Ariana Mirzada
Mount Menoikeion Seminar
June 15, 2016

Spirituality in the Medical Context

In Lavretsky's definition, spirituality "encompasses religion but spreads beyond to promote an understanding of the meaning of life, and an individual's relationship to the transcendent" as it "'transcends sense phenomena'" (Lavretsky, 2010). The idea of a spiritual connection as one that moves beyond what the senses can perceive is one that can appear incompatible with Western medicine, which relies on perception, diagnostic tests, and its constant innovations in technology and protocols. In this paper, I will focus on some of the obstacles between medicine and spirituality, underline the importance of recognizing the need for considering patients' beliefs in medical discourse, and explore how spirituality can even facilitate the healing process in Western medicine.

I turn to a highly-recognized text, *The Spirit Catches You and You Fall Down (Fadiman, 1997)*, on the very issue of the hindrance of healthcare as a partial result of misunderstood spiritual beliefs—this text is often referenced as a motivating factor for medical students to maintain consciousness of patient beliefs, and will thus serve as a prime example of the obstacles spirituality can allow for in medicine.

Western medicine is forced to become familiar with the foreign concept of spirituality in this medical anthropological book, which documents the life of Lia, a Hmong child with epilepsy living in California. Here, the realm and space of a Western hospital is encroached upon by spirituality, coupled with cultural and linguistic barriers. Lia's Hmong family viewed her disorder as a spiritual connection. According to this family, the seizures allowed Lia to perceive what most people could not, in that this disorder was outside the realm of the senses. The Hmong believe that the body is composed of many souls, and that the separation from one of these souls

can cause illness. The family recognized their daughter's illness, yet they also saw it as an honor and blessing, because she could become a shaman, or a "master of spirits" ("The split horn," 2001). This brief background information about the Hmong would be helpful in the manner in which a physician first approaches a Hmong patient; however, this basic spiritual understanding was sorely lacking in Lia's care.

The case began after an especially bad seizure, wherein Lia's parents had taken her to the Western hospital where she would be treated for years to come. There, the Hmong family was told to give Lia anticonvulsant medications to suppress her seizures. There was a high level of noncompliance with this medication regime from her parents, however, as doctors tried to determine the best course of treatment for Lia. She was prescribed several medications, both for her seizures and infections, each requiring different dosages and times of administration. The prescribed medications were constantly changing, and Lia's family was already reluctant with the hospital's care to begin with. Lia's mother stated that the medication changed her child's "spirit," and thus refused to administer it to her (Fadiman 60). When she did give medication to Lia, it was often given at incorrect dosages or intervals. Here, while we see that the physicians have authority over Lia's care when she is in the hospital itself, at home she is subject to a different set of standards under the authority of her parents.

The clash between the different authorities and spaces became apparent as Lia began to show signs of retardation, which her doctors saw as preventable had her anticonvulsant medications been given as directed. The doctors on Lia's case felt an extreme amount of frustration and lack of compassion toward her parents as they felt that her parents were hindering her care. Through this frustration, the concept of *otherness* was reinforced; instead of the hospital

and home being cohesive spaces for Lia's treatment, they were dramatically different from one another, stemming from a lack of perspective-taking and understanding.

With these issues of space in mind, we must consider another issue, cultural in nature, in that Lia was quite overweight, making IV access to administer anticonvulsant medication during seizures difficult. Because a "plump" Hmong child was an indication that he or she was healthy and well-taken care of, the family took little issue with Lia's weight (Fadiman 53). The family did not understand why Lia's weight would be a problem for the hospital workers, because of the aforementioned lack of adequate communication and understanding.

The hospital's clash with spirituality, in terms of lack of understanding from physicians and irreconcilability with the spiritual beliefs themselves, coupled with cultural incompetency of the Hmong led to miscommunications that continued to result in medication noncompliance and Lia's inconsistent treatment. These obstacles, further inflamed by language barriers, made it extremely difficult to give Lia the best care possible, which would ideally involve understanding and open dialogue between physician and patient.

These miscommunications perpetuated misperceptions in which the Hmong family believed the American doctors' treatment of Lia was actually harming her. For Lia's family, these misperceptions were easily reinforced, as Lia's case was not an isolated circumstance—aside from this specific case, Fadiman mentions a Hmong refugee camp in Thailand in which hospital workers undermined shamans' authority instead of working with them. For example, they cut the spirit strings tied around patients' wrists without considering that these strings were a part of Hmong healing; the strings prevented evil spirits from causing illness and returned the soul to the body ("The split horn," 2001). By assuming that Western medicine was the only way of treatment, an implicit power balance was created and as a result, Hmong were reluctant to

seek treatment from doctors. In a similar manner, Lia's family's spiritual practices were undermined as the doctors grew frustrated by the inconsistencies in Lia's treatment, contributed to by the noncompliance of the family, which the family did not understand to be an issue.

Ultimately, in this case, Lia's caretakers had little to no competency of Hmong spirituality, and as a result, there was physical health deterioration of a child. Fadiman observed that:

> "Sometimes [the Hmong] wanted to slaughter live animals in the hospital. Tom Sult, a former MCMC resident, recalled, 'They'd bang the crap out of some kind of musical instrument, and the American patients would complain. Finally we had to talk to them. No gongs. And no dead chickens.'" (75)

The Hmong view animal sacrifices as offerings to the spirits and as a way to repair lost souls. This practice is very important to the healing process, because, for the Hmong, physical health is tied to spirituality. Yes, slaughtering animals within the hospital would probably prove to be unhygienic and a violation of the space itself; however, the dismissal of these beliefs points to a larger issue. The apparent unwillingness to compromise and lack of respect for Hmong spirituality, as made evident by the resident's statement, allows for a glimpse at the gross issues of competency. While there were additional obstacles of a language barrier and lack of cultural competency that hindered medical treatment, the misunderstanding of Hmong spiritual beliefs was a core source of Lia's mistreatment as it fueled mistrust.

After looking at Lia's case, we can take note that a patient's beliefs, including spirituality, must be acknowledged during medical discourse. Patients and physicians need to reach an understanding so that the patient can reach a successful outcome without having to fully sacrifice his or her spirituality. In fact, several studies suggest a positive association between spirituality and physical health. One study focusing specifically on religious practices found that those who attended religious services had a longer life expectancy than those who did not, even

when accounting for the fact that those who are physically healthier would be more likely to attend a religious function (Hummer et al., 1999). Another study reported on associations between religiosity and recovery following heart surgery. Stronger religious beliefs were associated with shorter lengths of stay in the hospital and fewer complications post-surgery. In the same study, however, frequent religious attendance was correlated with longer lengths of stay (Contrada et al., 2004). Indeed, the relationship between spirituality and physical health is complex and not clear-cut. Just as there are studies displaying trends of positive medical outcomes with spirituality, there are cases in which spirituality poses as an obstacle in medical discourse.

There can certainly be frustration and obstacles in medical discourse if spirituality goes against medical discourse, as demonstrated in Lia's case. Take, for example, a practicing Jewish patient who needs a heart valve replacement. This patient may not feel uncomfortable with the idea of using a pig valve for the operation, and so alternatives like a mechanical valve could be employed. A Jehovah's Witness may be opposed to blood transfusions so a bloodless treatment could be considered, given that the patient understands the risks. Other cases may involve beliefs which do not directly affect medical care but are important in establishing trust and ease of communication. These can include Muslim patients who wish to be treated by a physician of the same gender, or Hindu patients who wish to use their right hand for eating and their left hand for toileting. Rather than immediately dismissing a patient's beliefs, cooperation should be strived for so that both physician and patient can establish trust and are on the same page.

As in Lia's case, we see that it can be difficult to distinguish the true effects of spirituality on patient outcomes when patients like the Hmong "view the hospital as a dreaded last resort to be hazarded only when all else fails" (Fadiman 74). When a patient seeks medical care only after

their condition has severely worsened, it is less likely for a favorable outcome to result than if medical attention was sought out from the beginning. Thus, establishing understanding and trust through spirituality is an important factor in a community's perception of the Western hospital. When there is a lack of respect for patients' beliefs and patients feel without a voice, it can paint the hospital as a place to be avoided. Furthermore, just like in Lia's scenario, cultural competency is an important consideration as culture often informs spirituality.

Despite the obstacles presented in this paper, I demonstrated that the concepts of spirituality and Western medicine are not mutually exclusive. Though, when spirituality does enter the realm of medicine, it is usually mentioned in the context of mental healing. Spirituality, including religion, is a commonly-employed tool and coping skill in therapeutic treatment, given that the medical practitioner demonstrates understanding and competency (Lavretsky, 2010). It may be tempting to discount the role of spirituality in physical healing, as practitioners did in Lia's case, but the direct and indirect impacts of spirituality on physical aspects of medicine can be profound. In fact, The Joint Commission, which accredits medical organizations in the United States, mandates that healthcare organizations evaluate and accommodate patients' spiritual needs (McCormick, 2014).

The potential for obstacles in medical discourse are a real concern today, and this is why many medical schools mandate their students to read about Lia's story and to be educated about the importance of patient beliefs. It is critical to ensure cooperation between patients, their families, and physicians, which can be facilitated by cultural and spiritual competency. When there is mistrust from both physicians and patients, the patient's care can be hindered, as shown with Lia. Spirituality can certainly be the obstacle that hinders care, but it can also be the means to facilitate it through competency and understanding.

References

Contrada, R. J., Goyal, T. M., Cather, C., Rafalson, L., Idler, E. L., & Krause, T. J. (2004). Psychosocial factors in outcomes of heart surgery: The impact of religious involvement and depressive symptoms. *Health Psychology, 23*, 227–238.

Fadiman, A. (1997). *The spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures*. New York: Farrar, Straus, and Giroux.

Hummer R.A., Rogers R.G., Nam C.B., Ellison C.G. (1999). Religious involvement and US adult mortality. *Demography, 36*(2), 273–285.

Lavretsky, Helen. (2010). Spirituality and aging. *Aging Health, 6*(6), 749-769.

McCormick, T.R. (2014). Spirituality and medicine. *University of Washington School of Medicine*.

The split horn: shamanism. (2001). In *PBS*.