituality in academic medicine as did a number of authors. I agree, particularly in General Practice, which as a young speciality, has spent the past thirty years trying to live up to the expectations of biomedical, hospital based medicine. The persistence of this biomedical medical model, that refuses to consider the existence of any other paradigm, makes it difficult to introduce spirituality into medical schools.

While spirituality is re-emerging in medical discourse in the community it is clear that at present the dominant voices in medical education are still those committed to EBM and ignoring spirituality. Even in the face of its serious shortcomings for individual care, the alliance of academics, managers, politicians and economists resist the replacement of EBM as the only paradigm because it appears to be open to audit and ‘scientifically’ justifiable.

GPs thought that spirituality education in the sense of self-awareness and patient awareness should be introduced early in the medical curriculum as an integral part of clinical skills. Taking the time to reflect, both individually and in small trusted groups was thought to be the best way of teaching and learning about spirituality.
The views of medical students suggest that students value teaching about spirituality early in their medical school curriculum, in preparation for learning about the chronic diseases, mental illness and care of the dying (Guck, et al., 2006). A start has been made in encouraging self-reflection in the Early Learning in Medicine (ELM) module at Otago medical school. Students and doctors also need to have small group and individual sessions to reflect for themselves as well as their patients. The recent introduction of writing thought provoking episodes and availability of mentors has continued to encourage self-awareness and reflection in the last two years of medical school. Such self-awareness enables both good caring of patients and good self care.

These approaches may help to counter a purely scientific approach to medical care and encourage the re-introduction of harmony and wisdom into the medical care of patients and into self-care for doctors. The other thing that might be helpful is encouraging students to engage in at least one creative activity apart from medicine.

6 Suggestions about future spirituality training

GPs were asked for suggestions of ways spirituality awareness and understanding could be taught at undergraduate and postgraduate levels. Interestingly, in spite of having discussed the importance of spirituality in their interviews and commented on the way in which medicine was taking over from religion as the place to take existential questions, none of them mentioned spirituality specifically in relation to teaching students, but they talked endlessly about deep human connection.

Some thought that spirituality could not be taught as such and felt students learnt about spirituality from the patients and by observing good clinical care. There were concerns that religious or spiritual understanding might be imposed on patients. Some also felt that offering tidy answers might stop the spiritual searching of students. One GP expressed concern that if spirituality was made a compulsory module, it could become regulated in ways that was profoundly unspiritual. I agreed with this GP, because it has certainly become clear that spirituality by its dynamic and ever changing nature cannot be regulated. I also think that in the current New Zealand context, finding ways of discussing spirituality in secular terms is essential.
The majority of GPs thought that awareness should be raised about spirituality. They saw it as central to good empathic care in whole person medicine. The central challenge of life is in the paradox of living and dying. GPs have a continual need to seek meaning for their patients and themselves, in the face of death. This needs both time and strategies for self-care.

Spirituality was something that connected the patient and the doctor. The clear links between spirituality, health, suffering and healing were a way GPs felt it could be introduced. Understanding compassion, trust and hope were very relevant. The other aspect they were very clear about was the need for patients and families to come to terms with spiritual issues as death approached.

GPs thought enquiry about spirituality should be part of normal history taking. One pointed out that New Zealand medicine is becoming very multi-cultural which made discussion about spirituality even more important. It should include beliefs and the things that supported those beliefs. Suggestions were made that spirituality could be introduced in the early clinical learning, as well as towards the end of undergraduate training as a module in final year. It was already included in palliative care modules, in care of the dying, in geriatrics as well as in general practice training. Those who had palliative care training said it was discussed in that training, whereas in general medicine and surgery it was not. Most were very clear that being aware of it and talking about it in normal conversation with patients was a way of making it an integral part of consultations. They also suggested that case studies and stories were the best way of ensuring that students participated in the discussion. Most thought that it was a subject that should be dealt with only in small groups. This would ensure the cultural safety of all students. They also felt the distinction between spirituality and religion was very important.

More needs to be done to support practitioners out in the community. The energy and intensity of the group sessions on spirituality in general practice facilitated for GPs and nurses as part of this research was impressive. Whether they were about dying, healing, hope, self-care or spirituality there was a deep engagement in the groups with each other and the subject. An amazing network of connections with self, other, the natural world and the transcendent emerged in the dialogue and feedback.

Having time for self-reflection, either individually or in small groups was seen as the key to ongoing engagement with and growth in spirituality by GPs. Since spirituality involves
emotions it seems self-evident that as GPs reflect on their own spiritual journey they become more empathic and aware of the spiritual journeys of their patients. One GP also talked about the importance of being self-aware in avoiding burnout and taking care of the self.

It seems important to recognise all these needs. Perhaps the Maori model of Kaitiaki could be looked at in large practices, so that each doctor had someone who was responsible for their wellbeing. Such a person could recognise when there were particular stresses and ensure the presence of extra care. Work places and managers that pay attention to spiritual care for staff as well as patients would also be helpful.

7 Summary
This section started by looking at the way community is important in enabling spiritual growth and sustenance and the way it has been eroded.

Next it considered the need for self-awareness and looked at ways of enabling this. Self-care of the whole person and focus on specific spiritual care was then discussed. It noted how very patient-centred GPs were trained to be, to the exclusion of themselves. It then looked at the lack of spiritual information or reflection in undergraduate and postgraduate training.

Suggestions were made of ways spiritual care and development could be introduced. It was seen as a life-long process and care of those in general practice was needed, starting in the early years of medical school. There also needs to clarity about religious and secular spirituality.

3 Conclusion
The discussion has looked at the results of the interviews in the light of literature on spirituality. It looked at understanding and experiencing spirituality. It then considered spirituality experienced in human connection and the way in which spirituality develops throughout life and emerges at transitions. It considered the paradigm conflicts that emerged as a result of world views and medical and management paradigms. It finished by exploring how spirituality for both doctors and patients may be sustained and developed.
The process of this thesis has been for me a spiritual journey of bearing witness to the lives of the GPs interviewed. Being listened to enabled them to realize they were on a spiritual journey. I also received energy, enlightenment and connection. They made me aware of the amazing way in which spirituality connects between, among and beyond the self in a new and much more visible way.

One GP said of patients ‘they come to you with a new chapter’ and for the GPs being listened to allowed them to be aware of their own narrative. It is now time to let go of them and move on, just as they moved on after telling their stories. As one said, and I can only agree ‘The journey never ends’.
Chapter 9

Further Research

This thesis has looked at the spirituality of twenty-two GPs and was done by a single investigator. It is the first research in New Zealand that specifically focused on the spirituality of GPs in their practices. It attempted to cover a wide variety of ages, stages and cultures in the participants but such a small sample is not representative and could be open to bias. There are many areas where further research is needed.

1 About spirituality

Spirituality shapes the community, the workplace and the individual. It underlies holistic health care and was found to be universally present in general practice for the doctors and patients in this study. Spirituality is both about the inner self and connection with others, the natural world and the transcendent. It grows throughout life. The transcendent is perceived in a number of ways theistically, atheistically and an unnamed power. The spiritual emerges both within linear time and outside it. This experience was described in relation to patients and to the inner self of the GPs.

What has been so unexpected in this study has been the experience and presence of spirituality in both doctors and patients. In spite of half a century of biomedicine and the hegemony of the scientific world-view in New Zealand, spirituality continues to emerge and be sought. I cannot help wondering how much of this is due to the continued presence of a traditional spirituality in Maori culture. Awareness of spirituality in health also appears to be present in Australia where there is an enduring traditional spirituality in the Aboriginal people.
Further research looking at spirituality in general practice in a country where there is no traditional spirituality might clarify the effect of traditional spiritualities.

In New Zealand there are two aspects of spirituality that seem to be particularly important – the relationship to the natural world and the land and the fact that for some people spirituality is secular and not religious. Spirituality emerged at all times of transition from birth to death. It enabled seeking new meaning and purpose in changed circumstances of life. Spirituality was certainly considered important by patients (Chapter 2:4:4). It appears crucial to enabling hope and healing.

Further research in New Zealand exploring the place of spirituality in healing and hope might be useful in enabling good holistic care.

While spirituality appeared to be universally present there is a ‘conspiracy of silence’ about it in medical schools in New Zealand, so that it does not emerges in academic medical discourse, in spite of spiritual health being enshrined as one of the pillars of Maori health. This may be due to the overriding presence of a single biomedical paradigm for medicine. This focuses on a reductive understanding of disease in the individual and seeks material explanations for all disease based on evidence-based research. It does not have tools for measuring individual spirituality.

Students here have not been trained to reflect on the spiritual health of patients or even to accept it is present, nor are they encouraged to reflect on their own health and inner harmony. Unlike Medical Schools in the UK and USA there is no training about spirituality. This needs to be addressed. The GPs in the study suggested case studies, small group work and individual self-reflection as ways of introducing spirituality. They also suggested it should be a normal part of the clinical examination to enquire about spiritual supports and needs. This is both about an awareness of its existence and ways of enquiring about it from the patients. A number of ways of doing this were suggested including case studies and small group work on self-reflection. Places suggested for the inclusion of spirituality for GPs included geriatric courses and those run by hospices.

75 This year the current Health in the Community curriculum in Early Learning in Medicine at Otago Medical School does introduce students to the spiritual aspect of patient care. There is also a system of optional mentors for more senior medical students.

76 Otago Community Hospice does discuss spirituality in some of the education courses run for GPs and nurses.
Further research would be useful to address the education and training of undergraduates about an understanding of spirituality and its place in enabling wellbeing, health and healing for patients.

Research into ways of enabling postgraduate GPs to explore their own spirituality and its importance to their patients is also needed.

2 Self-care

Spiritual self-care contributes to resilience as discussed in section 4 of Chapter 8. There is a resonance between the spirituality of doctors and patients. Failure of doctors to attend to their own spiritual needs and growth seems to contribute to a loss of resilience and a risk of burnout. There seemed to be a particular absence of time for self-reflection and attention to wellbeing. Burnout was experienced by seventeen of the participants at some stage in their careers. This made them distanced from their patients and unable to give good care, as well as distanced from their inner self. It occurred often when there were both personal and work stresses.

There was often a lack of self-awareness, as well as a lack of resources to help them reflect on their experiences and grow as a result of them, which contributed to the high level of burnout. Promotion of good health practices by acknowledging clear boundaries to work and time for creativity, exercise and relaxation is important. Maori practitioners were better supported by *kaitiaki* where one or two elders in the community were responsible for the care of the practitioner.

Very few workplaces supply mentoring or clinical supervision. Facilitated debriefing and reflection after stressful or difficult patient care also seems to be protective against burnout. Some peer groups seemed to provide opportunities for reflection and support. Peer groups are mandatory for reaccreditation in many branches of medicine. The GPs appreciated the opportunity to reflect on spirituality individually. They also appeared to find the experience of group sessions about spirituality an effective and unthreatening way of raising awareness.

More research is needed on spiritual self-care and personal support for GPs in New Zealand both on an individual basis and in groups.
3 Career stages

The GPs at different stages in their life discussed different practice patterns (Chapter 6). Having practices that encourage and enable good family care as well as good peer and patient communication seemed to reinforce the principle of good caring in a practice. More recent graduates do get mentoring as part of their GP training but those who have been in practice for some time do not. This group is particularly important to reach.

Major transitions are particularly prone to cause spiritual stress. The participants spoke of their own stresses at adolescence and mid life or when deaths, illnesses and births caused them to suffer burnout (Chapter 6). Joining new practices and leaving old ones also could be very stressful. Encouraging self-awareness at all stages would allow reflection on whether career changes need to be made. The two participants near retirement spoke of the difficulty they had letting go of practice. This group of GPs is increasing rapidly in size as the GP population ages. Careful preparation for retirement would enable both the retiring doctor and their patients to let go with less distress.

**Further research is needed on the spiritual welfare of doctors at different stages of their careers, particularly those moving towards retirement.**

4 Work styles

Participants spoke of work styles in their early training in hospitals that caused them stress and burnout. They complained about both excessive hours of work and lack of support both in hospitals and in practices (Chapter 6). As GPs they also spoke of the difficulties of finding good care for patients in hospitals when health resources were being cut. They advocated for patients which was time consuming and stressful, particularly when managers were not clinicians. They found the continual health reorganizations and the expansion of bureaucracy very time consuming.

A number spoke of having to do paperwork in their free time at weekends. They spoke of the cultures of their practices that expected very long hours of work. The other aspect of practice that was stressful was mandatory CME and auditing. The current work and social climate of New Zealand is a blaming and shaming one, which tends to add stress without improving performances.
When competition for resources was promoted between one practice and another it is more difficult for clinicians to form supportive communities of care. Such competition means energy is put into competing rather than cooperating and enabling the best care for patients. Participants also spoke of the loss of communities of care in hospitals as well as in the communities in which they worked.

More research is needed in the management styles and focus of practices. There is particular need to examine the basic values of practices in relation to the values underpinning health management changes and their impact on the spiritual health of practitioners.

Research is also needed into the ways in which communities of care may be enabled in general practice to facilitate the spiritual care of the doctors.

5 Continuity of care

The aspect of general practice that the GPs found most satisfying was continuity of care for patients and their families, over long periods of time and at important transitions. Thus being present for births, deaths and times of crisis made a lasting impression on the GPs, who saw it as a privilege and for some a ‘priestly’ role. The sense of on going connection with their patients and their patients with them lasted for years after they or the patients had moved on.

We considered above that work styles affect the people in a practice. Some participants described their experiences or those of parents as being available at all times for their patients. Current changes in the work experience of trainees in hospital and in practice have certainly had an effect on their expectations and their practice. Today house surgeons and registrars work shifts and so do not often have the chance to follow a patient from admission to discharge. They do not expect to work longer hours and be present throughout their patient’s crises. Just as specialisation fragments the understanding of patients physically and pathologically, work styles can also do this emotionally and spiritually. The challenge is to provide continuity of care without the doctor working excessively long hours.

The other aspect of practice that reduces connection to patients is working in a large group practice, where the patients do not belong to any one doctor but the practice. Current patterns

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77 I recall going back to the Chatham Islands after being elsewhere for ten years. One of my first patients came in and filled the doorway, “Gidday, Doc. You took my appendix out for me when I was just a little feller.” This same patient told someone quite recently about this, forty years after the event.
of practice where the after hours work is contracted out also mean that for patients often do not have their own GP at times of crisis.

There are some GPs who find an efficient and non-involved practice easier to cope with. However the discussions I had with most of the GPs suggest they and their patients appreciate the deep human connection that accompanies continuity of care. The tacit awareness they develop from such connection enabled the most amazing experiences. These grow out of suffering that is witnessed and the trust that accompanies ongoing care. Patients do not give such trust lightly. Having to deal with different doctors all the time, for example in a hospital, means they do not trust their doctors and do not divulge the important spiritual and emotional anguish they are experiencing.

Further research would be useful on the ways continuity of care may contribute to patient satisfaction and healing as part of the spiritual aspect of health care.

Given the shortage of general practitioners in New Zealand urgent research is also required on whether a reduction in continuity of care may reduce the work satisfaction and commitment of GPs.

6 Spiritual experiences

Spiritual experiences for the participants were a common occurrence but they were seldom talked about unless a direct enquiry was made. One of the ways in which they presented was in the close connection between doctor and patient. This led to a tacit awareness of the patient. There were occasions it seemed to show telesomatic awareness by the doctor, who sought out the patient at critical times. The importance of addressing the spiritual issues at the end of life was discussed by a number of participants. This seemed to pre-empt [pathological] grieving.

The size of this study has been numerically small. Further research on the spiritual experiences of GPs is needed.

Further research is also needed on the spiritual experiences of doctors in a variety of medical specialties to enable further consideration of the place of spirituality in current medical practice.
Bibliography


Vrettakos, N. The First Things of Creation.


Appendix 1: Spiritual issues from past workshops on health and spirituality

**Spiritual issues?**

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<td>hanging on</td>
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<td>safely held</td>
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Appendix 2: Discussion of outline with Department of General Practice
15/3/07

About 20 attended

Presented Lit review then list of spiritual issues. Some people wanted a definition of spirituality before we discussed it. I explained that since it was dynamic this was difficult and anyway I was interested in their perceptions of spirituality.

Comments
• Beliefs underpin action
• Meaning you ascribe to events
• Must identify concepts; need for philosophical basis;
• One person asserted there was no such thing as presence of evil; several thought fragmentation was not spiritual;
• one thought all the negative issues were not spiritual.

Written Additions:
life; death; humanness; faith; transcendence of suffering; failure; death, birth; grief; trust; purpose.
(only 8 returned to me)

Discussion:
• Not about religion;
• Is about beliefs and values;
• ethical behaviour;
• recognition of limits – mystery; transcendent – whatever it means – beyond comprehension and control;
• whole is more than sum of parts;
• Drs are trained to analyse ;
• problems with language;
• Maori health makes spirituality central;
• very personal and unique to each;
• meaning can only be found in dialogue;
• anxiety that it might become taken over and controlled by docs; this was countered by someone who said all we needed to do was acknowledge it;
• listen to the narrative;
• part of human identity.

Then I put up the five strands

1. Added suffering to mortality
2. Wholeness and coherence to purpose and direction
3. Some discussion about search
4. Added isolation and separation to this
5. Need for treating resentment and letting it go in clinical situation
Comments on the research questions

• One person thought they were too broad as I was looking at doctor’s and patient’s spirituality. I explained my interest was in the doctors – and they were my focus.

• Another raised the problem of my own biases – which I said I would write before I started. This person thought it was impossible to avoid self-bias but that my supervisors would guide me in this.

• There was criticism of the suggested 12 subjects feeling I should not specify how many. Also that by having different subjects they would not give any data that would be comparable. I explained I was looking for information and interested in the common threads rather than trying to draw comparisons from the participants.

• I explained I would like to have a wide variety of practitioners as I was gathering information rather than pursuing a hypothesis. One person did not like the use of “subject” and felt that “participant” would be better.

• There was no time to discuss the interpretation or organising styles. There was general agreement that a pilot interview or testing interview styles was important.

They did ask me to go back.

Responses to very informal questions in a peer group of 6

What makes practice satisfying for you?

Responses

1. Using Prescription ‘doctor’ – when teased out this meant self giving, listening, dialogue, “hopeful holding” even if no prescription treatment or other medical intervention is possible

2. Enabling a change and growth in the patient – eg moving from somatizing of symptoms to accepting that the primary cause of disease was grief at the loss of both parents in a year. Enabling a move out of impasse into a new state of being.

3. Staying with patients who do not comply with treatment and are often erratic at attending; continuing to try and engage them in dialogue.

4. Getting the diagnosis right – putting all the bits together

5. Advocating successfully for patients
Appendix 3: Workshops about spirituality

From Cure to Healing – How do we practice medicine? 15/8/06

CME for GP’s

A session to explore how we practice medicine.

What is the difference between cure and healing?

Why do some people get better and others continue to come with new or old complaints? How can we deal with these?

Introduce topic by asking the group to talk to their neighbour about their understanding of “cure” and “heal.” 5 minutes.

Feedback 15 minutes

Tell brief case study of the patient who comes with her fourth different physical symptom.

Ask the participants to think about similar patients for them and discuss.

Feedback 15 minutes –

 tease out the common threads as recording on OHP

Finish with a summary of difference between ‘curing’ and ‘healing’

From Cure to Healing – the inclusion of spirituality

Cure: to care; to feel concern; to sorrow; from Old High German OED

One of the problems with current medical care is that too little attention is given to healing as opposed to cure. The advances of medicine over the past 200 years, which have followed the scientific revolution, have been about cure not healing. Science, by its very nature fragments and analyses the processes of life and illness. It is by analysing that the cures or prevention of disease have been developed and aspects of living, which may lead to health, have been clarified. Unfortunately this does not make people feel healed or whole.

Curing someone of an illness often does not heal them, return them to a sense of wholeness and integrity. Cure occurs from the outside as a result of medicine or treatment given to the patient. It does not pay attention to the whole person but focuses on the disease. It therefore ignores the spiritual aspect of human being. There may be little engagement of doctor and patient as two human beings trying to make sense of a perplexing world.

There is an imbalance of power between the curer and the patient that disempowers the patient. This is signalled by the writing of a prescription, that is also in effect, a dismissal of the patient. The illness becomes a label – or perhaps a lens through which the patient is seen.
The patient becomes an object to be observed not a person to be communicated with. The real person in their complexity disappears behind the label. They are not engaged in the curing apart from taking their medicine, or not, and neither is the doctor, except in an intellectual sense.

Increasingly in the past fifty years the sense of lack of healing has been expressed in a number of ways. The extraordinary increase in the use of alternative therapies suggests that there is something missing in scientific medical care. It is not that the patients do not believe in science – they are all indoctrinated from early childhood that science has brought the human race to where it is now. They simply feel there is something missing.

Since cure does not engage the patient there is always a balance between the cure and its possible side effects and patients make decisions, often without sharing them with their doctors, as to which pills or treatment they will take and when. They fear that they will become dependent or addicted to medicines. They may reject the label of sickness and so refuse to take medicine. They may also stop drugs from time to time to cleanse their bodies or give their systems a rest. Most studies of patients in drug taking show only about 50% compliance.

“Nevertheless, while doctors may be in control during the consultation, the medical profession is oddly powerless once the person has left the surgery. Lay people have always exercised the power to reject prescriptions or modify their regimens. Undoubtedly they will continue to exercise this power as “normal” behaviour for them.”

Doctors are less good at deciding the cure they are offering is worse than the disease. They often feel angry and rejected when patients go to alternative therapists or refuse to accept the treatment offered. Treatments that cause mutilation by heroic surgery, radiotherapy or chemotherapy are often not seen by patients or their families as healing. Starting therapy like artificial feeding is quite straightforward but it is not always in the best interests of the patient.

As a junior registrar in the late 1960’s, I worked in a dialysis unit. It was directed by a urologist and I sometimes felt the selection of patients was not good. I vividly remember the seventy four year old man who had problems when he was being dialysed and said to me wearily “I just wish they would stop all this and let me die peacefully. I’ve had a good life and I’m ready to go”. I told the director this but he was unmoved – he knew what was best for the patient.

Perhaps the most striking of the modern ‘treatments’ are for genetic diseases. These often merely eliminate those who might suffer from them by abortion or embryo selection, which is hardly a cure.

Knowing as we do that we live in an evolving world, to try and produce perfect or super perfect human beings seems to run contrary to the idea of the real world. It is almost as if humans can ignore the natural world. We know, for example, that there is a normal range of intellectual, aesthetic and athletic abilities in humans so why is the focus on producing the more intelligent, more beautiful, more athletic and ignoring the fact that those less striking in

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their capabilities are often better at communicating and taking care of their fellow humans? In other words, when someone believes themself to be outstanding they also may believe others to be of lesser importance. Yet if we are all unique then as a human race we cannot afford to do without the insights gained from everyone from the least to the greatest.

Cure is only possible when there is treatment that works. It demands certainty, or at least good odds, and sees death as a defeat not as a normal part of being alive. Curative medicine engenders expectations in both the doctor and the patient. Curing is seen as a possession to be coveted not a gift to be shared.

If there is no further treatment available then the response of the doctor may be “there is nothing more we can do”. Unfortunately many doctors forget to add “for this disease”. The patient therefore hears this as “Nothing more we can do for you” and feels rightly aggrieved and abandoned. The group of patients who are most likely to seek help from alternative therapists are those with chronic diseases and those who have cancer, which is not curable.

A medical student went to interview her first patient. She was a young woman with cancer. She talked at her student for two hours on how angry she was with the doctors who had “taken away her hope” by telling her disease was incurable and there was nothing more they could do.

The student said after the interview she would never tell a patient that there was nothing more she could do and take away hope. She had abandoned her plan for the interview and just listened. She allowed herself to simply be with the woman. She was shattered by the strength of feeling of the woman.

Heal: to make whole; become whole; complete; restored to health; to save OED

Healing is about the whole person and therefore includes all levels of being – physical, mental and spiritual in the world environment. It is about the engagement of the patient and healer as two human beings body, mind and spirit. Wholeness is not just about the body but about the whole person – it is about being in harmony with the various levels of self and with the world. It may or may not involve the cure of disease. It is possible to be healed and to be dying if at that point in life the patient knows that this is the time for death, and they are at peace with themselves, with others and with the world.

Healing then is primarily about the way we relate to ourselves, our fellow humans and the world. If the expectations we have of ourselves do not match the reality “I am young and strong and powerful” when we are old and weak, we are not healthy. Healing is often about forgiving our bodies, our minds and spirits for not being what we expect – forgiving our families and friends for not being as we think they ought – and forgiving the world or the life force or God for not allowing us to be unchanging and eternal. It is about remaking our relationship with self, other and the world. It is of course a life long process.

Healing recognises we are all wounded and need healing. It demands a letting down of barriers to communication and in so doing renders the healer as well as the healed vulnerable. It is precisely this that makes it difficult for doctors to recognise and promote. Accepting yourself with all imperfections and life as it is requires letting go of ideal and illusions and accepting reality in all its untidiness and messiness, injustice and incompleteness. It accepts
both the mystery and paradox of the world. It also empowers both the healer and the healed as they understand that healing occurs only in a gift freely shared. This makes both grateful for its presence. Healing sees death as an integral part of life – our final gift of self to the world.

"For whether we like it or not, death is the process that helps keep the ecosystem renovated. It's the universal composter. In this sense, death is very much part of an endless recovery model. An endless process of renewal." (Frank, 2004)

**Feedback From Cure to Healing**

3 mentioned out of body experiences
3 mentioned near death experiences. All these were positive and took away the fear of death 1 talked of the privilege of hearing patient stories

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**Spirituality in End of Life Care 25/6/08**

Workshop for GP’s and Practice nurses at Otago Hospice

Last week I had to go to Christchurch. It was a perfect winter morning. As I drove over the hill above Shag Point the sun rose. The sea was a calm shimmering blue to the East and the rising sun caught the tops of the hills and snow-covered peaks inland. The junction of the land and sea was covered with a light fluffy mist which hid the place where land and sea met: each flowed into the other under that mist.

It seemed to me a perfect image of the liminal space – the boundary space between spirit and body, between living and dying.

This is the place where we have not yet left the old behind neither do we clearly perceive the new.

1 What does spirituality mean to you? 10mins

Feedback

2 Spirituality is
3 Spirituality as connection
4 Spiritual growth

Death which disconnects - challenges us to revisit our important questions about life slide

5 The primary questions about living we ask ourselves

6 Illness provokes other questions

7,8,9 There are three case studies. I am going to divide you into three groups and ask you to discuss one of these with the person next to you. 10 minutes

What I am interested in is the spiritual issues you can find in each.

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CME Workshop for General Practitioners

First Cry, Last Breath
7/8/08
The care of the whole person in General Practice

This session will be run as a workshop to consider what spirituality is and how it is a part of GP consultations.

What gives your life meaning and purpose?
What does spirituality mean to you?
Have you ever had a spiritual experience?
How have patients raised spiritual issues in your practice?
How do you support your patients spiritual needs?
How do you support your own spiritual needs?
What education in spirituality would be helpful for students/doctors?

11.12.07

7/2009

CME for GP’s

What made me do it – and why do I stay?

(why GP’s choose medicine and what keeps them there)
The presentation today is from work in progress for a PhD on Spiritual Issues in General Practice. I thought it would be of particular interest to a teaching department of General Practice to see the reasons that doctors give for choosing medicine and the reasons why they stay.

**Choice of medical career**

They were asked when and why they chose to do medicine. Career choices tend to be made at the time of adolescence, when the person is in a major life transition. A number of reasons were given, some of which were about their choices or life circumstances, others about encouragement from parents or schools. Two had had parents who died when they were young and both felt that this influenced their career choice.

As will emerge death or serious illness in the family has an important effect on spiritual wellbeing. This is because it challenges the meaning and purpose of life to be confronted with the reality of death. When it coincides with a major life transition, as it does in the two cases below, it may also influence life choices that are made at that time. 81

About that time I was thinking that veterinary medicine would become quite repetitive… and I was sort of questioning whether I actually wanted to do that…And I can actually remember the week before Mum died, because I was really annoyed that she was dying, saying to her, ‘Don’t worry I think I might do medicine Mum, I might be able to help somebody.’ So probably it was Mum and her illness that put me in that direction. Nobody in the family had ever done medicine. (9)

I had a cousin who would be about seven or eight years older than me, who chose to study medicine, and at the time he’d done that I was about ten or twelve. And I thought what a terrible job. And the only medicine I knew, the only doctor I knew was my family doctor…. Then Dad ended up … having a heart attack. And I went into this place and there was something about what was going on there that I suddenly thought, yes this is the place for me. I was fifteen, by then….

I did enjoy science but I was much more of a people person for God knows what reasons. And there was the opportunity to blend my enjoyment of doing this with scientific discipline. It’s a blend of science and arts. Bringing these two things together…So that kind of dictated my A levels and everything was convergent after that. From that moment I can still see myself in the (hospital) and seeing the name of Doctor Somebody on a door. And I thought maybe that’s where I’ll head. And from then on every subsequent possible choice or circumstance reaffirmed that. (6)

When this participant was seventeen, his father died of cancer. But he had his heart attack several years earlier.

Some participants chose medicine because they wanted to help people and make the world a better place, often because that was the family value. Clearly it was also a personal value

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81 For many years I puzzled at my own choice of medicine, which originated when I was five years old. There were no doctors in my family. Then I remembered that my mother was ill and in hospital for weeks when I was five and I really wanted to make her better.
which they lived out in a commitment to medicine. One aspect of spirituality is indeed living out deeply held values in relation to the well being of other people.

And I didn’t – I wanted to work with people. And I was brought up with a sense of helping the underdog. My father was a great socialist. And also a great sense to ever changing. That anything is possible. And so he was a doctor as well, so he had an influence on it. (3)

I’ve always been strong on the people bit. And, and quite, and probably intellectual; and interested in science. I was a mixture of a high view of myself, and a low view of myself, the two things were there, side by side. And I thought ‘Oh that’d be too difficult.’ And then we had, serendipitously, maybe grace, we had a medical student who’d come to stay…A family friend. And she told me what they did, and I enquired, and it all sounded really interesting. I was going to be …a chemical engineer, like my uncle…because he was the esteemed one in my family. (4)

I think, well I think everybody is altruistic when they are young – they want to do good. And I think my two ambitions were to be either a teacher or to be a doctor, because they were really the only things open to women.(in her culture at that time) Or nursing. But nursing was kind of infradig and my father wouldn’t have been very happy. So I think if I hadn’t got into medicine I would have become a teacher. Because I think mainly those were the only options that would be open to me. (11)

On the one hand is, um, when I think about it is a direct way to help people. Because I do believe that contributing or helping out is really important. But there’s lots of methods that you can do that, in vaccination or doing things. But I think alleviating people’s suffering is the most direct way of helping people. So that’s the reason I chose medicine. And I can be honest and say, like my Dad, I won’t say he actually pushed me towards that direction but he suggested like, you know. (12)

I wanted to change the world and make it a better place.(laughs)... A little idealistic..... Right from the time I remember the things I wanted to do were always medically orientated....Um, what stage did I decide I wanted to be a doctor, I don’t know – mid teens. But even the ideas before that had been along similar lines. (16)

Seven felt that they were encouraged to do medicine by their parents. Six had medical fathers, and some also had siblings or cousins in medicine. While the three below felt their father’s wished them to do medicine most said they were not pressured but that it was pleasing to their fathers when they chose it as a career.

Father joined a solo practitioner… So I used to accompany him on house visits. It was quite fun. …Well, there was a very strong feeling from him that that would be quite a good thing for me to do. (5)

He started off as a teacher and then went into university. But he wanted to be a doctor in fact so that may have been an influence on me…. I think I was very aware while growing up that my father would very much like me to be a doctor and I got to the end of schooling and I didn’t really know what I wanted to do but
the options seemed to be architecture, engineering or medicine. And I went along
to the three departments and spoke with people. And I thought with architecture, I
don’t have a good enough creative flair to be an architect. And engineering
seemed somehow to be just a bit dry. And medicine in a way seemed to offer the
most freedom of choice in life. (18)

I’m sure an influence was my father was a doctor though he never, I can never
recall him suggesting I should, or pressuring me to but that was the culture I grew
up in – being a doctor. And the only life style I knew. And then my older brother
did medicine, he’s six years older than me, and I don’t know what decided him to
do that. (20)

In two participants the expectation was very strong that they would do medicine and it was
decided and arranged by the community leaders in one case and an influential mother in the
other.

Well, that’s when I was at school, it was again one of my elders, the principle then
was tono (command). I was sent away. I didn’t have a choice. I was told to go off
and do medicine… Wasn’t an issue. You know. Brought up in an environment
where you know, pathways were clearly defined by those around. By one’s elders.
(7)

And so being a doctor was never really an option. Not that I didn’t think I could,
but that I didn’t think it was something that was acceptable in my family or even
something I was actually interested in. And it wasn’t until 6th form that my Mum,
my Mum is a very influential mother,(laughs).. So she saw the article about
medicine. She cut it out and said ‘ Why don’t you take this into school and see if
any of your friends would be interested in going to med school. Why don’t you
have a look at it while you’re on the train.’ (both laugh). And I was like ‘Hm. That
sounded like a hint’. So I had a look at it and thought it sounded OK and at that
stage I had no career options… And so when I was 6th form, my principal, as soon
as she got wind of it, it was only 90 kids at school, first of all I talked .to a
tohunga (Maori healer) about it, Mum would say this is going to be a good thing
and he said – yes we want a doctor that’s centred on the marae… So my principal
got a Maori doctor in to see me almost the next week, checking up what subjects I
had to get and what marks and that’s how it happened. (laughs) It wasn’t really
any passion to be a doctor – I had no idea what doctors did. (15)

In a third case it was definitely a family decision. In both the preceding cases and this one the
cultures of the participants were such that decisions about careers were usually taken by
elders of senior family members.

Medicine was actually a 3rd choice…Mum and Dad started having conversations
with me… ‘So what about medicine that seems quite good. When the 6th form
exams came out I’d passed but marks were not high enough to do medicine but I
certainly could do teacher’s college…So I went to teacher’s college – kind of just
accepted it. My third day there…Dad rings up and says …we think you should go
and do 6th form again and get a much better mark and then get into Med School.
And I said “OK” …and got into Med School. (14)

On the other hand one was strongly discouraged from doing medicine by her father, who was
a doctor. She did medicine to prove him wrong.
In fact my father tried to talk me out of it. That’s probably why I did it. It’s not a
great time to tell your 17-year-old daughter, that she shouldn’t do it, because it’s
not a good job for a woman. Emerging independence and stubbornness – I’ll show
him, I’ll do it anyway. …But he said, and ironically he was quite wrong, ‘Why
would you want to spend six years when you’re going to have children and you’ll
only ever practice part time. You’ll use up so much of your life qualifying for
what is a very difficult and challenging job and demanding.’ In reflection, I can
see that a lot of what he was talking about, in that medicine is a tough career and
asks an enormous amount of you as a person. It’s very challenging, it can be
traumatic, there are far easier and still very satisfying ways of living your life. But
as it’s turned out it is a perfect job… and it pays well and its flexible and there are
lots of different corners of it that you can choose. (10)

Three were told they were not bright enough, or medicine was too hard, which made them
determined to prove the school careers advisor wrong. In one of these the subject had a wish
to do medicine from early childhood.

And so I went in and sat down and he looked at me and said pure and applied
physics, that wasn’t you know, a question it was more of a statement, and I said
no, biology, chemistry and physics, I want to be a doctor. And he said ‘Too hard’.
That was it. That was my careers advice. ‘Too hard’ and so I thought, ‘Well, that’s
it, I’ll go with it now.’ (13)

But right from quite early in my childhood I wanted to be a doctor. But I didn’t
talk about it or tell anyone till I was about 16…. And I didn’t want to be a
nurse…It was confirmed for me when I was about 16 and we had a careers adviser
who asked me what I wanted to do. I said I wanted to be a doctor. She looked at
my marks and said – I think nursing would suit you better. That was it. I was
determined that I would do medicine. (19)

One thing I do remember was at high school the careers advisory people said –
You’ll never manage medicine, you’re not bright enough, so that determined me
to do medicine.(20)

Some were definitely encouraged by their schools.

School were very pushy. That’s where most of the influence came from. They
were quite adamant right from the start they kept saying to me – Oh, you’ll be
doing medicine! And I guess I went because I thought it was a prestigious thing
because I believed I was capable of it. And no doubt my fat
her had an influence
on that, although he never actually said anything. He wasn’t pushy himself for it.
(17)

So I grew up in that sort of medical family where father was at work and absent
all the time. With three younger brothers. And I guess what happened in the 7th
form when you are doing UE the teachers said why don’t you apply for medicine,
you’ll probably get good enough marks to get in. So I did, not being particularly
committed to it but at the same time quite interested in the broader concepts of
healing and wellness. (22)

For some the decision seems to have been almost by chance.
I don’t know if I could answer that question. I’d always been interested in what makes people well again from when they’re sick from when I was young. I was interested in science and used to play round with chemistry sets and all that sort of thing. Bit it wasn’t until the end of sixth form, and I can still remember the moment in time when it came into my head. I was sitting with a classmate of mine…And I said ‘Have you figured out what you’re going to do yet, you know with your life?’ And he said ‘I think I’m going to do law. Have you?’ And I said ‘I’m going to be a doctor.’ And it was just like that – and I suppose that’s the way my life has been really. (8)

The life choices made by adolescents about their future careers is clearly affected by a number of issues. There is no doubt that some participants chose medicine as an idealistic and ethical decision. Others fell into medicine as an option suggested for them by parents and schools. At least four did medicine because it was implied they were not up to it, or it was unsuitable for them. It is interesting to look at these choices in the light of what keeps doctor’s in practice. What is intriguing is that the reason they went into medicine does not seem to have a great bearing on how they practice. Having made the choice, or had it made for them, twenty out of twenty two have continued to practice. One is retiring at the age of 70 and the other is considering a non-clinical career. The table below shows the year of graduation of the participants.

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1 Reasons for staying in medicine 28/4

Many respondents when asked why they remained in practice said it was because of their fascination with patients. The unending variety of the lives and journeys of each person interested the doctors. Their relationship with the patients was treasured, particularly when they were patients over a long period of time. Relationships were not always positive and sometimes a challenge for both doctor and patient.

1.1 Knowing and caring for the whole person
It is endearing how doctors are attached to their patients and in some ways treat them like family, listening to them and providing them with support and nurture when they need it. Connecting is central to good care and good patient relationships and is what the doctors find satisfying. The need to recognise appropriate boundaries is ever present. What those boundaries are is sometimes questioned. The majority of the participants recognised the importance of human connection as well as clinical competence in good care of patients.

That’s what keeps me in medicine. It’s meeting all these people. And connected-making those connections… And I have to be terribly careful about not falling into the business of … self listening. And I’m very bad at doing self listening. I stop listening to them and… I’m doing my own journey prompted by their introduction…OK there’s a point of connection, that’s lovely. From then on I think our medical encounter, our human interaction, having made that strand of connection, will be more effective. (6)

The thing that is most satisfying and keeps you going in medicine is that relationship and rapport that you build up with people…. There’s also that – sometimes in general practice the other thing that keeps it interesting is knowing what is going on in people’s lives. It’s interesting to see what goes on in other people’s lives…. So I think that’s a significant part of enjoying medicine. Hearing, interacting with people. Talking to them. That’s why I run so late all the time. (2)

I’m full time in the programme but I do a half day …at the medical centre just to try and get a little semblance of knowing what the hell is going on out there. I think if I stopped seeing patients face to face I would very quickly lose interest in the other things that I do. It actually provides the stimulus to do the other stuff. (8)

The complete emotional and intellectual package of people’s lives through the consulting room. (18)

That you would, people would pour out their hearts to you and you would see them in the community. And um, I used to feel it must have been very awkward for them yet they would still come back and pour out their hearts the next time. (21)

Some of them indeed, talk about loving their patients – and then add ‘but not really’ having been trained to maintain a discreet distance from them. The need for clinical detachment emerged when talking about medical school experiences. What is interesting is the link that is made clear between trust and affection. This will be further discussed later.

So that’s why I am in there. Because I want to do something about changing it. (the medical system) And because I love people. (arms spread wide) (4)

It’s like, I remember the registrars saying to me often, especially in the early part of the year, saying ‘Look from the way you are talking you expect us to love everybody’ and I say – yes – and then you say ‘You don’t have to like everybody’. And they sort of get a bit quizzical about that, and I say you can not like somebody and still love them because it’s a different process. There are certain aspects of this person’s personality that just don’t jell with me, I can’t like them, but I still love them and I’m connected to them because I care about them.
And that’s what it’s about. And the only definition, worthwhile definition of love that I’ve ever heard, is understanding the needs of another person and wanting to tend to those needs. That’s what we do as doctors. So yes, it is that you have to love them, even the un-likeable ones. Because they’re un-likeable to you but lots of people probably do love them, they probably do like them as well even though you can’t. (8)

But I do love the patients. I loved the fact that I had two or three generations of the same family there… It’s those sort of things that keep you interested. (9)

She was a very nice lady already in her eighties who I just loved…. I suppose – and she loved me. You know she – it wasn’t love. It isn’t the right word. We had a deep affection for each other. So she trusted me and thought I could do things for her and when somebody trusts you, you automatically have affection for them. (11)

And I think that it really I don’t think I’ll ever stop learning about the richness of humankind, the diversity. That is one part I, which I love…if I ever go more into policy work…I think that the only thing I can draw on and that really grounds me is that contact with people. And I’m not removed from that. And I think that’s really important. (14)

Um. I think I love the people. You know what I mean? I love my patients, well (laughing) the majority of my patients to be realistic (both laugh) And financially that also keeps me there but I wouldn’t put that at the top of the list… (17)

Mm. I love stories. (laughs) Yeah. Yeah. And its great when you've got the patient to come for-they think they've just come for a prescription and then they tell you a new story just like I'm doing now.(1)

I think sometimes it’s habit. (laughs)...And the other thing is of course, the human story that people are willing to share with you. And it’s like going to a play. And all from person to person, just like - I feel very much like a patient, you asking me questions and me answering to the best of my ability. And coming out with things I didn’t know I would come out with. That’s, really it is a fascinating job. And it’s a vocation with me…(11)

So in working with patients that comes around their ability to engage and develop a rapport, develop a relationship both at a professional and clinical level. But where’s the boundary between that and that other dimension, the spiritual one. And I suppose people will bring their own spirituality, however they might define it, into that encounter, into that relationship, for whatever reason. (7)

I find that they educate me and I like the way they tell their stories…(17)

For some looking after whole families also had a complexity and completeness that made such practice more interesting. The connections are ever more complicated.
... and I guess I like, my favourite part of it is seeing the whole family and not just the individuals. (17)

It is sometimes possible to see the process of moving from the detached clinical to the human connection.

So what is it that keeps you in medicine – it’s that process where the lever is not something as concrete as oesophagitis, but it is something much more subtle about what is life like for this person. I say to all my students... I want you to ask two questions. Who am I meeting? Who is this person I’m meeting. And what is life like for them? (6)

One participant near retirement talks about the importance of relationships and another tells a story of a newly retired colleague missing his relationship with patients.

It’s not medicine so much now. I think it’s relationships. (21)

One of the doctors who used to work here (who had retired) … said, “I miss the gossip.” I think that is part of it – gossip is the wrong word but what he meant was just hearing what’s going on. In people’s lives. And he said thirty people a day there’s lots of little stories you pick up. And I guess that’s part of being human, part of socialising of people. (2)

Many of those interviewed realised the fascination of knowing intimate details of other people’s lives. Some recognised the importance of transmitting this fascination and respect to students.

General practice may seem very prosaic and low key, but it’s never boring…I know of GPs who get tired and burnt out but I’ve never heard a GP complain of being bored. The people are so varied and the stuff that comes through the door is so varied. There’s always potential. I enjoy the people… I get too caught up in what’s going on. (10)

They (students) might have read about it, but they haven’t seen it, and just how different that is in the social interaction and … things people will spontaneously say. Or the openness with which people will share intimate bits of their lives…. (13)

In terms of the respect with which people are held, the way in which you kind of get into people’s lives, the way in which that’s done in a comfortable manner… (13)

1.2 Long term care

For some participants being involved over a long period of time with the same person was important. It provided a different depth of relationship with their patients. It was also about the patients and their families moving through a number of life transitions.

I think it does I mean if you know your patient well – and that continuity of care thing, and you know what is going on in their lives it’s much easier to manage
people….And very easy to say to someone “d’you think you’re suffering from anxiety or stress because such and such is happening in the last five years in your life. Maybe that’s influencing it. (2)

And I can think of similar instances where there’s been an incremental development of a relationship over three or four years or longer. And that period of time has allowed the knowing of somebody else in a slightly more detailed, more expansive sort of way.(5)

And also I love watching people grow up. You know, diagnosing a positive pregnancy test and then seeing them at school, and now seeing them at secondary school. Just following them…looking at the teenagers coming in to see me and seeing where they are in their life. And just knowing they felt comfortable coming in about a very personal problem was actually quite lovely. (9)

I think there are two elements to it. There’s the one where you’ve known someone for a very long time, and they’re very comfortable and you know you’ve got all the background information, but equally there’s a thing about the physician patient setting that gives implicit trust. (13)

I think it does I mean if you know your patient well – and that continuity of care thing, and you know what is going on in their lives it’s much easier to manage people. Especially when it comes to dealing with symptoms that are due to like stress or anxiety, if you know what’s actually happening in the person’s life and at work or something, it’s really much easier to pick up. (2)

I know, and I think that is actually a very important part of what I enjoy about GP, the continuity. Something which you don’t get as a locum. (21)

I enjoy it. I enjoy being able to help people who are suffering, I think. In GP I enjoy basically having the relationship with the patients. Knowing them in an ongoing sense and helping them through their ups and downs in various things. (20)

One was very ambivalent about being in an ongoing relationship to patients and thinking of giving up clinical practice because of this. This doctor had a father who had been a GP in the same practice all his life and was available to his patients at any time.

Yes and No. There were parts of it I really enjoyed. I really enjoyed, as you do, you meet some people that you think – Oh gosh it was a real pleasure to meet that person and of course there’s all the attachment that goes on when you are in a place for a certain while, and M-----’s very strong for that. I quite like that and I also didn’t quite like it. D’you know what I mean?... I guess .... it’s taken me a long time to really determine exactly what would be satisfactory for me. Mainly because I do know I’ve got quite a restless and impatient temperament. So I do (need variety). So I think probably in five years time I’d like to be working in a non-clinical setting, possibly involved in health policy. (5)

1.3 Being transformed by patients

A number of participants remarked on how patients enriched their lives and made them grow by giving them insights into other ways of being. Most were very grateful to their patients for
this. It was one of the things that kept doctors in practice. Again here in being transformed by patients doctors seem to become more aware of their own ongoing transformation through life.

And so you have this understanding of the kind of layers that people hold in their lives and that makes you much less quick to judge people. (3)

There might be pain. It could be physical pain, it could be a psychological and emotional pain. Could be a spiritual pain. I think that’s something. So it’s being able to appreciate how does one engage in a narrative round their story. And I’d like to acknowledge that it works both ways (7)

Oh, you can just learn so much from your patients. I guess about how they see the world. How they see their health. How they get on in the world.... And some of them have fascinating occupations. I like learning about what they do in their life. (17)

But also just the ability to try and get a handle on this whole thing of meaning vicariously through patients has always been a fascination of what we do.... Your understanding of the world, because you’ve experienced that so much through other people’s lives. .. But it’s also a craving for understanding that continually needs renewal. Because what you understood one year ago or five years ago is not adequate for understanding how things are at the moment. (18)

The variety of needs that I see. The different stories. The way my patients make me grow. (19)

They also commented the practice of medicine made them a better person. This seems to refer to a sense of moral and spiritual growth.

So I think in a way that has made me a better person open to people (3)

Well the thing that played a big role during those critical years came through my contact with AA...that there is a power outside ourselves that we can call on for help, and how we call on it is entirely dependent on yourself, on how you want to do that...And ... when Bill W who started AA, went and visited the doctor who was alcoholic ...He said ‘I’m not here for you, doc,’ he said ‘I’m here for me.’ And by helping others we actually help ourselves, and I think that to some extent, it sounds kind of selfish I suppose, but to some extent medicine does that for me. I mean the practice of medicine does that for me. I feel better. I feel that it helps, if I can help other people it helps me to keep on a reasonable path. (8)

1.4 Challenge of medicine

For some doctors the reason they give for staying in practice is the ongoing challenge. This may be cultural, psychological, intellectual and spiritual.

I suppose I quite like that intensity and the challenge of it.... I think I ‘m so used to doing it now that I don’t actually (laughs) I sometimes wonder what it would be like to be an accountant, (I laugh) because you just get used to having an intense human interaction. All day, every day. So it becomes normal. (3)
I did obstetrics for about the first fifteen years … Not well trained for it. No I didn’t do (Dip Obs) because I hadn’t intended going into general practice, because I was doing surgical training….Yes. Fully intended to do surgery. I mean most of the role models that I’d, I suppose, I’d been impressed with, were people like Vic Pearson, John Hislop, who I’d worked for as a registrar, and Bill MacBeth. So I went off to practice for a couple of years … And it ended up so far thirty-seven years. Because I had no training as a GP. There was no training programme then So I practiced hospital based medicine in the community, trying to find the 3% of patients I’d been used to seeing in tertiary care out there in general practice…And I couldn’t work out why a lot of these patients were coming to see me. We were enjoying the adventure of --------- because it was in those days…. And everything needed to be developed, because the place was developing quickly and needed a medical centre. So there were big challenges and we just stayed on. (8)

Oh, for example for me when I started med school, I knew it was that I wanted to come out and set up this clinic that was very much kaupapa Maori (traditional Maori principles) driven and combined with noa (freeing from tapu) and all these type of things. And in my heart of heart I thought that will never happen. And now I’m starting that again… Well, I’d like to finish my GP training …, basically what I want to do as a doctor is work with Maori patients, I’m quite blunt about that. That’s what I’m passionate about and that’s where I feel comfortable. (15)

I like problem solving…I guess I find them (patients) really interesting. (17)

I think it is the endless challenge of it. The extraordinary thing about medicine—particularly general practice, you just think you’re getting good at it and then something terrible reveals to you how ignorant you are after all…. It’s a lot about the need to try and pin down the uncertainties of life into some concrete form and the near impossibility of doing that but there’s always the challenge of trying to gain that understanding. (18)

The variety of needs I can see and help with. The different stories. (19)

I enjoy it. I enjoy being able to help people who are suffering, I think. In GP I enjoy basically having the relationship with the patients. Knowing them in an ongoing sense and helping them through their ups and downs in various things. (20)

I really believe that any encounter with another human being, however you meet them and we meet lots of people in our work, is um something that you really need to honour… And when we have new patients I like them to sit down first to tell me their story. Where I can truly meet them (and hold their stories with reverence). (22)

They appreciated the intensity of their work and some even speculate what it would be like to be someone else.

I suppose I quite like that intensity and the challenge of it…. I think I ’m so used to doing it now that I don’t actually (laughs) I sometimes wonder what it would be like to be an accountant, because you just get used to having an intense human interaction. All day, every day. So it becomes normal. (3)
1.5 Making a difference

Some participants find meaning and purpose in their work. They continue in practice because they know they can make a difference to the lives of their patients.

Well I think there is a whole story around this medical school thing and transcending that in some way to create something better. And that’s probably given some direction in terms of work. D’you know what I mean? (3)

I think there’s a case for, all illness in some way relates to psychological, sociological and spiritual realities. And that excludes nothing of orthodox medicine, but expands it out into some other territory …So I hope by the grace of God, when I leave that somehow in some way I’ll be able to have done something to help that into the medical curricula.. And then you can put the two together and we can be generalist and holistic. (4)

I’m …saying “if I listen long enough and carefully enough I might find the lever that we can pull to break the log jam or solve the problem or start to move on. And I think that’s what my total attention, whether it’s listening to someone for a brief five-minute consultation for something relatively trivial or an hour long counselling session…You can’t remove your attention from them and its all about saying ‘Where is the point, Where is the pressure point…so that they can then move on…And you’re thinking… lets just attend to that and we can start to unravel the tangle. (6)

I think its what I am actually contributing. Because if you actually give a contribution that actually gives a lot of meaning in your life. (12)

Many things. I might even be in medicine from a selfish point of view. The warm fuzzies you get from helping people, and that’s got to be selfish too…the ultimate selfish act, altruism. (13)

Some days I don’t know (both laugh).. Ultimately, on the whole, the majority of the time I enjoy what I do and I do feel I’m making a difference. (16)

The variety of needs that I see and can help with. (19)

Teaching students

And I’d been really keen on teaching the students in Dunedin when I was working here …And so that teaching always has been an appealing thing to do. And when …they actually came round and said can we send trainee interns…It was fantastic… Seeing young people getting the hang of it and getting excited was very good.(8)
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Appendix 4: Request letter, information sheet and consent form

9/7/08

Dr John Doe
11 Smith Street
Christchurch

Dear Dr Doe,

During the course of a varied General Practice career of 37 years in a number of different cultures and situations, both urban and rural, I have been puzzled by the absence of a literature on spiritual issues in General Practice. I have therefore embarked on a PhD on Spiritual Issues in General Practice in the Department of Bioethics, University of Otago. I am intending to interview a number of general practitioners about this topic.

This letter is to ask if you would consider allowing me to interview you. The interview would be at a time and place convenient to you and would take approximately one hour. It would be taped and transcribed and the transcription returned to you for correction and comment.

I have included with this letter the information sheet and consent form and a reply envelope. This Research proposal has been approved by the Human Ethics Committee of the University of Otago and by the Ngai Tahu Research Consultation Committee.

If you wish to discuss this with me I am available by telephone or email.
Telephone numbers: 03 4712131 or 0272237155
Email address: holan136@student.otago.ac.nz

I am sending you a set of the information documents and consent form. Could you let me know by email or phone when and where you would like to be interviewed.

Kind regards,

Yours sincerely,

Dr. Anna Holmes
SPIRITUAL ISSUES IN GENERAL PRACTICE

INFORMATION SHEET FOR PARTICIPANTS

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate I thank you. If you decide not to take part there will be no disadvantage to you of any kind and I thank you for considering my request.

What is the aim of the project?

This project is addressing the question:

How are spiritual issues addressed by General Practitioners in New Zealand?

It is the research part of a PhD thesis and from it teaching material will be produced to enable understanding of spiritual matters in General Practice.

This is not a project about religion but spirituality. I am aware that some people do not believe in spirituality as a universal human characteristic. This does not disqualify them from becoming subjects.

What type of participants are being sought?

Urban and Rural General practitioners. It is hoped to interview GPs of different ages, stages and cultures.

What will participants be asked to do?

Should you agree to take part in this project, you will be asked to allow me to interview you for 1-2 hours. All subjects will be given a code. The interview will be at your convenience and in a venue you choose. It will be recorded and transcribed. The record and transcription will be kept securely by me to protect your privacy. Participants will have the opportunity to read their transcript before it is used.

The interview will be semi-structured and use open questions so that it will follow your lead rather than being a structured questionnaire. It will explore a number of routes by which spirituality may be dealt with. After the records are transcribed they will be analysed using qualitative methods to identify common themes and groups and sub-groups which can be validated.
There is no risk of harm to participants.

Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

**Can participants change their mind and withdraw from the project?**

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

**What data or Information will be collected and what use will be made of it?**

The interview recordings will be transcribed. They will be reviewed and qualitative methods will be used to analyse them and find common themes and patterns, groups and sub-groups. These will then be assembled in order to draw conclusions, and tested for validity.

The data will be viewed by the researcher, her two supervisors and the typist who does the transcribing. It is possible some of the information may be used in journal publications preserving the anonymity of the subjects.

The results of the project may be published and will be available in the library but every attempt will be made to preserve subject anonymity.

You are most welcome to request a copy of the conclusions of the project should you wish.

The data collected will be securely stored in such a way that only those mentioned above will be able to gain access to it. At the end of the project any personal information will be destroyed immediately except that, as required by the University's research policy, any raw data on which the results of the project depend will be retained in secure storage for five years, after which it will be destroyed.

Reasonable precautions will be taken to protect and destroy data gathered by email. However, the security of electronically transmitted information cannot be guaranteed. Caution is advised in the electronic transmission of sensitive material.
What if participants have any questions?

If you have any questions about our project, either now or in the future, please feel free to contact either:-

Dr Anna Holmes  or  Professor Grant Gillett

03 474 7977  or  03 474 7977
03 471 2131

This project has been reviewed and approved
by the University of Otago Human Ethics Committee
Reference Number 06/160

This project involves an open-questioning technique where the precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. Consequently, although the University of Otago Human Ethics Committee is aware of the general areas to be explored in the interview, the Committee has not been able to review the precise questions to be used.

In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind.
SPIRITUAL ISSUES IN GENERAL PRACTICE
CONSENT FORM FOR PARTICIPANTS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary.

2. I am free to withdraw from the project at any time without any disadvantage.

3. Personal identifying information will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for five years, after which they will be destroyed.

4. I understand this project involves an open-questioning technique where the precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops and that in the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.

5. The only risk of discomfort is over the way the questions develop. I may refuse to answer them.

6. I understand there is no remuneration for this project.

7. I understand the results of the project may be published and will be available in the library but my anonymity will be preserved.

8. I understand that reasonable precautions have been taken to protect data transmitted by email but that the security of the information cannot be guaranteed.

I agree to take part in this project.

.................................................................................................................. ........................................
(Signature of participant) (Date)

This project has been reviewed and approved by
the University of Otago Human Ethics Committee
Reference Number 06/160
Appendix 5: Interview Guide

Thank you for agreeing to be interviewed. I am going to start with a few questions about your own experience in medicine and in your life.

Preliminary Questions

Where were you born and grew up?
Where were you educated?
What do you see as your own culture? How do you understand it?

When did you graduate in medicine?
Where was it? How did you find medical school?
Have you done any other study, formally or informally, in medicine or any other subject since graduation?

What work have you done since graduation in medicine?
What kind of practice are you in now?
Where would you like to be in five years?

Do you have a partner?
Have you any children/grandchildren?
Are you responsible for the care of any other members of your family or friends?

Have you any particular social groups you belong to?
Do you enjoy any creative activities outside medicine?
What do you do to relax?

Opening Question

Interview Questions

1. How do doctors perceive and name spiritual issues in their patients and themselves?

What does spirituality mean to you?

Have you ever had a spiritual experience?
(a sense awe, the presence of God, the transcendent, connection)

What made you choose medicine as a career? Did you have any idea of a doctor’s role when you started?

We all carry patients who stay with us. Tell me about a memorable patient?

What about a memorable doctor?

How important for patients is a sense of connection with family, friends or the natural world?
Have you ever felt that there was something sacred, holy or mysterious in your work? Can you explain what you mean by using an example of a patient?

Do you see any difference between suffering and pain? What about cure and healing?

What keeps you practicing medicine, keeps you fascinated?

2. What language is used to describe spiritual issues?

What words do you hear your patients using to describe their suffering?
(I am distinguishing here between suffering that engages the whole person and pain that affects a particular part of the person.)

Questions of despair and hope often come up in consultations – How do they present to you?

Do you ever think your patients are stuck and unable to move on?

Why do you think they get stuck?

Have you ever had a patient who has presented what you would think of as spiritual issues?

3. How do doctors perceive their own spirituality in relation to their work?

How about you – what gives your life meaning, purpose and direction?

Do you have a sense of connection to family, friends, nature, the cosmos?

Have you any religious connection?

Have you had to deal with serious illness in your family or for yourself?

What helped you to cope?

Did it make a difference to the way you were able to deal with patients?

Do you grieve for and with your patients?

What for you makes a patient difficult?

4. How do doctors seek and find spiritual support for themselves?

Do you have any signals that tell you that you are stressed physically, mentally and spiritually?

What ways do you use for letting go of the suffering and distress handed to you each day?

How do you support yourself physically, mentally, emotionally and spiritually?
What do you do to relax and refresh yourself spiritually and emotionally?  
(family; friends; peers; nature; religion; creative activity; exercise; music; contemplation)

Have you ever felt close to burn out?

What was going on for you then?

How did you deal with it?

5. How do doctors seek and find spiritual support for their patients?

Can you tell me about a patient you have had with spiritual pain?

Has a patient ever asked you directly about a spiritual issue?

Has a patient ever talked to you about hearing, sensing or seeing someone who has recently died?

How did you deal with it?

Where would you refer a patient with spiritual issues?

Has a patient ever asked you to pray for or with them?

Do you ever pray for your patients or yourself?

6. In what ways could education and support could be offered to students and General Practitioners?

What did you learn about suffering, including spiritual pain, in your training?

What about since you graduated?

What did you find helpful?

What was unhelpful?

Is there anything you could suggest that might help students or GPs to understand and cope with spiritual issues from patients or themselves?

May I contact you next week when I have typed up the transcript?  
What is the best time to phone?  
Can you suggest anyone else who would be interesting for me to interview?
Appendix 6: Emerging themes from interviews and research questions

THEMES 9/10/07

Connection
Embodiment
Self
Family
Community
Cultural
With natural world: perceived and objectively experienced
With transcendent: perceived and subjectively experienced
Enfolding time not unfolding time (spiral not linear)

Distance
Boundaries – personal, professional, cultural
Intellectual – modernist, enlightenment, post modernist
Uprooted
Abandoned
Cultural

Personal experience of medicine
Reason for doing medicine
Medical school - tough; aggressive; confrontational; disrespectful
Medical culture – male, hierarchical, oppressive, limiting
Biomedical model
Practice
Cross cultural
Priestly role
Parental role

Personal experience in family
Values
Expectations
Conflicts
Closeness
Role models
Home
Dislocation
School
Deaths
Sickness
Children

Personal qualities
Good self esteem
Self-deprecation
Cultural awareness
Freedom
Driven
Compassion
Fear of mistakes/failure
Attachment
Independence
Truth telling
Justice
Equality
Ambivalence

Caring
Listening and hearing
Feeding
Being with – presence
Staying with – fidelity, hopeful holding, waiting for right time,
Facilitating healing
Parental wisdom
Keeping/guarding secrets

Spirituality
Essence of best self
Purpose and meaning
Bearing witness to
Balance
Integrity
Wholeness
Direction
Growth
Hope
Despair
Impasse
Creativity
Space to be
Sacred space

Spiritual experiences
Vulnerable before
Not comfortable/disrupting
Break in unexpectedly
Anguish
First cry
Last breath
Self
Adolescent self ? time of changing awareness
Dark night/impasse

Patients experiences
Of family
Of body
Of pain
Of medicine
Of community
Wild facts
Out of body
After death
Telesomatic
Precognition

Mystery
Beyond knowing – cf physics and astrophysics
Enormity of
Secrets
Reverence/awe

Coping strategies
Marking changed role – changing clothes
Eating with family/friends
Creativity – writing, cooking, children, singing, music
Familiar space to be – blobbing out
In touch with natural world; seasons;
Seeking roots – back to childhood places
Exercise: walking, swimming, surfing, fishing, running, athletics, biking, skiing,
Meditation/relaxation/yoga

Enabling understanding of spirituality for GPs/students
Expecting it to be there
Telling stories/case studies
Using reflection
Listening to stories
Need to create a community to do this
Referral people – ministers, spiritual directors, chaplains

Themes from research questions 22/05/07
Doctor perception of spiritual issues
For self
For patients
Words used to describe connection
Meaning and purpose in life
Cure and healing
Hope and despair
Words used to describe sacred/numinous/transcendent
Words used to describe mystery
Medicine as vocation/work
What keeps them working
Coping mechanisms
Ways of refreshing/renewing
Stress and burnout
Where is spiritual support?
How can education be offered/has it been
Appendix 7: First Cry – Last Breath seminar poster
First Cry — Last Breath
Spiritual Issues in Clinical Practice

Dr Anna Holmes, PhD candidate, University of Otago, Dunedin New Zealand
(holan136@student.otago.ac.nz)

Supervisors: Professor Grant Gillett, Professor Andrew Hornblow
Advisor: Dr Chrysta Jaye

What are we? Where have we come from? Where are we going?
These questions about our common existence come up frequently in clinical consultations although they are often not discussed.

Health is a balance of the physical, (te taha tinana) spiritual, (te taha wairua) psychological (te taha hinengaro) and social (te taha whanau) aspects of human beings in their particular place, time, culture and stage of development.

Aim
To explore how doctors in General Practice in New Zealand perceive spiritual issues in their patients and for themselves.

Introduction
Spirituality appears to be a universal human characteristic. It may or may not be associated with religious practice. It has cognitive, experiential, behavioural and transcendent aspects. These reflect on meaning, purpose and values; connection, resilience and transformation and moral behaviour, ritual and connection with the transcendent. Attention to spiritual issues appears to have effects on resilience, healing, living well with chronic disease and facing death peacefully.

The model of medicine taught to doctors over the past fifty years has been the bio-psycho-social one. Little attention has been paid to spirituality either in the process of healing and enabling health or in the wellbeing of doctors themselves. Yet both doctors and patients need to search for meaning and purpose in life and undergo transformation from one life stage to another. In clinical medicine this search is often part of the therapeutic relationship.

What doctors say about...

What doctors say about...experience of death in their family

Well it was a relief. The sudden death of a loved one brings a lot of relief. And it’s so much easier when you can let go of that feeling that there is some unresolved issues.

I was in a different world. You know my mother and father were good enough, the finances were with me, the music was with me, the gorgeous small, but beautiful and the clouds were beautiful, and it was truly a spiritual experience... it was right. And I was in the right place and the right time... And I felt like I’ve been lucky. And I’ve been blessed. And I do not ever stop thanking.

It was about three or four months after I’d had surgery and went to Dunedin and I’d got my results. Anyway this block that were in my heart in the angiogram in Christchurch had disappeared by the time I got to Dunedin. I’d had a perfect clear set of arteries.

It’s very difficult to come up with a definition. It’s about the core of who you are. It’s the part of you that is essential to you. It’s what makes you care for others, what makes you care for yourself. And about using your talents to bring the spirit of others and continuing to develop new talents all your life. Growing.

They were lovely... They’re the offspring of my existence.

spiritual experiences
meaning and spirituality

Conclusions
This qualitative study of General Practitioners in New Zealand raises many new areas of possible research.

Results
All subjects showed spiritual awareness and were able to identify what gave their lives meaning and purpose. The majority had come close to business with self and had developed strategies for dealing with stress.

Methods
This study used a modified snowball method to select the twenty two subjects who are all doctors working in General Practice. Eleven are male, eleven female. Their dates of graduation range from 1963 to 2004. They come from fourteen different cultural backgrounds. Semi-structured interviews, lasting between one and two hours with each subject, were taped and transcribed by the researcher. Follow up conversations were held with 19 subjects and these were also transcribed and any requested changes to the original interviews were made.

What doctors say about...what keeps them practicing

The thing that is most satisfying and helps them go on in medicine is that relationship and support that you build up with your patient. They trust you and feel privileged to care for you. They feel privileged to be part of their life.

I think sometimes it’s a habit... And the other thing is the human story that people are willing to share with you. And it’s like going on a journey... That’s really like a fascinating job, And it’s a vocation with real meaning to their lives.

Funding
PhD Scholarship from the University of Otago
Bioethics Department
Southwell Health

Thanks
To all the subjects who agreed to be interviewed.

Themes from Literature
These include: Connection (with others, natural world and transcendent); Wellbeing; Healing; Resistance to disease; Ability to cope with stress; Creative transformation; Living with chronic disease; Facing death peacefully.

FirstCry LastBreath
Spiritual Issues in Clinical Practice

This poster contains work in progress for a PhD from a qualitative study of General Practitioners in New Zealand. It considers how spiritual issues present in General Practice both for the General Practitioners and their patients.

Spiritual experiences frequently cover several aspects of spirituality.

Classifying them is like looking into a picture of water-lily pools painted by Monet. More layers become apparent the longer they are gazed at.

Preliminary analysis has shown a number of domains: - awareness of self and patient - communication with self and patient - care of self and patient - accepting mortality for self and patient

These correspond to the understanding of health that underpins this work. A recent paper describes the body mind spirit, social, transcendent model of spirituality which also underpins the model of health at left.


FirstCry LastBreath
Spiritual Issues in Clinical Practice

An interesting study in New Zealand found that there were spiritual blocks in the lives of many patients. It is now being considered that spiritual blocks may be a cause of illness.

This poster contains work in progress for a PhD from a qualitative study of General Practitioners in New Zealand. It considers how spiritual issues present in General Practice both for the General Practitioners and their patients.

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Appendix 8: Doctor’s Health Matters CME for GPs
August 2009

12/3/10
1

Doctors’ Health matters
11 August 2009

Doctors’ Health
Physicians’ personal actions, and the way that our actions help our patients make better choices, are a good place to start healing ourselves, our patients and our planet.

Professor Erica Frank
Vancouver

Doctors at work
Every other doctor has been away from work because of illness during the last year, although most often only a day or two. The patient record was seldom filled, nor was the responsibility for care always clear.

Dr Eliisa Maenpaa
Helsinki

Doctors taking sick leave
Nearly all doctors have at some time worked through an illness and two thirds have done so during the past year. This… reflects physicians’ commitment to their work. On the other hand these doctors might be a danger to their patients as also to themselves

Professor Irma Virjo
Helsinki

Doctor’s Actions
Recorded sickness absence was lower than self-reported sickness absence.

Dr Ian Murphy
Sheffield
12/3/10

2 Sickness surveillance ODHB staff absences
ODHB staff absences Staff vaccination
Sickness behaviour
If you woke in the morning with a streaming cold and headache, would you take the day off work?

Christopher McKeivitt et al 1997

Sickness presenteeism

Christopher McKeivitt et al 1997
12/3/10
3 Sickness presenteeism
Sickness presenteeism (SP) is a term coined in the 1990s to describe people still turning up at their jobs despite having complaints and feeling ill.

Gunnar Aronsson et al 2000
Kevin Dew et al 2005

Attitudes in Dunedin
Nearly 50% of participants who were sick with an infectious illness at any point in the previous 12 months did not take leave whilst ill (sickness presenteeism). The most frequent reason given for working with a personal infectious illness was that the participant did not want to increase the workload of others (53.5%).

Trainee Intern Project February 2009

Dunedin 2009
Trainee Intern Project February 2009

Stress
What do you find stressful?

Stressors
• Paperwork/Bureaucracy
• Time pressures/Family needs
• Long consultation times/Inappropriate demands
• Cost of care to patients
• Fear of litigation/college/Locum shortage

Stress levels Morale
• Very high/High 54.8 39.9
• average 33.6 33.4
• low/very low 11.426.7


Stress Symptoms and Signs?
What tells you you are stressed?

12/3/10

Stress signs
• The patient who is complex – you think – I don’t want to hear this!
• The feeling I’m pretending the doctor role
• As one of our peer group said – like the time he wanted to slap somebody’s face and just didn’t do it
• Oh yes, I feel like having a cigarette or a stiff gin. Then I know I’m stressed
• And all three of us identified the experience of getting quite panicky at times… and just wanting to get up and run away.
• And I remember driving home in tears about this woman’s cancer and how young she was…and when I rang her up the next day …she said “It’s wonderful, it’s fantastic, I’ve finally got a diagnosis...”
Stress symptoms

Physical
- Headaches
- Irritable bowel
- Eating ++
- Drinking ++
- Eczema
- Palpitations
- Stiff neck
- Sore back
- Exhaustion
- Sleeping ++
- Poor sleep

Emotional/psychological
- Exhaustion
- Irritable
- Want to run away
- Tearful
- Angry at self/patient/family
- Anxious
- Restless – twitchy
- Sense of urgency
- Weeping at patient’s problems
- Odd dreams
- Forgetful

Stress related impairment
- 10% NZ doctors are very stressed GHQ>8
- 30% have significant psychological symptoms
- 55 doctors had MPS/MAS counselling from Jan 2006 and July 2008
- Service provided confidentially & free of charge
- work stresses:
  - complaints; time; workplace relationships; patient deaths; burnout;

  family stresses:
  - depression; family health; relationships; alcohol abuse; grief and loneliness; cultural stress
- NB A recent study of hospital consultants in the NZMJ gave 20-30% with high burnout
  Cunningham, W & Cookson, T and Surgenor, L & Spearing, R et al NZMJ 2009

Burn out 1
- May be:
  - Psychological/emotional
  - Physical
  - Social
  - Spiritual
Burn out 2
- Often occurs when concurrent:
  - Family stresses - illness, death, conflict
  - Health stresses - physical or psychological
  - Practice stresses - conflict, changes
  - Community stresses

Doctors who treat themselves

Self-prescribing
- Self-prescribing: 25-90% US & Europe
- Taking samples: 26% of all meds; 42% of self prescribed
- Family practice members: 96% take samples
- 54% family physicians 0-9 yrs graduated self-prescribed at least once in past year
- 90% of all meds taken self-prescriptions; common ones: antibiotics, anti-allergy, contraceptives, hypnotics

- Predictors for self prescribing:
  - male, with somatic complaints
  - No personal GP
  - Ashamed to be sick

12/3/10

5 Treating Own Families
Why do we do it?
Convenience; concerns about quality of care; not wanting to bother peers; ‘doctor’s families should not get sick’.

Where to draw the line?
- OK to do repeat prescription; not OK to start treatment for hypertension; depression; diabetes…???

- “Providing care for your own family …raises a number of ethical, emotional and competency issues”
Can we be objective enough, caring enough, skilled enough, accountable enough? Do we keep records?
Krall, EJ, WMJ 2008

Where can you get help?
MAS/MPS
To access confidential support service
0800 2255677

MCNZ
Doctors Health Advisory Service assists doctors and their families with personal and health problems. It can be contacted on: 08004712654
Email:mcnz@mcnz.org.nz

Are you in balance? Care of self body/mind/spirit and community
Doctors’ Health Matters
What do you do for yourself to keep healthy
In body
In psyche
In spirit
In relationships?

Keeping a Healthy Body
Marking boundaries
• Changing clothes when leaves work
• Exercise
  • walking, biking, gym, skiing, running, mountain climbing, kayaking, diving.
  • Gardening, planting trees, looking after animals.
• Eating well
• Adequate sleep
• Knowing physical self

Keeping a Healthy Psyche
• Choosing appropriate work load
• Leaving work at work
• Ongoing learning
• Reading
• Yoga
• Relaxation exercises
• Clinical supervision
• Mentoring
• Travelling
• Watching films that make me laugh
12/3/10

Keeping a Healthy Spirit
• Taking time to be in solitude
• Connecting with natural world
• Meditation
• Mindfulness/grounding
• Creative activity – writing, sewing, music, gardening, woodwork, singing, drama, photography, painting, cooking, craft work etc
• Spiritual/Religious activities
• Rituals

Keeping Healthy Relationships
• Time with family
• Time with friends
• Peer groups
• Appreciating support
• Being with children
• Having a pet
• Belonging and contributing to a community
Appendix 9: 2009 RNZCGP Conference Wellington

The Hidden Dimension: Spiritual Issues in General Practice
September 10 2009

Introduction

This session is based on the experience of interviewing twenty-two GPs for my PhD. This is on spiritual issues in general practice. It is also based on my life experience. I have had a long-term interest in spirituality and health, encouraged of working as a GP in a number of different cultures, and finding spirituality central to healing in all of them. I currently work as a medical officer in the Otago community hospice in Dunedin.

I am delighted to be here to present some of the results from the past two years doing research for a PhD. It has been a fascinating journey thanks to the 22 GPs who agreed to be interviewed.

This session is going to be an interactive workshop session. This slide is the outline of the session. (Slide 2)

• Introduction to research (Slides 3 4 5 6)

Spirituality is an underlying aspect of humanity. It may or may not be mediated by religious practice. There is a secular spirituality.

• Understanding spirituality (Slide 7 collect results; Summary slide 8)

These were the main themes that emerged from the interviews – the connection is with the other – patient or not – the natural world the self and the transcendent. Spirituality is on the one hand a universal human characteristic and on the other developed in each person uniquely.

Spirituality and connection (Slide 9)

Spirituality and connection – this diagram attempts to show the way in which spirituality permeates the various aspects of self, other, and natural world – the gold background is intended to suggest the transcendent however that is experienced. There is a shared aspect to this in each of the other domains.

Spirituality is … (Slides 10, 11, 12, 13)

Examples of different understandings of spirituality from the participants.

Spirituality and tacit connection (Slide 14)

Spirituality is about a tacit or intuitive connection which is very much part of the process of general practice. This statue shows a mother and infant connecting by each enfolding the other in a smiling gaze that takes in the whole of the other. GP’s use this sort of gaze when their well known patients walk through the door. It is about having intuitive or tacit
knowledge about the other that ‘knows more than it can tell’ It is about entering into the other in a caring way. Doctors are trained in medical school to use the scientific ‘clinical gaze’ described as fragmenting, in which they focus down onto the offending organ or part that brings the patient to the doctor. I think in a consultation GP’s often oscillate between these ways of connecting in making a diagnosis.

Spirituality is prior to science, an inherent property of the natural world. It makes connections, enters into dialogue, thereby empowering humans by enabling continuing growth and transformation in seeking meaning and purpose. This unique capacity to connect is exercised in relation to self, other human beings, the natural world and the transcendent. These four aspects of spirituality are found in most cultures and analyses of spirituality. It is difficult though, to define it as it is so multilayered and dynamic. The image that seems to fit it best is that of the lily pools painted by Monet – the longer you gaze at them the more layers you see.

Meaning and purpose (Slide 15)

What keeps you in practice (Slides 16, 17, 18)

1 Reasons for staying in medicine

1.1 Knowing and caring for the whole person
1.2 Long term care
1.3 Being transformed by patients
1.4 Challenge of medicine
1.5 Making a difference

Many respondents when asked why they remained in practice said it was because of their fascination with patients. The unending variety of the lives and journeys of each person interested the doctors. Their relationship with the patients was treasured, particularly when they were patients over a long period of time.

Relationships were not always positive and sometimes a challenge for both doctor and patient.

It is endearing how doctors are attached to their patients and in some ways treat them like family, listening to them and providing them with support and nurture when they need it. Connecting is central to good care and good patient relationships and is what the doctors find satisfying. The need to recognise appropriate boundaries is ever present. What those boundaries are is sometimes questioned. The majority of the participants recognised the importance of human connection as well as clinical competence in good care of patients.

*It’s not medicine so much now. I think it’s relationships.* (21)

*The complete emotional and intellectual package of people’s lives through the consulting room.* (18)

*But I do love the patients. I loved the fact that I had two or three generations of the same family there... It’s those sort of things that keep you interested.* (9)

*The variety of needs that I see. The different stories. The way my patients make me grow.* (19)
So what is it that keeps you in medicine ... it is something much more subtle about what is life like for this person.(6)

I love stories. (laughs) Yeah. Yeah. And its great when you've got the patient ...they think they've just come for a prescription and then they tell you a new story just like I'm doing now.(1)

I think if I stopped seeing patients face to face I would very quickly lose interest in the other things that I do. It actually provides the stimulus to do the other stuff. (8)

Some days I don’t know (both laugh)..Ultimately, on the whole, the majority of the time I enjoy what I do and I do feel I’m making a difference.(16)

And so you have this understanding of the kind of layers that people hold in their lives and that makes you much less quick to judge people.(3)

I like problem solving...I guess I find them (patients) really interesting. (17)

There appears to be a resonance between the transcendent within and without – and the transcendent within each person. This may explain some of the responses discussed in the results, and may perhaps throw light on the process of empathy and deep connection which participants struggled to describe.

**How do you care for yourself? (Slide 19)**

Doctors are notoriously bad at looking after themselves. They tend to work long hours. They go to work when they are ill. They fail to take holidays. They often treat themselves, rather badly, instead of having a GP. They treat their own families – usually with samples given by drug companies. They do not ask for help because from early in their career they are told that doctors should not get ill. When they do get ill they often have difficulty being treated as a patient. I think the idea of healing the healer is an excellent one.

Physicians’ personal actions, and the way that our actions help our patients make better choices, are a good place to start healing ourselves, our patients and our planet.

Professor Erica Frank
Vancouver

**How do you deal with stress? (Slide 20)**

**What creative activities do you allow yourself apart from work?**

**Stress symptoms (Slide 21)**

**Stress Signs (Slide 22)**

**Supporting spirituality (Slide 23)**

**Spiritual issues (Slide 24)**

**Spiritual issues in practice (Slide 25)**
Spiritual support to patients (Slide 26)

Supporting patients (Slide 27)

I was fascinated to find in the research 17/22 doctors prayed about patients and/or for themselves. This included 11 who had no current religious attachment and one who had never had one. It also included three who would pray for patients in the surgery if requested.

Where do you get your own support? (Slide 28)

Spiritual support to doctors (Slide 29)

Spiritual experiences

Spiritual experiences (Slide 30)

Spiritual experiences

These were extremely varied and unique as you can see from the slides. Some were in relation to the doctor and other in relation to a patient, family member, or the natural world.

Transcendent presence
Connection with natural world
Feeling sent to someone
Unexpected healing
Extraordinary human experiences
   Foresight
   Out of body experience
   Near death
   Experiencing spirits
   Ineffable experience beyond words

And I just went up the hill, and just got up to the top and was thinking – Oh! this is beautiful. all the gorse was in flower and we had the fragrance. And there were the yellow-headed finches, you know. And they flew with me as I got up and I was listening to this music and it was utter, utter, I was in a different world... the finches were with me, the music was with me, and the gorse smelt beautiful and the clouds were beautiful, and it was truly a spiritual experience and I think that people who can pray properly probably feel that. (11)

And I had some very beautiful what I would term spiritual experiences. Experiences of awe and wonder in a religious context. (10)

Natural world

Mountaineering is where I, when I get up there, I get into a sort of transported state. And that happens every time I go into the mountains..., I think it’s when something spiritual is going on, there’s something transcendent, beyond the material facts...There’s something totally transcendent in my spirit, I feel elevated, I feel joy... (6)
Being up in India in the Himalayas was pretty amazing. Sometimes in the afternoons I’d go for a walk just by myself... Just being up on a path and you wouldn’t see anybody and there’d be this vast expanse of nothingness...And although it was desolate you felt connected with it which is a very odd thing to say...I think we’ve got so much to be grateful for and I think we do need to appreciate it. (9)

It was one day when I was skiing up on a ski field...there was absolutely no one around – just me and the snow and the mountain. And blue sky and sun And, yeah. That to me would be that feeling of deep inner peace. (16)

Feeling sent to someone

And she lived alone.. She loved her cat and would stroke it and say “She and I will go together. And you know I never go out for lunch because it’s always busy. It was a beautiful day and I thought – I’ll go for a wee walk. And I went ... past her house and her roses were beautiful so I just lingered to sniff one of the roses and I saw the cat lying on the driveway. And it was very still and I thought – is that cat alright!. And you know when I got there it was dead. And I thought – Oh God – this is Mrs D’s house. I’d better just go and check.... So I went in and called her. There was no reply and the doors were open and I knew her bedroom and there she was in her bedroom gasping .... And so I just held her and she died. (11)

Deep connection with other

Birth and death both very deep, Life changing. To, to hear that first cry and last breath.(1)

Outside self

But when you can truly sit in the patients shoes and get drawn in I think there are times when that happens and everything stops for a moment, ... and that’s the moment you’ve got to shake yourself out of when the patient’s gone. But I can’t get any closer to it than that unfortunately..(8)

Unexpected healing

A young man who ...had been admitted ... I can’t remember what the circumstances, but he refused to eat anything whatsoever...(for ten days) And the ward rang me this day...Would you be able to come up and maybe have a talk to him. All my thoughts said – no this is ridiculous and a waste of time. But I did...I sat on his bed and put my hand on his arm...And the door was open and there were people running about...And I thought – this is just a total waste of time, being here. So I basically prayed and I said – Lord, there’s nothing I can do about this, but if there’s anything to be done maybe you can. And as I finished saying that. To myself. He propped himself on the bed and he leaned over and he took a banana from the bowl beside the bed and peeled it and ate it. (20)

It was about three or four months after I’d had angina and went to --------- and I’d been prayed for. Anyway the blocks that were in my heart in the angiogram in
------- had disappeared. By the time I went to ------ I had a perfectly clear set of arteries. (21)

Extraordinary human experiences

   Foresight

   I knew the moment my mother had died. I was coming back on the school bus and at 4 o’clock I said “Oh, I think she’s died” Which seems an odd thing for a sixteen-year-old to say and when I got off the bus I found subsequently at four o’clock she had died. So for me that was quite powerful at the time. (9)

   Out of body experience

   I had another patient … it was all a bit incoherent, … he said I was in ----’s room a few months ago and I collapsed, … He said ‘I found myself over at the door, looking back at … me, slumped forward in the chair and him attending to me.’ He was totally freaked out by it. (4)

   Near Death experience

   I’ve had a patient who had a cardiac arrest who I resuscitated who very clearly was leaving himself and being pulled back again… And he described very clearly leaving himself and going towards this big hill and light and then being pulled back again. And he sort of said jokingly he really wished I hadn’t pulled him back, but he now knew what was ahead of him and he wasn’t afraid any more. (20)

   Seeing or experiencing spirits

   Well I had this patient… he’s an older Maori man … When he’s unwell he speaks about spirits and says he’s visited by people in his house….And I think that’s a privilege too, he tells me that, because when he goes to hospital he doesn’t tell anyone. (2)

   Sense of presence of dead person

   I think after a person dies you can still be, particularly with people you’ve been close to or connected to, you can still be in contact with that person. Yes. (9)

Spiritual experiences quotes (Slides 31, 32)

   A last word (Slide 33)

   I think this last word sums up the richness of the interviews very well. NZ may be a very secular country with 32% in the last census claiming no religion and another 13% refusing to answer the question or objecting to it. It seems to me, however that spirituality is very much a part of General Practice.

Thank you very much (Slide 34)
Healing the Healer – Spiritual Self-care

From first cry to last breath

Physicians’ personal actions, and the way that our actions help our patients make better choices, are a good place to start healing ourselves, our patients and our planet.

Professor Erica Frank
Vancouver

Doctors are notoriously bad at looking after themselves. They tend to work long hours. They go to work when they are ill. They fail to take holidays. They often treat themselves, rather badly, instead of having a GP. They treat their own families – usually with samples given by drug companies. They do not ask for help because from early in their career they are told that doctors should not get ill. When they do get ill they often have difficulty being treated as a patient. I think the idea of this weekend – healing the healer is an excellent one.

We live in an age when the spiritual aspect of human beings is becoming important after being ignored in health for the last fifty years. I was trained in medicine at Edinburgh, Scotland in the early sixties. At that time medicine was moving into the modernist paradigm in which science was believed to be the only way to health. In Edinburgh we were the last generation of medical students to be taught by clinicians trained before the scientific paradigm became dominant.

I remember being very shocked when in 1963 I went to the Rochester, New York, and discovered the reductive biomedical model that ignored the human being in need of healing, and focussed on the disease process and cure. As you all know this model has continued to grow in dominance until quite recently. There are still many scientific fundamentalists in medicine who believe that EBM using RCT’s is the only legitimate form of medicine.

I am relieved to find there are now some academic doctors seriously questioning the biomedical model as the dominant one. I heard a wonderful paper from Professor Ian Kerridge from Sydney at the Australasian Bioethics Conference here in Queenstown last month. He said of EBM:

It may displace clinical judgement and patient values and narratives from decision making.

It is based on self-sustaining circularity as it gives priority for those things for which there is good data- in a world where not everything is amenable to measurement…according to the epidemiological or biomedical methods preferred by EBM – the RCT, systematic review and meta-analysis.

That it promises but is unable to apply epidemiological data to the care of individuals.
In other words, although EBM has a place in unravelling the way diseases appear in populations it is inadequate in dealing with unique individuals whose lived experience is not all measurable by scientific methods.

_What may be required is an ongoing assessment of evidence: comparison with the individual; attention to narrative; care and presence._

The reason why this change in paradigm is possible is that we have moved on from the era when science promised to solve all the problems of health, hunger and ageing. In fact the effect of science unconstrained by wisdom has been detrimental to health, the distribution of food and ageing – it has also been extremely damaging to the environment.

Our post-modern age is open to uncertainty and mystery in a way that the scientific fundamentalism of the sixties and seventies was not.

This session is based on the experience of interviewing twenty-two GPs for my PhD. This is on spiritual issues in general practice. It is also based on my life experience. I have had a long term interest in spirituality and health, encouraged of working as a GP in a number of different cultures, and finding spirituality central to healing in all of them. I currently work as a medical officer in the Otago community hospice in Dunedin.

This evening I think the place to start is with you.

**What does spirituality mean to you? (discuss)**

Man lives in three dimensions: the somatic, the mental and the spiritual…. Three factors characterize human existence as such: spirituality… freedom, responsibility. The spirituality of man is no epiphenomenon. It cannot be derived from and causally explained by something not spiritual; it is irreducible and indeducible….(Frankl, 1954)

Spirituality is an underlying aspect of humanity. It is the unique capacity to connect, which is exercised in relation to self, other human beings, the natural world and the transcendent. These four aspects of spirituality are found in most cultures and in many analyses of spirituality.

Spirituality is prior to science, an inherent property of the natural world. It makes connections, enters into dialogue, thereby empowering humans by enabling continuing growth and transformation. It may or may not be mediated by religious practice. There is a secular spirituality.

I believe it (spirituality) is a built-in, biologically structured dimension of the lives of all members of the human species. Therefore there are secular as well as religious expressions of spirituality, and many of them.(Hay, 2006)

Ananadarajah(Anandarajah, 2008) speaks of spirituality as having cognitive, experiential, behavioural and transcendent dimensions. I think this is helpful in considering spirituality. It is difficult though, to define it as it is so multilayered and dynamic. The image that seems to fit it is that of the lily pools painted by Monet – the longer you gaze at them the more layers you see.
Spirituality and connection

When I asked this question of the participants in my PhD research they responded in a wide variety of ways which fitted the four areas above. The more I reflected on it the more it became obvious that the spirituality is about connection – in time and out of it, with other humans and the natural world as well as the transcendent.

The three leaves of the diagram represent the self the natural world and the human other. The space at the centre represents the transcendent within and the space around represents the transcendent without. The beauty of this diagram is that it shows the intimate interconnection of the whole so that although it is possible to speak about aspects of spirituality in relation to the self, the other and the natural world and transcendent in reality all aspects are interconnected and changes in one aspect inevitably affect all the others.

There appears to be a resonance between the transcendent within and without – and the transcendent within each person. This may explain some of the responses discussed in the results, and may perhaps throw light on the process of empathy and deep connection which participants struggled to describe.

Spirituality is an embodied awareness and experience, with tendrils that reach every part and every level of the human person.

Normal somatic functions are conditional to the unfolding of spiritual life, but they do not cause or produce it. (Frankl, 1954)

It is both known and passed on by intuitive and tacit knowledge in which ‘we know more than we can tell. ‘(Polanyi, 1967) Tacit knowledge perceives the whole of that which we are aware of and know. Using it we can enter into the mind or world-view of another person seeking to learn how to ‘dwell within them’ and therefore understand them.
In a sense, with tacit knowledge we gaze at the whole person rather than reducing them to fragments, which is what the biomedical ‘clinical gaze’ of Foucault describes. (Foucault, 1973) I think many GP’s use both the enfolding gaze and the fragmenting clinical one in the course of consultations. They gaze at the whole person walking through their surgery door, then focus down onto the offending organ brought as the reason for coming to the doctor. Colloquio means conversation – the normal way in which human beings connect with each other.

![Madonna del Colloquio](image)

**Madonna del Colloquio**  
Giovanni Pisano  
Pisa

**What are the ways in which you experience spirituality?**

**Connection**

**Patients and self**

It’s about the essence of being human I think. Which is partly about yourself, but a lot of it is about your relationship to other human beings and to, you know, the physical earth as well. (3)

Just connecting with them is part of the process. Connecting and showing a willingness to reconnect. So that you become a sustaining thread. (18)

**Connection with other**

Reason for staying in medicine  
Bearing witness to suffering  
Sacred in medicine  
Letting go of control – accommodating death

400
Natural world

I need to be outside. In the depths of winter when it's dark the stars are incredible. And most times, there's only that little time. It is very important. …I walk that same route every day and it's always different – new. It's a very good sorting out time. (1)

Mountaineering is where… I get into a sort of transported state, which is spiritually much higher than when I think about it. I can think – wouldn’t it be fantastic up there – and yet when I get there, its even more. And that happens every time I go into the mountains…(6)

Well, you might have heard me talk about being connected, connected to the landscape, connected to the past, to stories, connected to generations beyond mine. Connected, you know interesting from the Maori perspective and the Maori paradigm, in all our talk, so we talk it, and we try and walk it and we try and live it. So it’s a real tangible perspective, really, so it becomes a belief. (7)

Transcendent

And then my Mum just kept praying for him because Mums always looks after their children. …Yes, she prayed specifically for my brother. So she is thinking about my brother and saying to the Buddha ‘Can you help my son?’ Yes. Yes mainly that. So when someone is sick or someone has physical problems or whatever that is the one we pray to. (12)

And I just went up the hill, and just got up to the top and was thinking – Oh! this is beautiful. - all the gorse was in flower and we had the fragrance. And there were the yellow-headed finches, you know. And they flew with me as I got up and I was listening to this music and it was utter, utter, I was in a different world. …the finches were with me, the music was with me, and the gorse smelt beautiful and the clouds were beautiful, and it was truly a spiritual experience ….But it was right. And I was in the right time and the right place. (11)

Mystery

Birth and death both very deep. Life changing. To, to hear that first cry and last breath. (1)

I think there is mystery, I think there is great mystery in the world….I suppose it’s a mystery. What is this about? How does that happen to a human being. (3)

Certainly something mysterious. There are times, there are times when you are with a patient and something happens in the consultation. (8)

Uniqueness

The people are so varied and the stuff that comes through the door is so varied. I know of GPs who get tired and burnt out but I’ve never heard a GP complain of being bored. There’s always potential. (10)
Now that’s another hard question. I believe everyone has their own spirituality….(16)

We are all very unique and different and I certainly think it is about respecting the uniqueness….And there’s always something that’s good there and the uniqueness. And when I can find that, I actually find I’m involved with them in a very meaningful way. (19)

**Unknownable beyond the rational and religious**

Spirituality is belief in things we can’t rationalise. That’s the way I’d look at it. When we go to medical school when we go wherever we’re taught there’s physics and biology to explain things but we can’t rationalise other things we believe in. (2)

What is spirituality? I don’t actually have the language about it .. there aren’t any words to, that aren’t (religious). (3)

And.. so there is something about spirit which is essentially unknowable for me. And probably, maybe that’s just the essence that is unknowable. And will for ever be. I’ve no expectation of ever understanding it, or even a desire to. I mean it is so, its like trying to imagine the end of the universe. (6)

And the concept of something great out there is much more concrete for some and much more nebulous for others. I think that for all of us there is something. (8)

**Centre of self**

Because to me the spirit of a person is the essence of a person, it’s their life force, and I think after a person dies the body is there but the life force leaves that person. (9)

And, but true goodness is you’re giving without a price tag of any sort attached. So you’re not making a martyr of yourself which is sort of making yourself a victim and putting a price on in reverse, in a way. (16)

It’s very difficult to come up with a tidy definition. . It’s about the core, the centre of you….We can only do what – each of us has been given something and we have to find from which we’re at – the better self I suppose. (19)

**Meaning and Purpose**

Some focussed on the meaning and purpose in life. This often had a sense of seeking and journey, as well as being connected to beliefs and values.

Probably doing and making a difference. And that comes from my father. Which is very big headed. But I need to be able to do what I can… (1)

So I’m not only the doctor who confirms the death, but if it’s a Maori they will ask me to help the spirit to begin the spiritual part of the journey, eh. So I have to do *karakia* or *awatia* as we call it. And to nurture the spirit and the soul on it’s way. (7)
I have a strong sense of life purpose or obligation to anything. I don’t have a defined faith that says this is what you are supposed to do but if there’s one thing that I’ve been given, or do well, or love doing it’s, that’s what my passion.(10)

The third thing is that…a sense of fairness and equity and desire to make the world a better place. Its sounds terrible, but that’s why I go into battle with politicians all the time…But that drives me. (13)

**Growth and transitions**

A number of participants reflected on the process of growth in their lives, spiritually as well as physically, emotionally and psychologically. Growth was seen as lifelong, from birth to death. The impetus for it may come from deeply held values within the person. It may also come from their life experiences both positive and negative.

And I think that’s basically what my idea of spirituality… is. It is growing within me as a person so I can be the best that I can be. And by the best I don’t mean materialistically the best or whatever, but the best person that I can be…. (16)

The other things, Anna, are parts of that journey and we can talk about beginnings, and I suppose there is no ending to the journey. (7)

To me it’s almost like a fourth dimension to a person. Perhaps it’s your subconscious encouraging you to point in a certain direction or giving you guidance. (9)

**Impasse and new experience of being**

I had…about fifteen years ago …four and a half years where God seemed like he was on the other side of the universe….And now I look back on it… that time… was in retrospect so rich, there were so many good things happening for me, and I couldn’t feel it or sense it in any way…. And so that time has revolutionised my spirituality. It hasn’t taken away anything, but it’s expanded it a lot more I had basically had the positive side of that not the negative on my map before. (4)

**Connection with higher power**

One group saw believed there was a higher power, something greater than humans, but had no sense of a personal God, as described in any of the major religions, more just a sense of something there. This ‘something’ varies in intensity for different people and causes awe and wonder for some. It appears to be both within and without the person. There is also a sense of the smallness and limits of humans in the natural world as well as a human need to seek for answers to the fundamental existential questions of life. These limits are physical, psychological and spiritual.

And the concept of something great out there is much more concrete for some and much more nebulous for others. I think that for all of us there is something. (8)

So it’s an unformed sense of spirit, but an optimistic one. There is no feel of a divine hand controlling the chaos but there is something more that the obvious
that does in some way form or govern or protect or determine what happens. But not in a sense I could ask for it to intervene in my life. (10)

I was thinking about that this morning because I thought that was one of the questions you would ask. I think, to me its more a feeling I get. … it’s a feeling of how small we are in the world compared to the size of it. A feeling of wonderment and .. – I had a few other words this morning that described it and they’ve left me now. It’s a feeling of contentment as well and sometimes it also comes with a feeling of achievement. (17)

**God immanent and transcendent**

Some of the participants were quite clear that their spirituality was religious. However for these, there was a clear understanding that in our present era the meaning of spirituality could not be confined to religious spirituality.

Well to me personally it means my relationship with God, and Jesus Christ but I accept that’s not what it is to a lot of people. That it doesn’t have to have any connection to any religious affiliations, necessarily, but for me it does… (20)

There’s a Samoan concept called, which is sort of like….It’s God within, really. Isn’t it. I really know how to describe it, it’s called Va, and it means, it’s like God, but I suspect it’s a pre-John Williams God. It’s more of an ether. And it’s within and without. And it’s everywhere. And it’s a God concept. (5)

I am not so clear whether there is – I am not so clear in my mind about the God and what that involves. But I still believe that there is a God and I feel very comfortable with that thought and I use it in my practice…. Even though that God figure is not as clear in my mind or shaky, I will still tune in with a someone. (14)

**Are you in balance?**
How do you care for your spiritual self?

Remember a time when life was difficult and a struggle and you felt stressed and fragmented. What was going on for you at that time?

Remember a time when you felt well integrated. What did you do at that time?

Spirit
- Self awareness
- Taking time to be in solitude
- Connecting with natural world
- Meditation
- Mindfulness/grounding
- Creative activity – writing, sewing, music, gardening, woodwork, singing, drama, photography, painting, cooking, craft work etc
- Spiritual/Religious activities
- Rituals
- Visiting healing places

Psyche
- Choosing appropriate work load
- Leaving work at work
- Ongoing learning
- Reading
- Yoga
- Relaxation exercises
- Clinical supervision
- Mentoring
- Travelling
- Sharing laughter – films/theatre/friends

Body
- Marking boundaries
- Changing clothes when leaves work
- Exercise
- walking, biking, gym, skiing, swimming, running, mountain climbing, kayaking, diving.
- Gardening, planting trees, looking after animals.
- Eating well
- Adequate sleep
- Knowing physical self

Relationships
- Time with family
- Time with friends
- Peer groups
- Appreciating support
- Being with children
- Having a pet
- Belonging and contributing to a community/communities
Healthy spirituality is unique, embodied, a search, a journey, a paradox. It has stops and starts and may be lonely and painful as well as fulfilling and enlivening. It continues from first cry to last breath.
Appendix 11: ABAANZ Conference Queenstown August 2009

From Noun to Verb - Is Hope an ethical issue?

Introduction

1 On hope
This paper came out of work in general practice and as a medical officer in a hospice. It includes comments from interviews with GP’s done as research for a PhD. Slides labelled participant are the comments from the GP’s. Unlabelled slides are my reflections.

What does hope mean? It is a dynamic and ever changing state arising from living with uncertainty from birth until death. There are many ways of looking at hope –its origin, meaning, intensity and changing focus. It refers both to internal dynamics and external ones. It comes from the depths of individuals as well as emerging in relationships with others, and for some with the transcendent.

2
Hope is such a central element of the human experience that it is creatively ensconced in mythologies and symbols from all civilisations.(Kodish, et al., 1995)

Hope unfolds throughout human life. It has been a concept from early history.

Since the time of the ancient Greeks, hope has been considered vital to us as human beings. It is an elevating, energising feeling that comes in the minds eye, from seeing a path to a better future.(Groopman, 2005)

3 The relational nature of hope
The hope in a clinical relationship resonates between the patient, patient’s family and health carer. Sometimes the patient or family is hopeful and the carer not and sometimes the carer is hopeful and the patient or family is in despair. This means that hope may be diminished or lost as a result of failing to communicate clearly.
Hope is offered patients and their families by hopeful professional carers. They may at times ‘hold’ patients in hope when they or their families find it impossible to hope. This quote talks of the physician but I would also include other health professionals and chaplains in this hopeful holding.

When the physician forms an empathic emotional connection with the patient, it conveys an unspoken but important message of caring, the physician’s steady presence is an almost physical shelter in the emotional storm that often accompanies impending death. (Whitney, et al., 2008)

Health professionals invest hope in their patients and find it hard when patients move from one stage of their disease to another.

4 **Two strands of hope**

In the literature about hope there are two main strands in the way people experience hope. One is external hope dependent on other people, happenings or circumstances. In this hope seems to be like an object which is may be possessed or lost. This is hope as a noun, objective or specific hope. The other hope is experienced as part of an internal sense of self. This hope is independent of outside events and indeed may exist in contradiction to them. This is hope as a verb, subjective or internal hope. (Elliott, et al., 2002; Whitney, et al., 2008)

In the process of moving towards death it appears that many people tend to move from the external focus of hope to the internal. However these two ways of experiencing hope can coexist and may sometimes be in conflict. I wonder if ‘hoping against hope’ does not say that.

5 **Biomedicine and hope as a noun**

Advances in medicine in the past century have enabled cure and prevention of disease where this did not previously exist. There is sometimes a tendency to overstate the technical possibilities and pursue treatment options to the bitter end. It is significant that the presentation of modern medicine in the media is nearly always about the amazing scientific technology and cures.
The focus of this biomedicine is on cure of a disease and death is seen as a failure.

Biomedicine is still the predominant model of medical care. The focus on cure presents particular problems to the health professionals caring for those with chronic disease, or who are dying. There may be a temptation is to discharge such patients out of hospital, so that the myth of cure can be protected. (Nekolaichuk, et al., 1998)

Because cure is promised, when relapses occur after initial treatment these are a greater challenge to the hope, of the patient, and health carer, than the initial diagnosis.

Relapse was described as ‘no man’s land’ where curative efforts often continue in the hope for survival whilst the families try to come to terms with an altered reality where fear of death is much closer. (De Graves, et al., 2005)

When cure is no longer possible patients are often referred to palliative services. They experience a loss of hope and may become angry when they are no longer allowed to continue going to the hospital clinic.

6 At the hospice they and their families make comments like:

‘The specialist said there is nothing more we can do, so we are referring you to the hospice. He has taken away my hope, he shouldn’t have done that’

This is because ‘There is nothing more we can do’ is nearly always heard by patients as ‘There is nothing anyone can do’.

With cure almost always the focus of treatment from diagnosis, initiating palliative care can be difficult, often presenting as a crisis late in the disease trajectory. (De Graves, et al., 2005)

An important task of hospice staff is to assure patients there is plenty that can still be done even if cure is no longer possible. It is enabling the birth of a new kind of hope, for living with a life threatening illness.

In the biomedical context then, hope seems to be a gift given or withdrawn by doctors. Yet the idea that only active therapeutic or surgical treatment offers help and hope is simplistic and may be damaging.

7 Hope and connection

Biomedical training suggests that doctors should be scientifically detached from patients. This was certainly not what I was told by the GP’s I interviewed. It was the connection to patients that made practice most satisfying for the doctors.

The thing that is most satisfying and keeps you going in medicine is that relationship and rapport that you build up with people. They trust you. (2)

Just connecting with them is part of the process. Connecting and showing a willingness to reconnect. So that you become a sustaining thread. (18)

There is also a sense that hope only occurs in relationship. Hope is conceived as away of living in courage and confidence that allows action. It is also a way of living and sharing in relation with others. (Cellarius, 2008)
This introduces the concept of hope as a verb.

**Hope as a verb**

Hope as a verb is the active desiring of a possible outcome in the future, engaging the whole person at their deepest level. (Eliott, et al., 2002) The person lives with hope. Such hope is enabled by holistic care of patients and their families.

8

This type of hope has been described as the ‘hoping self’, the part of the self which gives rise to hope. (Nekolaichuk, et al., 1998)

General practitioners interviewed took the importance of hope as a verb very seriously as can be seen by the example on the slide.

9

And our job, I believe, is always to try and sieve through and find the glimmer of hope. Find the small bit of flame that, the small ember that might be fanned back to life to give hope again. (8)

They were also conscious of the ways in which hope can be taken away.

But she really woke me up to how we as doctors can remove hope, and remove a sense of wellness and autonomy from people so easily. And try to be careful …to be realistic with people and give them information, so that they have the opportunity to choose their own path. But to really value wellness and what it does for people. (9)

It can be seen from these examples that hope as a verb is a dynamic and interactive process between patient, family and friends and health care professionals.

**Healing while dying**

Hope is not necessarily linked to cure. Prior to the biomedical age the search was for healing rather than cure. Healing is a process of coming to a new sense of wholeness. It does not require cure as a prerequisite but it always engages the hopeful self. Hope is an important support in healing. It enables engagement and continued living in the face of terminal illness rather than just waiting to die. (Johnson, 2007)

There is evidence that healing only occurs within a healing relationship. This also requires ongoing commitment by the health professional to the patient. (Scott, et al., 2008) The GP’s interviewed agreed with this.

10

I thought I’d do a Masters thesis on that. I think there’s an interesting idea – can you actually heal outside a relationship? Most people sort of seem – we talk about healing happening in a relationship.
People may live hopefully and well when they have come to terms with the reality of their dying. They are healed even if not cured as the next example shows. A failure in biomedical terms is transformed into a triumph of hope.

He died after a ten-year dementia process. And he died quite blessedly... And I’ll never know if it was being on oxygen that gave him a bit of a new lease of life in his brain but he was far more present in his dying than he had been for two or three years. He knew who we were. He said goodbye. He told us he was proud of us. I remember him hugging me and telling me how much he loved me... And he hadn’t called me by name in two years. And he was incredibly present and lucid and peaceful and completely aware that he was dying. It was lovely... and he had three or four days to make his peace with people and tell my mother how much he loved her..... But yes, it was an extraordinary privilege (10)

Those who are at peace with dying are able to be a sign of hope for others.

Just this morning a woman asked me why I was here and I replied, because I have cancer and have come home to die. As she was pressing my hand I knew I was bringing her hope. To me that’s the wonderful thing, that we can always give hope to others, especially in our dying. (McCabe, 2008)

This was also commented on by the GPs.

Healing can occur even in the process of dying. Well we’re all going to die. And if medicine sees death as the enemy and the ultimate negative outcome they’ve got it all wrong. (10)

False hope

‘False hope’ is sometimes used by health professionals when patients or their families seem to be failing to face the reality of the clinical condition or the prognosis.

The most difficult situation for doctors is when one member of a family insists on continuing treatment, which is unpleasant for the patient. This is particularly so when the patient is a child, or is ready to stop active treatment.

But for some patients ignoring the facts or refusing to explore gloomy prognoses is a way of maintaining hope and needs to be respected as such. Giving statistics is seldom helpful. (Sinclair, et al., 2006)

(Her oncologist) would say ‘Oh, I don’t know a 30% chance and .... I think you need more of this’ and she’d say ‘Oh you useless old woman’ she’d say to him ‘I’m well!’ And she didn’t turn back from any treatments, she wasn’t in denial, she was just saying ‘I refuse to accept people being negative and defeatist. I am well aware of the odds but I am determined I am not going to be a victim to them. And I am not interested in the weeping and wailing and wringing of hands that goes on in the hospital. He told me I have a 20% chance of living for five years – well I am totally invested in the 20%.’(10)
For such patients too much information, or information that is forced on them may be destructive of hope and unhelpful to their wellbeing. Health professionals need to be sensitive to the way information is given and the amount that is given, allowing plenty of time for discussion and exploration of what it means, and giving continued assurance of support.

14 Is hope an ethical issue?
Well, appropriately for an ethics conference the answer is both yes and no. The most critical issue is truth telling.

Truth telling

Truth telling and maleficence
The real problem in truth telling in medicine is the classical one – ‘what is the truth’ or ‘who’s truth’. Fifty years ago it was normal for doctors to protect patients by not giving them bad news. Cancer was presented in euphemisms as ‘a growth’ ‘a mass’ ‘a space occupying lesion’. In some places this practice continued for much longer, and was I found, associated with poorer care.

In 1980 I visited an aunt who was ill, in Ireland. When I arrived my uncle told me that she had a pleural tumour but did not know. I realised she also had a great deal of fluid in her abdomen, which was very uncomfortable. Her GP had told them everything was going well and she was going to be fine. I then asked if she had an oncologist and was told the GP did not think it was needed. I suggested that the fluid that was making her uncomfortable could be drained, and oncologists might be able to stop it collecting again.

This practice changed rapidly and by 1970 patients were usually told their diagnosis. Truth telling in biomedicine must be according to Evidence Based Medicine (EBM) using Randomised Controlled Trials (RCT). These do not give the true facts about a unique individual, they give probabilities about populations.

It is however, necessary to distinguish between what is known as a fact and what is probability. Many people do not understand probabilities or risk factors. If they are told 70% of people with their condition will survive six months, what they hear is ‘You have six months to live’. They start counting down the days.

15\[\text{hope} \propto \text{trust} \propto \text{truth telling}\]

Hope for the unique individual depends on their own view of self as will be seen by some examples below. Doctors need to be truthful with their patients as this is one of the main ways in which trust is established and maintained. Telling the truth to patients builds both hope and trust.

Truth telling and other ethical principles
When autonomy became the key ethical principle in the West doctors were expected to tell patients the truth. Informed consent, and involvement in decision making were a necessary (and good) result of this.(Kodish, et al., 1995; Clayton, et al., 2008) When doctors began to be
castigated for not telling patients the truth, they told all possibilities and probabilities to protect themselves.

But truth needs to be told with compassion. Clinicians must consider the effect on patients when they fail to explain the difference between probabilities, risk and fact. This leaves patients and families in a state of miserable uncertainty, as the example on the slide illustrates. It is not possible to diagnose talipes by a scan.

16

A young couple, expecting their first baby, presented to have a scan. The radiologist told them that the scan showed that their infant probably had talipes (club feet) and would need treatment after birth. He put them in touch with the Talipes Association. They spent six months worrying about this yet to be born infant. She was perfectly normal at birth. There is evidence that parents who are told they have an abnormal child may have difficulty attaching to that child.

It is also important to remember that there are cultures, particularly in the East and in the Moslem world, where truth telling to patients about diagnosis, prognosis and treatment is not acceptable. In these cultures autonomy is not seen as a primary ethical principle. In such cultures telling the patient a terminal diagnosis is akin to wishing them dead. If they do not know the diagnosis they are still able to hope for survival. In such cultures it is family who decide what the patient is told. (Kodish, et al., 1995)

17

What I have found … here the patient signs a consent form for operations and they do their own decision. However in Taiwan the family members need to sign the consent form for the operation…. Lots of times the family members will know about the prognosis the patient has, however the patient him or her self doesn’t know that he or she has cancer…. They think if the patient doesn’t know, then he or she will be able to live as normal. Participant 12

The patient is not told because telling someone they will die from their disease is akin to wishing them dead.

Not wanting to know

It must not however, be forgotten that information needs to be offered not imposed. Some patients really do not want to know how their tumour is growing or whether it has spread. They are content to live each day without such technical detail. For these patients telling the truth in the face of their resistance is damaging.

Truth telling and justice

Just distribution of medical resources is an important ethical issue in the present hard economic times. Some clinicians find it hard to let go of patients. They hesitate to refer them for palliative care.

This may have implications for just use of resources. New cases who might respond to treatment are not seen because so many are being followed up. It may also lead to the palliative care needs of patients and their families not being met, for these are not always available in acute facilities.
**Fostering hope**

Other strategies are also important for maintaining hope. Being given good symptom control for physical, psychological and spiritual symptoms is central. Being part of a supportive network of family and friends who remain well connected is also important. Leaving behind a legacy and reflecting on life story gives meaning to the final days of the dying person. (Johnson, 2007)

Hope is an ever changing concept – from hoping for a new cure to emerge, to hoping to have a day without vomiting or pain – to hoping that a much loved family member or friend will arrive to say goodbye. Sometimes it is as simple as waiting for a flower to open, a butterfly to emerge, or the ducklings from the creek coming for a visit.

It is enabled by compassionate care that gives dignity and a sense of meaning to the patient. The final stage of hope is for a peaceful death, which is often achieved by forgiveness and reconciliation within the dying person and with their family and friends. Self-forgiveness is often important at this stage, and most difficult.

This trajectory of hope in the shadow of death is a moving experience for the patient and their family and health professionals. They all feel enriched and expanded by it.

**18 Symbols of hope**

Symbols of hope are very important for those threatened with a mortal illness. Health professionals looking after these patients need to be very sensitive to such symbols. The next two slides illustrate this well.

Visiting a patient, I noticed a large tussock in the corner of the room, instead of a bunch of flowers. I said ‘What a lovely tussock. I have lots of it in my garden and it is so beautiful when it blows in the wind.’

His eyes lit up, and from lying flat looking sad he sat up. He talked animatedly for half an hour about the importance of tussock to those mustering in the mountains. He told me how each musterer and dog chose their own clump of tussock to relax in after lunch, and how soft it was and what a wonderful smell it had.

Tussock was a symbol of hope for that patient, reminding him of the mountains he had worked in and loved. It struck me how sensitive his son was to bring it to him to remind him of happier times.

Symbols of hope are extremely varied and personal. In a hospice many patients have their cards and letters put in view so that they can draw strength from them. They also have photographs of family, friends, home and pets. One GP told me about symbols of hope and a patient had apparently incurable cancer and is still alive and well 10 years later.

She was given the choice of stronger curative chemotherapy with a 50% chance of killing her or palliative one. She felt she could not fight her own body. People from all over sent cards and letters and we hung them on the nylon line we had up for Christmas cards. She said these are like the prayer wheels and flags. They’re all the good thoughts and wishes…

Participant 1
**Conclusion**

Hope is an essential aspect of human being in the face of the uncertainty present from birth until death. We have looked at the complexity and meaning of hope from a number of viewpoints.

We then considered two main strands of hope. Hope as a noun, fixed on particular outcomes, which will change throughout life. This kind of hope is often dependent on others for its fulfilment. Hope, as a verb is subjective, ongoing and continually adapting to the person’s need and changed life stage. It is present within the person, a part of the self, and persists until death.

We have looked at these aspects through the comments of doctors and patients. These kinds of hope are active in health professionals as well as in the patient and their family. This relational resonance of hope makes it more resilient.

We spent some time considering the ramifications of hope and various ethical principles. We also noted cultural differences in the ethical issues. I agree.

20  
Hope should be seen more as a process rather than a state to be obtained. (Sinclair, et al., 2006)

Hope is a dynamic aspect of human beings important to their well-being. It envelops more than just their clinical condition.

When patients use the word hope as a verb it signifies their active engagement in far broader aspects of life than the medical, and this hope could endure and sustain them despite death being certain. (Clayton, et al., 2008)

I suggest that it is important for all health carers to be open to the changing nature and expression of hope in patients and their families. Dismissing ‘false hope’ as irrelevant and misleading can be very unhelpful and damaging.

21  
We caution that the chameleon like nature of hope…ensures that medical staff can neither wisely nor ethically assume a shared or enduring meaning of hope as some patients may hold ‘there is no hope’ yet conclude ‘one can always hope’ (Eliott, et al., 2002)

There are ethical aspects to hope. Maintaining hope becomes an important aspect of care as death approaches. Moving from curative treatment to palliative care needs to be done sensitively. I like the suggestion on the slide.

The difficulties faced by health care professionals and families in accepting palliative care whilst life prolonging treatments continue can be lessened by adopting a model of care where cure… and palliative care coexist… (De Graves, et al., 2005)

22  
Hope is maintained in the face of death by health professionals being prepared to share the journey and attend to physical, spiritual, psychological and social symptoms of patients and their families.
Health professionals also need to pay attention to their own psychological and spiritual support of hope and compassion.

And the healing comes from within that narrative… Healing is to make better. Healing is an ongoing process of keeping well, keeping better. Is cure an end in itself? …. Heal thyself, O doctor. (7)

I think this comment sums it up well.

23 The principle of respect for hope should be more prominent and explicit in medicine and bioethics. (Kodish, et al., 1995)

As a final reflection:

24 This is Hope – one of the three aeroplanes that protected Malta from invasion during the Second World War. They were ‘bitsa’ planes kept together with engines and propellers and many pieces from other models.

Hope looks a bit battered round the edges but is obviously much loved and attended to. Perhaps that is all that is needed to revive hope – flexibility, acceptance of many different models, and ongoing relationships. Then hope can be reborn anew.
Appendix 12: September 2009 International Conference on Aging and Spirituality

Auckland

Spirituality in a Secular Age

Abstract

This paper will discuss the ways in which General Practitioners in New Zealand understand and define spirituality. It will consider the ways in which spirituality is experienced both by the doctors and as reported from their patients.

It is based on research undertaken as part of a PhD on Spiritual Issues in General Practice in 2007-8. Twenty-two General Practitioners, eleven women and eleven men, had a semi-structured interview lasting between 1-2 hours. These were then analysed using a generic qualitative method.

What is very clear in the results is that spirituality is an underlying human aspect which connects people with themselves, each other, the natural world, and the transcendent. It seeks answers to the questions: Who am I? Where am I going? Where have I come from? Attention to spirituality enables resilience and compassion at work.

Key Words: Spiritual awareness; spiritual experiences; health care; self-care.

Introduction

I am delighted to be here today. I realised that I forgot to include the important people in my life in my bio – my husband of 44 years, my three children and their partners and six grandchildren who I gather round me here.

1 This paper will discuss the ways in which General Practitioners in New Zealand understand and define spirituality. It will consider the ways in which spirituality is experienced both by the doctors and as reported from their patients.

2 From the statistics of the census New Zealand appears to be a very secular society. The census questions asked about religion not spirituality. Thirty-two per cent (28) claim no religion. A further 6% (6) objected to the question and 7% (8) did not answer it.82 Thus 45% of the population in 2006 seem to be secular.

The reasons for increasing secularity in the Western world are many. The philosopher, Charles Taylor identifies a process of disenchantment, a loss of the sacred, of society beginning in the late middle ages. Prior to this the world was seen as ordered cosmos having spiritual and secular realms.

82 Department of Statistics Census 2006. Figures in brackets 2001 census. The census question asks about religion not spirituality.
Disenchantment resulted in the loss of a sense of the sacred and the rise of the ‘buffered self’. The buffered self believed that human endeavour alone is responsible for social order in the world. The combination of this and the rise of science at the time of the enlightenment made belief in religion and spirituality more difficult. (Taylor, 2007a) This was further advanced by Darwin in his theory of evolution, which was seen by many as a nail in the coffin of religion. The ongoing struggle that the main religious traditions have had trying to respond to the rise of reductive scientific materialism and individualism has been about trying to maintain contact with the past and respond appropriately to new discoveries.

The current scientific world-view is based on an understanding of the universe which is evolving and has both order and chaos coexisting. This is very different from the religious world-view described in the book of Genesis. It is also very different from the modernist view, still espoused by some scientific fundamentalists, that proposes science and rationality alone will solve all existential and practical earthly problems. This view is increasingly difficult to defend in the current social and ecological state of the world. However, it also shaped and directed the biomedical model.

The biomedical model

The dominance of the biomedical model in health care over the past 50 years has led to an ignoring of the spiritual aspect of human beings because it rests on evidence based medicine - a reductive scientific paradigm that is unable to perceive that which cannot be measured.

3 Professor Ian Kerridge, at the Australasian Bioethics Conference last month, described it well.

EBM promised and initially provided a simple approach to complex medical problems, a way to mediate between competing data, interests or claims and a promise of objectivity, impartiality, consistency, rationality, truth and certainty. But EBM could provide none of these things as evidence is not value-free, self-apparent, disinterested or atheoretical but is socially and culturally constructed, relational, gendered, embodied, intersubjective and communal. (Kerridge, 2009)

He concludes:

What may be required is an ongoing assessment of evidence, comparison with the individual, attention to narrative, care and presence.

EBM works with populations but is therefore unable to describe the unique, the particular and that which cannot be measured by the methods it uses. It remains of course useful for looking at cost of health services and population health, for which it was originally designed.
4 The research method

- 22 General practitioners interviewed
- 11 female and 11 male
- Purposive sampling for variety of participants
- Modified snowball selection
- Semi-structured interviews of 1-2 hours
- Rural, urban and remote practices
- Graduation dates from 1963-2002
- 10 identified from one culture and 12 more than one
- Data was recorded, transcribed, returned for comment
- Constant comparative analysis

This slide shows the research outline. The research participants were chosen by purposive sampling. The sample was not intended to be representative but was intended to provide a wide variety of participants in terms of age, type of practice and spiritual and religious background. Some participants were selected because they had no religious connection or belief. A modified snowball method was used.

5

![Year of Graduation](image)

The cultural background was also varied with more than half the sample identifying with two or more cultures. You can also see that from 1982 the numbers of women doctors rose rapidly.
The patterns of practice were also quite varied as can be seen from the table below.

### Patterns of Practice

<table>
<thead>
<tr>
<th></th>
<th>Urban</th>
<th>Rural town</th>
<th>Remote</th>
<th>GPTP</th>
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</thead>
<tbody>
<tr>
<td>Total</td>
<td>14</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Full Time</td>
<td>5F 5M</td>
<td>1F</td>
<td>2M</td>
<td>1F</td>
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<tr>
<td>Part Time</td>
<td>2F 2M</td>
<td>2F 2M</td>
<td>1M</td>
<td></td>
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<tr>
<td>Academic</td>
<td>1F 1M</td>
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<tr>
<td>Locum</td>
<td>1 F</td>
<td>1M</td>
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<td></td>
</tr>
<tr>
<td>Teaching</td>
<td>12</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

### The Research Question

How do New Zealand general practitioners deal with spiritual issues in their practice and for themselves?

This question allows the researcher to examine both the spiritual issues for the doctor and the spiritual issues arising in consultations with their patients. It is important, at this point, to clarify the difference between religion and spirituality. Spirituality is an underlying human characteristic and religion provides a way of ordering spirituality in beliefs, rituals and community.

Spirituality is an underlying aspect of humanity. It is the unique capacity to creatively connect, which is exercised in relation to self, other human beings, the natural world and the transcendent. These four aspects of spirituality are found in most cultures and in many analyses of spirituality.

Spirituality is prior to science, an inherent property of human beings. (Cook, et al., 2009) It is an embodied awareness and experience, with tendrils that reach every part and every level of the human person. It makes connections, enters into dialogue, thereby empowering humans by enabling continuing growth and transformation. It may or may not be mediated by religious practice. There is a secular spirituality.

### Table of Religious Attachment

<table>
<thead>
<tr>
<th>Past Attachment</th>
<th>Present Attachment</th>
<th>Past Attachment</th>
<th>Present Attachment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglican</td>
<td>7</td>
<td>Buddhist</td>
<td>1</td>
</tr>
<tr>
<td>Catholic</td>
<td>4</td>
<td>1</td>
<td>Evangelical</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>1</td>
<td>Indigenous</td>
<td>1</td>
</tr>
<tr>
<td>Baptist</td>
<td>2</td>
<td>CCC</td>
<td>1</td>
</tr>
<tr>
<td>Islam</td>
<td>1</td>
<td>House Church</td>
<td>1</td>
</tr>
<tr>
<td>PIC</td>
<td>2</td>
<td>Total</td>
<td>17</td>
</tr>
<tr>
<td>Methodist</td>
<td>1</td>
<td>NONE</td>
<td>5</td>
</tr>
</tbody>
</table>

# Some participants have moved through more than one religion
*Pacific Island Church
**Christian Community Church
### others attend various churches occasionally
This thesis primarily focuses on spirituality. However it is impossible to exclude religion from the research since this is a common way of ordering spirituality. It is important to realise some participants had moved through more than one religion, so the total in the past attachment column is more than 22. PIC is Pacific Island church and CCC is Christian Community church.

The religious attendance of the participants was quite high with four attending regularly, eleven occasionally including two with no religious attachment, and seven not attending any religious services. Many of the occasional attendance group said they went to support patients and families at funerals.

What was very interesting was their response to a question about prayer – for themselves or their patients. Seventeen said they prayed, including ten with no religious affiliation and one who had no religious attachment ever. One (not the Buddhist) used a prayer wheel. Fourteen prayed for both self and other; 1 for other, 1 used a prayer wheel. Ten who prayed had no current religious affiliation. Three doctors prayed for patients in their surgery on request. Three said patients prayed for them.

9 How did they understand spirituality?

Connection
Mystery
Uniqueness
Unknowable – beyond rational and religious
Centre of self
Meaning and purpose
Growth and transitions - Seeking right path
Religious beliefs

All participants were asked what they understood by spirituality. Some struggled to find words to describe this. Quite frequently they were not able to, but at a later point in the interview their underlying beliefs and experiences were put very clearly.

It was interesting how often people were at a loss for words to describe it. ‘It’s difficult’, ‘I don’t really know what it means’ ‘so there is something about spirit which is essentially unknowable ‘ and so on. There were also many comments on spirituality being unique in each person. This suggests any system of religious dogma is inadequate in describing spiritual uniqueness.
The overriding theme of spirituality was about connection. It was very clearly put by some participants. The diagram attempts to show the interconnection of the spiritual with self, other, the natural world and the transcendent. The transcendent is within and around each aspect.

The three leaves of the diagram represent the self the natural world and the human other. The background represents the transcendent within each aspect of spirituality and without. The beauty of this diagram is that it shows the intimate interconnection of spirituality so that although it is possible to speak about aspects of spirituality, in relation to the self, the other, the natural world and transcendent in reality all aspects are interconnected and changes in one aspect inevitably affect all the others. Because it is a dynamic and ever changing state it is impossible to define – but possible to talk about different aspects of it.

There was a great deal of variation in the amount of reflection that participants had done about spirituality. Some had not really reflected about it, or agreed to participate in order to reflect, while others had clearly spent much time and effort on considering spirituality in their lives. Some chose to be interviewed specifically in order to reflect on spirituality.

The other aspect of a uniquely New Zealand spirituality that emerged was that of Maori spirituality. This appears to be a spirituality in which the world is still an enchanted, interconnected, sacred place as it was in pre-enlightenment Christianity. This sense of interconnection seems to touch all spirituality in New Zealand. One participant put it clearly when asked what spirituality was:

If there’s one word, I suppose I’d use the word connected…(7)
And went on to say:

11 So I was born in this place here. Under this mountain, that’s our spiritual home. Our connection to this place is embraced in that Titirangi...And the river that comes down here is Uawanui-Atuamatua. So the tribal people are the Hauiti who are descendents of an ancestor called Hauiti related to Pororangi. And so from Pororangi comes Ngati Poro – the people all the descendents....And so that’s the relationship between the East Coast and down south. The people of the south island, the Ngai Tahu people is through her...So, yes, I was born here, a long story about that birth, and I’m from here and not surprisingly I’m still here. (7)

What was very interesting was the way in which this well earthed spirituality affected many of the non-Maori New Zealand participants in their passionate sense of connection to the natural world. Below are some quotes from the participants.

12 Connection with self

It’s very difficult to come up with a tidy definition. It’s about the core, the centre of you...It’s the best part of me, that wants to care for others. It’s also about using your talents for the good of others...We can only do what – each of us has been given something and we have to find from which we’re at – the better self I suppose... (19)

Connection with other

Just connecting with them is part of the process. Connecting and showing a willingness to reconnect. So that you become a sustaining thread. (18)

It’s about the essence of being human I think. Which is partly about yourself, but a lot of it is about your relationship to other human beings and to, you know, the physical earth as well. (3)

13 Essentially unknowable

And.. so there is something about spirit which is essentially unknowable for me. And probably, maybe that’s just the essence that is unknowable. And will forever be, I’ve no expectation of ever understanding it, or even a desire to. I mean it is so, its like trying to imagine the end of the universe. I’m never going to try...I feel like that about the spirit. We’re aware of it. We know there is a universe that goes on and on, we know there is spirit, but um, I don’t even struggle to come to terms with it (6)

Because if you actually give a contribution that actually gives a lot of meaning in your life. But on the other way things that you believe maybe you won’t see or you can’t see currently but you still believe in them. That’s also another meaning of my life I find. For example, in my religion we believe in re-incarnation which...you can’t see in front of your eyes, but I still believe in that concept. (12)

14 Meaning and purpose
I am hugely aware of how we all need some source of meaning in our lives and I think that whole notion is best captured by the term spirituality – seeking for meaning. And I find it very hard to articulate beyond that…. I was generalising from my own personal need, sometimes I would think of myself as an atheist in search of conversion. So I think we all need some source of meaning in the sense often supplied by religion.(18)

I mean I don’t have a religion per se, but I do believe that there is a reason for us being here….To me it’s almost like a fourth dimension to a person. Perhaps it’s your subconscious encouraging you to point in a certain direction or giving you guidance. (9)

**Growth and transitions**

But I do believe there is something there…is it without of me – or is it within me. I’m not entirely sure I can answer that. …And I think that’s basically what my idea of spirituality… is. It is growing within me as a person so I can be the best that I can be. And by the best I don’t mean materialistically the best or whatever, but the best person that I can be…. (16)

**Connection with higher power**

And the concept of something great out there is much more concrete for some and much more nebulous for others. I think that for all of us there is something. (8)

There’s a Samoan concept….It’s God within, really. Isn’t it. I really don’t know how to describe it, it’s called Va, and it means, it’s like God, but I suspect it’s a pre-John Williams God. Its more of an ether. And it’s within and without. And it’s everywhere. And it’s a God concept. (5)

I am not so clear in my mind about the God and what that involves. But I still believe that there is a God and I feel very comfortable with that thought and I use it in my practice…. Even though that God figure is not as clear in my mind or shaky, I will still tune in with a someone.(14)

**15 Spiritual experiences**

These were extremely varied and unique as you can see from the slide. Some were in relation to the doctor and other in relation to a patient, family member, or the natural world.

- Transcendent presence
- Feeling sent to someone
- Unexpected healing
- Extraordinary human experiences
  - Foresight
  - Out of body experience
  - Near death
  - Experiencing spirits
  - Ineffable experience beyond words

**Transcendent presence**
And I just went up the hill, and just got up to the top and was thinking – Oh! this is beautiful. All the gorse was in flower and we had the fragrance. And there were the yellow-headed finches, you know. And they flew with me as I got up and I was listening to this music and it was utter, utter, I was in a different world. You know my endorphins were good enough, the finches were with me, the music was with me, and the gorse smelt beautiful and the clouds were beautiful, and it was truly a spiritual experience and I think that people who can pray properly probably feel that. (reflective silence)(11)

Feeling sent to someone

And she lived alone. She loved her cat and would stroke it and say, “She and I will go together.” And you know I never go out for lunch because it’s always busy. It was a beautiful day and I thought – I’ll go for a wee walk. And I went … past her house and her roses were beautiful so I just lingered to sniff one of the roses and I saw the cat lying on the driveway. And it was very still and I thought – is that cat alright!. And you know when I got there it was dead. And I thought – Oh God – this is Mrs D’s house. I’d better just go and check…. So I went in and called her. There was no reply and the doors were open and I knew her bedroom and there she was in her bedroom gasping …. And so I just held her and she died. (11)

Unexpected healing

A young man who …had been admitted … I can’t remember what the circumstances, but he refused to eat anything whatsoever…(for ten days) And the ward rang me this day…Would you be able to come up and maybe have a talk to him. All my thoughts said – no this is ridiculous and a waste of time. But I did…I sat on his bed and put my hand on his arm…And the door was open and there were people running about…And I thought – this is just a total waste of time, being here. So I basically prayed and I said – Lord, there’s nothing I can do about this, but if there’s anything to be done maybe you can. And as I finished saying that. (To myself.) He propped himself on the bed and he leaned over and he took a banana from the bowl beside the bed and peeled it and ate it. (20)

Outside self / ineffable experience beyond words

I got to the end of praying. I got really angry with God. And I got to the end of praying so all I had was my inner, kind of groans of emotion to let go. And in a way that’s really important to me….Because (became tearful) because it’s important…prayer beyond words. And the words, I’ve always been full of them…I don’t think I can say anything more about that at the moment. (4)

But when you can truly sit in the patients shoes and get drawn in I think there are times when that happens and everything stops for a moment, and … in that moment I think, and that’s the moment you’ve got to shake yourself out of when the patient’s gone. But I can’t get any closer to it than that unfortunately..(8)

Extraordinary human experiences

Foresight
I knew the moment my mother had died. I was coming back on the school bus and at 4 o’clock I said “Oh, I think she’s died” Which seems an odd thing for a sixteen-year-old to say and when I got off the bus I found subsequently at four o’clock she had died. So for me that was quite powerful at the time. (9)

**Out of body experience**

I had another patient …it was all a bit incoherent, …he said I was in ----‘s room a few months ago and I collapsed, … He said ‘I found myself over at the door, looking back at … me, slumped forward in the chair and him attending to me.’ He was totally freaked out by it.(4)

**Near Death experience**

I’ve had a patient who had a cardiac arrest who I resuscitated who very clearly was leaving himself and being pulled back again…And he described very clearly leaving himself and going towards this big hill and light and then being pulled back again. And he sort of said jokingly he really wished I hadn’t pulled him back, but he now knew what was ahead of him and he wasn’t afraid any more. (20)

**Seeing or experiencing spirits**

Well I had this patient… he’s an older Maori man … When he’s unwell he speaks about spirits and says he’s visited by people in his house….And I think that’s a privilege too, he tells me that, because when he goes to hospital he doesn’t tell anyone.(2)

**Sense of presence of dead person**

I think after a person dies you can still be, particularly with people you’ve been close to or connected to, you can still be in contact with that person. Yes.(9)

**16 Spiritual self-care**

Spiritual self-care was asked about in the interviews. Participants came up with a number of ways of caring for their spiritual self. They agreed that it was important to take care of themselves and almost all wished to do something creative apart from their work. As can be seen from the slide many were extremely creative. However there were also others who failed to give themselves time. The commonest reason for this was the culture of the practice they were in. There was also a sense that for some it was considered selfish to take time for themselves.

I have included psychic self-care as well because as you can see there are area of overlap between these two aspects of being human just as there are of the physical and relational aspects which we have no time to cover.

**Spirit**

- Self awareness
- Taking time to be in solitude
- Connecting with natural world
• Meditation
• Mindfulness/grounding
• Creative activity – writing, sewing, music, gardening, woodwork, singing, drama, photography, painting, cooking, craft work etc
• Spiritual/Religious activities
• Rituals
• Visiting healing places

**Psyche**
• Choosing appropriate work load
• Leaving work at work
• Ongoing learning
• Reading
• Thankfulness
• Forgiveness
• Relaxation exercises
• Clinical supervision
• Mentoring
• Travelling
• Sharing laughter – films/theatre/friends

The reality of whole person care is about balance – physical, mental, social and spiritual. This applies equally to both the participant doctors and their patients.

18 A matter of balance
From all that has emerged it can be said that spirituality is very much part of general practice. It is unique, embodied, a search, a journey, a paradox. It has stops and starts and may be lonely and painful as well as fulfilling and enlivening. It continues from first cry to last breath. For GPs it is a journey enlivened and accompanied by patients.

I will leave the last word to this participant who put it so well.

19 I think to some extent, in a secular world … there is a priestly function. Of confession. Of hearing people’s secrets and truths and fears, and not, at least trying not to judge those. And I think that is, that’s a sacred task. I think there is something, there is an aspect of healing in the literal laying on of hands. And whether that is examining a chest, or taking a blood pressure or feeling a pulse, there is something that occurs in that interaction which is more than just in their physical action. A transfer of compassion as well in crucial times.(10)

Thank you very much.
Appendix 13: Bearing Witness to Suffering: Letting Go of Control

Psycho-Oncology New Zealand Conference Dunedin
November 2009

Abstract

Care of the whole person demands bearing witness to suffering, in ways that are often demanding for clinical carers. This comes about because good care needs compassionate empathy with the patient at the same time as achieving appropriate clinical distance.

As patients move towards death there is also a process of letting go of control by both patient and clinician. Accommodation with death and letting go of life are spiritual issues that touch into the sacred in medicine.

These matters will be discussed in the light of interviews with 22 General Practitioners as research for a PhD on Spiritual Issues in General Practice.

Introduction

Suffering
Loss of meaning
Loss of sense of self

Bearing Witness
Being there
A place of courage
Offering hope
Dying
Saying goodbye

Letting go of control
Self awareness
Trust
Transitions

This session comes out of research for a PhD exploring spiritual issues in general practice. I interviewed 11 male and 11 female GPs from different types of practice who graduated between 1963 and 2004. This has been a rich experience for me. I am well aware, working in a hospice that many of the comments would apply to other carers as well.

As I have wrestled with more than 500 pages of transcripts one thing has become very clear. Doctors, patients and patient families are in an interwoven relationship. GPs respond to patients not just at a clinical and distant level but at an intuitive or tacit level as well.

Doctors also respond to patients out of their life experiences as well as their clinical training and knowledge. Being self-aware for clinicians is extremely important. I asked the participants about their family experiences of illness and death as well as about their patients.
For those of us who work with people approaching death there is a need to keep in mind our own understanding of mortality. Dying is dismissed as a failure by biomedicine, the current paradigm of medical care. It is a normal part of life that our particular society tends to ignore.

Never send to know for whom the bell tolls: It tolls for thee.

Bearing Witness to suffering

Bearing witness to suffering was an important theme that emerged from the participants. They spoke of the connection they had with their patients and how this connection and its ongoing nature kept a number of them practicing medicine. They also recognized the privilege and uniqueness of each medical encounter. Suffering arises out of a loss of meaning and purpose or a loss of the sense of self. It is well illustrated by the patients who say as they approach death, “I’m not myself any more”.

Many of the participants recognized the privilege of sharing their patient’s lives.

I think there is an incredible privilege to being part of birth and death. That doctors have a privileged role to be witness to birth, death and other forms, other times of jeopardy for people, when they’re right out on the edge of despair as well.

Suffering is about your whole person.

Bearing witness is a direct result of having empathy with patients. Empathy is one of the positive emotions that enables community. It is about trying to imagine what life is like for that patient. The doctors interviewed were very clear that it was not possible to be healers without empathy. That it is in the relationship that healing occurs. Bearing witness acknowledges suffering and thereby gives it meaning.

We’re not just talking about – how’s your pain today. But how is everything else going on. How are you feeling about dying and you know – do you need any help in that direction.

Suffering is the effect that happens in… all of them. It affects their personality as much as it does their physical ability to do anything, or their mental ability to try and recover. …And the relieving suffering… expands out, like allowing people to get better, helping people come to terms with that which won’t go away, a quite separate issue from pills, which is probably the easiest bit.

Being there

The first principle of bearing witness is being there: available to the patient when they need it. This is not always easy and demands courage.
I spoke to the consultant about how I didn’t want to go into the (woman’s) room. And she said to me ‘You just go into the room. You don’t have to say anything. You don’t have to do anything. You just sit there’ So I went into her room and just sat there…. I don’t know how much time passed but she just started to weep and weep and sob and sob and I didn’t say anything and she didn’t say anything and that was quite powerful for me…. that in the end you are just one human being to another really…Well. Maybe I was just facing her suffering…..(3)

Sometimes the bearing witness is to the courage of the patient as well as the doctor.  

I think I was just the witness really. But maybe a witness is a very important thing in people’s recovery as it were….You have to be quite brave actually… but then that’s an acknowledgement of how brave the other person is too, in a way.(3)

…she knew what her life expectancy was short and she lived every moment to the full. Courage and making the most of what you’ve got. . There are patients that have come and gone. But she probably stands out as the one I really bonded with. (16)

Offering hope

The second principle was listening well to what patients say and offering them hope.  

But if a patient says to me ‘Just be straight with me doc, how long have I got?’ my question is ‘How long do you want. How long do you need?’ Those two questions I think are important….And I think that there are words that heal. There are words that give patients hope and the can leave your rooms with the sort of outlook … that at least gives them a chance to deal with this thing. (8)

I have to listen, listen…to get to the issue…our listening is picking up the threads and trying to make sense of them for the patient. Again it’s the fascination of the job… It probably keeps me going. It keeps me alive. (6)

Offering hope is not always done. It is easy to take away hope by, for example, giving a prognosis in terms of a set time. When this is done patients start counting the days.

But she really woke me up to how we as doctors can remove hope, and remove a sense of wellness and autonomy from people so easily. And try to be careful …to be realistic with people and give them information, so that they have the opportunity to choose their own path. But to really value wellness and what it does for people. (10)

Letting go of control

One of the aspects of medicine that concerned doctors was the overriding need to be in control. Biomedicine expects doctors to know what they are doing, to remain objective and not become emotionally involved with patients. They must predict cure and death with accuracy. Their information has to be evidence based. Cure is done to patients in this biomedical model.
It was the expectation of certainty that most disturbed the GPs. Living in the real world outside the hospital they know uncertainty is as integral part of it, just as empathy is part of a healing relationship. Yet both media images and hospitals tend to focus on the certainty and objective power of technology and science.

Letting go of control also runs counter to biomedicine. This is not about being out of control but recognizing the limits to medicine and the inevitability of death. All pain cannot be fixed. Patients are the arbiters of their own healing, which doctors and others may facilitate or interfere with. Much of evidence-based medicine is really a best guess in view of the individual variations in response. Appearing certain may, paradoxically, make patients feel less not more secure. For uncertainty in the face of death leaves room for hope. If patients are given a definite time for survival – you’ve got three months - they start counting the days.

The first aspect of letting go of control recognized the need to deal with the doctor’s own emotions when they cannot fix things.

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It’s very much an internal personal challenge because you’re confronted with yourself the whole time. You’re confronted with your own emotions that come up about it as a response to someone else; and you’re confronted with your need to fix things when you can’t. (3)

Trust

Trust is one of the aspects of practice that allows patients and doctors to let go of control. Doctors tend to see this as a sacred responsibility. Some of them were clearly very moved by the level of trust given to them.

12

To have this job where there’s given this level of trust and the opportunity to be part of people’s lives at critical times in their lives. You know I say I don’t cry much but that sometimes makes me feel a bit tearful.(6)

I think some of it is about trust and that you have someone who is looking out for you in a complex system. And the iller you get the more vulnerable you are. (13)

Interestingly the doctors interviewed also talked about this as a two way process – patients trust doctors to look after them – but doctors also trust patients to work at their own healing.

13

And a couple of times when I’ve been really kind of worried about someone I’ve told them that I trust them to do the right thing and it’s kind of an interesting idea and … I think that’s worked quite well. It’s partly a handing over of responsibility, partly … you know when people are teetering towards recovery - kind of letting them go in a way. Which is very hard to do. But I think that’s sort of empowering isn’t it. Enabling power. (3)

Patient autonomy – accompanying transitions

Many of the participants talked about accompanying transitions for patients, seeing them grow and develop. These transitions start with birth and end with death. The transitions that doctors accompany include the normal process of growth and development but also the
transitions that occur from health to sickness and back to health. They also commented on the way in which the journey of patients enables the growth of their doctors. This is part of the joy of medicine.

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She’s a person who, you class her as a difficult patient, because she always questions, she always wants to be in control, but at the end of the day she’s always right. She’s actually taught me a lot about the fact that me a general practitioner is just an advisor...And providing it’s an informed decision, we’re not there… to dictate... (9)

And so I think that that sort of connection with a patient is quite unique and only happens … one on one physician and patient. And I think it has something to do… with the healing process between two people… I have that kind of experience with patients from time to time, it doesn’t happen all the time.(8)

The other aspect of transitions that was referred to was impasse or getting stuck for the patient, the doctor and sometimes the family.

15

I'm frustrated where I'm at because I can see what the problem is but I can't move her. I can nudge…just chipping away at it. I don't think she even knows. (1)

I can think of a few patients who I’ve seen endlessly over the years the ones where whatever you do its not right or its not gong to work …So that relates to the stuckness and I think you said – do I feel the patients get stuck – I think we experience it as we are stuck….Sometimes we say it to patients, ‘You know, I can’t see anything else to do. Is there anything else you can tell me which would give me an idea we could work on’. (6)

Impasse is sometimes caused by a lack of forgiveness. This may be about the forgiveness of people who have wounded the patient, or forgiveness of self for mistakes, or forgiveness of their body for letting the person down.

16

It does involve a lot of forgiveness. And forgiveness is so powerful in terms of healing… I think it’s a large part of our job in General Practice. It goes back to being non-judgmental. If the first step that one can take for our patients is to start to forgive themselves. (6)

Well very often there is a lack of forgiveness in relation to depression. And they can’t see any hope. …And they will often acknowledge they are the ones who are suffering but they can’t let go of their anger and resentment and bitterness. …the step they need to take to start the forgiveness process is very hard for many of them to take. You can hopefully over a period of time get them to take little steps leading towards forgiveness (21)

Dying

The final letting go is dying. One of the things that a number of participants talked about was the healing when dying that may occur.
She was told here that there probably wasn’t anything more that could be done….she went over to the Gawler institute and….did quite well for two or three years …But the thing was (she) had been a rather tense, rather unhappy, non-trusting person. And the amazing change that happened to her …that she became almost a saint like figure….And she developed an aura around her of calm and happiness and contented, that sense of coherence that we talked about before.(8)

Patients and their families also need to let go of control in accepting death as inevitable. As many of you will know this is not easy and may cause real conflict within families.

And we sat round the bedside, and prayed together and acknowledged where she was at in her life. But really the purpose of the gathering was having the people she felt some kind of responsibility to….and together we all gave her permission to let go. This is the season she was in at this time to let go. I don’t know whether she died the next day or a few days later …(4)

And you have families where Mum’s dying and Dad and the children don’t ever want her to know and discuss it with her. And it’s so sad that a couple who perhaps have had good communication all their life, at a very important time of their life could no longer communicate, because usually it was the person who wasn’t dying who couldn’t handle the concept of accepting the situation and talking about it openly.(21)

In Maori communities there is a process for facilitating the departure of the person dying. This recognises the need to move on but maintains the sense of connection both for the dying person and the people left behind.

Once they let go, then there’s the next stage of that facilitating. … So that,…until we meet again a tono wa. …People need place. … They need permanence. I didn’t think about it in the context of hope, but I think about it in the context of connection. That’s the spiritual connection. Until our spirits meet, your spirit is there waiting. And so we say words like whanganga or tatarianga. We say Haere ke ratou ke tititangi mo koutou – go to the ones who are waiting…go to those who are already there ke ratou, Beyond the veil. So there’s a spiritual waiting place.(7)

Saying goodbye

Two participants talked of the pain of sudden death in their own families when they were unable to say goodbye. One described it like having a skyscraper on their head because it was so overwhelming. Doctors also regretted times when they were unable to say goodbye to patients they had known for a long time. I asked the participants if they went to patient funerals. Some did and some did not. Saying goodbye is very important. Certainly patients in the hospice will often hang on for a family member to arrive.

So I’ve had a few experiences …. Seeing people who had …been in a coma for three days suddenly wake up, sing a hymn, say goodbye to their family and just die (10)
And those special patients who die – I will go to their funeral. And it was a goodbye for me and goodbye to her and her daughter…So … perhaps I go to three or four funerals a year of those patients I’ve been close to. For me it’s not so much grieving as saying goodbye. (11)

One of the things, sometimes I’m unsatisfied when somebody you’ve known for a long time goes into hospital and they unexpectedly become terminally ill and die and you’ve got no time to say goodbye. (13)

Saying goodbye is also important for doctors when they retire. Letting go of the carer role may be a painful process. I thought I was ready to retire but what I found was that in fact after a few months I sort of got a dose of the ‘poor me’s’. You know – I needed to be needed. And I actually wonder how many health service professionals do have that need to be needed. And it was quite an interesting revelation … But I think I have actually come to that point where I can cope with that.(21)

Conclusions

This afternoon we have looked at the process of bearing witness to suffering and letting go of control.

Bearing witness to suffering not only affirms and enables patients and their families but also makes doctors grow and develop. It sharpens their self awareness and demands courage and good listening skills. Leaving a space for hope was also important.

The process of letting go of control both in the care of patients and in their dying was then discussed. Saying goodbye is important for patients, their families and doctors..

What is, perhaps the most striking aspect of this is the way in which doctors, patients and patient families constantly mirror each other’s responses to living and dying. Perhaps we should finish as we started with John Donne.

Any man’s death diminishes me, because I am involved with mankind
And therefore never send to know for whom the bell tolls
: it tolls for thee
Appendix 14: Spiritual Issues in Palliative Care seminar poster
Spiritual Issues in Palliative Care
Bearing Witness to Suffering, Offering Hope, Letting go of Control

Dr Anna Holmes, PhD Candidate
University of Otago

Superiors: Professor Grant Gillett, Professor Andrew Hornblow,
Advisor: Dr Chrysa Jaye

Accommodation with death and letting go of life are spiritual issues that touch into the sacred in medicine. Care of the whole person demands bearing witness to suffering, in ways that are often demanding for clinical carers.

BEARING WITNESS TO SUFFERING

Bearing witness is not being an idle bystander. It is allowing yourself to be drawn into the world of the ‘other’. General Practitioners described a sense of loneliness in deep suffering and death, both in relation to their own losses and in relation to patients. It requires courage to provide a bridge to the suffering person. It demands a letting go of the protective carapace of the biomedical role, acknowledging that at this time both doctors and patients are vulnerable human beings. When this happens there is a transforming and enriching encounter.

Courage

“I spoke to the consultant about how I didn’t want to go into her room…. You have to be quite brave. But then that’s an acknowledgement of how brave the other person is too.” (3)

Being there

“She said to me ‘You just go into the room. You don’t have to do anything. You just sit there’. So I went into her room and just sat there… and she started to weep and weep and sob and sob…” (3)

Connecting

“In the end you are just one human being to another.” (3)

“Just connecting with them is part of the process. Connecting and showing a willingness to reconnect. So that you become a sustaining thread.” (18)

“And that’s wonderful connection. I think what do I live for, what is meaning? Moments like that of human connection are meaning for me. At it’s highest point.” (6)

OFFERING HOPE

Humans live with uncertainty and paradox from the moment of birth, since they know they will die. Such uncertainty would be intolerable were it not for hope. Hope is both a way of living and an aspiration for the future. It is dependent on external relationships with others and an internal core of self-meaning. Hope unfolds throughout life. Hope in a clinical relationship is an aspect of spiritual connection and resonates between the patient, patient’s family, health carer and the transcendent.

External and internal hope

“But if a patient says to me ‘just be straight with me doc, how long have I got?’ my question is ‘How long do you want? How long do you need?’... And I think that there are words that heal. There are words that give patient’s hope... And our job, I believe, is always to try and sieze through and find the glimmer of hope.” (5)

Healing

“And curing is a biomedical idea diagnosis and treatment. And healing is a restoration of your sense of self as a human being with purpose.” (3)

“Healing is about the whole person. About coming to peace.” (1)

Symbols of hope

Symbols of hope connect patients to good experiences. I once visited a dying patient who had a large tussock in the corner of his room. When I admired it, he sat up and talked animatedly on the meaning, smell, texture, uses and place of tussock in high country farming. I had reconnected this patient with the life and mountains he had loved. The joy remembered illuminated the present moment.

LETTING GO OF CONTROL

Spiritual transitions, including illness and death, demand a letting go of the past and moving on to the new one. Transitions are not usually sought but emerge as part of life from birth to death. Transitions cause a loss of the known self and a search to reconnect with a new self. In transitions there may be impasses. These may be an experience of a loss of coherence, a loss of clarity of self-understanding. Patients often say “I’m not myself any more”.

Trust

“And... when I’ve been... worried about someone I’ve told them that I trust them ... It’s partly a handing over of responsibility, partly a sort of letting them go in a way. Which is very hard to do.” (3)

“To have this job where there’s given this level of trust and the opportunity to be part of people’s lives at critical times in their lives. You know I say I don’t cry much but that sometimes makes me feel a bit tearful.” (6)

Letting go

“It’s very much an internal personal challenge because you’re confronted... with your own emotions... as a response to someone else and you’re confronted with your need to fix things when you can’t.” (3)

“And I went through quite a process of black despair, feeling trapped…. And then I kind of burst through that and suddenly moved to a new (stage).” (10)

Saying goodbye

“So with Maori we return to the departing place for spirits : Haere ki raro henga. Go to the underworld. Haere ki rongo ki raro... Farewell. And that’s an active process, it’s a process that’s never ending... connections between the physical and spiritual dimension... I think about it in the context of connection. Until our spirits meet, your spirit is there waiting.” (7)

“I go to as many funerals as I can of patients... because it’s part of the grieving process for yourself.” (6)

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