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Spiritual Palliative Care for Religious Asians

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Abstract

Although the so-called "believing without belonging" phenomenon is increasingly becoming the religious stance in the world, Asians are still deeply religious in nature. Deep-seated faith commitments affect people's perceptions of life's various circumstances. When it comes to the experience of pain and suffering, widely known studies have already concluded the paradoxical effect of religion as either stress-buffering or anxiety-inducing, depending on the hermeneutical leaning of patients. Whatever the case may be, in addition to addressing their physical pain, palliative care providers need to consider the psychological, existential, and spiritual anxieties of suffering people. Holistic palliative care is needed to address "total pain." To accomplish this, care providers need to be aware of what their Asian patients think about pain and suffering, their psychological struggles, their existential anxieties, and what considerations they are taking in deciding the nature and level of treatment they wish to receive. This calls for an interdisciplinary approach to palliative care, especially between medical sciences and religious studies. Although the reality of the plurality of religions in Asia entails a multiplicity of religious views, there are common perceptions shared by Christianity, Buddhism, Hinduism, and Islam. Knowledge of these dominant themes will help care providers become more effective in dealing with suffering patients.

Keywords

palliative care, pain, suffering, Asian religions, spiritual care, interdisciplinary

Introduction

Since the inauguration of palliative care in the mid-nineteenth century through the work of Cicely Saunders, the principle of caring for ailing patients in medical facilities has been widely adopted as an integral part of the medical profession. Various advocates of modern hospice care, such as Elisabeth Kübler-Ross and Balfour Mount in the third quarter of the twentieth century, solidified its importance in medical practice. With the support of major players such as the Institute of Medicine, the American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education officially recognized Hospice and Palliative Medicine as a medical subdiscipline in 2006.

However, because palliative care has a very short history as a medical specialty, it still has a lot of room for improvement, particularly in providing a whole-rounded approach to the alleviation of suffering. Since Saunders was a professing Christian, the origin of palliative care is indubitably heavily influenced by Christian values. However, as history progressed, much of the spiritual aspects have been marginalized—intentionally or unintentionally—in medical theories and practices. Anti-Christian sentiments aggressively promulgated by influential personalities such as Sigmund Freud in psychoanalysis certainly influenced ensuing medical bias, leading to preferences toward naturalistic palliative measures before the turn of the century. Freud preferred the use of "intoxicating substances" (Clack, 2014, p. 33). In his *Civilization and Its Discontents,* Freud (2001) even quoted Wilhelm Busch's famous aphorism, "*Wer Sorgen hat, hat auch Likör,*" or "he who has cares has liquor" (p. 75). His preference for the use of narcotics in pain management is further exhibited in his study on cocaine and its anti-depressant effects. His addiction to cigar—or nicotine—may have eschewed his views also. Moreover, his purely physicalist understanding of suffering as "nothing else than sensation" (Freud, 2001, p. 78) led him to conclude that it can easily be regulated: "With the help of this 'drowner of cares' one can at any time withdraw from the pressure of reality and find refuge in a world of one's own with better conditions of sensibility" (Freud, 2001, p. 78). His assertations have merits if one is only seeking temporary pain alleviation. While narcotics truly have de-numbing effects (from Greek *narkotikos*), at the final analysis, its only accomplishment is to induce temporary amnesia. The defense mechanism only postpones sufferers from facing existential agonies. At a certain point, patients will have to deal with the sense of ontological misalignment plaguing their psyche as a consequence of the suffocating simultaneity of physical, emotional, psychological, and spiritual pain.

This article argues that a purely physicalist notion of palliative care is not only insufficient; it also has disastrous consequences, particularly in Asia, where the majority of people are still religious. Sociologists admit that although attendance in religious gatherings has declined; people have not completely abandoned their faith (Berger, 1999). Noting the resurgence of religion in non-Western societies, Harvey Cox rescinded his prophesied secularization of the world (Cox, 1965) in his later publication of *Fire from Heaven* (1995). In his book *The Next*

Christendom, Jenkins (2002) noted the shift from the north to the south in religious influence. This article, thus, seeks to highlight Asians' religious consciousness and how it influences their perception and response to suffering. This will help medical practitioners come to grips with what Saunders termed "total pain," because Asian sufferers grapple both with their bodily ailments and spiritual concerns. If the goal of palliative care is to manage pain and distress, then the medical field in Asia must be sensitive to the multifarious dimensions of the Asian psyche to be effective in fulfilling its important vocation.

Defining Pain and Suffering

The concept of "total pain" is an important consideration because it affects our philosophy, policies, and procedures in pain control and management. To put it succinctly, pain is experienced by the self in the totality of its being. Although the scholastic approach of categorizing pain according to various dimensions is helpful for the sake of understanding nuances, pain must be perceived as the objective feeling of holistic dis-ease, where a specific somatic dysfunction entails the collapse of the whole self's well-being (Clark, 2000). In fact, non-physical agonies—that physical sufferings bring about—that are emotional, psychological, existential, spiritual in nature are more difficult to address. The distinction between pain and suffering proposed by Rattner (2019) is helpful because while pain is easier to manage, suffering easily eludes comprehension and control (Gregory & English, 1999, p. 18). In addition, although suffering is an experience shared by all humanity, when it comes to deep suffering, as existentialist philosophers remind us, we are each quite alone (Reiss, 2000, p. 43). Quoting *Basic Hospice Caregiver Training Course,* Burton (2003) provides a helpful definition of spiritual suffering: "[it] arises when the [patient's] view of [their] spiritual life and [their] experience of life are in a state of mismatch or conflict" (p. 438). In short, the sufferer's interpretation is *the* key factor. As inherently hermeneutical beings, we perceive pain differently from one another. The words of Stoic philosopher Epictetus in the *Enchiridion* are wise: "When you see anyone weeping in grief because his son has gone abroad, or is dead, or because he has suffered in his affairs, be careful that the appearance may not misdirect you. Instead, distinguish within your own mind, and be prepared to say, 'It's not the accident that distresses this person…, it is the judgment which he makes about it'." Individuality and subjectivity—influenced by culture, environment, upbringing, and religious commitments—affect human reflective conceptualizations.

Anesthetic Role of Religion

The religious diversity in Asia unavoidably results in a multiplicity of interpretations of suffering, but there are common threads among them. What follows are some of the major themes found particularly in Buddhism, Hinduism, Islam, and Christianity. These four religions were chosen without prejudice to the smaller ones across Asia because these are the biggest in terms of the number of followers. The presentation is important because of three

considerations. First, in a very calculative society such as ours, certain measurable outcomes are expected from our caregivers. Relief of suffering is the vocational obligation of care providers. However, although care providers are expected to successfully relieve their patients' suffering, what exactly are the expectations concerning non-physical suffering? Second, advances in medical technology allow practitioners to perform procedures that may actually run contradictory to patients' worldviews, so just because we can, should we? The prevailing physicalist-naturalistic approach to "medicalize human suffering" (Gozdjak, 2004, p. 206) potentially results in a conflicting sense of satisfaction from receiving somatic pain alleviation while feeling guilty because of violated religious affirmations. The somatic suffering is thus only replaced by another, and probably deadlier, form of suffering. Because of the communal nature of religion in Asia, along with the prevalent honor-shame culture, the psychological agony of having committed something contrary to the expectations of one's social belongingness is probably more permanently damaging to patients (Louie, 2013). Third, in any psycho-somatic support, the principle of participation is crucial. What is the participation of the patient in the courses of palliative action? Do they have the right to deny specific procedures without being misjudged? Rattner (2019) talks about the unfortunate "disciplining of grief" in palliative care (p. 358), where specific narratives are the established norm. The dominant discourse (to use Foucauldian phraseology) then expects and justifies certain ways of doing things (Chambon et al., 1999, p. 160). It also renders the validity of variegated reactions to suffering questionable. So will those who choose atypical courses of palliative action be dismissed simply as stubborn, uncooperative patients?

Suffering as Appropriate Consequence

Major religions tend to teach that human suffering arises because of our own doing. In short, we create our own suffering because we are accountable for our own actions. The principle is that of just retribution. We suffer as a consequence of our past misbehavior, poor judgment, or lack of discipline. Our suffering, thus, is a just consequence that must be wholeheartedly embraced, either for the expiation of guilt or the liberation of the self from its past ties. Hinduism, for instance, believes in the just law of *karma*. One accumulates both *punya* (meritorious karma) and *papa* (demeritorious karma) in one's former existence and enters *samsara* (rebirth) in accordance with the just weight of one's actions or inactions. Because the law of the world dictated that one be born with leprosy, for instance, the afflicted person must willingly face the suffering associated with it to conform to justice. Any attempt to alleviate or shorten the suffering results in accumulating more bad karma. Enduring physical suffering, on the other hand, leads to a more fortunate rebirth (Thrane, 2010, pp. 337-342).

Although not as doctrinally and dogmatically emphasized, a similar view may be found in Islam and Christianity. The important common denominator is free will, which may be used or misused to cause suffering to both the moral agents and the people surrounding them. In Islam, when the *nafs amarra* or the lower state of the soul pursues its desires without regard for

consequences, suffering follows naturally (Pimpinella, 2011, p. 73). Physical ailments and suffering exist because we have chosen unhealthy, harmful habits that produce negative short-term or long-term consequences.

Although the official dogma of Christianity does not accept suffering as the manifestation of divine punishment, the thought lingers among Christians, particularly because this element of Jewish faith is found in the judgment of Job's three friends (Job 4:7-8; 8:20; 11:14-17) and the question of Jesus' disciples in John 9:2. There is also biblical support (Genesis 19:1-29; Luke 13:4). The syllogistic reasoning is clear: One suffers because of one's wickedness. Majority of grassroots Christians maintain an enduring affirmation of this view. This has serious ramifications on how sufferers understand their situation. A suffering person with persistent feelings of guilt because of wrongdoing may develop a masochistic tendency to welcome suffering of all kinds and even rejoice in them because of their perceived redemptive value (Rancour-Laferriere, 1995, p. 112). They may choose to refuse narcotic intervention or medical procedures. In Hindu and Buddhist societies, for instance, palliative care may not be desired by patients or recommended by their relatives for fear of either going against the dictates of *karma*. This is because temporary relief might delay or increase the bad *karma* of their loved one, resulting in even more severe suffering in the next rebirth (Pimpinella, 2011, p. 171). True mercy might be seen as allowing the self or others to suffer in the present in exchange for an assured better future.

Que Sera, Sera

Resignation can be a religious response to suffering. Because people must be accountable and responsible for their past actions and accept their current situation, fatalism is not considered as a mindless or self-destructive response; it is perceived as a suitable passivity in the face of justice. Fear of contradicting divine imperative (Islam and Christianity), accumulating more bad karma (Hinduism), or going against established reality may be reasons for a fatalistic response. In Buddhism, suffering is perceived as a natural mark of existence. Buddhism's First Noble Truth states that *dukkha* (suffering) defines human existence, not only because of bad *karma* accumulated throughout past rebirths but also because of human desires and the sorrows brought by changes in our lives (Meghaprasara, 2013, p. 382). So long as earthly existence continues, there will be inevitable suffering. The three marks of existence are interrelated—*anicca* (impermanence), *dukkha* (suffering), and *anatta* (no-self)—and so long as *anicca* and *anatta* remain, physical, emotional, and mental *dukkha* is humanity's inescapable reality (Thawn, 2020, pp. 39-40). But Buddhism does not end with the recognition of earthly suffering. Buddha reveals a means of escape. Ironically, however, *nirvana* or salvation from the cycle of rebirth and therefore from suffering is an unattainable goal in one's present existence (Maier, 2014, p. 9-42). Relief is available, but one has to wait for its realization in the following rebirth. In the meantime, and closely related to Hinduism, one is called to abandon fleshly pleasures, embrace material destitution, and endure physical suffering. The elimination of

suffering in the future is contingent on one's willingness to embrace suffering in the present (Thera, 2002, p. 49).

Some branches of the Islamic faith have even more passive responses to suffering. The nomadic life of early Muslims, characterized by living under unpredictable and unforeseeable circumstances in the desert, planted an ethos of acceptance of difficulties in the Islamic psyche. Watt (1979) writes: "The fatalism of the nomadic Arab… is not something to be regretted, but a quality which he must have if he is to make a success of life" (p. 9). It must be noted that the word "Islam" literally means "submission," which means that followers of Allah must be ready to submit to divine prerogative. Every experience—including seemingly unfortunate ones—is willed by Allah. The most worshipful response is obedient submission. In the face of suffering, what is required are *sabr,* patience or patient endurance, and *lawakkul,* trust in Allah and his future deliverance (Watt, 1979, p. 11). This is applied to all misfortunes, including facing opposition from unbelievers, pain because of physical ailments, and all other forms of suffering.

Not My Will, But Thine

Patience as a prescription is grounded in another important element in Asian religions, which is that suffering transpires within the scope of divine providence. Although Hinduism espouses a belief in the universal principle of justice in *karma*, it also believes that its plethora of gods are involved in the affairs of mortals. In animistic societies, fortunes and misfortunes are explained through the existence of benevolent and malevolent gods and spirits that need to be pleased and appeased. Suffering, thus, is not merely a naturalistic consequence of actions toward oneself; it is the prerogative of divine will. This is most explicitly found in Islam as a religion of absolute surrender to the will of Allah in the particularities of human life. In his justice and wisdom, Allah allows suffering to befall his followers as he forges their destiny. Suffering occurs only because Allah permits it, and "he obviously wills it for some reason, either to cure the sinner or to exact reparation for the evil that has been done" (Keating & White, 2009, p. 331). When facing whatever suffering, Muslims encourage each other by saying *Alhamdulliah* ("All praises are due to Allah") or *Insha' Allah* ("Allah willing") or *Masha Allah* ("with the will of Allah") (Akhtar, 2018, p. 15). In addition, a Muslim must not fear suffering as punishment because it is evidence of God's special attention upon a person. During suffering, the ideal is that hope is birthed, and trust in Allah's divine and perfect plan is strengthened (Loufty & Berguno, 2005, pp. 150-151). Because God is involved in either inflicting or allowing suffering, religious adherents believe that suffering serves as a test that will be rewarded when passed. Job's story in the Christian Bible is paradigmatic. His response to his abject predicament serves as the ideal template when one considers divine action in the face of terrible evil: "You are talking like a foolish woman. Shall we accept good from God, and not trouble?" (Job 2:10).

Silver Lining

For religious believers, patience is an important virtue because, ultimately, suffering is temporary. It also serves several purposes. First, the acceptance of suffering is evidence of contrition and repentance. Willingness to undergo suffering, especially if it is perceived as just punishment for wrongdoing, is for the soul's eternal benefit: "No fatigue, nor disease, nor sorrow, nor sadness, nor hurt, nor distress befalls a Muslim, even if it were the prick he received from a thorn, but that God expiates some of his sins for that" (*Sahih al-Bukhari*, Book 70, Number 545). To undergo suffering, thus, is like going through a ritual of sin-cleansing. Humans have afflictions for their good: "When God intends to do good to somebody, He afflicts him with trials" (*Sahih al-Bukhari*, Book 70, Number 548). The idea of purification through fire in Christianity resonates with this Islamic view. The Apostle Peter, preaching to Christians facing persecution at the hands of both Jews and Romans, wrote: "In all this, you greatly rejoice, though now for a little while you may have had to suffer grief in all kinds of trials. These have come so that the proven genuineness of your faith—of greater worth than gold, which perishes even though refined by fire—may result in praise, glory, and honor when Jesus Christ is revealed" (1 Peter 1:7). Overall, the Christian sentiment is that "in all things God works for the good of those who love him" (Romans 8:28).

Second, pain and suffering function as timely warnings that lead believers to moments of self-introspection about their current spiritual condition. Suffering is treated merely as a symptom of an even deeper problem. Without pain and suffering, people will not be given a chance to pause in meaningful religious reflection. In biology, congenial painlessness results in greater bodily tragedies, and most people who don't feel pain die young (Reiss, 2000, p. 41). Pain is "an ingenious system of biological communication without which the quality of our lives would be seriously compromised, even fatally so" (Stackhouse, 1998, p. 61). Since pain brings awareness of an anatomical problem that needs to be addressed, suffering is an indication of a spiritual concern that requires immediate attention. Thus, suffering is an opportunity for growth in religious piety and commitment:

> [Rumi] resorts to total submission to the ultimate and solitary source of power, intelligence, enlightenment, creativity, and absolute beauty. He advises yielding to the supreme will that governs the entirety of all that now exists, ever has, or ever will. Submitting to this will and surrendering to the empowering servitude of this power is the only viable course to salvation and the sole straight path to the destination of fulfillment, enlightenment, transcendent consciousness, and sustaining peace. (Akhtar, 2008, p. 52)

Clearly, for religious people, suffering may NOT be a problem that needs to be eased hastily. Facing suffering is meritorious because it provides an avenue for spiritual growth, connection, and transformation (Norris, 2009). Paul writes: "We also glory in our sufferings because we

know that suffering produces perseverance; perseverance, character; and character, hope" (Romans 5:3-4). Even atheistic Buddhism highlights that humanity's experience of *dukkha* enables us to acknowledge its reality, which then motivates us to determine its causes and pursue liberation. Suffering is an inanimate *guru* that signals a looming threat to our well-being. Fitzpatrick et al. (2016) succinctly express it: "Suffering involves an awareness on our part of a harmony that should exist, whether in our physical or mental being, or our moral being, or between loved ones, or between ourselves and God, and a further awareness that that harmony is currently being damaged, rent asunder" (p. 163). Such an awareness then serves "a salutary role in a moral agent's life, leading her to repair that which can be repaired, and to develop virtues that are necessary for that reparative work" (Fitzpatrick et al., 2016, p. 163).

For others, suffering provides the necessary impetus for one to reflect on life's meaning. This is not surprising, because "the problem of suffering is very closely related to the question of human destiny" (Yewangoe, 1987, p. 8). Suffering disturbs routine, creating a pause in the busyness of work and the abuse of the psycho-somatic self, thus allowing a rare moment of serious analysis about what led to the unwelcome disruption and how it may be prevented in the future. In this sense, suffering is the gateway to a therapeutic journey toward self-betterment. It can "force us to confront ultimate issues that normally lie obscured behind our everyday preoccupations" (Stackhouse, 1998, p. 62). It compels people to try to understand the real meaning of free will and its exercise. It serves as a noisy alarm that wakes our slumbering minds regarding our destructive habits. It leads to the recognition of the necessity of life balance. It teaches that meaning is not found in the reckless pursuit of fleshly pleasures. Although suffering is essentially intrusive in a person's normal state of affairs, suffering is afforded an instrumental value in religious societies.

Addressing Spiritual Pain

In the light of the preceding section, one can foresee the difficulties faced by palliative care providers when dealing with religious people. Diehl (2009) is right: "Since one's personal sense for the meaning of life is highly individualized, people may cope, react and act in many different, unpredictable and even surprising ways toward any external and personal conditions of human suffering" (pp. 43-44). Because religious Asians attach spiritual significance to suffering, hasty medical intervention and alleviation may be ill-advised because it may be at the expense of robbing the religious person of the opportunity toward spiritual growth (Fitzpatrick et al., 2016, p. 163). Because suffering is embraced as an integral part of human life, which includes one's spiritual connection with the divine, it can easily be regarded as a momentary life event that needs to be willingly endured, not quickly cured. External help, though well-intentioned, might even be deemed as unwelcome meddling. If not careful, medical practitioners may be indicted as evil witches offering poisoned apples; they give temporary relief for hunger while inadvertently causing long-term damage.

Writing from an agnostic perspective, Clack (2014) is mystified at "the precise location of religion in the typology of palliatives" (p. 59). He asked:

> Is it to be classified as one among a number of *powerful deflections* allowing people to make light of misery; as a *substitutive satisfaction* providing a displaced gratification for a thwarted impulse; or as something akin to the *intoxicating substances* that, in one way or another, diminish pain and produce pleasurable sensations? (Clack, 2014, p. 59, italics original)

He then argued, along the lines of Feuerbach, Marx, and Freud, that religion is a human-invented psychological sedative emerging from the combination of a sense of helplessness and wishful thinking. In short, for atheists, religion is an illusion. Nevertheless, Clack acknowledges the role of religion as a palliative, albeit negatively:

> Religious belief (in true palliative fashion) relieves pain without curing the underlying problem; such relief comes in a narcotic form since the set of beliefs uniquely offered by religion (the idea of a loving God, the promise of a blissful afterlife) serves to benumb the believer, producing a state of beautiful indifference to one's suffering and a sense of being at peace with the world. (2014, p. 64)

What may seem all too naturalistic—such as pain and suffering—to areligious scholars and medical practitioners "may be infused with deep meaning, perhaps even to the point of being salvific" for religious people (Henson, 2015, p. 808). Relieving patients' non-physical suffering is challenging, but may comprise the larger part of the palliative care discourse (Rattner, 2019, p. 358). Care providers simply cannot dismiss the reality that religious consciousness influences how patients make decisions concerning palliative care and its various offers.

One of the key roles of care providers is to give religious people sufficient space that will provide the opportunity for patients to experience holistic redemption. Patients must be involved in the process of taking something chaotic, ugly, or unpleasant and placing it into "cordial consent with being-in-general" (Henderson, 2005, p. 42). A growing body of studies has already concluded that meaning-making is the typical response of suffering patients (Mount et al., 2007; Kearsley, 2010; Breaden et al., 2012). This means that sufferers make the best of their circumstances to give them the opportunity to experience personal growth and consequently become resilient. The obverse implication is that if care providers are unable to facilitate meaning-making or disrupt the process, the available opportunity for growth and resilience disperses too. Care providers, therefore, have a huge responsibility. Their sensitivity to non-physical suffering and their patients' religious commitments and unspoken psycho-emotional pain is crucial. Burton (2003) is correct: "An assessment of spiritual pain will have to depend at least as much upon the spirituality of the caregiver, and upon their capacity for contemplation, for close listening to the narrative, for intuition, and discernment" (p. 442).

The level of religious commitment of patients affects how they respond to pain in general. The study of Dezutter et al. (2010) concluded that the centrality of the religious meaning system is a key element in how people respond to suffering. Other previous studies agree. Belief in a higher power aids sufferers to cope with life's challenges and gives them purpose and meaning (Princeton Religious Research Center 2000; Greenfield et al., 2009). In fact, as Dezutter et al. (2010) concluded, "when the religious meaning system was reported as being not central to one's life, pain severity compromised life satisfaction ratings. Conversely, the life satisfaction ratings of patients who reported a very central religious meaning system were not negatively influenced by higher levels of pain" (p. 513). Strong religious belief, in short, buffers stress and feelings of pain and fatigue to a significant degree (Baetz & Bowen, 2008). In the appraisal process of their current predicament, religious beliefs help patients reframe their experience of suffering (Park, 2007). What one believes about the nature of suffering, its relation to the divine, and its potential outcome are crucial in the patients' adjustments. Negative perceptions about pain lead to a poor psychological adjustment to pain, while positive perceptions lead to better adjustment (McParland et al., 2005). Perceptions influence human will, so patients can either suffer terribly in non-physical agonies or embody hopeful resilience (Henderson, 2005, p. 36).

The challenge for care providers is that of determining the level of faith commitment or religiosity of their patients. This is where things become complicated. The observation that religiosity in Western countries has become increasingly personal and detached (Dezutter et al., 2010, p. 509) is also applicable in Asia. This "believing without belonging" phenomenon also characterizes much of our current generation. However, irregular participation in religious rituals and detachment from any recognized religious group does not necessarily imply atheism. People remain committed to their religious beliefs at the deepest level. This is particularly true when they face challenges beyond their control.

Conclusions, Challenges, and Opportunities

The unique circumstance and response of religious people to pain and suffering necessitate a different approach to their palliative care. Naturalistic perspectives that hastily "medicalize human suffering" (Gozdjak, 2004, p. 206) and treat all pain purely as mere physiological phenomena do not do justice to the complexity of the Asian experience. Although indeed, physiological pain troubles everyone and cures are often immediately sought, cultural, relational, and spiritual worldviews deeply entrenched in the Asian psyche might mean that physical pain is the least of their numerous concerns. Quick fixes aimed at pain alleviation, very common in narcotics-based solutions (Stone, 2007), while temporarily helpful, do not necessarily represent the ideal course of intervention for chronic pain or long-term battle with suffering. The longer the suffering is endured, the more patients engage in serious reflection. Although no study has yet been conducted on the length of time before patients come to grips with their personal situation, it cannot be that long from the first onset of symptoms of illness.

As such, the longer the sickness has been ongoing, the more the necessity of holistic care becomes apparent.

A caveat must be mentioned. Not all religious adherents respond positively to suffering. The possibility that possessing deep religious commitments may actually bring greater spiritual suffering to patients cannot be dismissed. If Burton (2003, p. 438) is correct that spiritual suffering "arises when the [patient's] view of [their] spiritual life and [their] experience of life are in a state of mismatch or conflict," then the predicament of the patient may actually induce deep religious and existential questions. In particular, the actual experience of genuine debilitating pain leads to serious doubts concerning the existence of an omnipotent and all-good deity. Saunders asserted the reality of spiritual pain among suffering patients. Prolonged sickness leads to anxiety and other negative sentiments such as "bitter anger at the unfairness of what is happening, and at much of what has gone before, and above all a desolate feeling of meaninglessness" (Saunders, 2006, p. 218; Ásgeirsdóttir et al., 2014a, p. 6).

Spiritual suffering is characterized by "constant and chronic pain; withdrawal or isolation from spiritual support systems; conflict with family members, friends, or support staff; anxiety, fear, or mistrust of family, physicians, and hospice staff; anger; depression; self-loathing; hopelessness; feelings of failure in respect of one's life; lack of sense of humor; unforgiveness; despair; and fear/dread" (Burton, 2003, 439). All these points to what Kissane et al., (2001) refer to as "demoralization syndrome" in which patients exposed to prolonged pain and suffering experience "the loss of meaning, purpose, and hope that sustains the will to live or the loss of any potential for future joy" (Kissane, 2012, p. 1504). This is a major problem for care providers because even routine responsibilities like administering medicines and other forms of sustenance become increasingly challenging. It is also at this point that medical practitioners must recognize that the problem is not merely physiological and that treatments require much more than ingesting drugs and injecting sedatives.

It is here that the marriage between theology and medicine is important because the spiritual component of suffering is given similar attention with the physical, psychological, and social dimensions. Because the whole self and its well-being are threatened, holistic treatment is required. To accomplish this, an interdisciplinary team of care providers is needed (Ásgeirsdóttir et al., 2014b, p. 148). Thankfully, the exploration of the alliance between spirituality and medicine is growing, and researches are being conducted on their complementarity in addressing patients' needs in hospitals and hospices (Tarumi et al., 2003). This reveals that (1) natural sciences and the medical profession now recognize the limitations of their own fields in addressing the complexity of human experiences; (2) certain resources—human, cognitive, and psychological—may be found outside modern medicine; and (3) charitable openness in dialoguing and collaborating with other fields such as religious/theological studies is an important ingredient of progress towards common goals. Scientism, or "the philosophical notion which refuses to admit the validity of forms of

knowledge other than those of the positive sciences" (Henson, 2015, p. 810), is appropriately losing its ground.

Because the interrelationship between medical science and religion in palliative care is very young, no tested course of action is available to be *the* concrete prescription for all. What we have right now are sporadic studies and assertions, already alluded to in this article, that highlight the importance of sensitivity to emotional, existential, or spiritual distress experienced by ailing patients. It does not matter who addresses these unique dimensions of human need. What is crucial is that they are addressed. There are proposals that the phrase "pastoral care" is too replete with Christian connotations and therefore must be replaced by more neutral terms (Tarumi et al., 2003). After all, the argument goes, not all hospitals have on-call ministers; they may only have areligious personnel who are responsible for the spiritual care of patients. The sharp distinction between the concepts of religion and spirituality must also be revisited (Ásgeirsdóttir et al., 2014b, p. 147) to allow areligious caregivers to offer spiritual care to their patients. While this is not ideal, it at least forces care providers to be holistic in their approach. Otherwise, hospitals will need to hire spiritual caregivers from each of the various religions.

There are limited studies on palliative care of Hindus, Buddhists, and Muslims. Much of the available literature is written from a Christian perspective. Pointed advice available for Christians ministers concerning the task of theology to suffering people (Ásgeirsdóttir et al., 2014b, 162; Weisbrich, 2019) is scarcely found in relation to other religions (Vähäkanga, 2014). This reveals the need for more research studies in this area, which will, in turn, enable medical practitioners to have access to resources that can provide appropriate courses of action when offering assistance to religious patients. Until then, palliative care will remain incapacitated in addressing the complexity of suffering, particularly of Asian patients who are plagued by deep-seated faith commitments and concerns that exacerbate their already debilitating physiological condition.

Conflict of Interest

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