



Challenges Posed by a Scientific Approach to Spiritual Issues

MARK R. ELLIS, MD, MSPH
Springfield, Missouri

I saw a young woman with a heart problem in clinic yesterday. Her chest pain was sharp and fleeting, and she described no coronary risk factors other than “heart problems” in her mother. I examined her, then attempted to reassure her that her heart was fine. Only then did I notice her broken gaze and realize that no, her heart was not fine. I subsequently learned that her heart was broken—because of betrayal of trust in childhood relationships, estrangement from her ex-husband and daughter, and ultimately, because she believed God had deserted her. In my haste to reassure her, I had assumed she was concerned about a biomedical problem and nearly missed the spiritual substance of her pain.

I fear that I am not alone in this error. At a time when medical literature gives more attention to spiritual issues,^{1,3} health care providers are nevertheless crippled by our inability to deal with patients’ spiritual concerns. Physicians’ acceptance of a scientific world-view and use of scientific methodology create tunnel vision that impedes our consideration of religious issues. Our attitudes toward suffering and death make discussions of end-of-life issues less fruitful. Differences between scientific and religious language create barriers to spiritual discussions. The importance of considering our patients as whole persons demands that we face these challenges to the consideration of spiritual issues.

SCIENTIFIC TUNNEL VISION

Science and religion share the view that each person has value and dignity. Science and religion differ, however, principally in that science seeks to answer “how,” and religion seeks to answer “why” and “who.” Unfortunately, scientists and religionists may embrace their world-view so strongly that they fail to appreciate alternative views and to identify their perspective’s limitations. This leads to tunnel vision.

Dogmatism is one source of tunnel vision. Both science and religion create dogma in that they provide ways of understanding our world and define sets of rules that govern it. Science and religion also share a risk of unthinking adherence to dogma. Scientists can be dogmatic in defending the rightness of their world-view and in denouncing religion as primitive or anti-intellectual.⁴

Scientific methodology intensifies scientific tunnel vision. The adage that what we cannot measure, we cannot know, and therefore is unworthy of our observation⁴ articulates a common position in the scientific community. Even spiritual health researchers are subject to the quantifiable. Indeed, the association of religiosity with disease incidence and biomedical parameters is increasingly well studied.⁵ Spirituality’s qualitative effects, however, are incompletely discussed in the medical literature.

A strictly scientific approach to medical care overlooks important considerations—life’s meaning and purpose, the quest for a relationship with our maker, and the gift of hope. If we disavow these spiritual entities, we lose opportunities to stress their value in our patients’ lives.

ATTITUDES TOWARD SUFFERING AND DEATH

Physicians’ attitudes toward suffering and death are additional obstacles to consideration of spiritual issues. The notion that suffering can foster spiritual growth is common to Christianity, Judaism, Islam, and Eastern religions. Yet affirming the value of suffering clashes with medicine’s appropriate goal of relieving suffering. Similarly, many view death as the ultimate adversary rather than as a natural part of existence. As Stanley Hauerwas suggests, “Cure, not care, has become medicine’s primary purpose, [and] physicians have become warriors engaged in combat with . . . death.”⁶

Numerous reasons may explain physicians’ discomfort with suffering and death. Physicians may regard discussions of suffering and dying as requiring an emotional commitment that adversely affects their role.⁷ Dealing with patients’ deaths may require physicians to face personal fears of dying or confusion about spiritual issues.⁸ Physicians may view patients’ deaths as a sign of defeat.⁹ They may regard suffering as having no intrinsic value.⁸

Medicine’s discomfort with suffering and death has unfortunate consequences. Our profession’s pursuit of longevity counters the need to prepare for death. Suffering can lead to a heightened awareness

From the Cox Family Practice Residency. Reprint requests should be addressed to Mark R. Ellis, MD, MSPH, Cox Family Practice Residency, 1423 N. Jefferson Ave, #A-10, Springfield, MO 65802. E-mail: mellis@coxnet.org.

of the importance of one's inner life and to a daily cherishing of life.¹⁰ By overlooking these aspects of suffering, we lose opportunities to share meaningful experiences with our patients.

COMMUNICATION BARRIERS

Physicians discussing patients' spiritual issues also face communication barriers. C.S. Lewis suggests that these barriers result from differences between scientific and religious language.¹¹

Religious language is qualitative and descriptive, much like poetry. Consider these examples:

"Ah, bitter chill it was! The owl, for all his feathers was a-cold; The hare limped trembling through the frozen grass, /And silent was the flock in woolly fold: Numb'd were the Beadsman' fingers." (John Keats)¹¹

"God is light." (1 John 1:5)

Keats's poem uses factors within our experience (being cold) as pointers to something outside our experience (a shepherd's experience on a winter night). Lewis maintains that to benefit from this qualitative information, readers must trust the poet's observations and insight. Understanding religious language requires similar trust. A person understanding only scientific language might dismiss the religious creed "God is light," because "a sentient Being cannot be a stream of subatomic particles." In doing so, that person would be overlooking the writer's key concept—perhaps that God, like light, is infinite and life-giving. Here we see the limitations of a scientific vocabulary. Quantitative language cannot convey the content of religious beliefs.

Much of patients' language is poetic. Schooled in scientific language, physicians may mistakenly view their patients' language as imprecise and unsophisticated and trivialize spiritual issues. To justify studying spirituality, researchers may use quasi-scientific language that fails to express spiritual truths. Finally, we may argue with the poet. In my opening scenario, uncovering the spiritual content of the chest pain was not possible until I accepted that a broken heart could be caused by estrangement from God.

BEYOND THE BARRIERS

How can we overcome language barriers, our attitudes toward suffering and death, and scientific tunnel vision? First, we should remember that simply sitting and listening has value. The act of listening fosters human connectedness and healing, so our primary response to physician-patient language barriers should be to listen. Also, we should remove

labels that hinder spiritual communication. In considering spiritual issues, we are not physician, scientist, patient, and subject. We are all spiritual beings; this frees us to take the bold step of relating as equal partners in a spiritual realm.

Overcoming biases toward suffering and death requires a personal solution. We must challenge ourselves to find meaning in our own struggles. Perhaps this will allow us to affirm that growth is possible in our patients' suffering. To enhance the quality of our dying patients' lives, we must come to terms with the inevitability of our patients' deaths—and our own deaths.

To avoid tunnel vision, we must ask questions. What is the purpose of spirituality? Is it a tool for prolonging life and enhancing health, or is it something broader, such as a source of life purpose? What are the nonquantifiable health benefits of spirituality? How does it enhance patients' ability to cope with and grow from suffering?

These fundamental questions are for us all to ponder—clinician, teacher, researcher, and patient. As we simultaneously ask questions about the purpose and health benefits of spirituality, we should be reminded that at their core, medicine and religion are closely linked. Nowhere is this more apparent than in the image of a heart—a biological pump; a symbol of love; a symbol of life's power; for many, a symbol of life's creator. As scientists and spiritual beings we should affirm the importance of all broken hearts whatever their source—because the heart is life.

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