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ESSAY/PERSONAL REFLECTIONS

Guidelines for conducting a spiritual assessment

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INTRODUCTION

The proposed guideline to a spiritual assessment has been field tested at Cape Breton University where I developed courses on spirituality and health for nursing students in 2002. I have also used these guidelines in a dozen workshops I conducted on the rights of clients in nursing homes and vocational settings in the Cape Breton catchment area (Bryson, 2003).

The majority of articles and books on spirituality align it with deep-seated beliefs about the meaning of life. The search for spiritual meaning can have a vertical dimension (transcendent) or a horizontal dimension (natural), or both. The National Cancer Institute sees spirituality as "Having to do with deep, often religious feelings and beliefs, including a person's sense of peace, purpose, connection to others, and beliefs about the meaning of life." Dr. Christina Puchalsky, Director of the George Washington Institute for Spirituality and Health says that spirituality "is the way you find meaning, hope, comfort, and inner peace in your life." The American Academy of Family Physicians and the Association of American Medical Colleges express a like-minded view of spirituality as being a critical factor in health and illness. The aim of this paper is to provide a guide for locating the place of lost spiritual meaning in the life of a patient.

We can be spiritual without being religious. I base my assessment of spirituality on what is missing from a patient's life rather than on where future meaning lies. The proposed Spiritual Assessment System (SAS), therefore, identifies places where meaning is lost in the life of a person. The possibility of personal death can be the utmost source of lost meaning. The goal of SAS is to prepare the way for personal healing by pointing the way toward the identification and recovery of lost meaning. The first step is to invite the patient to tell us how he or she finds meaning in life. The person conducting SAS helps them do this because not all patients are aware of the exact reason for lost meaning other than a general sense of hopelessness because life is at an end. The task of a caregiver demands a non-judgmental ability to meet patients where they are at in their hour of need. The nurse functions as an enabler, that is, as a sounding board for the release of the pain of the other. To that end, I encourage my students to keep a daily journal so that they can become aware of how they find and lose meaning in life. That discovery of painful disassociations subsequently serves as a bridge to the other. The nurse's experience with journaling and the subsequent discovery of lost meaning builds an existential bond of trust between caregiver and patient (Bryson, 2006).

We do not find meaning in the same way. The reason is that human beings are not equally personal. The distinction between being human and being a person is central to the philosophy of SAS. We acquire meaning because of developments taking place on three interconnected "person-making" fronts. The first source of meaning arises out of our biological characteristics. At birth, we are carbon atoms that share in the condition of the biotic community. The second source of meaning is the social-self. The third is the neocortical self. This last stream is the place where we process the first two sources of meaning while devising ways of finding fresh meaning. Persons are human beings that know themselves to be in relationships. All losses including the loss of personal health destroy meaning on one or more of those pathways. This leaves empty spaces in the life of a person that block acceptance. The goal of SAS is to identify those places of emptiness and to help patients find meaning when life is at an end. Healing can take place in the absence of cure.

OVERVIEW

1. Sources of personal meaning: (1) carbon-self; (2) social-self; (3) self-awareness.

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2. Disease empties life of meaning where it exists on each of those three arms.
3. Spiritual healing rebuilds meaning on those three arms.
4. A "systems" approach to healing maintains the human element of medicine.

THE ARGUMENT

Part 1

The paper is in two parts. The first part contains the theoretical details of the proposed guidelines whereas the second part is an application of theory to practice. Some readers might prefer to go directly to the second part and Table 1.

The word spiritual is from the Latin root spiritus meaning breath or life. All human beings are spiritual. Spirituality is an innate tendency toward the search for meaning. As shown in the literature (Taylor, 2002; Burkhardt & Nagai-Jacobson, 1985; Dossey, Keegan & Guzzetta, 2005; Ponomareff & Bryson, 2006), the development of spirituality takes place through relationships. Spirituality is broader than religion because it finds an outlet in all forms of human activity. Religion is more specific. All major religions express a desire to enter into relationship with a Transcendent Being. Thus, authentic religion's vertical dimension is spiritual. The horizontal dimension of spirituality — the love of family, neighbor, country etc. — takes place inside and outside religion. The existential experience of human restlessness mirrors spirituality at work. It suggests that no single source of meaning ever completely satisfies us. This explains why we strive toward the discovery of the ultimate meaning of life as sources of meaning cascade into increasingly comprehensive visions of what life is about. The individual's culture (attitudes, values, and beliefs) determines the process.

SAS is a measure of how disease contributes to a patient's loss of meaning. The process of spiritual welding (Bryson, 2004) restores lost meaning. Spirituality presents as an inborn tendency. Experience fine-tunes it. Everyone wants to be happy. Spirituality directs us toward those goals that make us happy. The biblical text of Genesis 1:26 announce that God makes us in his image and likeness (Bryson, 2011). This explains why adherents of the Abraham religions express a spiritual craving for God or Allah. The spiritual tendency is factual rather than normative. Spirituality requires specification (Bryson, 2013). It unfolds as a cultural process. Hinduism focuses on holistic health while Buddhist spirituality moves toward the attainment of the no-self state. Meditation and yoga provide paths towards enlightenment and spiritual fulfillment. The moment of death is especially important in Buddhism because negative emotions generate bad Karma. Neville Kirkwood (2005) has written a useful guide to meeting the needs of the dying across religious settings. The easiest way to ascertain the spiritual needs of non-religious patients is to ask them how they find meaning in life. Keep in mind that the horizontal and vertical dimensions of spirituality are not necessarily mutually exclusive.

We can also pour spiritual energies into bad connections. Spiritual welding is a process of restoring a sense of purpose in life by unplugging the connections that generate negative emotions. We are equally spiritual but we are not equally personal. Some activities promote well-being and health while other sources of meaning promote division from self, other persons, and the environment. Poor spiritual connections promote death. The character of a human emotion reflects good and bad connections. Sour connections lead to negative emotions while good connections lead to positive emotions. Because of this dual attraction between good and evil, the spiritual search for meaning can lead to personal destruction as well as to personal growth depending on how we feed our emotions.

The other point about spirituality is that it evolves as a person's life experiences accrue. Spirituality is a process rather than an event. This explains why human beings are not equally personal. In order to explain how this works, we need to discuss what makes us personal. SAS is a measure of being a person, not the measure of being human.

What Is A Person?

Before we can rebuild lost meaning, we need a theory on what it means to be a person. The traditional view of persons as rational animals is not necessarily wrong, but clearly not very useful in measuring SAS. Many non-humans have problem solving abilities. The ability to use logic does not necessarily make us more personal, though reasoning is part of what it means to be a person. A more complete answer to my question is that we are the output of other equally important associations and relationships. In my opinion, being a person arises as the output of three streams of associations or relationships, active and passive (Bryson, 2010).

Our most basic trait is that we are matter. This perspective always drives the search for meaning. Our carbon genealogy contains the genetic coding that characterizes our physical dimension. We are cells that add and divide; carbon atoms along other carbon atoms, eating and being eaten in turn. In

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Table 1. *Spirituality Assessment Questionnaire*

File a patient's response to the following questions on the relevant arm of the person-making template. The responses provide a profile of lost meaning due to disease. It tells us where to look for missing peace. The actual state and relevance of meaning seeking associations varies with the nature of disease and the needs of individual patients. Not all questions provided here are appropriate for all patients. Once we know the particulars of a case in more detail, we can always add or delete questions.

The Carbon-Based Self and the Search for Meaning (Horizontal and/or Vertical)
Does my disease affect how I find physical meaning in life?
Do I have concerns about my home?
Do I have concerns about what happens to my body (ventilator, transfusion, organ transplant, etc?)
Is my physical care satisfactory?
Do I have other physical needs?
Am I sleeping OK?
Is my appetite OK?
Do I have a fear of pain?
Am I in pain?
Am I physically tired, nauseous, do I have shortness of breath?
Does the hospital setting provide sufficient resources to meet all my bodily needs?
Do I have a fear of death and of what will happen to my body (burial and such)?
Are my funeral plans complete?
Is my hospital environment OK?
Am I embarrassed about my appearance?
Does incontinence embarrass me?
Do I have sufficient privacy?
Is there anything I miss about nature (sun, rain, wind, sky etc?)
Do I have financial concerns (adequate insurance coverage or pension income for loved ones etc)?
Do I have other physical concerns?

The Social-Self and the Search for Meaning (Horizontal and/or Vertical)
Does my disease affect how I find social meaning in life?
Do I have unresolved social issues?
What social relationships are most important to me?
Is my family supporting me in my disease?
Do I worry about what will happen to my family?
Is my employer supportive?
Do my friends and neighbors know about my condition?
Are friends and neighbors supportive?
Do I have the support of my religious community?
Do I belong to a support group?
Do I worry about what is going to happen to a pet?
Do I need to make apologies or amends to anyone?
Do I have religious needs (ask for chaplain, rabbi, priest, Buddhist teacher?)
Do I have anxiety, guilt, fear, or any other negative emotion?
Do I want a visitation (wake), funeral service, cremation, burial?
Do I have interpersonal issues (privacy, confidentiality, secrecy?)
Am I lonely; do I have visitors?
Are visits from nurses, and doctors becoming less frequent?
Am I getting the right message from my caregivers?
Is there a special way someone could help me?
Is it OK for me to cry and show emotion?
Do I have other social concerns?

The Neo-Cortical Self and the Search for Meaning (Horizontal and/or Vertical)
Does my disease affect my intellectual life (how I find the cognitive meaning of life)?
What moral/ethical values are important to me?
Has my disease generated unexpected psychological issues?
How does disease change the way I find meaning in life?
How am I coping with my condition?
Am I ready for death, or do I have death anxiety?
Am I at peace (unity of mind and body, happy or sad?)
Do I think that others are acting in my best interest (autonomy, informed consent, beneficence, non-maleficence?)
What is my quality of life?
Do I wish for death?
Does the existence of an afterlife state worry me?
Do I believe in reincarnation?
Do I have good Karma?

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Are my cultural needs met (attitudes, values, and beliefs)?
Is my life in order?
Do I have any unfinished business, outstanding legal issues or political concerns?
Do I have financial worries?
Do I have any other unresolved issue bothering me?
Do I have religious concerns, fears or doubts?
Do I think that God is mad at me?
Do I think I am going to die?
Am I angry, lonely, or depressed?
Do I want to negotiate with God for a longer life?
How do I feel about my life; have I accomplished what I wanted to do in life?
Do I feel I have done the right thing in life?
Do I have any other ethical or moral concerns?
Do I have other concerns?

this frame, a patient's search for meaning presents at the crossroads of medicine and biology. We are the output of DNA and genetic predisposition, diet and exercise, shelter and wealth, lifestyles good and bad. Science can observe, measure, and dissolve this aspect of self in a solvent. The carbon-self is not the whole of a person but it expresses the most basic associations that make us search for meaning. It includes a patient's zygotic beginnings, diet, mass, age, brain activity, exercise history, geography of place, even how we dress (. . .) as sources of meaning. SAS begins with the identification of how a patient finds meaning as a carbon-self. The detailed patient's medical history tells some of that story. The loss of physical health can generate negative emotion. The point is to identify the place of lost meaning. The first step in healing work is to ask the patient questions about all the energy-based features of his or her carbon-self. How is your appetite, are you warm, or thirsty? Are you in any pain? How is your sleep? Is the hospital room comfortable? Can we do anything to make you more comfortable? Since this is a patient's first source of meaning, healing is possible even when a cure is not possible. We can fill the gap between failing health and the search for meaning in numerous other ways. The search for meaning moves on to the social-self as second great source of meaning, once the body is at peace.

The kindness, compassion, and professional care of a genuinely concerned nurse put us in the presence of a loving other. In vertical spirituality, God exists in good food and pain management, but also in the caring presence of the other. This is the social-self. In the beginning, we are the output of loving parents, family, friends, and all other human beings. Unfortunately, this includes relationships with individuals that do not always seek to empower us. Graver still is the fact that family and friends are not always available in our time of need. Professional visionary care anticipates the connection between the loss of loved ones and the search for meaning. The third string of life giving meaning derives from self-awareness or the neocortical-self. The stories that have the most meaning at the end of life originate out of the realm of relationships and right-brain insight rather than left-brain logic.

SAS continues as the nurse encourages the patient to identify the range of meaning in each stream. The identification of a negative emotion maps the place of a spiritual misfire. Persons freely carve out associations and relationships, but not all of them. No one has a say in his or her genetic profile, though medicine and biology combine resources to reverse some conditions. We cannot fix all bad connections, although acceptance promotes healing.

It seems possible to consider the person-making process along the "three brains" theory developed by Chopra and Tanzi (2012). The mind-brain distinction adds a fresh layer of intelligibility to the search for meaning. The carbon-self is the "reptilian brain" with its attendant focus on hunger, thirst, sex drive, and such. This stream includes all the observable, measurable, particulars of the patient's geography including health, age, diet, weight, medication, and room layout. The social-self, on the other hand, corresponds to Chopra and Tanzi's "emotional brain." This aspect of personality includes all emotional ties with other persons and pets. This is the repository of positive and negative emotions. The third arm of the person-making process is the "neocortical brain" or center that processes all data, memory, and imagination. Thomas Aquinas anticipated that mind-body vision in the 13th century. He establishes a relationship of dependence and independence between mind and brain. Persons need brains to think but thought contents are not reducible to the activity of the brain during thought. This explains why healing remains a possibility when curing is not. Chopra and Tanzi provide empirical verification.

A spiritual assessment always begins with the known facts of the case. How does the patient find meaning in his or her life? SAS files the patient's

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biographical data on the appropriate arm of his/her person-making process. The process opens with the patient's medical history but moves beyond that history to include the patient's non-medical narrative on the meaning of life. We express this data as atomistic strings of meaning carrying propositions. We can identify broken associations at a glance. The whole of SAS expresses a molecular statement about the patient's wellness, while broken associations stand out as being in need of spiritual welding. Spiritual welding is the process of assisting the patient's recovery of meaning lost from broken associations. I see this as an inclusive, holistic approach to health care. The goal of SAS is to lace all broken strings of meaning into an integrated whole. For instance, the experience of grief flares up on the social-arm. The emotional recoil from the loss of a loved one or personal death can produce a negative emotion such as rage, anger, guilt. The process of identifying this loss and filling it with the presence of loving memories, or providing patients with an opportunity to grow new caring relationships with medical staffs, candy stripers, visitors, other patients etc. gradually transforms negative into positive grief. The patient or client is encouraged to do this for him or herself. The nurse is a facilitator of healing, only. The first step is to register the fact that the patient experiences a negative emotion or bad response to a loss. Then the content of the narrative focuses on the connection between a social loss and that negative emotion. We fix the attention on the patient as agent of change. No one can heal another person. Patients that do not recover the meaning of life because of a broken association remain in the state of emotional brokenness or bad grief until they do for themselves what no one else can do for them. The challenge is to acknowledge the pain before moving on to doing something about it. We can mend other associations medically. For instance, we repair genetically based carbon associations several ways depending on context. Often, we do so through medical intervention, medication, diet, exercise, rest, and such. The nature of personhood suggests that the search for healing is ongoing. The ebb and flow of meaningful associations arises as a normal part of aging and all our losses. Positive and negative emotions form clusters on the arms of the person-making process. The patient and hospital staffs are simultaneously powerful and powerless in the face of these clusters. We are simultaneously powerful and powerless in the face of death. It functions as a source of inspiration to move on but also as a source of despair to stay with our losses. Death is simultaneously timely and untimely. The cortical brain grapples with this paradox while staffs promote healing in a caring responsive way. The shift toward right-brain thinking solves the paradox that the left-brain alone cannot manage. The medicine of the future shows great promise in reconfiguring biological predispositions before they arise, but we always remain programed to die and experience losses during the life span. There are things we can do to offset genetic predisposition to cardiovascular problems, and other deficiencies that program some of us for Alzheimer's, Huntington's, and so on. At times, it seems easier to cure than heal. Still, the shift from brain (carbon-self) to mind, especially right-brain insight, suggests the possibility that repeated instruction from the mind can rewire the brain. The experience of Jill Bolte Taylor (2009) continues to fascinate me.

HEALING AS PERSONAL ACTION

Part 2

The next step designs to humanize medicine. Rapid growth in medical technology has come at a great price because with each new test, scan and medical intervention, the relationship between medical staffs and patients becomes increasingly impersonal. One of the mantras of sustainable developments reminds us "there is no free lunch." The art of healing has not progressed at the same pace. The medical machinery has conquered disease but has it lost the art of healing patients?

The Regional Palliative Care Program at Capital Health Hospital, Edmonton, Alberta, provides guidelines for using a Symptom Assessment System (ESAS, http://www.ncbi.nlm.nih.gov/pubmed/1714502) to chart the intensity of patient symptoms at end of life. Patients rate their feelings of pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, wellbeing, shortness of breath, and "other" on a system ranging from zero (least possible) to 10 (worst possible). ESAS provides valuable information we can use but we need further specification to plot the patient's response to ESAS on the arms of SAS. The goal of SAS is to raise symptoms assessment to a platform where the patient is empowered to find meaning in all areas of human development.

It seems possible to further personalize patient care through a set of seven systems — culture, society, polity and law, economics, resources, environment, and ethics. These systems provide a window or lenses through which we can develop a patient centered focus on healing. The "systems based" approach to SAS casts light on how we define meaning in an age of pervasive technology. The science, technology, and society movement (STS) embodies a systems approach in science to anticipate and prevent the undesirable consequences of technological developments before they happen. Paul Durbin (1992)

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adopts a "social worker" stance ". . . professional work alone is not enough, that it must be supplemented by vigorous activism" (Durbin (1992, 39). The goal of using a systems approach to healing is to introduce activism into medicine; activism because medical budgets need to include a focus on healing along with the primacy of curing disease. The use of systems in SAS preserves the integrity of medicine as a science but raises the bar to include a healing focus on the patient as the outcome of personal relationships.

ILLUSTRATION OF A SYSTEM BASED SPIRITUAL ASSESSMENT METHODOLOGY

Key Question: How Do We View the Self Through Cultural Lenses?

The seven systems are interconnected and the division of one from the other is somewhat arbitrary. Culture is primarily the repository of a person's attitudes, values and beliefs about the world. This focus forms the basis for how we view nature, the biotic community and other persons. Respect for nature is respect of the human body. All living things resist death. Death is an insult to our carbon-self. We are carbon atoms existing side-by-side with other carbon atoms, eating and eaten. We are not outside of nature looking at ourselves. We are an integral part of nature. Environmental disease arises as a direct consequence of pollution. We pollute the eco-systems and the human body, and suffer the consequence. Greed and addiction are modern day curses. They direct the search for meaning into bad sockets. In that case, the carbon-arm of the personal self fills with unanticipated new diseases and mind-body divisions. Siegel (1984) found a connection between the environment and accidental heroin overdose that illustrates the classical conditioning mode of drug tolerance. Seven of 10 drug overdose survivors reported that they ingested the heroin in an environment not previously associated with drug use. We are eco-system dependents: the carbon-self finds curing in conservation and healing in preservation.

Key Question: How Do We View the Self Through Societal Lens?

Society houses groups that pursue common interests such as health care. The second determinant of being persons arises out of the love/nurturing we receive from parents. The social-self includes our relationships with siblings and the family at large, friends, neighbors and persons we have yet to meet. Further, we establish loving connections with animals. The way the individual frames society generates emotional states of association or disassociation with others. We can be available or unavailable to others, faithful or not, loving or not, kind to animals or not. These relationships take place passively and proactively and play a determining role in the emotional quality of persons. The observation that a patient is without visitors is an indication of a broken association. Perhaps a patient is experiencing guilt. The impersonal approach embedded in medical technology makes that problem even worse. This reminds us of the critical role of healing as art form. The carbon-self downloads into the social-self as we choose to disempower the environment (greed) or empower the environment (preservation), and other persons at large. These in turn download into the neocortical-self, as we vary and institute fresh meaning generating associations, or personal demise (euthanasia suicide, and assisted suicide), and interact with the global village as citizens seeking friendship or war.

Key Question: How Do We View the Reflexive-Self Through an Economics Lens?

Economics houses the commercial ways in which we grow or fail to develop as persons. The contrast between economic development and human development provides a further case of how we actually empower or disempower the environment, other persons, and self-awareness. The high cost of medicine forces us to make difficult choices in the allocation of scarce medical resources and personal contact with patients. This system, as is the case with all other systems, downloads into the neocortical-self. The attitude of greed leads us to disempower nature (our own body) and other persons (negative emotions). This happens as logic overtakes what it means to be a person. The process of healing the neocortical-self takes place through slow and often painful inner work. We freely choose to be loving, caring, compassionate correlates of all living things, or frame all things as standing resource for personal greed. We decide whether to empower or disempower our relationships. To assign priority to economic growth rather than to human growth in an age of abundant resources is to diminish the value of our own life. Descartes, the man of genius, missed this about persons. In place of "I think, therefore, I am," he should have said "carbon exists, others exist, and therefore, I am a being in relationships." The focus on human development transforms economic alienation into personal availability so we can share in one another's joys and sorrows. The attempt to maximize the use of scarce medical resources is not always conducive to healing outcomes. We need to make time in our busy hospitals to be present to patients. This is not cost effective but it places the value of human life

above an economic policy based only on the management of technological resources.

Key Question: How Do We View the Reflexive-Self Through the Lens of Polity?

Politics is the process of laws and regulations used to promote liberty and order. Violence, repression, insecurity and civic chaos arise as the outcome of bad government, weak administration, warfare, and government control. In the absence of sound government based on the value of being personal, the whole of life is devalued. Good governance is founded on an ethics that assigns primacy to the person, individually and at-large. In place of inviting politicians to look to law to generate the ethics, we urge them to look to ethics to generate laws that value the sanctity of life in all conditions of existence.

Key Question: How Do We Manifest a Patient Centered Environment?

The goal is to develop a patient centered environment based on pain management and the feeding of love and professional caring. A few years ago, I had the opportunity to develop a "to do" list with Fr. Colin MacKinnon while he was Chaplain at the Cape Breton Regional Hospital. While the list does not pretend to be complete, it serves as an introduction to the critical importance of being patient centered.

Preparation: The SAS process does not get off the ground without trust and story-telling. Inner work such as journaling prepares the way to the discovery of deep-seated losses within us that we can use as a gateway to a patient's pain. A nursery rhyme puts it best, "doctor, doctor will I die. Yes, my child and so will I" (author unknown).

Cultivating a User-Friendly Setting

A few years ago in one of my spirituality and health classes, Fr. Colin MacKinnon, Chaplain, Cape Breton Regional Hospital in Sydney, Nova Scotia, and I framed some leading questions for staffs to ensure the comfort and care of patients.

1. Develop listening skills, sensitivity, and compassion.
2. Develop intuition.
3. Do not judge others; meet them where they are coming from.
4. Bring comfort to others as you help them face personal death.
5. Encourage patients to tell their stories.
6. Identify how a patient feels.
7. Recognize a patient's negative emotions as arising out of a loss of meaning.
8. Seek ways to help patients attain personal reconciliation.
9. Be mindful of the dehumanizing elements of a hospital environment, notably loss of privacy ("everyone hears everything"), helplessness (inability to look after self), loss of dignity (uncontrollable bodily functions), loss of self-esteem and personal worth (feeling like a burden on others), financial concerns etc.
10. Be mindful of how medications can affect some patients (disoriented, scrambled, confused)
11. What can I do to offset my patient's loss of personal autonomy?
12. Can I assuage my patient's fear of pain?
13. Can I assuage my patient's fear of death?
14. Am I sensitive to my patient's end of life religious needs?
15. Am I sensitive to the fact that dying can lead to feelings of grief, anger, insecurity, and vulnerability?
16. Am I sensitive to the fact that a patient's awareness of personal deficiencies can lead to depression (what have I accomplished in my life?)
17. Am I sensitive to a patient's feelings of guilt: Why me; Am I being punished by God?
18. Is my patient lonely? What will happen if my patient has no visitors? Do I have an alternative for the missing energy and comfort that others bring?
19. Do I know that my patient is angry because of the threat of personal death?
20. What is my own comfort level as caregiver? Do I feel awkward because a patient asked me to pray with them? Am I comfortable with my spiritual health? Do I have death anxieties?

Key Question: How Do We Do the Right Thing?

The Hippocratic Oath assigns unqualified value to human life. In our day, however, life often has no value outside the conditions that surround it. Sadly, the nature of these conditions is often relative to context. For instance, Peter Singer and Helga Kuhse endorse a radical formula first developed by Alan Williams, a British health economist. In this model, two main factors come into play. One is life

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expectancy; the other is the adjusted quality of life, or QALY (1985). Williams claims that some states of life are worse than being dead. I think that doing the right thing means treating human life as sacred. Otherwise we could only act in a patient's best interest if the conditions prescribed by law justify doing so. Economics strives toward the discovery of efficiencies in health care. Society has professional codes of ethics to guide health care policies based on justice and fairness (Bryson, 2009). Politics and law enforce the observance of ethical codes of conduct. However, in our day, politics replaces ethics. In that event, what becomes of medical ethics and the belief in the sanctity of human life? How can we support cherished principles such as autonomy, informed consent, beneficence, and non-maleficence, and justice when polity generates the ethics? How is that shift away from traditional ethics in harmony with the deontological promise (Hippocrates) to bring no harm to anyone? Why do we allow this to happen? Has the fear of lawsuits trumped the ethical obligation to do the right thing?

CONCLUSION

The three streams of associations that individuate persons are distinct but they are not separate from the whole. These strings overlap and can be examined in any order because they merge in a model of the person as a dynamic unit. Disease breaks down the unity of persons by crushing the strings of associations that define us. The goal of holistic medicine is to identify these broken places and restore a sense of meaning to a dying or convalescing patient. The process of healing the part affects primarily the whole person and only secondarily the part. The vertical order exists on each arm of the person-making process rather than in an invisible fourth category.

SAS guidelines invite us to enter details on how a patient finds the meaning of life. The data is posted on a three dimensional person-making chart. The process of filtering questions through the lenses of systems provides a thorough conceptual synopsis of how a patient finds meaning in life. A spiritual assessment is an ongoing process where the discovery and spiritual welding of broken atomic spiritual associations on the arms of the person-making process transforms into molecular statements of wellbeing. Palliative and supportive care has not done everything possible until a patient surrounded by the caring presence of one individual reaching out to another dies at peace.

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