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Explaining suffering and healing:

A comparison of Pentecostal and secular general practitioners

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ABSTRACT

People who experience personal suffering and/or affliction often strive to find plausible explanations or *theodicies* for these experiences. Similarly their quest for healing can carry connotations of salvation or *soteriology*. General practitioners, like their patients, experience affliction and have a need to explain these experiences. This paper reports on a study that investigated the ways in which Pentecostal and 'secular' (with no religious affiliation) general practitioners explained their own experiences of suffering and their health seeking behaviour. Like their patients, GPs seek healing in ways that are consonant with their explanations for their suffering. Soteriology and theodicy provide a useful framework within which to understand illness experiences, and health seeking behaviours. The clinical encounter is not merely the engagement of individuals, but also the engagement of diverse sets of soteriologies and theodicies.

Keywords

Soteriology, theodicy, general practitioners

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Introduction

A recent paper suggested that 'heartsink' patients represent a challenge to biomedicine in their presentation to the GP of problems which may be social, psychological or spiritual rather than medical in origin.[1] The authors suggested that the heartsink patient's quest for treatment is also a quest for salvation. They also developed Good's[2] assertion that soteriological concerns are always present within medical care by challenging general practice to recognise and address the heartsink patient's need for salvation in the clinical encounter.[1]

Soteriology is traditionally defined as the Christian doctrine of salvation[3] although it has a less common definition as a discourse of health or the science of promoting and preserving health.[4] The secular intersection of these definitions is useful in explaining people's hopes and expectations of healing as a *transformation* from a state of 'unwellness' to a state of wellbeing.

Suffering, or the anticipation of suffering, is generally accepted as the motivating force underlying the quest for healing and curing, as it is the quest for salvation, or soteriology. Cassell[5] noted more than a decade ago that 'suffering' is difficult to define, particularly if relying upon medical literature to do so. He sug-

gested that it must always be recognised that *persons* in a holistic sense suffer, and also noted that suffering can be said to occur as a consequence of a person's sense of wholeness or integrity (physical or otherwise) being threatened in some way.

It is useful to talk about soteriology and suffering within the context of theodicy. In its classical definition theodicy indicates the defence of God against the existence of suffering in the world. The meaning of theodicy has been extended beyond its original definition, or secularised, by social scientists to indicate the struggle of building a coherent account of why suffering should exist in the world.[6] If soteriology is to be employed as a meaningful way of exploring the clinical encounter and the goals of medicine, it needs to be situated within the context of theodicy.

Although there is a growing body of literature demonstrating that the health needs of physicians are not well met for a variety of reasons,[7-9] and several well known 'pathographies',[10-12] neither physicians' personal experiences of suffering and understandings of pain, illness and affliction, nor their health seeking behaviours and experiences of healing are well researched. The term 'pathography' refers to autobiographical accounts of doctors' experiences of illness and therapy. As an example of this genre, Oliver Sacks' *A Leg to Stand On*[10] is a very poignant account of his experiences from initial injury to full recovery.

This paper reports on research comparing the attitudes of Pentecostal and secular (those professing no religious affiliation) GPs toward suffering and healing, and the health seeking strategies utilised by each group. It argues that soteriological concerns are also present when GPs experience illness or affliction, and seek healing. The author suggests that soteriology as a simultaneous quest for healing and/or salvation needs to be viewed within the context of theodicy as a means of explaining why suffering and affliction occur. Soteriology and theodicy constitute a useful framework for understanding illness experiences and clinical encounters, not only for 'lay' patients but also for physician patients.

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Method

This research was conducted as part of a larger project investigating the meanings of suffering, healing, and examining health seeking strategies among Pentecostals, Christian Scientists and doctors in a New Zealand setting.[13] The research used ethnographic methodology, relying on a combination of participant observation and formal interviews. Participant observation involved the immersion of the researcher in the community for a prolonged period of time. In conjunction with this immersion in the field, a relatively small number of qualitative interviews were conducted with members of the community under observation, as is usual.[14]

The author spent approximately 18 months in attendance at a local Pentecostal church, and conducted formal interviews with 15 members of the congregation, four of whom were also general practitioners. The general practitioners shared a basic theology with the rest of the participants, and, like them, made a conscious attempt to integrate their theology and their Christian identity with their professional identity. They were distinguished from other participants because as medical professionals they had much more practical experience dealing with 'life and death' issues. Religious belief and clinical practice converge on many ethical and moral issues, such as withdrawing life support for brain dead trauma victims, or providing emergency contraception.

Interviews were also conducted with six general practitioners who did not profess any strong religious affiliation. The comparison between these two groups of GPs shows striking differences in their understanding of the meanings of suffering and healing.

The taped interviews followed a loosely structured in-depth schedule that took between 60 and 90 minutes to complete. The transcripts of these interviews were returned to participants before analysis for their comment and corrections. In some cases, a secondary interview was conducted to clarify issues.

I have chosen to not offer biographical details on respondents because it is imperative that anonymity be guarded. Although I have not identified the research setting, some of my respondents have a relatively high profile within their church and within the medical profession. Having said this, the age of respondents in each group ranged from late 20s to early 50s. Most participants were married and had families. There were equal numbers of male and female respondents. Three of the five women participants were Pentecostal GPs, two were secular. Conversely, two of the five male participants were Pentecostal and three were secular GPs.

Results and discussion

Explaining suffering

General practitioners who professed no religious affiliation tended to define suffering in terms of medical criteria. Suffering, moreover, was often defined in terms of pain, both physical and psychological. Most of these GPs suggested that suffering was simply an inevitable condition of human existence. This was often linked with the animal nature of humanity.

It (suffering) just occurs. It's the way the world functions and people are animals and they behave like animals and sometimes they control their behaviour quite well and other times they can't... We say that a person is so cruel or heartless that they're not human. But I think that part of being human is the cruelty of inhuman-

ity – it's a contradiction but it's the way people are.

These secular GPs viewed suffering through the lens of what Weber might call an instrumental rational dimension.[15] Respondents tended to understand suffering as the result of a particular identifiable process that could be remedied through a series of rational steps or responses. Similarly there was a strong emphasis among this group on the pragmatic, tangible and quantifiable outcomes of pain and episodes of illness.

However, some respondents acknowledged that the experience of illness and pain has the capacity to evoke existential crises and can force individuals to reassess their biography, their values and to confront their futures.

Frequently a significant illness does tend to provide the person with an image of their own mortality... and can give them some insight into their own being almost and that leads them to question their real values in life... and in the long term can actually improve and enrich their lives.

Noticeably absent among this group was any tendency to attribute spiritual significance to suffering, or to equate it with sin in any form other than as a natural consequence of lifestyle choices. Respondents espoused a secular theodicy that used naturalistic arguments (without recourse to supernatural, magical, or religious arguments) to explain the existence of suffering on both general and personal levels.

Pentecostal GPs differed from the secular GPs in that they explained suffering using a Christian as well as a medical framework. For these respondents, suffering often provoked the difficult paradox of classical theodicy where a logical solution is sought to the question of how suffering can exist in the world created by a 'good' God. General suffering was attributed in the first instance to the biblical story in Genesis where Adam and Eve are evicted from Paradise after wilfully disobeying God. Personal suffering tended to be constructed with reference to the GP's relationship with God and with varying categories of sin.

When we decided that we weren't going to follow God's way then God left us up to the natural consequences of our choices and I think a lot of suffering and what happens is just the natural consequences of our choices.

These respondents tended to infuse biomedical explanations with Christian ones. Medical knowledge and religious belief were continually juxtaposed. Their views on pain illustrate this.

> Healing was viewed as a complex process distinct to that of curing which in its narrowest sense signals the efficacy of treatment

Pain is very much a protective mechanism. It tells you something's wrong and hopefully stimulates you to do something about it... From a Christian point of view you can always find some good end result from a bad experience.

Personal experiences of pain and illness were also viewed as inherently beneficial on a spiritual level because it had the potential to bring the GP, as a Christian, closer to God. When personal suffering occurred, Pentecostal GPs struggled to construct theodicies that vindicated a 'good' God. Personal suffering was often given meaning by arguing that it was part of God's larger long term plan for that particular person.

And now I think I see the point (to my suffering) and I'm really actually quite grateful to God... I think God really used it to make me who I am today and I wouldn't be the same person if I hadn't gone through those things... And I think that maybe it was a sign of God's love.

Health seeking strategies

The differences apparent in the ways that respondents in both groups explained suffering were also apparent in the health seeking strategies used by secular GPs and Pentecostal GPs. The former tended to define health in functional, structural and organic terms that proceed from the 'Enlightenment' ideal of the unfettered autonomous individual. In talking of their own health seeking behaviour, which was largely predicated upon physical symptoms, secular GPs established 'therapeutic plots' for themselves and narrated the unfolding 'medical plot' which was determined by the course of the affliction and by their own response to it, in the same way that they did for patients.[16]

While Pentecostal GPs shared these pragmatic views about health, they also added another dimension. These respondents talked about health in terms of community responsibility, as well as spiritual harmony and relationality. In particular, an important aspect of the definition and maintenance of health on a personal level was the relationship that each GP had with God.

When these GPs needed health care for themselves they utilised both biomedical resources and divine healing. They were adamant that medical and divine forms of healing complement each other and tended to subsume biomedicine as a medical umbrella into that of divine healing by arguing that ultimately it is God who heals, even when the therapy is biomedical.

I see medicine... I don't see it as being separate from God. I don't see them as separate at all. I see God as being the one who gives doctors wisdom and He's the one who gives people knowledge.

Salvation, healing and curing

Secular GPs tended to assign meaning to affliction against a backdrop of biomedical knowledge and practice. Affliction was treated according to biomedical criteria and the healing

of these afflictions was also explained in terms of biomedical process.

Well, my shoulder hurt. I put it down to some lifting I was doing at a particular time. I tended to use it less and less, and then I couldn't use it at all. I had to have a manipulation under anaesthetic for that to free it up. It had a quick result from it almost immediately so it was good. I haven't had any further problem from that.

These GPs defined healing in terms of resolution of illness although some suggested that healing could also be an improved situation or, at least, acceptance of one's situation. Healing was seen to occur against a rich contextual social network of relationships, biography, and decision making. Respondents suggested that healing, per se, could never fail although treatment fails frequently. Healing was viewed as a complex process distinct to that of curing which in its narrowest sense signals the efficacy of treatment.

Healing doesn't fail. Treatment 'fails' all the time. If, for instance, you're treating someone with cancer and you're not actually stopping the growth of the cancer any more. You have to go into what you call the palliative management and the support stuff where you're looking after their fear and their needs. That doesn't fail – that part of healing.

When describing qualities that they found desirable in a personal GP, these respondents were more concerned with a doctor's practical knowledge of medicine than with attributes such as patient centredness or empathy.

If someone has a good knowledge base and can utilise that knowledge base to problem solve I regard that person as being an appropriate doctor for me... Doctors need to be good communicators and so forth. That sort of stuff is not so important for me... Knowledge base is the most important thing to me.

Pentecostal GPs, however, tended to place greater value on qualities of caring, compassion and communication skills in their own GP. Where secular GPs sought professional competence in a personal physician, the former sought a *healer* in the person of the physician. Two of the Pentecostal GPs also preferred that their own physician was Christian. Prayer was a routine preventative therapy practised by all these respondents, and healing was very much seen as a holistic transformative process that evolves out of prayer. In their view while medicine addressed the physical aspects of the body, it may or may not result in healing, while prayer which addressed the person in totality, including their spirituality, always resulted in some degree of healing. Healing was often defined in terms of a restoration of a close and dependent relationship with God. Interestingly, these GPs, where biomedical therapy and prayer have been used concurrently, tended to attribute improvements in health to divine healing. Coupled with biomedical treatment, prayer was seen to fill the gaps that the former fails to address. While biomedicine treated the physical symptoms and causes of affliction, prayer was understood to address the unseen, and therefore non-quantifiable, inner aspects of affliction and suffering – not simply addressing the lesion, but addressing the 'lesion in *me*'.[10]

> The qualities that each group valued in a personal physician illustrated the different goals associated with healing

Medical anthropologists and sociologists, doctors and theologians have acknowledged that suffering, affliction, and the quest for healing, and the nature of healer/patient relationships are central concerns for human societies.[5,17,18] Both religion and medicine can be viewed as human attempts to provide explanations and contexts for suffering and the experience of affliction.

From a theological perspective, healing (to become healthy and/or whole) has often been described as salvation (as deliverance from sin and the suffering associated with sin) on the earthly plane.[18-20]

Social scientists use salvation in a secular sense so that while it can still carry connotations of deliverance from sin it also is used in the sense of a transformation or deliverance from the suffering implicit in illness within particular social and cultural contexts to an improved or 'ideal' state of health, again defined within social and cultural parameters. Good,[2] for example, suggested that salvation is promised in the technical efficacy of modern medicine. He argues that medicine is deeply implicated in the western concept of suffering from which deliverance is sought. In particular, it is the conjoining of the physiological and soteriological that is central to the constitution of medicine as a modern institution. Turner,[21] among others, has noted the common concerns of both religion and medicine that is apparent in the verbs to 'save' the soul, and 'salve' the body.

Kleinman[22] suggested that people formulate 'explanatory models' to explain *specific* episodes of illness and affliction and that these are influenced by cultural locations and perspectives. Physicians could be expected to employ explanatory models that differ from lay explanatory models. Theodicies differ from explanatory models in that they provide a *general* context for the explanation of personal suffering, and underlie the quest for healing.

While there is no disputing the diversity in values, beliefs, and attitudes of general practitioners, it has been suggested that physicians share a common outlook or paradigm because they have a common training that places a high value on scientific rationality.[23, 24] Respondents in this study did share this medical professionalism and the

paradigmatic perspectives that underlie this. The theodicies constructed by participants were based on common cultural perspectives – the backdrop of medical professionalism in the instance of secular GPs, and a combination of medical professionalism and Pentecostalism in the case of Pentecostal GPs.

For secular GPs, the quest for healing centred on medical treatment. Pentecostal GPs, however, while in no way devaluing the efficacy of medical treatments, also sought healing through prayer.

The qualities that each group valued in a personal physician illustrated the different goals associated with healing. For Pentecostal GPs, healing had an overt soteriological dimension in that it was associated with the individual's relationship with God and with deliverance from personal sin.

Secular GPs employed secular theodicies and their quests for healing had a soteriological dimension insofar as the individual modified lifestyle factors that either directly or indirectly caused ill health, and in the case of the terminally ill, repaired relationships prior to death.

Conclusion

General practitioners, like their patients, have a need to find meaning in experiences of suffering and affliction. They also seek healing in ways that are consonant with the explanations they have for their suffering. Healing is often equated either directly or indirectly with the quest for salvation. The soteriological dimension in GPs' quest for healing is underpinned by specific theodicies constructed in ways that explain specific and unique experiences of affliction and suffering.

Soteriology and theodicy, in both their religious and secularised forms, provide a powerful framework within which to understand illness experiences, and health seeking behaviours. The clinical encounter does not merely involve the engagement of individuals, but also the engagement of diverse sets of soteriologies and theodicies.

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