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Short Communication

Gastroenterology and Spirituality. The Digestive System is the Abode of the Soul

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Introduction

This work proposes a third pathway in the brain-gut relationship, introducing the "feelings, the soul" pathway alongside the neural and mediator pathways, as well as a scoring model to assess the influence of more sensitive factors in the individual-disease relationship.

Article

Over more than 40 years practicing Gastroenterology, I have always noticed a gap between the manifestations/symptoms/signs of diseases and their pathophysiological basis, as well as a disproportion between the severity of the disease and its actual physical presentation.

The brain-gut axis is now recognized as part of our digestive system, hence its nickname, the "second brain." The interaction between the two is explained, according to current science, through neural or mediators pathways. I propose a new pathway: that of FEELINGS, of the SOUL, as I consider the brain not just a collection of neurons and synapses, but, above all, the repository of a life story and the entirety of events throughout our existence.

Science cannot frame this constellation of personal stories into a neat and tidy diagram. Emotional responses, and consequently their influence on our organs, especially in the digestive and cardiac systems, are absolutely individual and uniquely divine. For one person, a memory, a sight, a piece of music, or a gesture can ignite a spark, a fire; for others, nothing happens.

With these considerations in mind and having earned the trust and respect of the patient during treatment, I try to "touch their soul." With due sensitivity, I inquire about their lives, anxieties, fears, and frustrations… many become agitated: their eyes well up, or they even break down emotionally.

It is in the soul, in spirituality, that the starting point lies, where this individual begins to interact particularly with the disease. Science calls this somatization. I fully agree with this, but in my view, this somatization occurs precisely in the person who most lacks spirituality, a true sense of life, an understanding of the temporality of our existence, allowing themselves to be influenced by others, losing sight of the idea that happiness is above all internal and not measured by social parameters. These individuals end up creating goals and achievements that do not originate from their core, thus living in torment.

Pathophysiology, the mechanism of action of viruses and bacteria-beings devoid of souls-are easily understood and even tamed. However, healthcare professionals, when delving into spirituality, become lost in countless behavioral theories that offer little clarity in this infinite kaleidoscope.

The wondrous science, the mother of so many advances in all fields of human knowledge, proves incapable when it delves into what we call the soul or spirit, the ethereal, the intangibility of the sea of feelings, and the complexity and singularity of each individual.

Regarding Gastroenterology, I have witnessed countless times the disproportion between the set of symptoms/signs and the actual findings of endoscopy, ultrasound, etc. The suffering expressed on patients' faces and verbalized by them does not always correspond to the examination findings.

We have numerous studies and works in various fields of medicine; however, there is a gap concerning spirituality, the soul itself, to better understand the genesis of the disease and the individual's coexistence with it. This approach appears biased, as if it were something of lesser importance or even anti-science.

The classical anamnesis, the formulation of diagnostic hypotheses, complementary tests, and the growing technological input-as if this would protect both doctor and patient from possible medical errors-often interfere with the formation of a good doctor-patient relationship with excessive technicality bordering on neurosis, if that is the right term. Over the years, I have noticed that this increasing stance even influences the training of new generations of doctors, dehumanizing them and stripping them of the necessary "shoulder," fundamental empathy, and warmth. Even the choice of the medical profession currently often shows signs of market influence, given that it remains lucrative. This, in a way, conflicts with some important aspects: the necessary poetic nature; humanity in the approach; sensitivity to arts, culture, and transcendence. These attributes are essential for those who will deal with fear, insecurities, doubts, losses… with the tightrope between life and death.

I return to the initial concerns. How many times do we encounter patients whose examination findings do not correspond to their constellation of complaints/symptoms? How many end up in the offices of psychologists, psychiatrists, or analysts? These professionals have their field of expertise, but they were sought out because patients were seen as bothersome, difficult, complaining: poly-complainers who never improve. The neural, hormonal pathways, and biochemical mediators cannot explain this mismatch. It is SPIRITUALITY, the SOUL reaching the 2nd brain, the digestive system, through the pathway of feelings. Hence, this system is the ABODE OF THE SOUL.

Adding to this complexity is the fact that our contact with the patient occurs during a moment of health imbalance, when their psyche is influenced by this situation. Depending on the diagnosis, the course of their life may change, like Herodotus' river, who bequeathed us a famous saying: "No man ever steps in the same river twice, for it's not the same river and he's not the same man."

From these years of experiences, a restlessness was born, resulting in the creation of a SCORE (Rosa's) consisting of four components that directly impact the individuality of patients and their relationship with the disease, whether it is short-term, long-term, or permanent.

I based it on four aspects that, in summary, most directly impact the state of the soul: 1. Personal aspect; 2. Family aspect; 3. Professional aspect; 4. Transcendental aspect.

From there, I developed a basic scoring system, ranging from -2 to +2 (-2, -1, 0, +1, +2). -2 refers to the maximum degree of discomfort caused by the item; +2, to the extreme positive; 0 when it is neutral.

Points to consider in these items

- **Personal:** Basically self-esteem, contentment with oneself, conformity with appearance, personal traits that may bother, temperament, traumas, etc.
- **Family:** Relationship with partner, children, and relatives.
- **Professional:** Achievement, stress level, harmony with superiors/subordinates, financial reward, etc.
- **Transcendental:** Reliance on any faith or spirituality in difficulties, degree of detachment, awareness of the temporality of life, etc.

Patients with a score of +8 (scoring +2 in all four items), who are rare, are sympathetic, interesting, and stimulating, showing an ability to endure their illness and trials with optimism and demonstrating an above-average response to treatment. Conversely, at the other extreme, patients with a score of -8 (-2 in all four items) are invariably pessimistic, exhibit a symptom intensity beyond the reality of the pathology itself, and always report something negative regarding a procedure, medication, or treatment outcome.

The final reading of these score numbers does not cancel themselves out but objectively translates, in a rough way, the patient's

subjective aspects to correlate these data with the understanding of their relationship with the disease. Evidently, the intensity of this score depends directly on the pathology in question: whether it is something transient (a dysentery or even a gastritis); something longer-lasting or permanent (UC, Crohn's, permanent colostomy); something inexorable, such as, for example, an aggressive cancer. For this reason, I added a letter to each item, C (short-term), L (long-term), or P (permanent), so that the weight of each item can be better understood.

Conclusion

I believe that, if provided with a "window" of opportunity to make them understand the need to look upward, to detach from toxic situations, to show them the beauty of simplicity, to cultivate understanding, love and forgiveness, charity, and other positive attitudes, we could make them more capable of enduring this eminently competitive and cold society. I believe that this "window," this vision of the patient's soul, is yet another tool for the doctor to help their patient, family, and surroundings in this journey.

Developing this sensitivity would be better achieved if, during academic training, students were more humanized, with encouragement for extracurricular reading, as well as spiritual elevation through the development of artistic skills, such as painting, music, and others. This is necessary so that they do not become mere technology transmitters, drug prescribers, and humanoids in lab coats. Let us recall Antoine de Saint-Exupéry's statement that "what is essential is invisible to the eye, and can only be seen with the heart."

May the perception of this 3rd pathway contribute to making the encounter provided by destiny between these two souls, the doctor and the patient, be enveloped and blessed by divine love and crowned by the miracle of living.