

從“生物醫學模式”到“生物社會心理精神醫學模式”——西方醫學史的教訓

Jeffrey P. Bishop

摘要

生物—心理—社會—精神醫學在西方世界裡是一個歷史的產物。生物醫學發端於 19 世紀後半葉，並在美國醫學中引發了一場大規模的醫學教育改革。這種科學的生物醫學在醫學實踐中表現出的冷冰冰的、無人格的態度，常常與病人的道德和精神需求相抵觸。為改善這種狀況，自 20 世紀中葉起，醫生與倫理學家嘗試了多種方式的改革，包括生命倫理學，生物—心理—社會醫學，和生物—心理—社會—精神醫學。這些改革的共同社會歷史背景是世俗主義在美國的興起，而每一種改革也都以不同的方式試圖把握醫療照護中的超越維度，這一超越維度已被生物醫學的還原主義的態度所邊緣化。但是，因為生物醫學的科學主義態度，以上的改革都失敗了。雖然生物—心理—社會—精神醫學意圖以一種整全的方式照護病人，但是因為它仍然延續了一種科學主義的態度，以至於這種醫學模式不

Jeffrey P. Bishop，美國聖路易斯大學哲學系教授、醫學倫理學主任，美國。

能滿足病人的道德和精神需求，也無法把握對病人而言超越的中心意義。

【關鍵字】 生物醫學 生物—心理—社會—精神醫學 科學主義 世俗主義 還原主義

Biopsychosociospiritual Medicine is the latest craze in health care in the United States (US). (Sulmasy 2002; Katerndahl and Oyiriari 2007; Akrawi et al. 2015; Freire et al. 2015; Jim et al 2015; Sherman et al. 2015; Park et al. 2015; Salsman, Pustejovsky et al. 2015; Salsman, Fitchett et al. 2015; Koenig et al. 2015; Booker et al. 2015; Schoonover-Shoffner 2015) It is mainly a reform movement within medicine that is meant to personalize the colder aspects of scientifically and technologically advanced Biomedicine. Several historical and political forces have been at work over about a century in the history of Western medicine that would culminate in the reform movement, Biopsychosociospiritual Medicine. It is only the latest of the reform movements aimed at reconfiguring Biomedicine. In this essay, I will give a brief and focused history of Biomedicine in the US as it relates to science and religion. I will explore several attempts to reform the scientific attitudes within Biomedicine. By “scientific,” I mean the tendency to assume that every problem faced by humans must be addressed through the lens of scientific enquiry. I will also describe the Biopsychosociospiritual Medicine reform of Biomedicine in this context, and I will argue that the way it is being appropriated in the US context will only result in its failure to reform Biomedicine. Thus Biomedicine is never truly transformed by its reform movements, because it continually attempts to translate the psychological, social, personal, moral, and spiritual aspects of people’s lives into a scientific idiom. I will conclude with a few reflections for what this movement might mean in the Chinese context.

I. Science, Scientism, and Western Biomedicine

The rise of a scientific medicine in the US was the result of a concerted effort of the American Medical Association (AMA) beginning in the late 19th Century, resulting in the AMA’s creation of the Council on Medical Education (CME) in 1904. (Starr 1984; Beck 2004) Medical school education had been, up until that time, mostly an apprenticeship style of training, with a few medical schools on the East Coast having fully embraced a more scientific approach to medical

education. The CME wanted to reform medical education, and by doing so began a long process by which it reformed medical practice such that it was more in line with scientific thought. The CME published a curriculum in which science, particularly anatomy and physiology, figured prominently.

In 1908, the CME worked closely with the Carnegie Foundation to carry out a major study of medical education in the US. (Flexner 1910) The researcher to carry out the study was Abraham Flexner, the brother of prominent physician-scientist Simon Flexner. The report came to be known as the Flexner Report, and was published in 1910. Prior to the publication and implementation of the Flexner Report, science played a prominent role only in about a one-fifth of all medical schools. Of course, the importance of science to medicine had begun much earlier in the 19th Century with thinkers like Xavier Bichat and Claude Bernard. (Bichat 1978, Bernard 1957) The AMA would play a central in the establishment of a scientific medicine and by 1904 there was a push to transform medical education. (Starr 1984; Beck 2004)

Prior to the publication and implementation of the Flexner Report, medical education in the US was mostly an apprenticeship model, with science playing a prominent role only in about a one-fifth of all medical schools. The Flexner Report recommended that, of the 155 medical schools operating in the US in 1908, all but 31 should be closed and a more scientific curriculum implemented in those that were to remain open. (Flexner 1910) The number that closed as a result of the report is unclear. It is clear that a majority of the medical schools did close and a new curriculum was implemented for those surviving medical schools. The result was an emphasis on anatomy and physiology, as well as other sciences like bacteriology, pathology, and biochemistry. The Flexner Report—which highlighted the importance of scientific approaches to medicine—would shape the whole of medical education and practice for years to come. (Bishop 2011)

As a result of the Flexner Report, Biomedicine began its ascendancy in the US. Scientific approaches to medicine would become the arbiter of all medical practice, from anatomy and physiology, to statistical medicine and evidence-based medicine. (Bishop 2011, 77-85) Biomedicine's dependence on the scientific method, its commitment to naturalism, and its highly mechanistic understanding of the world are accepted dogmatically by Biomedicine. These commitments, these dogmas of science have been referred to as scientism, which is the belief that the scientific method is appropriate to any and all human problems. When applied to medicine, the belief of scientism is that the human body, the patient's psyche, and the social circumstances within which the patient suffers disease, illness, and sickness are best understood in terms of the scientific method.

By the mid-1970s, Biomedicine had become reductive in its approach to the body and to disease, including psychiatric disease. (Engel 1977) By the mid-1960s, the catecholamine hypothesis of psychiatric disorders was competing very strongly with the older psychodynamic schools, which had a much more personalized style and included things like the patient's religious and spiritual beliefs. (Schildkraut 1965, Kübler-Ross 2003) The results were that psychological, social, and spiritual issues that patients often experienced when faced with an illness became marginalized so that a more scientific Biomedicine could flourish. Thus, Biomedicine came to be seen as cold, impersonal, dictatorial, and mechanical.

Still despite its technical successes, many called for reforms to scientism within Biomedicine. By the mid-1960s, many perceived medicine to be in crisis where the more personal, psychological, social, and spiritual dimensions of disease and treatment were pushed to the side. (Kübler-Ross 2003, Becker 1973, Ramsey 1974, Engel 1961, 1977, Szasz 1974) Patients became more like machines to be managed and manipulated, rather than subjective beings with perceptions, feelings, and desires for the goods of living. In the mid-1960s and 1970s, at the moment of crisis, we see several reform movements rise, mostly originating from theology, religion, and spirituality.

I shall describe the first attempt at the reformation of Biomedicine. It arose from theological and religious circles. The first attempt at reform is best known as Bioethics. In order to fully understand the Bioethical reform and its various iterations, one must also understand the secularization of medicine, in which theology, religion, and spirituality are marginalized. Thus, after explaining the Bioethical reform, I shall then describe the forces at work that marginalized theology, religion, and spirituality. I shall then be in a position to show that the attempts to reform Biomedicine failed precisely because they rejected the original theological, religious, or spiritual reform.

II. The Bioethical Reform of Biomedicine

The first bioethicists were theologians. (Evans 2012, Jonsen 2003) Al Jonsen's descriptive historical account points to a "Trinity" of mid-twentieth century theologians—Joseph Fletcher, Paul Ramsey, and Richard McCormick. (Jonsen 2003, 41-42) While to Evans and Jonsen these three thinkers were theologians and religious thinkers, there have been those, like H. Tristram Engelhardt, Jr. and Stanley Hauerwas, who have claimed that these thinkers were insufficiently theological. (Engelhardt 1998, 2002, 2003, 2014; Hauerwas 1995) The truth about Fletcher, Ramsey, and McCormick is somewhere in between these divergent camps. Still, there is wide consensus that

these three thinkers were key players in what I am calling the Bioethics reform of Biomedicine.

Joseph Fletcher was especially prescient. As early as 1949, Fletcher—an Episcopal priest and theologian (a version of Protestantism)—gave a series of important lectures on medicine and the kinds of moral and ethical conundrums to which it would give rise.¹ (Fletcher 1960) In 1949, medical technology had not yet advanced to the point that ethical issues had come into clear relief, yet this theologian could already see problems arising. He continued to publish on medical moral issues into the 1970s. While his concerns originated out of his Christian thinking, in time Fletcher’s approach moved away from Christian doctrine. In fact, Fletcher eventually left his post teaching theology in a divinity school and took up residence in a medical school. He went on to identify himself as an act-utilitarian, eschewing any prohibitive ethical claims that might halt or hinder research or treatment options, and often embracing moral positions that most traditional Christian theologians would reject. (Jonsen 2003, 42-47) So, while even though Fletcher was a religious thinker, Engelhardt is also correct that Fletcher began to jettison his theological thinking in order to fit into the rising tide of scientific Biomedicine. (Engelhardt 2003, 2014)

Paul Ramsey, another esteemed Protestant theologian was also a reformer of the more scientific medicine. (Ramsey 1974) Unlike Fletcher, Ramsey maintained that his Christian commitments shaped all of his work in Bioethics. (Ramsey 1982) Ramsey had achieved great stature as a Christian ethicist long before he began to write on matters arising in medicine. If Fletcher’s ethic was a utilitarian one, Ramsey’s Christian ethic was a deontological one. (Ramsey 1950, 89) Where Fletcher became self-consciously less Christian, Ramsey did not consciously choose to be less Christian, though his writings on medicine were written in such a way that his specific theological commitments were not central. In fact, with the exception of the preface to *The Patient as Person*, Ramsey hardly appealed to theological themes as he wrestled with such questions as consent to the treatment of children, the definition of death and the care of the dying, vital organ transplantation, and sparse medical resources. (Ramsey 1974) Ramsey, the Protestant, also turned to the Roman Catholic

(1) Protestantism is the general term for those Christian traditions that, in the 16th and 17th centuries of the Common Era (CE), attempted to reform the theology of the Catholic Church, which was the dominant form Christianity in southern, northern, and western Europe.

tradition of moral inquiry—especially its natural law threads.² Most Protestant moralists do not embrace natural law approaches to ethics, because these approaches do not appeal to special revelation. Ramsey’s turn to Catholic thinkers indicates his willingness to embrace a form of moral discourse that does not appeal to anything uniquely Christian. Thus, Ramsey began to diminish the actual theological content of his reflections on medical ethics—even while insisting that he remained a Christian theologian—precisely so that he could be heard by a secularizing scientific Biomedicine

This Protestant turn to Roman Catholic moral teaching brings us to the third of Jonsen’s “Trinity” of theologians. Richard McCormick was a Jesuit priest and a Catholic moral theologian. (McCormick 1974, 1978) Roman Catholic moral inquiry has long turned to natural law, a theory that—at least in principle—does not require direct appeal to Christian revelation or fully elaborated doctrine. Through natural law and the use of natural reason, McCormick and his Protestant friend Ramsey developed a fruitful dialogue in which each began to develop his own distinct ethic. In fact, Ramsey, the deontologist, sided with McCormick more frequently than he ever did with his fellow Protestant Fletcher. Thus, like Fletcher, neither Ramsey nor McCormick would make an appeal to doctrine or any exclusively Christian themes when speaking in the public domain. Again, getting a hearing from scientific Biomedicine was important to all three thinkers, thus in a way, each had to diminish the theological character of their thinking.

There is a sense in which each of these thinkers was accepted by the medical establishment precisely because they were able to translate their moral schemes from a specifically Christian language—whether Catholic or Protestant—into the secular idiom of the day. The fascinating question about the “trinity” of theologians is the one Stanley Hauerwas once asked of Ramsey: Had they really ever been Christian in their approach to medical ethics? (Hauerwas 1995, 11-28)

So medical ethicists, being the good priests they are, went to where the power is in liberal societies—medical schools.

(2) Natural law approaches arose from the 13th Century CE Christian thinker named Thomas Aquinas. Aquinas and the heirs of the natural law tradition hold that morality is written into the fabric of the universe and, through right reason, humans have access to the natural moral law written into the fabric of the universe. While some thinkers would hold that one need not believe in God in order to discern the natural law (Finnis 2011), other major thinkers would hold that it was because Thomas Aquinas was a theologian first and not a philosopher first, that he could uphold natural law. (Stump 2012) It is typically a form of moral reasoning to which many Catholic Christians hold, despite the fact that these thinkers claim that no belief in the Christian faith is necessary in order to discern the natural law.

Kings and princes once surrounded themselves with priests for legitimization. Likewise, politicians today surround themselves with social scientists to give those they rule the impression that they really know what is going on and can plan accordingly. Physicians, in an increasingly secular society, surround themselves with medical ethicists. God no longer exists, the sacred universe of values has replaced God, and allegedly ethicists think about values and decisions that involve values. (Hauerwas 1995, 14)

In fact, Hauerwas notes that within the US context, there is a sublime and deep connection between liberal Protestantism and America's secular social orders. In fact, the rise of secularization was the unintended consequence of the Protestant Reformation. (Gregory 2012) It is ironic that this relationship resulted in policies that drove the theology out of theological attempts to reform the reductive, naturalist, and mechanistic medicine.

The result was that Bioethics became more generic and compatible with secular assumptions, including the identification of salvation with the maintenance of physical life at virtually any cost. (Kaufman 2005) From the 1960s, we see the increased and largely indiscriminating use of technological therapies in Intensive Care Units, reductive and mechanistic medicine at its finest. We also find medicine increasingly surveilling the public with preventative medical measures and with public health initiatives. (Bishop 2011, 77-85) A theological concern with salvation of the soul had yielded almost completely to the biomedical salvation of the mechanics of the body.

Two things seem to be at work here. First, the “trinity” of theologians, at least in part, deflated the Christian content of their critiques in order to be heard in this secularized scientific Biomedicine. Second, the powerful world of medical science demanded that Christian ontology and teleology not get in the way of progress. Supporting the first claim, Ramsey believed that there was a remnant of Christianity in the political structures and social institutions in Western democracies, including the institution of medicine. It was this remnant that gave him the authority to do “public ethics,” as he called it, even as he longed for the day when Church ethics would become the “dominant secular” viewpoint. (Hauerwas 1995, 17-18, Ramsey 1982, 47) Yet in order for the increasingly secular medical establishment to hear these theologians, each theologian either muted the Christian content to conform to secular forms of rationality—Fletcher—or attenuated the content of their theological insights and critiques—Ramsey and McCormick—in order to be heard.

Fletcher abandoned his Christian faith altogether. Ramsey seemed hardly to appeal to any Christian content, though he was clearly a devout Christian. McCormick, while a committed and believing Catholic, simply appealed to natural law and proportionate reasoning, which for the most part claims that moral reflection needs very little in the way of Christian content specifically, or any religious content generally. Perhaps the fact that the social and political structures of the West have their origin in Western Christian theological concepts meant that these theologians would be the best suited to give voice to the metaphysical moral concerns felt by the public. But in order to do so, each had to modulate his voice to make it acceptable to the dominant forms of secular reasoning. With increased secularization in the US, a division of labor was beginning to emerge: Bioethics would handle the moral dimension of the Biomedical care offered to patients, while Biomedicine would deal with the mechanics of the body.

Thus far I have explained how a theological bioethics, which was intended to reform Biomedicine, became more and more secularized itself and how even the moral dimension of care of the patient would be relegated away from theologians and pastoral care practitioners. The pastoral care offered to patients for the psychological, social, and personal aspects of health care moved out of the hands of the doctors and into the hands of a professionalized Chaplaincy group. Thus, we begin to see Biomedicine dividing the patient into a biological/medical domain, a moral domain, and (as we will see in a moment) into a psychological, social, and even a spiritual domain. Before moving on to describe how Biomedicine further divides the patient into the psychological, social, and spiritual dimensions, I shall need first to make a few more comments about secularization in the West.

III. The Rise of Secularization in the West

Another important dimension in the rise of Biopsychosociospiritual Medicine is secularization. While secularization has a long history, it is primarily a process by which the state began to separate itself from the various theological ideas. (Engelhardt 1991, Milbank 2006, Gregory 2012, Cavanaugh 2009, Harrison 2015) I shall have to focus specifically on its rise in Biomedicine and Bioethics, but this history will have repercussions in the day-to-day practice of medicine in the West. John Evans gives an account of this history that is different and more critical than Al Jonsen's history mentioned above. (Evans 2012) It is an account with which I agree in some aspects, but with which I will take issue in other aspects. Evans claims that the robust content of theological ends was

condensed and simplified into broadly acceptable secular ends, and that reasoning towards those ends took an increasingly secular form. (Evans 2012, 7-8) In other words, Evans holds that the thick ends of theology were “thinned out” to accommodate the ends of a secularist medicine. But contra Evans, the ends of medical technological science are not, in reality, thin, which is precisely why so many keep trying to reform scientific Biomedicine.

From the beginning of the Bioethical reform of Biomedicine, there were many physicians and medical scientists, who—*anxious to protect their turf*—perceived the theological reform of Biomedicine as threats to the progress of scientific Biomedicine. These scientific thinkers would increasingly marginalize the critical theological voices. For example, Harvard microbiologist Bernard Davis believed that theological voices had both exaggerated the dangers of genetic research and downplayed its possible successes.³ (Davis 1970) He even tried to tie theological attempts to be thoughtful about research ethics to Communist political ideology: theologians were stifling progress as much, in their way, as the communists were, according to Davis. (Davis 1970, 1283) The theologians, each of whom called for caution, were pitted against the progressive ideas that animate much of scientific research, with its promises to end suffering for humanity.⁴

The whole story is one that involves both Evans’s and Jonsen’s accounts. The medical establishment insisted that theology thin out its language in order for theological and religious voices to come to the table. After all, the government of the US is secular and thus theological and religious voices are always suspect in the public sphere. Theological voices were marginalized, enabling medicine to march free from the theological and religious challenge toward an inevitable future. When theologians stopped using robust ontological or teleological language in their critiques of contemporary medicine, the Biomedical ethos, with its own ontologies and teleologies of the body, became sovereign. In other words, as the morally thick language of Christianity began to thin in the US, and as theologians began to translate their arguments into secular terms, they forfeited the debate about the ends of medicine and allowed medicine’s own robust ethos, with its different sets of ends, to win the day.

That outcome leads me to disagree with Evans’s thesis that religious ends became morally ‘thin’ in order to conform to the ‘thin’ secular ethics. Theological and religious ends were not merely

(3) The desire to do away with bioethics because it seems to get in the way of medical progress was also the result of a recent essay by Steven Pinker. (Pinker 2015)

(4) For an excellent analysis of the progressivist tendencies in medicine, see McKenny 1997.

translated and thinned out into generic secular ends. Medical science itself carries with it various kinds of *teloī*—much more robust ends with a thicker content—than it lets on. The *telos* of scientific endeavors are veiled in a vague language, promising cures and a world where there is no disease or sorrow (depression). It promises unabated happiness and an end to the limits of embodiment. I would argue that scientific apologists enacted a particular ethos very different from the ethos of the theologians, and it was that ethos that caused McCormick and Ramsey so much consternation. The ethos of science carries with it a very different understanding of the good life from those entailed in Christian theological ethics. In fact, the battle between theologians like Ramsey and McCormick and scientists like Davis originates in very different understandings of the ends and purposes of medicine.

Thus, this political battle between competing ontologies and teleologies—robust theological ends versus the robust secular scientific Biomedical ends—set in motion two other developments in Bioethics that were once the purview of theologians. The first development attempted to homogenize the differences in ends through various common morality theories, such as those of Tom Beauchamp and James Childress, Robert Veatch, or Jonathan Moreno. (Veatch 1981, Beauchamp and Childress 1994, Moreno 2011) Today, we think of this as Bioethics proper. These common morality theories, which argue that we ought to focus on what we can accept and endorse in common, were deployed through political means, for the most part. The various branches of federal and state government established advisory commissions to negotiate political fights about values, ends, and means. In other words, through various political means, including the various congressional and presidential councils and commissions on bioethics, secularization would push theological and religious voices out of Bioethics proper.

If bioethics became more secular, driving theological and religious voices from Biomedicine, the same would happen with clinical medicine. Yet, Bioethics only spoke to the moral dimension of the patient experience. A second reform of Biomedicine was needed for the day-to-day matters of medical practice. This second reform would come from within the practice of medicine itself and it would maintain the anti-religious stance of secularized scientific Biomedicine. The second reform, which focused on clinical practice of medicine, is called the Biopsychosocial Model of Medicine.

IV. Biomedicine and its Biopsychosocial Reform

In 1977, George Engel published a famous essay called “The Biopsychosocial Model of Medicine.” His essay is an articulate

crystallization of much of the spirit of the time. It would come to shape all of medical practice to this day. He argued that not only could psychiatry not be reduced to brain physiology and chemistry, but neither could any medical endeavor. Let me unpack his essay as it is illustrative for our purposes, and moves us closer to the development of Biopsychosociospiritual Medicine.

Engel notes that the old Biomedical model that focused on diseases and bodies is no longer adequate “for the scientific tasks and social responsibilities of either medicine or psychiatry” (Engel 1977, 129). Note that the biomedical model that emphasized diseases failed psychiatry and medicine because it was not adequate to either social or scientific tasks. Thus, there is both a scientific and political impetus to change medicine’s model from what it had been under the regime of biomedicine. Psychiatry’s crisis was apparent in that, at the time, psychiatrists were not certain whether “the categories of human distress” that they treated “are properly considered ‘disease’” (Engel 1977, 129). Medicine’s crisis, on the other hand, lies in the fact that, in the mid-1970s, many doctors were calling on medicine to deal with the real, organic diseases and “to not get lost in the psychosociological underbrush” (Engel 1977, 129). In other words, psychiatry was feeling the pressures created by Biomedicine.

This Biomedical model resulted in the crisis because it is a dogmatic biological reductionism, resulting in the exclusion of nonphysicalist disorders from medicine (Engel 1977, 130). Biomedicine, Engel claims, fails to recognize that it carries with it a model that is as cultural as the folk cures of tribal cultures. Engel notes that healing practices emerge out of social contexts where communities respond to various physical and psychological threats (Engel 1977, 130). Like other cultural models of disease and healing, Western biomedicine too is a social response created to deal with these threats. Thus, according to Engel, the biomedical model—the reductionistic model—of medicine has reached its limits. It is too dualistic.

Engel gave voice to the spirit of his time. He was trying to solve the problem of the reductive nature of science. He does not repudiate Western science, but merely the reductive nature of Western medicine. However, even though he attempts to avoid the reductive nature of Western science, he actually reproduces it. Rather than saying that it is science itself that is reductive, Engel lays the blame at the feet of a Biomedical science infected by Christian theology. The soul-body dualism that Engel claims is present in Western culture would see the body as separable mechanism, resulting in a science with too much emphasis on the physical body and not enough emphasis placed on psyche and society. Anyone with even a modicum of understanding of

traditional Christianity and the history of Western thought knows that Christianity is not fundamentally dualistic.⁵ We can forgive Engel, a psychiatrist, for not understanding the history of thought. He does not understand that the dualism against which he rants has its origins in Cartesian science, and not in orthodox Christianity. Thus, we see that part of what Engel is arguing is that Biopsychosocial Medicine needs to be rid of any religious content. The Biomedical model no longer serves the needs of Western societies, because it was affect by Christian thought, even while Engel is confused about the history of Western thought.

According to Engel, there are a couple of responses to the crises presented by Western Biomedicine. One response comes from those, like Thomas Szasz (1974), who argues that mental illness is a myth because it does not conform to the usual pattern for defining disease as that which has definitive, observable, and therefore real lesions in the brain. In other words, many psychiatric disorders at the time did not have a biological basis for their explanations. Those psychiatrists like Szasz could claim that only those psychiatric disorders that have neurological correlates qualify as diseases. Under Szasz's model, these psychiatric disorders would actually be neurological diseases and should be cared-for by neurologists. Thus, basically in the mid-1970s only three classes of psychiatric disorders should count as medical disorders—Major Depressive Disorder, Bipolar Disorder, and Schizophrenia, under Szasz's system. On the other hand, those disorders without clear neurological correlates should be classified as “problems of living,” according to Szasz. Thus, the “problems of living” ought to be treated through reeducation by behavioral psychotherapists, whose body of knowledge would emerge from behavioral scientists rather than the medical scientists.

Engel found Szasz unpalatable, and with the failures of the biomedical model clearly evident, he put forward a different reform for Biomedicine, the Biopsychosocial Model. According to Engel, the biomedical model of disease is too narrow and must be broadened in order to capture human experience of disease more adequately and to facilitate its treatment more efficiently and effectively. Engel hopes to

(5) There is a common belief that Christianity is dualist because it believes that when a person dies, the body dies and the soul “goes to heaven.” Only in modernist and Protestant Christianities do you find this kind of dualism that you mean. In ancient Christianity, as well as in contemporary Catholic and Orthodox Christianity (and even in most sophisticated Protestant Christianities), the resurrection of the body is absolutely essential to the belief structure. The soul must be returned to the body in order for the human being to be whole in the next life. Thus, the idea is that at death one falls asleep, and awaits the resurrection of the body. God sustains the soul in its sleep since by nature its existence necessitates a body. The idea that one dies and the soul goes to heaven is really rather recent in origin.

create a kinder and gentler medicine, one that does not ignore the psychological and social components of disease (Engel 1977, 131). The doctor must distinguish if the patient is sick or not. If the patient is sick, he must ask why and in what ways is he sick; and then he must decide a course of treatment to restore or maintain health. (Engel 1977, 132). The “boundaries between health and disease, between well and sick are far from clear and never will be clear, for they are diffused in cultural, social, and psychological considerations” (Engel 1977, 132).

Engel presents six features of medical practice to justify the Biopsychosocial model of medicine that he proposes. 1) Symptoms are always articulated and interpreted by the patient through cultural and social particulars, which come to shape and give substance and meaning to the experience of disease. 2) The patient’s experience of his body derives from bodily experiences in early life, “resulting in a significant degree of ambiguity in the language patients use to report symptoms,” which affects how the clinician analyzes and interprets the symptoms and necessitates “scientifically rational approach[es] to behavioral and psychosocial data” and thus also necessitates robust human sciences (Engel 1977, 132). 3) There are higher degrees of ill health among those populations who are “exposed to incongruity between the demands of the social system in which they are living and working and the culture they bring with them” (Engel 1977, 132). 4) Biomedical factors alone do not determine the time when a person accepts the role or status of “patient” and seeks medical attention. Cultural and psychological factors are also at work. 5) Psychological and social variables help to structure and determine the length of time the person remains in the role of patient; even after the biochemical abnormality is treated. 6) The relationship between patient and physician can “powerfully influence therapeutic outcome” (Engel 1977, 132).

Moreover, a biopsychosocial model of medicine broadens the doctor’s vision so as not to overlook any aspect of the disease, or the illness experience. Engel continues:

The doctor’s task is to account for the dysphoria and the dysfunction which lead individuals to seek medical help, adopt the sick role, and accept the status of patienthood. He must weight the relative contributions of social and psychological as well as biological factors implicated in the patient’s dysphoria and dysfunction as well as in his decision to accept or not accept patienthood and with it the responsibility to cooperate in his own health care. (Engel 1977, 133)

In short, the “real” disease is not merely the Biomedical factors, because the Biomedical factors are not separable from the modes of its presentation.

Moreover, biomedicine itself emerges out of a particular social and historical milieu, a point with which I am in agreement with Engel. It emerges from the social and historical milieu of the late-modern West. Engel states:

To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician’s role and the health care system. This requires a biopsychosocial model. (Engel 1977, 132)

A myriad of phenomena might disrupt a person’s social functioning and thus might prompt him to seek medical attention. These phenomena might be as mundane as a sore back that prevents a person from working or a person’s hearing voices that might disconcert him or those around him. In addition, various social models emerge to help the person to return to normal social functioning in all cultures, and Biomedicine is the social model created in the West to achieve this task. Oddly enough, that means that Western biomedicine is a social model that denies its social foundations.

An example might be helpful. Many people with chronic back might live with that pain for weeks or years before going to see a doctor. The patient might interpret his back pain to mean: “I am working too hard in my construction job and I need to rest more” (Bishop 2000). Having his own folk explanation of the pain, the patient might never seek medical attention. Thus, hard work serves as an explanation of the back pain. There may be biological causes, as well, such as prostate cancer to explain his pain. There may be a social or psychological cause such as dissatisfaction with a job he doesn’t like, which aids to his interpretation of the back pain. There might even be a psychological problem, like the recent loss of a friend from cancer whose presenting symptom was back pain that might prompt him to seek assistance from his doctor, even though he had all along thought that the pain was simply due to his job. Or there could be a psychosomatic problem in which a psychological trauma manifests itself in the body as back pain.

Therefore, Engel claims, the Biopsychosocial model provides a comprehensive framework for the doctor to get to the bottom of the problem, in order to find strategies to restore the person to his social

functioning and psychological wholeness. In short, Engel claims that the Biopsychosocial model provides a better framework for explaining a myriad of phenomena that present themselves to doctors. The model gives doctors a more comprehensive way to engage a patient complaint. Moreover, the Biopsychosocial model provides an explanatory framework for the doctor to understand why some people do not seek medical attention. A person might very well have a biological disorder, but he might not acknowledge it as an illness, or may acknowledge it merely as a routine problem encountered in daily living. Thus, the Biopsychosocial model preserves a space for the patient to interpret his or her own pain.

Engel's claim that the Biopsychosocial model is a more comprehensive model rests on the notion that medicine exists in a larger social milieu. A person functions within this larger social framework. Her identity is tied to that framework, and she comes to value her own personal purposes and meanings that are congruent with the social framework, even while those purposes may be more or less congruent in various components of the framework. Disease comes to threaten that person's place within that social framework. Disease might deform her appearance, or change her goals, but either way, the person and the society around her come to experience distress (Engel 1977, 130). According to Engel, then, the Biomedical model—like other folk models—is a social response to the perceived threats to function, where function is understood as functioning within the larger social framework (Engel 1977, 130). And since medicine is a social practice emerging out of a social milieu, it therefore must take into consideration the social, as well as psychological aspects of disease.

Thus scientific Biomedicine must extend itself beyond the biological space of disease. Taking grief as his example, Engel states:

Hence the physician's basic professional knowledge and skills must span the social, psychological and biological for his decisions and actions on the patient's behalf involve all three. Is the patient suffering normal grief or melancholia? Are the fatigue and weakness of the woman who recently lost her husband conversion symptoms, psychophysiological reactions, manifestations of a somatic disorder, or a combination of these? The patient soliciting the aid of a physician must have confidence that the M.D. degree has indeed rendered that physician competent to make such differentiations. (Engel 1977, 133)

Thus, the Biopsychosocial model serves as the tool by which medicine can gain a broader and more comprehensive view of the patient. The patient is not just a mechanical body, but a body with a psyche and a

body within the larger social milieu, rife with meanings and purposes well beyond the mere biology. With the new biopsychosocial model, the totality of human beings can be engaged.

The physician would cover the totality of the patient's life. He would not only know the Biomedical aspects of the patient's life, but he would also know the psychological aspects drawing on the science of psychology. In addition, the physician would also know the social dimension of a patient's life, drawing on the science of sociology. Thus, while the Biopsychosocial Model of Medicine purports to be a reform of reductive Biomedicine, Biopsychosocial Medicine also seems to bring the scientific into the more personal dimensions of the patient's life. So rather than being less reductive, or less scientific, the Biopsychosocial Medicine seems to promote more scientism, such that each domain of a patient's life—his body, his psyche, and his social dimension—are subjected to different sciences. The patient's life becomes totalized, and submitted to scientific analysis, including not only the biological/medical, but also the psychological and social dimension.

If Biomedicine would provide the scientific explanation of disease, and if Bioethics would take on the moral dimension of the patient's life, then the Biopsychosocial medicine would cover the other personal dimension of disease and healthcare, namely the dimension of the psychological and the social. However, where bioethics created a separate domain for itself, Biopsychosocial Medicine would remain more "holistic" in that Engel's model thought that the physician would continue to work on the biological, psychological, and social dimensions of health and disease, all informed by the scientific medicine. Far from being a reform of the scientism of Biomedicine, the Biopsychosocial Medicine reproduces it. Thus a new reform is called for, one that once and for all attempts to get past the reductive scientism of Biomedicine and Biopsychosocial Medicine and that new model of medicine would be called the Biopsychosociospiritual Medicine, and this version has the benefit of introducing spirituality back into medicine; or so the story goes.

V. From Biopsychosocial to Biopsychosociospiritual Medicine

For Engel, then, the problem was that scientific Biomedicine had focused too much on the mechanics of the body, reducing all disease to biology. He thought that Biomedicine had not yet sufficiently turned itself to the analysis of the psychological and social dysfunction. He sees scientific reduction of the body as the problem, while promoting

the use of science in the psychological and social dimensions of a patient's life. Certainly, psychology and sociology predate Engel, but to Engel's assessment, Biomedicine had not yet learned from these other human sciences, which equally deserve the noble title of science. For these sciences to be utilized by the clinician, new forms of assessment and diagnosis shall have to be developed. The point is that around the time of Engel's writing, we find an explosion of new scientifically informed techniques to assess everything from grief to spirituality.

Yet, spiritual care of patients had been part of the care of patients from the earliest times of medicine. From the earliest times of Western medical care, Christian spirituality had been present. (Bishop, Rosemann, and Schmidt 2008, Ferngren 2009) Spiritual care of the sick had always been present Catholic hospitals in the US. The Catholic nursing sisters from various orders had emphasized the spiritual care of patients from the time that they began offering medical care on the American frontier in the late 1800s. (Kauffman 1995) In addition, several Protestant Churches in the US also ran hospitals, and by the 1940s the American Protestant Hospital Association created a special section for ministers who provided spiritual care of the sick. These hospitals had been staffed by ministers and pastors from their respective traditions. The Episcopal hospital would have Episcopal priests, Presbyterian hospitals would have Presbyterian pastors, Baptist hospitals would have Baptist ministers on staff. The various Protestant denominations maintained a religious identity for its hospitals.

Eminent clinicians like William Osler and Richard Cabot had understood the spiritual dimension of medical care, and its importance for the care of the patient. (Cabot and Dicks 1936; Coulehan 2010) Yet, as Biomedicine increasingly became scientific through the 1950s, the spiritual dimension of medical care became more and more marginal. As long as the hospitals maintained their religious identities and kept pastors on staff, the spiritual dimension of patient care would be met. Hospital chaplains committed to the religious identities of the particular religious tradition were there to fill in the vacuum of personalized care as Biomedicine became more and more mechanical.

However, by the 1950s, Biomedicine had begun to specialize, and the priests, pastors, and ministers who worked at the hospitals felt pressure to professionalize creating the profession of the hospital chaplain. Shortly thereafter, the professionalized chaplains would create standards of practice for all hospital chaplains, whatever the religious identities of the hospitals that they worked for. Moreover, chaplaincy became more and more generic such that the chaplain himself or herself, could minister to any patient regardless of the

chaplain's or the patient's religious identity. In fact, a whole field of chaplain education was begun in the 1950s known as Clinical Pastoral Education (CPE). Moreover, hospital chaplaincy began not merely as a means to meet the personal, non-biomedical needs of patients, but it began as the result of certain intellectual trends in the US. For example, Lawrence Holst noted that four major intellectual streams gave birth to chaplaincy—theological liberalism, philosophical pragmatism, psychology, and religious existentialism. (Holst 1985, 47) Joseph Kotva noted:

From theological liberalism and religious existentialism, CPE garnered antiauthoritarian and individualistic tendencies. From pragmatism, CPE learned to attend more to function than to the content of convictions. And psychology taught CPE to emphasize the “inner dynamic world” of the unconscious. (Kotva 1998, 260)

Whereas spiritual care had long been associated with specific traditions and specific versions kinds of spiritual care practices had been deployed, now any chaplain of whatever faith had standards to care for any patient of whatever faith.

In fact, chaplaincy as it is configured today does not even require that the chaplain have any faith commitments at all, except to adhere to the standards of generic chaplaincy. Thus, by the 1980s, the chaplain had taken on an instrumental role of making sure that patients adhere to Biomedical directives. The chaplain does not advocate for a particular tradition of belief, nor does he merely adhere to the patient's spiritual beliefs. Rather the chaplain advocates for the more neutral and objective value of health, health as defined by Biomedicine. (Kotva 1998, 261-262; Browning 1986, 70) Thus, even chaplaincy has become more and more generic, and begun to align itself more and more with Biomedicine.

Moreover, the demand amongst physicians for better spiritual care for their patients began to increase in the 1990s. In fact, numerous scholars have remarked on the importance of spirituality to day-to-day practice of medicine. Thus, a new reform movement began with several publications by Christine Pulchalski, who argued for an approach to medical care that was open to the patient's spiritual and religious beliefs. She created a little tool to help the physician remember to ask about patient spiritual needs. The tool is called FICA and prompts the physician to ask about the physician the following questions:

F – Faith and Belief: Do you consider yourself spiritual or religious? Do you have spiritual beliefs, values, or practices

that help you cope with stress?*

No, the health care provider might ask, What gives your life meaning?

I – Importance: What importance does your faith or belief have in your life? Have your beliefs influenced you in how you handle stress? Do you have specific beliefs that might influence your health care decisions? If so, are you willing to share those with your health care team?

C – Community: Are you part of a spiritual or religious community? This community can be church, temple, mosque, or like-minded friends, family, etc. Is this of support to you and how? Is there a group of people you really love or who are important to you?

A – Address in Care: How should I address these issues in your health care? This is also to remind clinicians to develop a plan to address patient spiritual distress or other spiritual issues.⁶ (Puchalski 2014)

The tool was primarily meant to assist health care practitioners in their care of the patient. However, Puchalski has been a major proponent for increased scientifically scrutinized instruments of spiritual assessment. (Puchalski et al. 2009, Puchalski 2004, Yi et al. 2006) (Puchalski 2008a, 2008b, 2009; Puchalski et al. 2009)

Still, even before Puchalski there were pushes for actual scientifically validated spiritual assessment tools, and the call for these tools was not primarily from patient care circles. In the 1980s, hospital chaplaincy offices came under intense scrutiny because of increasing health care costs. Chaplaincy offices began to be required by hospital administrators to prove their benefit to patient care. In order to meet this demand, hospital chaplains had to demonstrate their benefit to patient care. Thus, several hospital chaplains began to try to do science on the work that they did. They needed to come up with ways to measure spiritual care and to show that they improved patient experience. A model of spiritual assessment was developed by McSherry (1987) was touted as the means to modernize the clinical science of chaplaincy in the era of Diagnostic Related Groups. In other words, by showing that they are assessing patient spirituality, chaplains can demonstrate their value to their hospital institution because they can show that she is improving care. (McSherry and

(6) It should be noted that the FICA Spiritual History Tool was copyrighted in 1996 by Dr. Puchalski. The tool has been supported by the George Washington Institute for Spirituality and Health for a long time before the tool was first published. Originally, it was an aid to history taking, but lately it has been called a tool of Spiritual Assessment.

Nelson 1987; McSherry 1987; Fitchett 1993a, 1993b) Yet, there has been a booming business in creating spiritual and religious assessments.

In fact in 1999, Hall and Hood documented 125 different social scientific measures of spirituality and religiosity. Of these social scientific assessment tools of spirituality and religiosity, there are many different conceptual models that emphasize different aspects of the spiritual, depending on the disciplines of those who do the research, and depending on the context within which the research is carried out and the purpose for which the researchers wish to do the research. Measures exist that focus on attitudes toward religion (Francis and Stubbs 1987), concepts of God (Benson and Spilka 1973), faith development (analogous to psychological development) (Barnes, Doyle, and Johnson 1989; Fowler 1995), religious commitment (Roof and Perkins 1975), and religious coping (Pargament 1997; Pargament, Koenig, and Perez 2000). There are even secular measures for spirituality that include both existential well-being and religious well-being (Paloutzian and Ellison 1982; Ellison 1983).

In addition, hospital chaplains, nurses, and others concerned with the spiritual well-being of patients in medical settings have also developed new assessment tools for different purposes. For instance, Ivy (1987), a hospital chaplain, created a model of spiritual assessment that relies heavily on Fowler's (1995) Stages of Faith Development. Fowler is of course heavily dependent on Kohlberg's (1981) stages of moral development; Kohlberg, in turn, is dependent on Piaget's (1954) theory of cognitive development. Thus, at least for Ivy, it is clear that spirituality is conceived along psychological functioning, and the unit of analysis is development, and the setting for which Ivy developed it was the hospital. Yet, what remains true is that spirituality has to be translated into a psychological theory of cognitive development.

Because there are so many different spiritual assessment tools, it would be difficult to analyze each of them. However, I would like to demonstrate a major problem with a specific spiritual assessment tool in order to demonstrate a problem that any such tool will have. In order to study something like spirituality, one must convert it into the language of science. One such tool is called the RCOPE. The RCOPE conceived of spirituality in terms of psychological coping. That is to say, it conceived of religion as an instrument aimed at psychological coping. In other words, religion is conceived as first and foremost as a psychological coping mechanism. The RCOPE is a tool to determine the religious coping mechanism of patients. It was developed by a psychologist name Kenneth Pargament in the mid-1990s, and further developed just a few years ago into the BriefRCOPE, a more simple

version of the assessment tool. (Pargament 1997; Pargament, Koenig, and Perez 2000; Pargament, Feuille, and Burdzy 2011)

Pargament and his research colleagues developed the RCOPE as an inventory items to help figure out what religious thinking does to psychological functioning. “Measures of religious coping should be grounded theoretically in a functional view of religion and the roles it plays in coping” (Pargament, Koenig, and Perez 2000, 520) They defined religion as having five different psychological functions: meaning, control, comfort, intimacy, and life transformation. Each function is given three to six subscales, and each subscale has five items. Now to many religious traditions, say for example Christianity or Judaism, the concept of a transcendent being—God—is essential to their religious identity. Of the five psychological functions of religion according to the RCOPE, only two—comfort and intimacy—open onto the idea of God. Or rather, I should say only two functions open onto the idea of something transcending the individual, because the instrument itself only refers to God in one instance.

Moreover, when referring to God, the RCOPE seems one-sided. Let me give an example. One of the religious functions according to Pargament, Koenig, and Perez is the creation of meaning. Under the heading of creation of meaning, there are several subscales. These subscales are called: Benevolent Religious Reappraisal, Punishing God Reappraisal, Demonic Reappraisal, and Reappraisal of God’s Power. Each subscale has five items. For example, under the subscale, “Punishing God Reappraisal,” the five items which the respondents rate using a 4-point Likert scale, are: Wondered What I did for God to punish me; Decided that God was punishing me for my sins; Felt punished by God for my lack of devotion; Wondered if God allowed this event to happen to me because of my sins; and Wondered whether God was punishing me because of my lack of faith. One can easily see that the inventory is designed to uncover those who believe that God is punishing them and that this belief gets in the way of return to normal social function.

Yet, for those people who claim to be Christian or Jewish, the notion of a God is conceived not as punishing, but mostly in very positive lights. Moreover, God is not merely an instrumental means of making people critically reassess their lives. For Christians and Jews, God is benevolent, kind, and so far exceeds human capacities to know Him that He could never be reduced to a concept of any kind, let alone a concept of psychological functioning. Thus, one could ask the relevance of the RCOPE for assessing the spirituality of a Christian or a Jew with such an instrument. And the same would seem to hold true of Buddhism or Confucianism. In other words, the particular claims of particular practitioners of Christianity, Judaism, Buddhism, or

Confucianism cannot be reduced to the psychological theories that inform any one particular instrument of the myriad of instruments for spiritual assessment. Put differently, in order to deploy a science on something like religiosity or spirituality, one must inevitably change it into something that the religion or spiritual tradition will no longer recognize.

The point here is to show that even spirituality in Biopsychosociospiritual Medicine has come under the domain of scientific Biomedicine. Even spirituality must submit to the scientific realm if it is to be admitted into Biomedicine. It is, thus, scientific. Numerous arguments for the problems of spiritual assessment have been made. For example, Devan Stahl argued that three of the greatest thinkers in the Christian tradition might be labeled as spiritually dysfunctional. She performed a different spiritual assessment on each of three saints in the Christian tradition, and the spiritual assessment concluded that each saint was defective (Stahl 2013). Of course, Stahl's point is that each spiritual assessment is defective. Emily Trancik argued that these generic spiritual assessments may miss the important features of particular faith traditions. She noted that some spiritual assessments would be offensive to Roman Catholics. (Trancik 2013) I myself have claimed that the rich tapestry of spiritual identity gets reduced to psychological and social labels, giving practitioners the sense that in fact are addressing a patient's spiritual needs, when in fact, these spiritual assessments are creating a false image of the patient's spiritual needs and thus miss out on the reality of what is at stake for patients. (Bishop 2013)

Thus, it seems to me that the drive toward a Biopsychosociospiritual Medicine, a medicine that covers, not only the biological aspects of the disease, but also the psychological, the social, and the spiritual aspects is highly problematic. While there can be little doubt that those thinkers who have called for greater spiritual care for patients, and have called for multidisciplinary teams of care, it also seems that this comprehensive care risks reducing every aspect of the patient's life to the totality of all sciences designed to help patients. In other words, the Biopsychosociospiritual reform of medicine is no reform at all. It is the same old scientism that has plagued medicine for just over a century now.

VI. Conclusions

It should be clear by now that Biopsychosociospiritual Medicine is something that develops out of the history of medicine in the West. That history is not just a history of medicine in the US. It is also the result of battles between the various versions of Christianity (Catholic

vs. Protestant) and the rise of the nation-state in Europe. (Musazawa 2005; Milbank 2006; Cavanaugh 2009; Gregory 2012) Secularization began in Europe and moved from their into the US context. Moreover, the discord between science and religion in the West was the direct result of developments within Christianity and its understanding of religion as a set of beliefs (as opposed to a set of practices) over against the supposed facts that emerge through scientific investigation. (Barbour 1997; Harrison 2015)

It was from within this intellectual milieu that Biomedicine grew. The scientific method was thought to be the only method by which truth could be known, and as such scientific Biomedicine deployed its scientific methodology on all matters within medicine. The result was a medicine that was increasingly impersonal, cold, mechanical, and often devoid of purpose. The various reforms that I have rehearsed were attempts to address various of the impersonal qualities of Biomedicine. The first reform was the Bioethics reform. As noted, the first reform originated from theological and religious thinkers. However, given the history of science's relationship to religion, Biomedicine would not permit any theological or religious language and Bioethics quickly lost its theological character and became influenced by common morality theories.

From within clinical medicine, a different reform began. That was the Biopsychosocial reform of medicine. As I noted in detail, George Engel, a psychiatrist, called for medicine to get past its impersonal qualities with more attention being paid to the psychological and the social dimensions of health care. As noted, Engel specifically laid the blame for medicine's reductivism at the feet of Christianity, even while he did not understand the history of scientific dualism, which is not at all a Christian idea. In other words, Engel's reform was a call to better psychological and social science and was not a call to reform the scientism of Biomedicine. Rather, Engel's reform would only make matters worse putting us on the road to a kind of totalizing medicine—a Biopsychosociospiritual Medicine.

The Biopsychosociospiritual reform attempted to bring theological, religious, and spiritual traditions of care back into Biomedicine. As noted, health care in the West began out Christian ideals for the care of the sick. The term hospital and hospice, both used widely today, originated from the Benedictine monks who set up monasteries all over Europe. Attached to each monastery was a house to be used by the poor and the sick. These houses were called the hospitalum, because it is where hospitality—the chief Benedictine virtue—was given to the poor and the sick. (Bishop, Rosemann, and Schmidt 2008) So the creation of hospitals and the recent resurrection of hospice in the US (and around the world) began primarily as a

spiritual movement to offer care to the dying. (Bishop 2011, 252-258) Those like Puchalski and Sulmasy who have called for more spirituality in medicine have unwittingly also undermined it. By attempting to create spiritual assessment tools, the proponents of Biopsychosociospiritual Medicine have sowed the seeds of its failure. In transforming theological concepts and religious practices into something that can be assessed by psychological and social science, in turning spirituality into religious coping, one turns spirituality into something that it is not for the purposes of measuring it. Thus, Biopsychosociospiritual Medicine is doomed to fail as well.

Whenever a human being is faced with his death, whenever he is faced with the death of someone he loves, one cannot merely reduce the problem to a problem of science. The personal aspects will always be a part of it. In fact, spiritual traditions—even those spiritual traditions that deny that they are spiritual—continuously shape the fact of our bodily frailty. It is as true for the Christian as it is true for the Confucian. And while, for the purposes of manipulating the body, one can abstract from the patient's lifeworld, one can never deploy a biomedical answer without other non-scientific, non-reductive elements entering in. Thus, while much of the world hopes to achieve what the US has achieved in Biomedicine, it should be noted that those achievements came with a deep price. Patients feel abandoned; they feel like cogs in the wheel of medical therapies; they feel left out in the cold.

It seems to me that the science of Western medicine, which emerges out of the social and political particularities of Western Europe, Britain, and the US, gave birth to that science. It is born out of the life-world of the West. Thus, Biomedicine with its reductive and scientific tendencies produced a kind of medicine in need of multiple reforms. Yet each attempt to reform removed important aspects of human experience in order to preserve a supposedly acultural understanding of scientific Biomedicine, a Biomedicine untouched by theology, religion, or spirituality. Yet all that has happened is the recapitulation of scientific attitudes on the problem created by Biomedicine. Thus, the Biopsychosociospiritual Medicine is doomed to failure as well. Put differently, the view of the dominant culture in the US and in Western Europe has a life-world that is scientific.

Thus, rather than embracing Western Biomedicine, or Western Biopsychosociospiritual Medicine, China should turn to its own spiritual traditions born out of the life-worlds of its people. A Confucian Medicine born out of Confucian life-world and its virtues and values might produce a medicine that seamlessly links the biological with the personal such that a Confucian Medicine may not be a Biomedicine in need of a Biopsychosociospiritual Reform. The

same might hold true for Buddhism in China, or Daoism. Each life-world would produce a different understanding of the body and a different understanding of the personal, moral, and spiritual dimensions of a life. The same might even be true for a Chinese Christian Medicine, one that has not been influenced by European and American influences on science and religion. After all, we humans are the animals that both produce and are produced by our cultures. We can never get away from our cultural ways of making meaning and purpose for our lives, even when we might need assistance from some kind of medicine to sustain them.

參考文獻

- Akrawi D, Bartrop R, Potter U, Touyz S. “Religiosity, Spirituality in Relation to Disordered Eating and Body Image Concerns: A Systematic Review.” *J Eat Disord.* 2015 Aug 15;3:29. doi: 10.1186/s40337-015-0064-0.
- Barbour, Ian. *Religion in an Age of Science: Historical and Contemporary Issues* (San Francisco: Harper Collins, 1997).
- Barnes, M., D. Doyle, and B. Johnson. “The Formulation of a Fowler Scale: An Empirical Assessment among Catholics,” *Review of Religious Research* 30(1989), pp.412–420.
- Beauchamp, Tom L. *Principles of Biomedical Ethics / Tom L. Beauchamp, James F. Childress.* 4th ed. (New York: Oxford University Press, 1994).
- Beck, Andrew H. “The Flexner Report and American Medical Education,” *JAMA* 291:17(2004), pp.2139-2140.
- Becker, Ernest. *The Denial of Death* (New York: Free Press, 1973).
- Benson, P. and B. Spilka. “God Image: A Function of Self-esteem and Locus Control,” *Journal for Scientific Study of Religion* 12(1973), pp.297–310.
- Bernard, Claude. *An Introduction to the Study of Experimental Medicine.* Translated by Henry Copley Greene. (New York: Dover Publications. Original edition, 1957). Originally published in 1865 as *Introduction a l’etude de la medecine.*
- Bichat, Marie Francois Xavier. *Physiological Researches on Life and Death.* Translated by F Gold. Edited by Daniel N Robinson, *Physiological Psychology Series (Significant Contributions to the History of Psychology)* (Washington DC: University Publications of America, 1978). Original edition, Originally published in 1805 as *Recherches physiologiques sur la vie et la mort.* Reprint, A reprint of the 1827 translation published by Richardson and Lord, Boston.
- Bishop, J. P. “Creating Narratives in the Clinical Encounter,” *Med Humanit Rev* 14:1(2000), pp.10-23.
- _____. *The Anticipatory Corpse: Medicine, Power and the Care of the Dying* (South Bend, IN: University of Notre Dame Press, 2011).

- _____. "Of Idolatries and Ersatz Liturgies: On the False Gods of Biopsychosociospiritual Medicine," *Christian Bioethics* 19:3(2013), pp.332-347.
- Bishop, Jeffrey P, Philipp W Rosemann, and Frederick W Schmidt. "Fides Ancilla Medicinae: On the Ersatz Liturgy of Death in Biopsychosociospiritual Medicine," *Heythrop Journal* 49:1(2008), pp.20-43.
- Booker SQ. "Older African Americans' Beliefs about Pain, Biomedicine, and Spiritual Medicine," *J Christ Nurs* 32:3(Jul-Sep 2015), pp.148-55.
- Browning, D.S. 'Hospital Chaplaincy as Public Ministry,' Second Opinion 1:1(March 1986), p.69.
- Cabot, Richard C. and Russell L. Dicks. *The Art of Ministering to the Sick* (New York: MacMillan Publishers, 1936).
- Coulehan, Jack. "Religio Medici," *Osler's Bedside Library: Great Writers who Inspired a Great Physician* (New York: American College of Physicians, 2010), pp.11-26.
- Cavanaugh, William T. *The Myth of Religious Violence* (New York: Oxford University Press, 2009).
- Davis, Bernard. "Prospects for Genetic Intervention in Man," *Science* 170 (1970), pp.1279-1283.
- Ellison, C. W. "Spiritual Well-being: Conceptualization and Measurement," *Journal of Psychology and Theology* 11(1983), pp.330-340.
- Engel, G. L. "Is Grief a Disease? A Challenge for Medical Research." *Psychosom Med* 23(1961), pp.18-22.
- Engel, G. L. "The Need for a New Medical Model: A Challenge for Biomedicine," *Science* 196:4286(1977), pp.129-136.
- Engelhardt, H. Tristram. *Bioethics and Secular Humanism: The Search for a Common Morality* (Philadelphia; London: SCM Press; Trinity Press International, 1991).
- Engelhardt, Jr., H. Tristram. "Generic Chaplaincy: Providing Spiritual Care in a Post-Christian Age," *Christian Bioethics* 4(1998), pp.231-238.
- _____. "The Ordination of Bioethicists as Secular Moral Experts," *Social Philosophy and Policy* 19:2(2002), pp.59-72.
- _____. "The Dechristianization of Christian Hospital Chaplaincy: Some Bioethics Reflections on Professionalization, Ecumenization, and Secularization," *Christian Bioethics* 9:1(2003), p.139.
- _____. "The Recent History of Christian Bioethics Critically Reassessed," *Christian Bioethics* 20:2(2014), pp.146-167. doi: 10.1093/cb/cbu018.
- Evans, John Hyde. *The History and Future of Bioethics* (New York: Oxford University Press, 2012).
- Ferngren, Gary B. *Medicine and Health Care in Early Christianity* (Baltimore, Maryland: Johns Hopkins University Press, 2009).
- Finnis, John. *Natural Law and Natural Right*. Edited by H.L.A. Hart, *Clarendon Law* (Oxford: Oxford University Press, 2011).
- Fitchett, G. *Assessing Spiritual Needs* (Minneapolis: Augsburg Fortress, 1993a).
- _____. *Spiritual Assessment in Pastoral Care: A Guide to Selected Resources* (Decatur, GA: Journal of Pastoral Care Publications, 1993b).

- Fitchett, G., B. D. Rybarczyk, G. A. DeMarco, and J. J. Nicholas. “The Role of Religion in Medical Rehabilitation Outcomes: A Longitudinal Study,” *Rehabilitation Psychology* 44 (1999), p.333.
- Fletcher, Joseph. *Morals and Medicine* (Boston: Beacon Press. Original edition, 1954). Reprint, Reprint with preface, 1960.
- Flexner, Abraham. *Medical Education in the United States and Canada* (Washington, DC: Science and Health Publications, 1910).
- Fowler, J. W. *Stages of Faith: The Psychology of Human Development* (New York: Harper Collins, 1995).
- Francis, L. J. and M. T. Stubbs. “Measuring Attitudes towards Christianity: From Childhood into Adulthood,” *Personality and Individual Differences* 8(1987), pp.741–743.
- Freire E, Williams C, Messow CM, Cooper M, Elliott R, McConnachie A, Walker A, Heard D, Morrison J. “Counseling versus Low-intensity Cognitive Behavioural Therapy for Persistent Sub-threshold and Mild Depression (CLICD): A Pilot/Feasibility Randomised Controlled Trial,” *BMC Psychiatry* 15(2015), p.197. doi: 10.1186/s12888-015-0582-y.
- Gregory, Brad S. *The Unintended Reformation* (Cambridge, Mass: Belknap Press of Harvard University Press, 2012).
- Harrison, Peter. *The Territories of Religion and Science* (Chicago: University of Chicago Press, 2015).
- Hauerwas, Stanley. “How Christian Ethics Became Medical Ethics,” *Christian Bioethics* 1:1(1995), pp.11-28.
- Holst, Laurence. *Hospital Ministry: The Role of the Chaplain Today* (New York: Crossroad, 1985).
- Hill, P. C. and R. W. Hood, Jr. *Measures of Religiosity* (Birmingham, AL: Religious Education Press, 1999).
- Ivy, S. S. “A Faith Development/Self-development Model for Pastoral Assessment,” *Journal of Pastoral Care* 14 (1987), pp.329–340.
- Jonsen, Albert R. *The Birth of Bioethics* (Oxford: Oxford University Press Inc., 2003).
- Jim HS, Pustejovsky JE, Park CL, Danhauer SC, Sherman AC, Fitchett G, Merluzzi TV, Munoz AR, George L, Snyder MA, Salsman JM. “Religion, Spirituality, and Physical Health in Cancer Patients: A Meta-analysis” *Cancer* (2015) doi: 10.1002/cncr.29353.
- Katerndahl, D. and D. Oyiriaru. “Assessing the Biopsychosociospiritual Model in Primary Care: Development of the Biopsychosociospiritual Inventory,” *International Journal of Psychiatry and Medicine* 37:4(2007), pp.393-414.
- Kauffman, Christopher J. *Ministry and Meaning: A Religious History of Catholic Care in the United States* (New York: Crossroads Publishing, 1995).
- Kaufman, Sharon R. *And a Time to Die: How American Hospitals Shape the End of Life* (Chicago: University of Chicago Press, 2005).
- Koenig HG, Pearce MJ, Nelson B, Daher N. “Effects of Religious Versus Standard Cognitive-behavioral Therapy on Optimism in Persons with Major Depression and Chronic Medical Illness.” *Depress Anxiety* (2015) doi: 10.1002/da.22398.

- Kohlberg, L. *The Philosophy of Moral Development: Moral Stages and the Idea of Justice* (New York: Harper and Row, 1981).
- Kübler-Ross, Elisabeth. *On Death and Dying* (New York: Scribner. Original edition, 2003). Originally published in 1968.
- McCormick, R. A. "To Save or Let Die. The Dilemma of Modern Medicine," *JAMA* 229:2(1974), pp.172-176.
- McCormick, R. A. "The Quality of Life, the Sanctity of Life," *Hastings Center Report* 8:1(1978), pp.30-36.
- McKenny, Gerald P. *To Relieve the Human Condition: Bioethics, Technology, and the Body* (Albany: SUNY Press, 1997).
- McSherry, E. and W. A. Nelson. "The DRG Era: A Major Opportunity for Increased Pastoral Care Impact or a Crisis for Survival?" *Journal of Pastoral Care* 41(1987), p.201.
- McSherry, E. "Modernization of the Clinical Science of Chaplaincy," *Care Giver* 4 (1987), pp.1-13.
- Milbank, John. *Theology and Social Theory: Beyond Secular Reason*. 2nd ed. (Oxford, UK ; Malden, MA: Blackwell Pub., 2006).
- Moreno, Jonathan. *The Body Politic: The Battle over Science in America* (New York: Bellevue Literary Press, 2011).
- Musazawa, Tomoko. *The Invention of World Religions: Or, How European Universalism Was Preserved in the Language of Pluralism* (Chicago: University of Chicago Press, 2005).
- Pargament, K. I. *The Psychology of Religion and Coping* (New York: Guilford Press, 1997).
- Pargament, K. I., H. G. Koenig, & L. M. Perez. "The many Methods of Religious Coping: Development and Initial Validation of the RCOPE," *Journal of Clinical Psychology* 56(2000), pp.519-543.
- Pargament, K., M. Feuille, and D. Burdzy. "The Brief RCOPE: Current Psychometric Status of a Short Measure of Religious Coping," *Religions* 2(2011), pp.51-76.
- Park CL, Sherman AC, Jim HS, Salsman JM. "Religion/Spirituality and Health in the Context of Cancer: Cross-domain Integration, Unresolved Issues, and Future Directions," *Cancer* (2015) doi: 10.1002/cncr.29351.
- Piaget, J. *The Construction of Reality in the Child* (New York: Basic Books, 1954).
- Pinker, Steven. "The Moral Imperative for Bioethics," *The Bost Globe*, August 1, 2015, Opinion-Editorial.
<https://www.bostonglobe.com/opinion/2015/07/31/the-moral-imperative-for-bioethics/JmEkoyzITAu9oQV76JrK9N/story.html>. Accessed September 5, 2015.
- Puchalski, Christina M. "Listening to Stories of Pain and Joy," *HEALTH PROGRESS* 8:4(2004), p.20.
- Puchalski C.M. "Spiritual Issues as an Essential Element of Quality Palliative Care: A Commentary," *Journal of Clinical Ethics* 2008;19:2(2008a), pp.160-162.
- Puchalski, C.M. "Addressing Spiritual Needs of Patients," *Cancer Treatment and Research* 14(2008b), pp.79-91.

- Puchalski CM, Post SG, Sloan RP. “Physicians and Patients’ Spirituality,” *Virtual Mentor* 11:10(2009), pp.804-815.
- Puchalski, C., B. Ferrell, R. Virani, S. Otis-Green, P. Baird, J. Bull, H. Chochinov, G. Handzo, H. Nelson-Becker, and M. Prince-Paul. “Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference,” *Journal of Palliative Medicine* 12(2009), pp.885-904.
- Puchalski, C.M. “The FICA Spiritual History Tool #274,” *Journal of Palliative Medicine* 17:1(2014), pp.105-106.
- Ramsey, Paul. *Basic Christian Ethics* (New York: Scribner’s, 1950).
- Ramsey, Paul. *Patient as Person* (New Ed edition ed: Yale University Press, 1974).
- Ramsey, Paul. “Tradition and reflection in Christian life,” *Perkins Journal of Theology* XXXV:2(1982), pp.46-56.
- Roof, W. C. and R. P. Perkins. “On Conceptualizing Salience in Religious Commitment,” *Journal of the Scientific Study of Religion* 14(1975), pp.111-128.
- Salsman JM, Pustejovsky JE, Jim HS, Munoz AR, Merluzzi TV, George L, Park CL, Danhauer SC, Sherman AC, Snyder MA, Fitchett G. “A Meta-analytic Approach to Examining the Correlation between Religion/Spirituality and Mental Health in Cancer,” *Cancer* (2015) doi: 10.1002/cncr.29350.
- Salsman JM, Fitchett G, Merluzzi TV, Sherman AC, Park CL. “Religion, Spirituality, and Health Outcomes in Cancer: A Case for a Meta-analytic Investigation,” *Cancer* (2015). doi: 10.1002/cncr.29349.
- Schildkraut, J. J. “The Catecholamine Hypothesis of Affective Disorders: A Review of Supporting Evidence,” *Am J Psychiatry* 122:5(1965), pp.509-522.
- Schoonover-Shoffner K. “What’s the Impact of Religion at the Bedside?” *J Christ Nurs* 32:3(2015), p.138.
- Sherman AC, Merluzzi TV, Pustejovsky JE, Park CL, George L, Fitchett G, Jim HS, Munoz AR, Danhauer SC, Snyder MA, Salsman JM. “A Meta-analytic Review of Religious or Spiritual Involvement and Social Health among Cancer Patients,” *Cancer* (2015) doi: 10.1002/cncr.29352.
- Stahl, Devan. “On Poor Religious Coping: Spiritually Assessing Christianity’s Great Theologians,” *Christian Bioethics* 19:3(2013), pp.299-312.
- Stump, Eleonore. “The Non-Aristotelian Character of Aquinas’s Ethics: Aquinas on the Passions,” *Faith and Philosophy* 28:1(2012), pp.29-43. doi: 10.5840/faithphil201128114.
- Sulmasy, D.P. “A Biopsychosocial-spiritual Model for the Care of Patients at the End of Life.” *The Gerontologist* 42:suppl 3(2002), p.24.
- Starr, Paul. *The Social Transformation of Medicine* (New York: Basic Books Reprint Edition, 1984).
- Szasz, Thomas Stephen. *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. Rev. ed. (New York: Harper & Row, 1974).
- Trancik, Emily G. “Lost in Translation: Spiritual Assessment and the Religious Tradition,” *Christian Bioethics* 19:3(2013), pp.282-298.

- Veatch, Robert M. *A Theory of Medical Ethics* (New York: Basic Books, 1981).
- Yi, Michael S, Joseph M Mrus, Terrance J Wade, Mona L Ho, Richard W Hornung, Sian Cotton, Amy H Peterman, Christina M Puchalski, and Joel Tsevat. "Religion, Spirituality, and Depressive Symptoms in Patients with HIV/AIDS," *J Gen Intern Med* 21 (S5):S21-S27 (2006). doi: 10.1111/j.1525-1497.2006.00643.x.