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Revisioning the Therapeutic Relationship II

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Introduction

In the prior essay I raised the following questions:

What is the spiritual architecture of the space between doctor and patient? How do we recreate a mythic shared space that might allow for sharing of mutual vulnerability and anguish of living.

How do we create sacred spaces inside and outside the context of suffering?
Can we describe an imagined Presence that both actors may surrender to? That both healer and patient ascribe to a loving unconditionally accepting nonjudgmental interaction that resists bias and personal baggage.

Can we be humble enough to acknowledge that rational scientific left brain mastery of facts and data are insufficient to account of the entire being of the sentient person before us?

Can we humbly accept our ignorance as the starting point for surrendering to deeper forces at work in the symptomatology? That even unconscious forces are screaming for attention and accessible only through mutual sharing of vulnerability.

We must start with a theory of such a roadmap. What are essential component structures of both parties and how do they interact with each other than with the outside.

In this essay I will revision the inter-personal aspect of doctor-patient space.

Is it possible to reform from within? Let us look at the work of right hemisphere activity such as spirituality in the system, to determine whether this heals or exacerbates the split of the bicameral mind as it plays out in the systems of delivery of health care.

The relationship of science to religion long fascinated early anthropologists, who alternately reified a post-Renaissance "great break" between science and religion (Durkheim 1912; Tylor 1920) and made the case for similarities between these modes of understanding (Evans-Pritchard 1937).

For a time in medical anthropology we became focused on what separated medical science from religion (Foucault 1973; Lock and Gordon 1988; Taussig 1992).

Today, however, we are coming to see issues of faith and medicine merging in ways that highlight the discursive and contested nature of cultural forms and practice (Brodwin 2000; Franklin 1997; Franklin and Lock 2003; Haraway 1991; Strathern 1992).

In reviewing studies describing medical student training we see the relatively little weight attached to spiritual training.

Goldfarb et al writes: [1]

*We found that the medical students responsible for treating substance abuse are significantly less religiously and spirituality oriented than the patients they treat, and that the students **do not** indicate that spirituality is an important component in the care of these patients.*

It may be clinically relevant to train medical students in the potential importance of spirituality in addiction treatment so that they can incorporate spirituality into the treatment of addictions.

In the table below, the total disconnect between what medical students thought their patients' attitudes towards healing were as opposed to patients direct reporting were glaring.

MEDICAL STUDENTS	PATIENTS	WHAT MEDICAL STUD. THINK PATIENTS THINK
1. Housing	1. Inner Peace	1. Housing
2. Government	2. God	2. Outpatient Treatment
3. Medical Services	3. Medical Services	3. Medical Services
4. Outpatient Treatment	4. AA	4. Job
5. Job	5. Housing	5. Trusting People
6. Community	6. Spirituality	6. AA
7. Trusting People	7. Outpatient Treatment	7. Inner Peace
8. Inner Peace	8. Community	8. Community
9. God	9. Government	9. Government
10. Spirituality	10. Trusting People	10. Spirituality
11. AA	11. Job	11. God

Similarly, Lydia Fazzio et al. [2] performed a two-phase study on attitudes of medical students toward Alcoholics Anonymous. The first phase compares views of addiction faculty to third-year medical students on the importance of spirituality in addiction treatment.

The faculty viewed spirituality as relatively more important in addiction treatment than did the students. The second phase was designed to assess whether medical student attitudes toward spiritually based treatments changed over the course of a psychiatry clerkship.

At the beginning of the clerkship, students rated a spiritually oriented approach as important in addiction treatment as a biological approach, whereas, at the end of the clerkship, they rated the biological approach as more important.

The above studies clearly demonstrated that education skews the science of medical practice toward a biological model (left hemispheric function) so that by the end of training their attitudes have solidified into a mechanistic view of what patients believe (projection) as well as what they believe after training.

After attending AA meeting Kastenholz and Argawal [3]. reported that Medical students found their experience attending an AA meeting to be educationally valuable. They reported their familiarity with AA prior to this experience was largely limited to popular media depictions. Students reported understanding alcoholism as a disease with both biological and psychosocial components.

Yet they were often concerned with the presence of religiosity and spirituality at the meetings. Following the experience, students felt more comfortable referring patients to AA and identified empathy, honesty, and openness as crucial contributors to the efficacy of AA.

Faced with suffering and death, critically ill patients and their families need a source of comfort and hope. Spiritual care is intended to bring relief to them by responding to their spiritual needs. Usually provided by chaplains spiritual care improves the quality of life of patients, satisfaction with medical care and even prevents or alleviates the negative psychological consequences of hospitalization.

Goldfarb Maciej W Klimasinzki writes: [4]

Moreover, it is beneficial to the ICU personnel, to their motivation, work efficiency, well-being and reduces the risk of burnout. Basic spiritual care that can be provided by any ICU physician on a daily basis is nothing more than the way of behaving towards a patient: seeing an individual who has his/her dignity, history, personality, beliefs, fears and hopes. Whenever disease-associated stress has led to an existential crisis, the ICU staff may request a hospital chaplain's visit. The physician can support the conscious patient by establishing a relationship with him: by showing concern, compassion and solicituide.

The problem is that the chaplain is very low on the totem pole of power structures in the hospital hierarchy.

Christina M. Puchalski writes:[5]

The technological advances of the past century tended to change the focus of medicine from a caring, service oriented model to a technological, cure-oriented model. Technology has led to phenomenal advances in medicine and has given us the ability to prolong life.

However, in the past few decades physicians have attempted to balance their care by reclaiming medicine's more spiritual roots, recognizing that until modern times spirituality was often linked with health care. Spiritual or compassionate care involves serving the whole person—the physical, emotional, social, and spiritual.

Such service is inherently a spiritual activity. Rachel Naomi Remen, MD, who has developed Commonweal retreats for people with cancer, described it well: [6].

Helping, fixing, and serving represent three different ways of seeing life. When you help, you see life as weak. When you fix, you see life as broken. When you serve, you see life as whole. Fixing and helping may be the work of the ego, and service the work of the soul.

The drive for training reform is based on the understanding that focusing on the spiritual aspect of patients enables one to deliver more compassionate care.

In addition, the Association of American Medical Colleges (AAMC) has embarked on a study of medical education. It convened a consensus group of deans and faculty of medical schools to determine the key elements of a medical school curriculum. In its first report, it listed the essential attributes of physicians. The first attribute is that physicians should be altruistic: "Physicians must be compassionate and empathic in caring for patients. . . . In all of their interactions with patients, they must seek to understand the meaning of the patients' stories in the context of the patients' beliefs and family and cultural values. . . . They must continue to care for dying patients even when disease-specific therapy is no longer available or desired"[7].

The AAMC has also addressed the curriculum in spirituality, cultural issues, and end-of-life care. In its third report, the association outlined outcome goals and learning objectives for spirituality below [8].

Learning Objectives

With regard to spirituality and cultural issues, before graduation students will have demonstrated to the satisfaction of the faculty:

- The ability to elicit a spiritual history
- An understanding that the spiritual dimension of people's lives is an avenue for compassionate caregiving
- The ability to apply the understanding of a patient's spirituality and cultural beliefs and behaviors to appropriate clinical contexts (e.g., in prevention, case formulation, treatment planning, challenging clinical situations)
- Knowledge of research data on the impact of spirituality on health and on health care outcomes, and on the impact of patients' cultural identity, beliefs, and practices on their health, access to and interactions with health care providers, and health outcomes
- An understanding of, and respect for, the role of clergy and other spiritual leaders, and culturally based healers and care providers, and how to communicate and/or collaborate with them on behalf of patients' physical and/or spiritual needs
- An understanding of their own spirituality and how it can be nurtured as part of their professional growth, promotion of their well-being, and the basis of their calling as a physician

First, the consensus group noted that we are coming to understand health as a process by which individuals maintain their sense of coherence and meaning in life in the face of changes in themselves such as illness.

The AAMC's definition of spirituality is a broad one: Spirituality is recognized as a factor that contributes to health in many persons. The concept of spirituality is found in all cultures and societies. It is expressed in an individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All of these factors can influence how patients and health care professionals perceive health and illness and how they interact with one another.

Unfortunately the emphasis on spiritual care as divorced from conventional medical practice only tends to exacerbate the very spit between practitioners and the weight the patient gives to respective providers.

In revisioning the therapeutic relationship space these biases will need to be addressed before training begins.

Let us now turn to the very institutional space, the hospital/clinic where healing takes place to determine whether this model can possible be used for a healing space.

The Doctor, Sir Luke Fildes (1891)

Ethnography

In The Birth of the Clinic: Michel Foucault [9], presents the development of la clinique, the teaching hospital, as a medical institution, identifies and describes the concept of *Le regard médical* (lit. 'the medical gaze'), and the epistemic re-organization of the research structures of medicine in the production of medical knowledge, at the end of the eighteenth century. Although originally limited to the academic discourses of post-modernism and post-structuralism, the medical gaze term is used in graduate medicine and social work.

The medical gaze

In the genealogy of medicine—knowledge about the human body—the term *Le regard médical* (The medical gaze) identifies the doctor's practice of objectifying the body of the patient, as separate and apart from his or her personal identity. In the treatment of illness, the intellectual and material structures of la clinique, the teaching hospital, made possible the inspection, examination, and analysis of the human body, yet the clinic was part of the socio-economic interests of power. This has only exacerbated under the American system whereby corporate intrusion into healthcare has steamrolled the sanctity of the doctor patient space in the interest of profit.

Therefore, when the patient's body entered the field of medicine, it also entered the field of power where the patient can be manipulated by the professional authority of the medical gaze, and the influence of financial gatekeeping of access to care.

In the 18th century, when the French (1789–1799) and the American (1775–1783) revolutions inaugurated the Modern era those events also established a meta-narrative of scientific discourse that presented scientists as sages—specifically, the medical doctors—who would abolish sickness and resolve the problems of humanity. By that cultural perception, 19th-century society replaced the scientifically discredited mediaeval clergy with medical doctors.

The myth of medical sagacity was integral to the meta-narrative discourse of Humanism and of the Age of Enlightenment (17th–18th c.)—a historical period when people believed that the human body was the person. Such biological reductionism gave power of authority to doctors when they applied their medical gaze to the body of the patient, an interaction that allowed unparalleled medical understanding of patient and illness. In turn, the cultural perception of the medical gaze was the doctor's near-mystical capability to discover hidden truth.

A Change in Image-Objectification

In Birth of the Clinic (1973) Michel Foucault argues that man's relationship to himself has been transformed through medical discourse. The physician's entry into the human body via autopsy allowed the critical epistemological shift of the doctor's "gaze" from the patient as participating subject to the patient as an object of medical practice.

Institutions, such as hospitals, communicate the moral order, which then becomes internalized by the patient and practitioner, whose knowledge of their structured repression is obscured by an ongoing accumulation of knowledge and power. The shift, according to Foucault, is a structural one that is obscured by ideology and played out at the site of the human body.

Byron Good (1994) responds, arguing that practice is situated somewhere between structure and experience. He explains that medicine is a "symbolic form through which reality is formulated and organized in a distinctive manner". He writes, "learning the language of medicine consists not of learning new words for the common-sense world, but the construction of a new world altogether". Good examines the formative practices of medical students and finds that medical education is a two-way practice that both shapes new ways of "seeing," "writing," and "speaking" and is, in turn, shaped by those who "see," "write," and "speak" within this world of experience.

Good argues that medical practice is somewhat more flexible and permeable than a Foucauldian perspective would suggest. He finds that marginalized discourses, particularly around issues of salvation and existence, are not only present in medical practice but may also be fundamental to it.

The different space of the hospital, different rules of engagement, difficulty in approaching patients, and the fact that the medical conception of a patient body is quite different from their own are some of the main obstacles that chaplain interns new to the setting of State University Hospital experience. What does this mean? On one level, it is a matter of socialization and acclimation in an otherwise unfamiliar environment. Good (1994) describes this process as a formative practice that occurs among participating agents as they negotiate structure and experience, learning to construct conceptions of the patient through seeing, writing, and speaking the language of medicine.

Hospitals originated prior to the Renaissance as religious and charitable institutions designed to contain the sick and the poor and to care for their

chronic ills. Following the Renaissance, science and scientific modes of understanding broke from religion, giving primacy to the physicality of the body over issues of mind or spirit (Mauceri 1986; Porter 1997:217–245). Nowhere was this shift more apparent than in the hospital.

Historical sociologist Paul Starr suggests that, with the advent of antisepsis techniques and the increasingly successful ability of medicine to cure acute illnesses (especially through surgery), the poor, the insane, and the contagious or chronically ill were separated out from this newly designated hospital population. The focus of hospital staff, then, shifted from one of caring and empathy for a long-term patient population to one of curing and acute care relief for a revolving-door population of patients.

The shift was away from moralistic objectives toward medical objectives focused on the treatment of disease and injury (Starr 1982:145–162). This culminated in a secularization of hospitals, which reached its peak in the United States in the 1970s and 1980s (Koenig and Lawson 2004:103).

By the 1980s and 1990s another shift in medicine took form as patients and practitioners alike called for holistic, integrative, or spiritual approaches to medicine and health (Dossey 1993; Hiatt 1986; Larson and Larson 1992; Radetsky 1978; Remen 1996; Weil 1983).

No Longer a Sacred Space

Hospital space is probably the pinnacle of medical space in terms of its developed insulation from the outside world (Foucault 1973; Foucault 1979). Mortar and brick mark the physical boundaries of State University Hospital, while technology, interior layout (from artwork to floor space design), staff hierarchies, and different rules of engagement (from washing hands to introductions) are just some of the major ways in which cultural and symbolic space is ritualized and communicated within the hospital setting.

Medical students are subjected to a process of socialization in order to acclimate to, the world of hospital medicine and negotiate these spaces, culturally and architecturally.

The hospital is a different space that literally divides and compartmentalizes illness and the human body by arranging patients and disease spatially by floors—cardiac, neurology, oncology, pediatric, and so on (Foucault 1973). Here, the informal rules for moving, touching, and speaking are markedly different from rules that structure interaction outside of the hospital environment.

Negotiating these spaces requires skill in moving in:

1. The bureaucratic space of the hospital and some of the different rules for moving around the hospital and engaging others within that space;
2. Figuring out how to approach patients in an environment that was not always set up to provide safe spaces,
3. Becoming familiar and comfortable with medicine's view of the patient body.

Meeting the Medical Patient Body

Frances Norwood [10], describes the different orientation that medicine has to the patient body.

The position of the modern-day hospital chaplain within a world of medicine is a difficult one that is situated between structural differences that revere medical forms of power, hierarchy, and practice over religious ones. The result is an ambivalent chaplain who must alternately embrace one or the other paradigm in order to survive. The chaplain experience in modern-day hospital medicine is largely one of marginalization. It is not, however, an experience without agency.

Part of the shock of hospital bureaucracy and rules for engaging in this space, like hand washing and entering a patient's room, is a symptom of the shock that interns feel with regard to how medicine has carved up the human body in its attempts to heal and create medical order.

Chaplains interns learn very quickly in the hospital that the patient body is medicine's body first (Csordas 1994; Foucault 1978; Haraway 1991; Turner 1984). Thomas Csordas (1994) states that the body has become a "terrain of medical practice." This medicalized body is often passive and objectified—a body that is "disciplined and made" through the authority of medical practice—and it is a body that is thought to be partial, revealed to medicine predominantly through the internal physiology of the body and rarely in the lived experience of the patient.

Conceptions of a medical body vary from a body revealed through the surgeon's knife (Foucault 1973) to conceptions of gendered bodies (Franklin 1997; Haraway 1991), and bodies at the forefront of technology (Brodwin 2000; Franklin and Lock 2003; Strathern 1992) and medical advancement (Hogle 1999; Lock 2002).

The consequence for the chaplain, however, is fairly consistent. As demonstrated in the excerpt above, even in death, the patient body continues to be defined and retained by medicine. Through medicine's authority, chaplains are marginalized within this setting and the divide is communicated in multiple ways, from the structural (e.g., spatial arrangement of hospital space and staff hierarchies that limit chaplain contact with patients) to the ideological (e.g., staff stereotypes and assumptions of chaplains and chaplain work that limit their inclusion in hospital routines)

Chaplains are not present in the hospital simply because they have learned the world of hospital medicine and learned to downplay the differences between religion and medicine. They are present in the hospital because of their difference, because medicine is not complete without the perspective and the orientation that chaplains bring. I am not arguing, as does Byron Good (1994: 67–86), that orientations to suffering or the existential are necessary, or "fundamental," to medicine but, rather, that the process of exclusion in medicine is not complete.

Norwood feels that the porous nature of the culture allows the chaplain space to do his or her work.

What chaplains bring to the world of medicine is a different conception of the patient body. To the chaplain, the body is what Norwood calls "a holy body", a (w)holy body that is not separated by organ, disease, or skin; or by conceptions of sacred and profane.

Nor is it separated from familial, societal, or Divine relationships. It is

through this concept of the holy body that chaplains embrace their religious orientation to the world, bringing perspective, practice, and authority to the hospital setting that staff, patients, and families recognize.

Unfortunately the chaplain works within the split system of medicine and only exacerbates the split within and without the patient/doctor relationship by supporting the hierarchical dominance of the medical model.

Can we fix Communication under the present disproportionate power structure?

Keshavarzi et al, writes:[11]

Communication skills are an essential part of life skills defined as communicating effectively and efficiently with others leading to responses.

This relationship is formed when the physician and the patient consciously tend to accept each other. An effective physician-patient relationship increases the patients' confidence and willingness to communicate.

Several studies have confirmed the influential role of patient-physician communication in treatment outcomes. According to the available reports, establishing a proper relationship between the physician and patient can improve the patient's satisfaction with the treatment process and attract participation, leading to faster recovery and better outcomes [12].

A good physician-patient relationship positively affects the patients' health and recovery [13] Stavropolu (2011), in a study entitled the "Non-Compliance with the Treatment and the Physician-Patient Relationship" which was conducted across Europe, concluded that the physician-patient relationship plays a significant role in the patients' decision-making to accept and follow the treatment recommendations, and a good relationship can predict the patients' follow-up outcomes [14].

Warner, in a study, showed that the "Physicians believe that their skills are such that the patients are not in a position to judge how they are treated and how they act because they are unprofessional and cannot make judgments about the physicians' performance on a non-professional basis. These assessments are also about the interaction between two different and conflicting sets of norms [15].

In a research paper, Delghandi investigated the causes regarding the propagation of the patients' complaints to the physicians and stated that: "According to the medical experts, in most cases, physicians did not commit the negligence, and most of the complaints were about the inappropriate interaction between the physician and the patient and the patient's lack of proper justification before treatment" [16].

There are many obstacles to establishing strong relationships between physicians and patients in medical activities. Undoubtedly, in medical professionalism, identifying some of these obstacles will improve the physician-patient relationship and improve the quality of medical care [17].

This study was conducted to explore barriers of physician-patient relationships in professionalism based on physician experiences.

Physician's sense of self-superiority

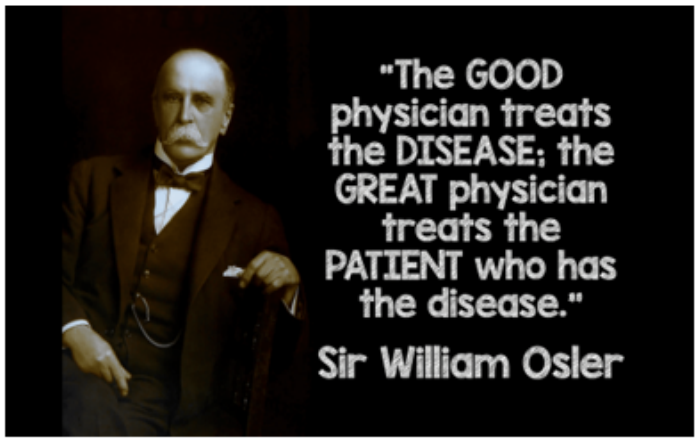
The concept of physicians' sense of self-superiority includes the physician's disregard for the patient's complaints, disrespect for the patient's time, and obligation by the physician.

In a study, Robert Ratbarton et al. (2016) investigated the relationship between the physicians' humility, physician-patient relationship, and the patients' health. Their results showed a relationship between the physicians'humility and effective communication between the physician and patient, so that the humble physicians were more successful in interacting with their patients than the arrogant ones [18]. The physician was shown to be a key indicator for evaluating the quality of services. Paying attention to this factor plays an essential role in the patients' satisfaction [18, 19].

Patients' cultural differences

This concept refers to the patient's improper expectations, lack of understanding of the examination and diagnosis process, failure to follow the physician's advice, and weakness in interaction with the physician. Insufficient patients' educational level reduces the patients' awareness and trust in the physician-patient relationship.

To emphasize the role of cultural weakness of the patients, Zheng in a study showed that the interaction between the physicians and patients was significantly compromised when the cultural perspectives of the participants were ignored. As a result of confusion, uncertainty was one of the issues raised by the patients [19].



Physician Humility and Physician-Patient Communication

Peter M. Ruberton writes: [20]

Cultural portrayals of physicians suggest an unclear and even contradictory role for humility in the physician-patient relationship. Despite the social importance of humility, however, little empirical research has linked humility in physicians with patient outcomes or the characteristics of the doctor-patient visit. The present study investigated the relationship between physician humility, physician-patient communication, and patients' perceptions of their health during a planned medical visit.

Humility is a psychological state characterized by a secure and accepting identity, an accurate view of oneself and one's strengths and weaknesses, an egalitarian view of all individuals, and a high level of other-valuation and other-focus. It has been described as a character strength and is considered by laypeople to be a valuable personal quality [21].

Humility has also been related to a variety of socially desirable outcomes.

Humble individuals are more likely to help a peer in need, more generous with their time and money, and more cooperative and less selfish in economic games than less humble individuals. Notably, humility is not characterized by poor self-esteem or low self-confidence [22], an important distinction in a medical context in which forwardness and assertiveness may be adaptive (e.g., when a physician needs to give a clear, direct recommendation to a patient [23].

Consistent with general theoretical definitions of humility, medical humility has been described as "unflinching self-awareness; empathetic openness to others; and a keen appreciation of, and gratitude for, the privilege of caring for sick persons" [24].

Yet despite the social importance of humility, little empirical research has linked humility in physicians with patient outcomes, such as improved physician-patient communication and patients' perceptions of their health. Physician humility may be positively associated with patient outcomes in several ways.

Because humility involves a relatively high focus on others rather than on oneself, humble physicians should be more attuned to their patients' physical and emotional needs than less humble physicians, and therefore communicate more instructive and relevant information to patients.

Effective physician-patient communication, in turn, is associated with improved patient outcomes, including greater adherence to treatment regimens and better subjective (i.e., patient-reports of overall health) and objective (e.g., physical signs) health [25].

An experimental study found that physician communication training increased patients' satisfaction with their physicians and promoted discussions of health-promoting behaviors, this improvement in physician communication may in turn promote better patient health outcomes. Additionally, physicians communicate less effectively with patients of low socioeconomic status [26] however, because humble individuals are highly egalitarian, humble physicians are likely to treat all patients as equals.

Finally, patient health may actually promote more humble behaviors in physicians: Physicians react more negatively to distressed patients than to healthy patients [27], so relatively healthy patients may enable physicians to behave more comfortably and securely, and thus more humbly, than they do with their less healthy patients during physician-patient interactions.

patients. Physicians who were generally humble around their patients were rated as communicating more effectively with those patients than physicians In this study, physician communication strongly predicted patients' satisfaction with the care they received, suggesting that physician humility may provide indirect benefits for patient satisfaction. Although the causal direction of the relationship cannot be inferred, the results suggest that increasing physicians' levels of humility may be a means of promoting improved physician-patient communication and thus better patient outcomes and better patient satisfaction with care.

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