Just being

> The secret of the care of the patient is caring for the patient
>
> *Care of the Patient*
> F PEABODY, 1927[1]

> The secret of the care of the patient is caring for oneself while caring for the patient.
>
> *Medicine and the Family: A Feminist Perspective*
> L CANDIB, 1995[2]

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SELF-CARING AND SELF-KNOWLEDGE

Caring for oneself, like caring for others, is not always a simple matter. This is because caring always involves knowing.[2,3] I am not speaking of *knowing about*, the accumulation of details that constitute medical records and life stories; these descriptors do not necessarily lead to caring. However, *knowing* does, through a deep appreciation of how experiences, desires, and dispositions contribute to daily actions.

For me, the most fruitful means for self-knowledge have been music and meditation. I hesitate to subsume either under the category of self-care or well-being, as I believe that neither discipline should be limited by having to have an end result. Not that end results are unimportant—Plato and the neo-Platonists regarded music, for example, as having aspects that were essential for moral education and reflection as well as entertainment, and the Pythagoreans regarded mathematics and physics as subdisciplines of music.[4] More recently, studies indicate that music education alters brain structure and function,[5,6] and may enhance learning.[7,8] But I do not—and should not—learn to play a Bach fugue just because it improves my problem-solving skills or makes me feel well. There is more—an element of dedication, engrossment, and relationship with the task that is part of the purpose. So, when I learn a Bach fugue, I transmit both the beauty and structure of musical expression while creating relationships among the music, the audience, and myself.

MEDITATION

In 1971, I took a daylong course in Transcendental Meditation. The turmoils of adolescence during a turbulent era made advertisements promising inner peace very appealing. Although some of the exotic trappings were a bit much for me, the inner process was engaging. I started a meditation practice to begin each day. I left college temporarily to become a student of Zen Buddhism. Part of e reason I chose Harvard Medical School several years ater was to explore the current research on the medical benefits of meditation. Promising studies suggested that meditation could help control blood pressure,[9,10] chronic pain,[11-13] psoriasis,[14] and anxiety.[15] I also sought out other clinicians who would validate my own experiences and help me translate them into a medical culture. This proved less obvious and more difficult then I had hoped. With the exception of some aspects of psychiatric training and Balint groups,[16] I did not see much explicit attention to the self of the practitioner.

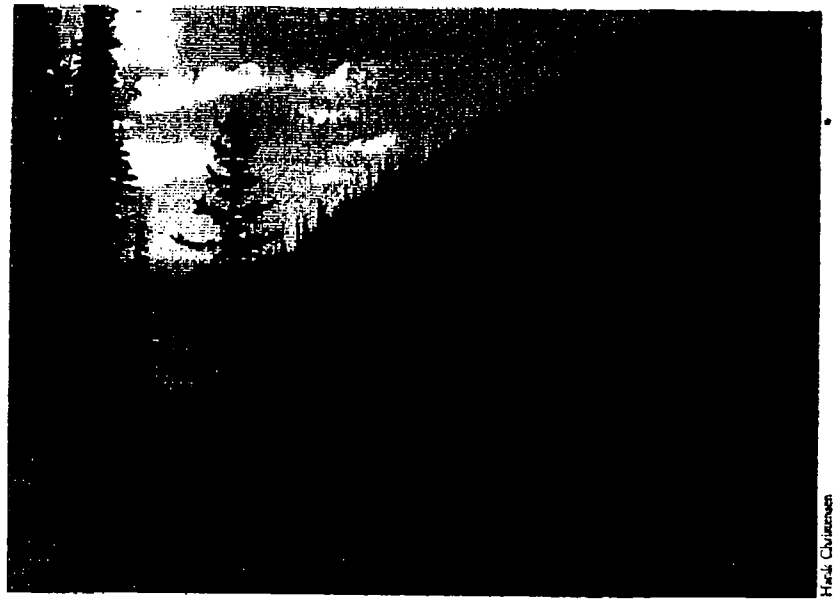
Imperceptibly, meditation has become a habit. Like brushing my teeth each morning, the day feels incomplete without it. It is a habit of practicing presence, just presence—no more, no less. It has been years since I have attended an intensive meditation retreat. For me now, it is a solitary, quiet endeavor. In fact, only some of my friends and a few of my colleagues know about my daily practice. Like many habits, it seems perfectly ordinary. I had always considered it part of my private life. I do have some trepidation about going public, though, in that I do not want to promote one method, especially one that may have religious connotations for some. Nor do I consider myself an expert or a teacher of meditation. There are many other quiet meditators in medicine—I am far from alone.

MINDFULNESS

Mindfulness means paying attention, on purpose, to one's own thoughts, feelings, and judgments[17]—"observing the observer, observing the observed."[18] Buddhist meditation is the practice of mindfulness and requires only the belief that knowing oneself can foster compassion.[19] There is no other requirement, including adherence to any particular cosmology; many people practice meditation and continue to observe Judaism, Christianity, or Islam.

The simplest mindfulness practice involves finding a place free from distractions. With eyes either closed or partially open (depending on the tradition) while in an upright sitting posture, the practitioner pays attention to thoughts and feelings as they arise without trying to change, judge, or categorize them. Some traditions use the breath to focus attention, others use imagery, and some use nothing at all. Buddhist teachers call this "just sitting."[17,19,20]

Rather than a practice of well-being, I prefer to call mindfulness a practice of "just being." That is, as soon as another purpose is assigned (feeling good, lowering blood pressure, and so on), it somehow limits the process. I have to practice just being because it does not come naturally, and my efforts are always imperfect. There are also difficult moments, when insights are neither pretty nor de-



Hank Christensen

sired. At those moments, and others, a teacher and a community of others involved in similar activities can be very helpful to provide insight, support, and encouragement.

Meditation is visceral learning and feedback. The visceral lessons are transferable to clinical and teaching settings. My habit of pausing before I enter a patient's room is a momentary state of repose and stillness, usually invisible to others. I give myself the gift of being present with myself while trying to give my patients my attentive presence. I often experience moments of quiet in the midst of action. By allowing me to be more present and less distracted, I believe these moments contribute both to the patient's feelings of having been heard, as well as to my own feelings of satisfaction at the end of the day. These moments also contribute to creative thought and writing. In administrative meetings, mindful practice is more difficult for me to achieve. Perhaps it is because the purpose of such meetings is not always to foster healing, satisfaction, or presence. But I do believe that it is possible and especially necessary to cultivate mindfulness in such settings.

MUSIC

Musical practice has had a different influence. Because I trained first as a musician, then later as a physician, I was surprised in my otherwise excellent medical education by a striking lack of attention to the self of the practitioner. In contrast, in music study, which can be as theoretically and technically complex as any medical specialty, the self of the performer is an object of constant study and reflection. While the performer must experience other feelings, the

music must move and speak to a listener. There is l room for error; even the inattentive mind catches wr notes. Music requires observation-in-action and the ab to hear the sound—in one's mind—before it is produ The performer's presence creates a relationship with listener. In that way, musical performance is a bit m like being with patients, and meditation is more like silences in between.

BEING WELL

There are many ways for health professionals to enha well-being, to reflect, and to be mindful. A recent stu indicates that mindfulness meditation training for med students improved their psychological and spiritual w being and also improved their capacity for empathy

Organizations that offer instruction in mindfulness, meditation, well being, and self-care

The Center for Mindfulness in Medicine
University of Massachusetts
Phone: (508)856-2656; www.umassed.edu\cfm

Offers programs for professionals, patients, and the lay public

The Omega Institute
Rhinebeck, NY
Phone: (845) 266-4444; www.eomega.org

Offers seminars, workshops, and intensive courses for health professionals and the lay public

The National Association for the Clinical Application of Behavioral Medicine
Mansfield Center, CT
Phone: (860) 456-1153; www.nicabm.com

Offers conferences several times per year that include lectures and workshops

The San Francisco Zen Center
San Francisco, CA
Phone: (415) 863-3136; www.sfzc.com

Provides opportunities for training in meditation and is engaged in community and healthcare projects

Insight Meditation Society
Barre, MA
Phone (978) 355-4378; www.imsweb.org

Offers training and retreats in Vipassana Buddhist meditation

John Christensen, PhD
Portland, OR
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Penny Williamson, MD
Baltimore, MD
Phone: (410) 235-0544

Offer workshops to enhance physician life, clarity, and well-being

Meditation is not for everybody, however, nor is studying music. The Greeks advocated that music study be balanced with gymnastics. They felt that too much music softens the soul and too much wrestling hardens it. This seems like good advice, not only because of the medical benefits of exercise, but because it is useful to develop mindful practice in more than one sphere of life. There are many other means to become more present, reflective, and caring. These include keeping a journal, exercising, creating art, spending time in nature, and gardening.

What will it take for medicine to become a more reflective, mindful practice? In my view, more important than developing reflection groups in medical school and residency will be the collective work of individuals who are willing to let themselves be known. The commitment to develop and use self-knowledge may be as important in promoting self-caring and compassion as the insights gained. I am impressed by the number of physicians who do practice mindfully, but do so in isolation. Perhaps they feel that to reveal their inner lives would threaten their credibility as professionals. Mindfulness underlies all efforts to be with, to know, and to care. We have something to learn from musicians in that regard, for whom public demonstration and performance of a mindful activity is at the core of their profession.

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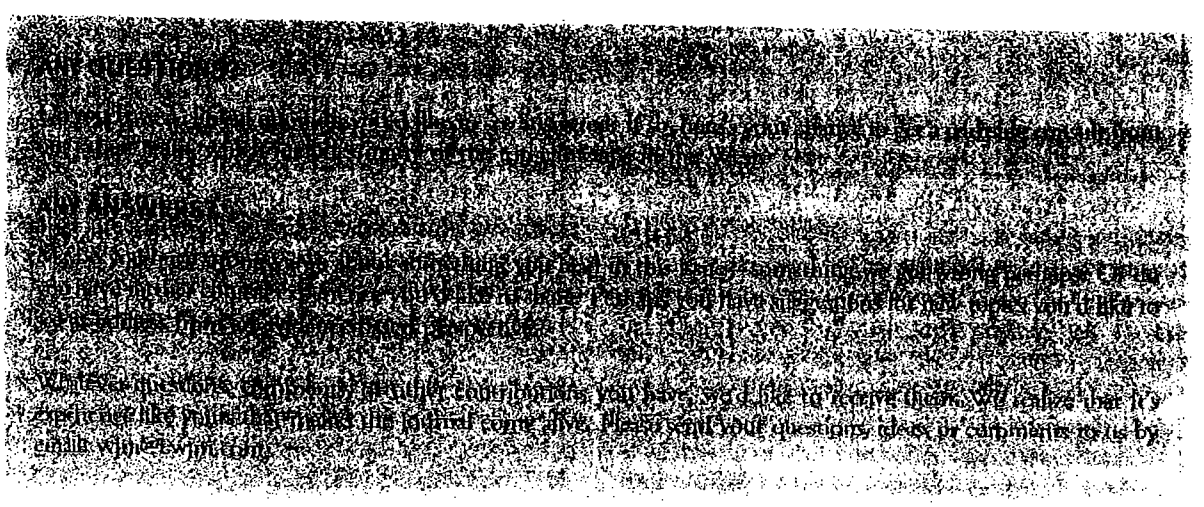

THE WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY, HEARING ON CAM AND WELLNESS

MARCH 27, 2001

Testimony of David B. Larson, M.D., M.S.P.H., President of the National Institute for Healthcare Research (NIHR).

I would like to thank Commission Chairman Gordon and the other Commissioners for inviting me to participate on this important panel on Complementary and Alternative Medicine in Wellness and Self-Care. My name is David Larson; I am a psychiatrist, outcomes epidemiologist, and President of the National Institute for Healthcare Research, or NIHR, which is a private, not-for-profit research institute focused on analyzing and disseminating published research findings on the relationship between spirituality and physical and mental health and well-being. You might say that I "sort of" stumbled onto this relevant health care factor some twenty-plus years ago, and then continued to study it while working at the National Institute for Mental Health in the 1980's and have been studying it ever since. In particular, I have been interested in spirituality as it relates to clinical prevention and coping with severe and chronic illness as well as enhancing treatment outcomes, particularly for those who already possess or have strong spiritual or religious beliefs.

I have been asked by the Commission to comment on the relationship between spirituality and health as well as the relationship between spirituality and complementary and alternative therapies. I've also been asked to comment on what I perceive to be some of the significant barriers and opportunities to incorporate spirituality into clinical care and to provide recommendations for steps and approaches that can be taken to begin to make spiritual factors a more integral part of health care. So, without further elaboration, I will go directly to these issues.

What it the Relationship Between Spirituality and Wellness?

It would be impossible in the amount of time I've been given to discuss all of the various areas of wellness - whether Physical health, mental health or social health to which spiritual and religious beliefs, practices, and behaviors have been found to be linked.

Oxford University Press recently published The Handbook of Religion and Health (Koenig et al., 2001), which reviews more than 1,000 published studies on the relationship between religion and/or spirituality and a variety of mental and physical health outcomes. I will give Dr. Gordon a copy of the book, which I co-authored with Harold Koenig, M.D., of Duke University Medical Center, and Michael McCullough, Ph.D., previously a colleague of mine at NIHR and now at Southern Methodist University, for the Commission to review.

I've chosen to focus on one area in the relationship between spirituality and religion and one substantially illustrative area of wellness -- longevity, or mortality, in other words, the rate of death in a given study or sample population. You might say that, for us epidemiologists at least, mortality is the best, if not one of the ultimate, measure of wellness, in that people who are more susceptible to illness, both physical and mental, will face an increased risk of mortality, or earlier death than those less susceptible. We epidemiologists like to examine potential protective factors for health and risk factors for illness by assessing whether or not they stand up to the test of "mortality analysis." In other words, we like to follow healthy populations over a number of years in a variety of locations and then see if a particular variable, in this case spirituality, predicts a longer or a shorter lifespan.

I'm going to provide you with a brief overview of the spirituality and mortality data. I have submitted a copy of a newsletter NIHR previously published concerning the topic to the Commissioners so that they can review for more details.

Religion, Spirituality, and Mortality

Early findings of an association between religious and/or spiritual factors and death rates, or mortality, were somewhat unexpectedly found. For example, in the early 1970s, Comstock and Partridge (1972) found in an epidemiological study assessing the role of social factors in death rates in nearby Washington County, Maryland, that there was an association between weekly church attendance and significantly lower rates of coronary disease, emphysema, cirrhosis, and suicide. Unfortunately, this study was the first of its kind, and was not followed up for a number of years. Therefore, the results were initially somewhat unnoticed.

However, beginning in the 1980s and then especially in the early 1990's, as the research findings grew at site after site, and the findings and research methods and controls for potential confounders or mediators improved, the results of this early study not only held up, but actually became stronger. Researchers, thus, began to take a much closer look. As a result, in the past few years, a number of large-scale longitudinal studies that *have* dealt specifically with spirituality and religion have continued to reveal a consistent association between a greater frequency of spiritual or religious participation and lowered mortality.

For example, in 1997, Strawbridge and colleagues analyzed the effect between frequent church attendance and mortality over 28 years for 5286 individuals living in Alameda County, California, which would certainly not be viewed as a "Bible Belt" area. This study found that

Alameda County residents who attended church frequently had lower mortality rates than infrequent attenders, and the relationship was stronger for women than for men (Strawbridge et al, 1997). Importantly, factoring in potential mediating factors, such as smoking and exercise, had little impact on this relationship, whereas adjustments for "social connections" reduced the relationship but it still remained significant. The authors concluded, therefore, that mortality rates are lower for frequent church attenders than infrequent attenders and that the lower mortality rates they found for frequent attenders are only partly explained by improved health practices, increased social contacts, and more stable marriages occurring in conjunction with church attendance. Indeed, the same authors found in a recent follow-up study published in the February 2001 issue of The Annals of Behavioral Medicine that frequent worship attenders were in better health at the start of the study, but more importantly, that those who didn't have good health habits to begin with, were more apt to develop healthier habits if they attended church more frequently.

In a 1998 study, Oman and Reed analyzed the prospective association between attending religious services and all-cause mortality among almost 2,000 elderly residents of Marin County, California. The purpose of this study was to determine if there was an association between religion and mortality and, if so, whether it was explainable by 6 potential confounding or mediating factors: (1) demographics, (2) health status, (3) physical functioning, (4) health habits, (5) social functioning and support, and (6) psychological state. This study found that persons who frequently attended religious services had a 24% lower risk of mortality, or premature death, compared to non-attenders (Oman and Reed, 1998). After adjusting for the six potential confounding and mediating variables, this relationship was reduced only slightly, primarily by including the levels of physical functioning and social support. The researchers did not find the

same health benefits when people they followed participated in other community groups, though they did find that attending worship services regularly and volunteering had a complementary effect with those who participated in both activities, living even longer than those who attended worship services on a regular basis.

More recently, Koenig and colleagues (1999) demonstrated a 28% decrease in relative hazard of dying for frequent church attenders compared to infrequent attenders. This finding was once again independent of demographics, health conditions, social connections, and health practices. Demographers Hummer and colleagues (1999) likewise recently analyzed data from the *National Health Interview Survey-Multiple Cause of Death Survey* and found that people who *never* attend church had almost *twice* (1.87 times) the risk of death in the studies follow-up period compared with people who attended church more than once a week. This translated into a clinically important "seven-year difference" in life expectancy between those who never attend church and those who attend more than once a week. The difference in life expectancy was even more dramatic for African Americans: with frequent attenders living on average 14 years longer than infrequent attenders.

Finally, a meta-analysis conducted by McCullough and colleagues (2000), which analyzed data from 42 published and unpublished data sets (representing nearly 126,000 people), found that religious involvement over all was associated with a 29% greater odds of survival (or conversely lower risk of death) for the follow-up periods of the studies with spirituality's effects being stronger for women than for men.

Admittedly, most of the studies I've just cited most frequently used a single-item measure of spirituality, that is, religion and most frequently a measure of worship attendance. However, the finding that frequently attending religious services can make such a consistent difference in life expectancy and one that according to the meta-analysis would take more than 1,400 "no relationship" findings to reverse, suggest that something is going on either during or in between attendance of such services that is keeping these individuals healthier or well. Indeed, something—either one's spirituality or associated activities and behaviors that go along with being spiritual--is helping spirituality or religiously committed people to maintain a more optimal level of wellness, both mentally and physically, and also providing them a higher quality of life in the process.

It should not surprise us that the relationship between religion and spirituality and health, however, is not always a positive one. Indeed, I ventured into this field wanting to follow up on what I was taught during my psychiatric training in the 1970's - that being overly religious was usually harmful to one's mental health. In fact, - there were a few studies at the time and a minority of studies continue to be published that have demonstrated that certain types of spiritual or religious beliefs could be harmful to one's mental health or even physical health.

Nevertheless, the majority of research in this area continues to suggest a beneficial relationship for physical, mental, and social health for those who are more committed to their religious or spiritual beliefs, practice them frequently, and rely on them in their everyday lives. I refer you to the results of a series of NIH type consensus conferences that NIHR sponsored several years ago on the topic. For more details on this body of research (see Larson et al.,

1996), I will also provide a copy of this consensus conference report entitled *Scientific Research on Spirituality and Health: A Consensus Report* to the Commission.

What it the Relationship Between Spirituality and CAM

Turning to the second issue—what is the relationship between spirituality and CAM?—the New England Journal of Medicine and JAMA surveys conducted by David Eisenberg and his colleagues (Eisenberg et al., 1993, 1998) have demonstrated that religious practices such as prayer are among the most prevalent complementary and alternative practices used by people in the United States. Indeed, these and other surveys suggest that as many as one-third to one-half of those surveyed at the lease, use some form of spiritual approach to manage or cope with their illness (Koenig, McCullough and Larson, 2001). For example, several recent studies have documented that spiritual practices such as prayer end meditation are some of the most frequently used CAM approaches among cancer patients (Lippert et al, 1999; Sparber et al, 2000) and those facing other serious medical problems (Liu et al, 2000; Larson et al., 1996). The use of spiritual approaches to managing health and coping with and treating illness can become even higher among certain ethnic populations in the United States, such as Hispanics (Keegan, 1996) and Native Americans (Kim and Kwok, 1998; Marbella et al., 1998) as well as among the elderly (Foster et al., 2000, Koenig, McCullough and Larson, 2001). Furthermore, there is a significant spiritual component to many of the systems of medicine that are typically classified as CAM. Most of these traditional systems of medicine--such as Ayurvedic Medicine, Traditional Chinese and Oriental Medicine, and Native American Medicine--place a great deal of importance on the role of spirituality in maintaining health and treating disease.

For example, the fundamental concepts of Traditional Chinese and Oriental Medicine are embedded in the philosophical and metaphysical worldviews of Taoism, Confucianism, and Buddhism, which evolved and spread throughout East Asia over the past 2,500 years. As a result, treatment modalities, such as acupuncture, Qi Gong, Tai Chi, and even herbal treatments, are used to cleanse, strengthen, and circulate the vital life energy (Qi) and blood.

Similarly, Ayurveda, the traditional system of medicine coming out of India that has been practiced for more than 5,000 years, has as its central tenet that disease in the body begin with imbalance or stress in the *awareness,* or consciousness, of the individual. This mental stress leads to unhealthy lifestyles, which further promote ill health. The Ayurvedic practitioner, therefore, uses a variety of precise body postures, breathing exercises, and meditative techniques, all derived from the age-old Hindu discipline of Yoga, to maintain health and prevent illness. In addition, herbal preparations are added to the patient's diet for preventive and rejuvenative purposes as well as for the treatment of specific clinical disorders.

Native American healing practices also do not separate out body, emotions, or spirit in the context of health. This is why so much of the medical care among traditional Native Americans is considered as the wise use of powers and wisdom of plants and animals. Another implication is that spirituality and medicine are combined concepts for Native American practitioners and their patients. Indeed, the term "medicine" as used in English ("medicine woman," "medicine wheel") is usually a translation of various Native terms for "holy" and "power". Traditional Native American approaches to healing, such as "Sweating and Purging" are intended to purify the body as well as the spirit. Finally, Shamanic healing is also a relevant if not important part of nearly all traditional Native American healthcare as well.

What Are the Significant Barriers and Opportunities to Incorporate Spirituality into Healing?

Despite the historical and continuing relevance of spirituality to complementary and alternative medicine and now even conventional medicine, with 70 of 126 medical schools having frequently required courses in spirituality and medicine (Puchalski and Larson, 1998), it is surprising how little emphasis has been placed on this topic in CAM research. The National Institutes of Health is just beginning to fund some small pilot studies in the application of spiritual beliefs and practices in health. NIH funding, however, is chiefly coming form one Institute, the National Institute for Alcohol Abuse and Alcoholism, and these funds do not even approach what is needed to begin to address the potential of this "forgotten factor", but relevant clinical factor to not only to assist people in maintaining wellness but also to potentially reduce health care costs. To date, NCCAM has spent approximately a "wing and a prayer" in this arena. Although the Frontier Medicine initiative is a step in the right direction, most of those funds, as I understand it, are to be focused on "non-local" healing and intercessory prayer studies, not on the more basic types of studies that are really needed in the prevention, coping and improving treatment outcomes for this frequent "health care factor of choice" for our patients as well as those in the population.

In fact, research studies are beginning to emerge suggesting the mechanisms of how spirituality may aid in maintaining health as well as helping those who are ill to assist in recovering their health. There is evidence that social support, better health behaviors, the promotion of positive emotions (e.g., hope and optimism), the relief of guilt and anxiety, and even better immune functioning, may all play a role in the effects that religious and spiritual factors have on health outcomes (see Koenig et al., 2001, for a review of this literature). Yet, the prospective, longitudinal studies that are needed to demonstrate causality as well as begin to examine the precision of the

mediating relationships of spirituality on health are very expensive to conduct. The small amounts of funds that are currently available from the private foundations already supporting these efforts, including the Fetzer Foundation and the John Templeton Foundation, are not sufficient to face the task. In addition to the need for funding for studies of mediators, there is also a significant need for investigations focused on the role of spirituality in improving care and treatment outcomes supporting illness coping as well as improving the quality of life in those who life-threatening and chronic diseases and disabilities.

Finally, there also is a critical need for better access to information in this field. Indeed, until just a few years ago, studies on religion and spirituality and health were not included in most medical databases since they weren't keyworded even when they contained the word "spirituality" in the article's title. Therefore, most of the studies before the mid-1990s cannot be found in the major electronic databases. Furthermore, even though national databases, such as Medline, do now include keywords on religion and spirituality and include many of the journals that publish articles on this topic, most of the references on this topic are not abstracted. If they are, the abstracts are so meager that they do not tell one much about either the content or the quality of the articles. Also, the references in this area tend to be spread out over a variety of clinical and sociological databases.

A final major obstacle in the integration of spirituality into healthcare and wellness is the skepticism, which I've somewhat jokingly referred to as the "anti-tenure" factor, among many in the medical and scientific communities toward anything that might involve the "R" word (religion) or the "S" word (spirituality). In contrast, a majority of the American population (more than 90%) either describe themselves as religious and/or spiritual and almost three quarters say their spirituality is the most or a very important aspect of their lives and that they frequently utilize spirituality in

dealing with health-related matters. Sadly, as many of my psychiatrist colleagues once believed, many in the medical and research communities still assume that religion and spirituality are most frequently irrelevant or even harmful to one's health. That's not what the research reveals. Most clinical and research leaders remain unaware of the growing body of scientific research on this topic that has found quite the opposite. Indeed, there are now literally hundreds of studies documenting that, for the most part, spiritual beliefs and practices are beneficial to one's health and even can help reduce one's risk of developing a number of serious illnesses. Furthermore, when people do become ill, research suggests that spiritual beliefs patients cope more effectively and recover faster. Therefore, there is a critical need to increase education so that clinical leaders as well as practicing physicians become more aware of this important body of research, to what is going on now in US medical schools with the next generation of physicians.

Recommendations:

Based on the points I have elaborated, I thank the commission for permitting me to provide them with the following recommendations to consider:

-The establishment of a research Center for Health and Spirituality by the National Center for Complementary and Alternative Medicine. Such a Center would help to coordinate the research in the field by:

- providing grants both for basic research studies on studying the mechanisms of how spirituality impacts health
- providing grants for model programs that attempt to integrate this knowledge into clinical practice and can be enabled to research both patient and cost outcomes.

-The development of a centralized data base on spirituality and health that would contain not only the many extant and growing number of clinical research studies, but also information on how to obtain funding as well as literature on model care and educational programs and effective strategies for sensitively and ethically incorporating spirituality into healthcare (Post, Puchalski and Larson, 2000). Such a database would go a long way toward bridging the gap between research and clinical application.

-The support for and development of continuing education conferences and other educational materials to help make the clinical and research communities better aware of the research linking spiritual and religious factors to various aspects of health.

-Finally, there remains a critical need for forums where doctors can have the opportunity to interface and interact with clergy, chaplains, and pastoral care professionals, so that clinicians can develop a better understanding of the potentially important role religious professionals play in promoting health and healing. Many of the medical school courses are employing such a model where physicians are closely collaborating with chaplains; the same can be done to assist practicing physicians to realize the importance of a frequently "forgotten" part of the health care team, the chaplain.

In closing, I thank you for requesting me to come and present today. It has been my pleasure to highlight and recommend needed steps in advancing the research-based integration of spirituality, health and well-being.

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