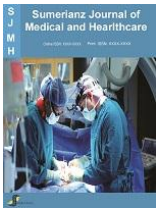
Sumerianz Journal of Medical and Healthcare, 2018, Vol. 1, No. 1, pp. 31-35
ISSN(e): 2663-421X, ISSN(p): 2706-8404
Website: https://www.sumerianz.com



Original Article Open Access

The Patient with Overestimated Faith, Expecting for a Miraculous Healing - Approaches from the Physician

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Abstract

Research from last three decades concluded that religious-spiritual beliefs and practices are significantly associated to better physical and mental health parameters. Religiosity and spirituality are important resources for coping with challenges of life, such as serious diseases and end-of life processes. Patient and his/her family may use their religious beliefs to reframe the distressing moment of these utmost situations. At such context, they are not necessarily wrong to hope for a miraculous healing. Problems arise for the physician-patient relationship if this attitude is a denial behavior, disguised as hope. Intervention from the clinical staff is needed if the belief is a source of distress or if it is motive for hazards, such as treatment abandonment. For the physician facing such situation, some attitudes are suggested in medical literature, aiming to mitigate possible impacts over clinical decisions. The present paper explores the nature of this problem, starting from the general relation between religiosity and health. The religious coping is then analyzed both on its positive form (which fosters meaning and purpose) and negative form (spiritual distress, religious struggle). The very concept of miracles in medicine is discussed, alongside with previous objective forms of documentation. The paper finishes with some guidelines for the physician to evaluate and to approach the situation where a unrealistic expectation confronts the clinical treatment.

Keywords: Medicine and religion; Medical philosophy; Humanities; Metaphysical mind body relation.

1. Religiosity and Health

A large number of published researches on the interplay of religion, spirituality, health and medicine have been published in major peer-reviewed journals. This growing body of evidence shows consistent positive association between religious involvement and better outcomes on individual and population health, either on physical and mental levels [1]. Religious and spiritual beliefs and practices are significantly associated to better mental health and greater adaptability to stress, expressed by lower anxiety, lesser degree and frequency of depression, lower suicide rates, less substance abuse, greater wellbeing, hope and optimism, more purpose and meaning in life, self-esteem, greater marital satisfaction and higher social support [2].

For medical and behavioral purposes, spirituality may be defined as the search for ultimate meaning, purpose and significance, in relation to oneself, family, others, community, nature, and "sacred", expressed through beliefs, values, traditions and practices [3]. Religiosity refers to attitudes toward integration and expression related to a particular religion. Although religiosity and spirituality are distinct constructs, the overlap between them is remarkable and consistent [4]. Thus, it is often adopted the term religiosity / spirituality (R/S) to refer to transcendent elements of meaning, purpose and connectivity [5].

The concept of faith has never been defined fully and encompasses elements of both spirituality and religious beliefs, which may be further modified by culture and personal value systems. Faith has a cognitive and an experiential aspect. The cognitive one associates “to have faith” with the profession of the learned doctrine. The experiential aspect is the inner courage that works as a shelter to help the person to endure difficulties of life [6]. When well constructed, the belief structure is a source of comfort, welfare, security, meaning, idealism and force. Many patients use their beliefs when coping with its illnesses, and the cure can be influenced by the positivist reinforcement of the patient.

2. Religious Coping (Positive Form)

Religiosity and spirituality are important resources for coping with the challenges of life. The term Spiritual-Religious Coping refers to ways that individuals utilize a personal religious or spiritual framework to cope with stress. Spiritual-Religious coping is based upon beliefs, attitudes or practices to reduce the emotional distress caused by adverse events of life, such as losses or changes, which gives suffering meaning and makes it more bearable. Such approach could regulate emotion during times of illness, change, and circumstances that are out of patients’ personal control [5]. Religion would assist people in developing stronger coping styles. When religion is used as part of a wider approach to coping this typically provided a beneficial outcome for mental health and reduced mental distress.

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In facing major life stressors, positive religious coping is a way of interpreting and responding to such events that reflect a secure relationship with beliefs, a sense of meaning and purpose in life, benevolent religious appraisals, a collaborative approach with the inspiration to solve problems, and searching for spiritual connectedness with others. This approach for coping with life's problems can help people conserve their beliefs in a higher power, help to surrender control, and to draw meaning from stressful circumstances [7]. Positive religious coping is linked to healthier psychological adjustment to stress, decreased levels of depression, anxiety, and elevated levels of happiness, well-being, and life satisfaction, as well as mental and physical health [7].

3. Religious Struggling (Negative Coping)

However, in contrast, religious misinterpretations may bring negative elements for both health status and treatment planning. A dysfunctional belief system may originate negative reactions that harm the healthcare evolution. If there is a disruption of the belief system, the spiritual distress can surge. The defensive behaviors that patient can develop consequently under spiritual distress may affect clinical decisions and quality of life. Negative religious coping can have more detrimental effects on quality of life, psychological adjustment, and behavior patterns. This leads to the topic of spiritual struggles.

Spiritual struggles refer to expressions of conflict, question, doubt, and tension about matters of faith, God, and religious relationships, developed from an intersection between stressful life experiences and an individual's personal orientation system [8]. Spiritual struggles can be understood as coping efforts to conserve or transform a spirituality that has been threatened or harmed. What differentiates spiritual struggles from other spiritual coping processes is the expression of spiritual stress, strain, or distress within the coping process.

Religion and spirituality can contribute to distress if there are struggles inherent in the method of spiritual coping. When faced with tragedy, fundamental assumptions regarding a benevolent divine and notions of a "just world" can be shattered and people can be hurled into existential crisis. Spiritual struggles may be fueled by the feelings of alienation from or guilt toward God or a higher power, with negative outcomes related to spiritual struggles [7].

4. Overestimated Faith and Miraculous Expectations

At times, some physicians may face a challenging situation: a patient is extremely ill and/or dying, and the family expects a miraculous recovery. Nothing wrong if the hope for a better outcome brings comfort to everyone involved in such distressful situation. However, the blind belief on a miraculous cure may produce some attitudes that go against some key clinical decisions. The difficulty for the physician is to respect the beliefs of the patients and/or relatives, at the same time offering the best treatment available.

According to Stanford Encyclopedia of Philosophy [9], a miracle (from the Latin mirari, to wonder) is an event that is not explicable by natural causes alone. A miracle requires, as its cause, something beyond the reach of human action and natural causes. Miracles are related to specific forms of theism, since the event in question could best (or only) be explained as the act of a particular deity. In Christian theology, five criteria for a miracle were outlined by Pope Benedict 14th in 1735 [10] and include an incurable disease which does not remit, is healed instantaneously, completely and without any therapy.

The expectation of divine intervention may be intensified by specific experiences and beliefs. These include [11]: previous personal experiences with miracles; the sense that the current situation is a "test of faith"; and the belief that the occurrence of the miracle is dependent on unwavering or unquestioning faith.

Derivative damages may arise from such coping styles where the individual waits for God to intervene on his/her behalf. The excessive reliance on the power of rituals or prayer may delay seeking for necessary help for health disorder, thus worsening the prognosis. Dysthanasia is the preference for continued aggressive care based on the belief that a miracle will occur, despite a clinician's belief that any further intervention is unlikely to have any meaningful benefit. This insistence on such interventions will only prolong the death process.

5. Is The Patient Always Wrong?

The search for scholarly articles with the word "miracle" results in limited findings, most of them addressing miracles from the perspective of saints, religions, or healers [12]. However, spontaneous regression of serious diseases is occasionally registered in literature as case reports, in which the outcome is rare and not well explained. Spontaneous Remission is disappearance, complete or incomplete, of a disease without medical treatment that is considered adequate to produce it". Spontaneous remission may not be so rare, and the impression of rarity is partly an artifact of underreporting. For example, the Institute of Noetic Sciences created a database of thousands of reported cases worldwide [13].

Unexplainable cures are essential signs of sainthood in the canonization process of The Catholic Church. This institution scrutinizes every potential miracle rigorously. To qualify, an event must defy all natural explanations, based on the most advanced scientific knowledge of the time. Physician testimony has always been crucial to the investigation of miracles for declaring the hopeless prognosis and the surprise at recovery. Although rare, unexplainable cures may happen. A survey of more than six hundred miracle records in the canonization files of the Vatican Secret Archives from the seventeenth century to the twentieth century reveals that more than 95 percent are healings from illness [14].

The reports of miraculous healings, such as those reported at Lourdes, France, show the extent to which faith and prayer can affect healing. The International Medical Committee at Lourdes was created in 1947 within the

Sanctuary of Our Lady of Lourdes. Their members rigorously examine the patient files, and they vote to declare or refuse whether a cure is inexplicable according to present scientific knowledge. The cures, carefully documented by the Committee, are sudden, complete and without medical treatment. According to the website of the Sanctuary (http://en.lourdes-france.org), to date there have been 65 cures accepted.

However, the patient must understand that a genuine miracle cannot be conjured. The conjurer is attempting to use God as an instrument of his/her will. God is neither a therapeutic nostrum nor a surgical implement to be wielded at will. Miraculous cures are not magic tricks. One cannot pray them into existence, make them happen, or force one's will upon God [15]. Theologically, the work of any prayer is for human beings to open themselves to the grace of God. The work of prayer is to tell God of one's deepest hopes and fears and to let God flood one's heart [15].

6. Attitudes of the Physician – Evaluation and Approaches

Belief in miracles and divine intervention is common and may play an important role in the decision-making process. Physicians should try to elicit, understand, and support the patient's and family's religious tradition. Although data remain limited, the provision of spiritual support and a proactive approach to medical decision making that allows patients and family members to voice their religious beliefs may improve outcomes for patients and surrogates [16].

A genuine hope is not simply being optimistic, being positive, or expressing the expectation of cure; it is also the belief that everything will be done that is humanly possible for the good of the patient, as well as the belief that something meaningful is yet to come [17]. Hope may become the meeting place between provider and patient, between what is possible and what is probable [17]. The physician may help the patient to evolve from hope in the cure for hope in a peaceful passage. Hope is assurance that the medical team is committed to the patient, regardless of the clinical outcome.

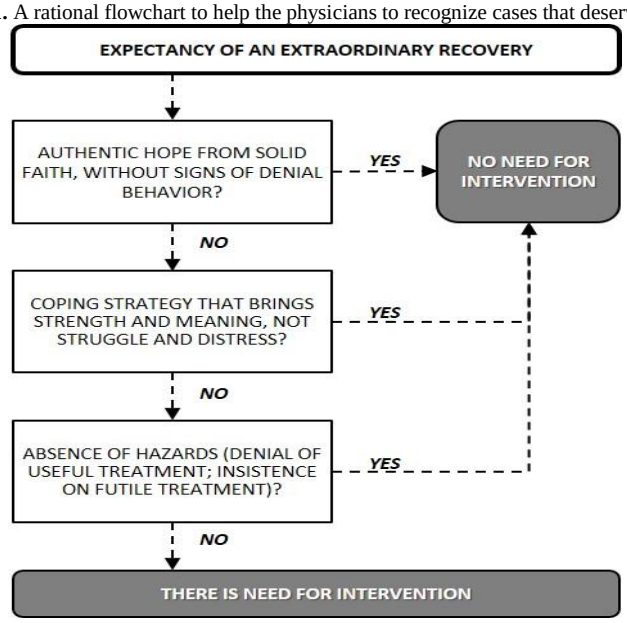
Clinical situations in which the anticipation of a miracle may suggest denial include the following [11] (1) when the family appears to lack understanding about the patient's diagnosis and prognosis; (2) when the family reaches conclusions about the patient's condition that are very different from those of the care team; and (3) when the family maintains a disproportionate optimism.

A fast screening may help the physician to distinguish a blind denial of the situation from an authentic faith in miracles. A proposition of a set of five simple questions [18] include: Does the patient acknowledge the possibility that the answer to the prayer for a miracle may be "no"? Is the patient able to acknowledge that God might not need the doctors to perform the hoped-for miracle? What is the effect of the patient's belief system on the patient's overall mood, sense of well-being, and sense of self? What are the effects of the patient's beliefs on relationships with others—family, friends, religious community, and staff? Is the patient willing to accept input regarding God's will from others in his or her own faith community?

Intervention can be justified if the situation reaches one of the following three conditions [18] (1) Requests for medical care reach the point of conscientious objection on the part of the clinicians (ie, the physician might be asked to do something to which the physician is morally opposed), and this might be respectfully refused. Or, (2) demands are made for care that is biomedically futile (ie, the patient or family may request a treatment that, to a reasonable degree of medical certitude, will not work from a strictly biomedical point of view), and such interventions might be respectfully refused. (3) It may be the case that the clinician feels that what the family is requesting might only harm the patient with no reasonable prospect of affecting the disease, and such interventions might also be respectfully refused.

Based upon the previous literature, Figure 1 brings a rational flowchart to help the physicians to recognize cases that deserve intervention.

Figure-1. A rational flowchart to help the physicians to recognize cases that deserve intervention



Medical literature cites some strategies for the physician when confronted with families who are hoping for miraculous healing [19]; [20]; [11]; [17]. Based upon such background, the present paper extracted and summed up some guidelines that are common on such literature:

- Understand who the patient is as a person; value and appreciate what patient and surrogates communicate; acknowledge their emotions by listening carefully.
- Assure the patient and family you are committed to them every step of the way, no matter what happens. Emphasize nonabandonment; your commitment to the well-being of the patient is a common ground.
- Ensure patient and family have adequate understanding of the clinical situation. Remember your professional obligations bringing to conversation the specific medical issues. Negotiate patient-centered compromises while practicing good medicine.
- Understand the meaning of the word "miracle" to them through conversations. Reframe the meaning and manifestation of the miracle; Suggest that if a miracle is to occur, physician actions will not prevent it.
- Affirm the patient's belief. Validate his/her position by saying "I join you in hoping (or praying) for a miracle." Allow hope for a miracle, as a way to acknowledge and respect another's beliefs, values, and faith.

7. Conclusion

Research from last three decades concluded that religious-spiritual beliefs and practices are significantly associated to better physical and mental health parameters. Religiosity and spirituality are important resources for coping with challenges of life, such as serious diseases and end-of life processes. Patient and his/her family may use their religious beliefs to reframe the distressing moment of these utmost situations. At such context, they are not necessarily wrong to hope for a miraculous healing. Problems arise for the physician-patient relationship if this attitude is a denial behavior, disguised as hope. Intervention from the clinical staff is needed if the belief is a source of distress or if it is motive for hazards, such as treatment abandonment. For the physician facing such situation, some attitudes are suggested in medical literature, aiming to mitigate possible impacts over clinical decisions.

Declarations

- ***Ethics approval and consent to participate:*** Not applicable. This manuscript does not report data collected from humans or animals.
- ***Competing interests:*** Not applicable. The authors declare that they have no competing interests.
- ***Funding:*** Not applicable. No support in form of grants is related to this publication.
- ***Authors' contributions:*** Marcelo Saad = main composing of text manuscript. Roberta de Medeiros = literature search, data extraction from papers, and suggestions for information sequence on text. All authors read and approved the final manuscript.

References

[1] Chattopadhyay, S., 2007. "Religion, spirituality, health and medicine: Why should Indian physicians care?" *J. Postgrad Med.*, vol. 53, pp. 262-266.

[2] Koenig, H. G., 2012. "Religion, spirituality, and health: the research and clinical implications." *ISRN Psychiatry*, Available: http://dx.doi.org/10.5402/2012/278730

[3] Puchalski, C. M., Vitillo, R., Hull, S. K., and Reller, N., 2014. "Improving the spiritual dimension of whole person care." *J. Palliat Med.*, vol. 17, pp. 642-656.

[4] Ammerman, N. T., 2013. "Spiritual but not religious? Beyond binary choices in the study of religion." *Journal for the Scientific Study of Religion*, vol. 52, pp. 258-278.

[5] Saad, M. and de Medeiros, R., 2012. *Spiritual-Religious Coping – Health services empowering patients' resources. In Saad M (Ed.): Complementary therapies for the contemporary healthcare*. Tech Publisher.

[6] Kalra, L., 2007. "Faith under the microscope stroke." *Epub.*, vol. 38, pp. 848-849.

[7] Faigin, C. A. and Pargament, K. I., 2011. *Strengthened by the Spirit: Religion, Spirituality, and Resilience Through Adulthood and Aging. In Resnick B, Gwyther LP, Roberto KA (Org.): Resilience in Aging - Concepts, Research, and Outcomes*. USA: Springer Publisher.

[8] Pargament, K. I., Magyar, G. M., Benore, E., and Mahoney, A., 2005. "Sacrilege: A study of sacred loss and desecration and their implications for health and wellbeing in a community sample." *Journal for the Scientific Study of Religion*, vol. 44, pp. 59-78.

[9] McGrew, T. M. and Zalta, E. N., 2015. "The stanford encyclopedia of philosophy (Winter 2015 Edition)." Available: http://plato.stanford.edu/archives/win2015/entries/miracles

[10] May, P., 2003. "Claimed contemporary miracles." *Med. Leg. J.*, vol. 71, pp. 144 -158.

[11] DeLisser, H. M., 2009. "A practical approach to the family that expects a miracle." *Chest*, vol. 135, pp. 1643–1647.

[12] Kub, J. and Groves, S., 2007. "Miracles and medicine: an annotated bibliography." *South Med J.*, vol. 100, pp. 1273-1276.

[13] Hirschberg, C. and O'Regan, B., 1993. *Spontaneous remission: An annotated bibliography*: Publisher: Institute of Noetic Sciences. p. 713.

[14] Duffin, J., 2007. "The doctor was surprised; or, how to diagnose a miracle." *Bull Hist Med.,* vol. 81, pp. 699-729.
[15] Sulmasy, D. P., 2007a. "What Is a Miracle?" *Southern Medical Journal,* vol. 100, pp. 1223-1228.
[16] Widera, E. W., Rosenfeld, K. E., Fromme, E. K., Sulmasy, D. P., and Arnold, R. M., 2011. "Approaching patients and family members who hope for a Miracle." *Journal of Pain and Symptom Management,* vol. 42, pp. 119-125.
[17] Cooper, R. S., Ferguson, A., Bodurtha, J. N., and Smith, T. J., 2014. "AMEN in challenging conversations: Bridging the gaps between faith, hope, and medicine." *J. Oncol Pract.,* vol. 10, pp. e191-e195.
[18] Sulmasy, D. P., 2007b. "Distinguishing denial from authentic faith in miracles: A clinical-pastoral approach." *Southern Medical Association,* vol. 100, pp. 1268-1272.
[19] Orr, R. D., 2007. "Responding to patient beliefs in miracles." *Southern Medical Journal,* vol. 100, pp. 1263-1267.
[20] Curtis, J. R. and White, D. B., 2008. "Practical guidance for evidence-based ICU family conferences." *Chest,* vol. 134, pp. 835- 843.