

# Is religious devotion relevant to the doctor-patient relationship?

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## Practice recommendations

- For the faithful, a secularist approach to “generic religion” is of little value; the value of religious belief lies precisely in its particularity (C).
- For the devout, no dimension of life is unaffected by religious beliefs (C).
- Even when physician and patient speak from religiously discordant perspectives, the physician can compassionately and sensitively engage the patient on the patient’s terms, rather than forcing the patient to address difficult questions within a foreign moral framework (C).
- An enriched dialectic will enable sensitive and appropriate care for religiously devout patients, ensuring that their concerns are addressed more than superficially (C).

As I walked toward the elevators at the end of a long call night, I saw a patient sitting on the edge of her bed, staring blankly into the hall. Like many on the oncology floor, she had lost her hair. I waved at her. She nodded. I took a few steps into her room.

I introduced myself; she told me her name—Julie. I asked Julie how she was feeling. “I’m trying to make a decision,” she said, choking back emotion. She explained she was trying to decide whether to allow placement of a permanent chest tube to drain her recurrent pleural effusion.

“I don’t know if I can take it any more,” Julie said. “I’ve been through too much.” She knew she was dying and was reluctant to endure another painful procedure.

As a medical student, I could not offer her advice. But I hoped my presence would be a comfort. We talked about her life, her work, her interests, and her family (she was alone in the city). As we talked, she reminisced, joked, and cried about the experiences that had enriched her life. On my way out, I told her that I would be praying for her—and she broke into tears. “Can you pray with me?” she asked.

## ■ A CHANGING LANDSCAPE

For years, the medical profession has witnessed a growing interest in all things spiritual. A recent increase in scholarly attention to spirituality in medicine reflects the larger trend in the culture.<sup>1</sup> In the past, patient beliefs regarding the spiritual

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dimensions of disease were dismissed as superstition or simply ignored as irrelevant. Today, medical school curricula include instruction on non-Western religions, the medical ethics of various faith traditions, and the components of spiritual assessment.<sup>2,3</sup> (See “Principles to make a spiritual assessment work in your practice,” pages 627–631.) Yet this renewed interest in faith is not without caveats.

### Scientific misunderstanding of faith

Empirical studies of the salutary effects of faith on everything from the immune system to recovery from surgery has, not surprisingly, elevated religion's effects over its claims, contributing to widespread support of what theologians Shuman and Meador call a “generic religion.”<sup>4</sup> Since research shows religious devotion is associated with better health, the argument goes, patients should be encouraged to embrace religion—any religion—if for no other reason than to reap health benefits. Thus the emphasis is on the act of believing and the effects of that act, rather than on the particular beliefs articulated by a religion.<sup>5</sup>

**Faith is not generic.** What this utilitarian perspective fails to grasp is that the value of a belief lies precisely in its particularity. For the faithful, “religion in general” is of little value; the revealed nature of the deity they venerate, the rituals and worship practices lived by their faith community, and personal experiences of the transcendent are distinctives essential to their understanding and experience of life. Moreover, for the believer, religious faith is not a means to the end of improved health outcomes. Rather, religious faithfulness is to be pursued for no ends except those defined within the religious tradition, and indeed, is that which gives meaning to every other dimension of life.

Several prominent social scientists and psychologists of religion have referred to this characteristic of the devout as *intrinsic religiosity*,<sup>6,7</sup> characterized as the extent to which individuals agree with statements such as, “I try hard to

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carry my religious beliefs into all my other dealings in life,” and “My whole approach to life is based on my religion.”<sup>6</sup> Simply put, intrinsic religiosity describes a person whose religion is the organizing principle and motivating force of his or her life.<sup>8</sup>

Intrinsic religiosity, or religious devotion, is distinct from and in some ways marginalized by the popular, individualized concept of spirituality. Whereas religious devotion implies visible commitment to a tradition and community, spirituality (as noted by Scheurich in a recent critique), is a nebulous term that includes “a potpourri of moral endorsements, reverence for nature, mere thoughtfulness, and vague references to the unity of being.”<sup>9</sup>

### Physician's dilemma

Against this background, a tension emerges for the physician. On the one hand, many patients clearly want their physicians to provide spiritual support during an illness. Studies indicate that the majority of patients want greater attention paid to their spiritual identity.<sup>10,11</sup> A recent multicenter survey of outpatients found that in the setting of dying, 70% of patients would welcome physician inquiry into their religious beliefs, 55% would appreciate silent prayer, and 50% believe their physician should pray with them.<sup>12</sup> On the other hand, generic, one-size-fits-all spirituality is inadequate, especially for those patients who are devoutly religious.

How, then, is a physician to respond to patients' religious concerns? Should she only listen? May she affirm? give counsel? pray? These questions have been addressed to some extent,<sup>13,14</sup> but they have not been adequately answered. Both the ethical form and content of legitimate spiritual discussions between patient and physician remain ill-defined.

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### ■ THE SECULARIST CRITIQUE

In response to this set of questions, several critics have argued that once a physician acknowledges a patient's spiritual concerns, a professional boundary has been reached. Any attempt to engage the patient in further dialogue is out of place. In general, critics' arguments fall along two lines.

#### **Physicians not qualified**

First, by virtue of the nature of their professional training, physicians are neither qualified nor entitled to engage in discussions of spiritual matters. Quite simply, spiritual questions are "none of the doctor's business." Modern specialization of health care services, the argument goes, has obviated the need for physicians to concern themselves with anything but strictly medical questions. Patients seek physicians not for spiritual counsel, but for care in health and disease. While physicians can legitimately inquire into patients' sexual practices, marital life, and social habits, one's religious beliefs and practices are irrelevant to the medical encounter and inquiries about them constitute a violation of privacy.<sup>13</sup> In addition, modern medical practice is characterized by time constraints incompatible with meaningful discussion of spiritual questions.<sup>15</sup>

Instead, physicians should act as triage points for holistic care and refer patients to clergy or hospital chaplains. This is a view articulated by several contemporary physicians: "physician-led prayer is acceptable only when pastoral care is not readily available, when the patient is intent on prayers with the physicians, and when the physician can pray without having to feign faith and without manipulating the patient."<sup>14</sup>

#### **Abuse of power**

Second, physicians occupy a privileged position of power; to use that position to provide spiritual

care amounts to an abuse of power and a threat to patient autonomy.<sup>16</sup> This criticism implies that devout physicians are at risk of bringing their religious commitments to bear in such a way that patients with differing views will feel coerced. Given the plurality of contemporary religious belief, the argument goes, physicians should preserve patient autonomy by maintaining absolute religious neutrality, what Scheurich calls a "separation of church and medicine."<sup>9</sup>

According to this view, anything short of secularism in the clinical encounter threatens the physician's relationship with those who have differing perspectives, whether agnostic or devout. "Physicians should respect patients' religious and spiritual views and avoid expounding or imposing their own beliefs."<sup>16</sup>

### ■ RESPONSE: TOWARD AN ENRICHED DIALECTIC

From the perspective of the religiously devout, both secularist objections arise from a foreign worldview. The first argument has its intellectual roots in the tradition of Western liberal political philosophy, the view that one's private concerns—including religion—should remain wholly separate from the public sphere.<sup>17,18</sup> One's private concerns have little relevance to the medical encounter and must be carefully segregated.

#### **Faith relevant to medical encounter**

What this line of reasoning ignores is that for the religiously devout, no dimension of life is unaffected by their religious beliefs. From prenatal diagnosis to end-of-life care, a devout patient's religious values are relevant to every aspect of the care she seeks.<sup>19</sup> Decisions regarding the good—medical, moral, or otherwise—are inevitably made from within a thought tradition, and insight into the ways traditions shape one's life enriches the doctor's care for her patient. As ethicist Alisdair MacIntyre notes, "The individual's search for his or her good is generally and characteristically conducted within a context defined by those traditions of which the individual's life is a part."<sup>20</sup>

### Empathetic engagement possible

That physicians, especially religious ones, violate patients' autonomy by inquiring into their spiritual concerns is another argument founded on premises not shared by the religiously devout. Contemporary literary theorists and philosophers of religion have articulated an objection to the modernist ethical tradition on which this claim is based.<sup>21,22</sup> Epistemological neutrality, the objective "view from nowhere," they argue, is both a theoretical and practical impossibility—everyone who speaks does so from within a tradition, a society, and a culture. The secularist physician's perspective, according to this interpretation, is no more neutral than that of his religious colleague; both have valuable insights to bring to the patient-physician relationship.<sup>19</sup>

Recognition of this principle levels the playing field for both religious and agnostic physicians, and points toward an ethic of tolerance and respect. We argue that rather than retreating from dialogue with their patients, physicians who are devoutly religious should recognize the particularities of their perspective, and begin to empathetically engage their patients' spiritual concerns. Even in the case where physician and patient speak from religiously discordant perspectives, the physician can compassionately and sensitively engage the patient on the patient's terms, rather than forcing the patient to address difficult questions within a foreign moral framework. (See "Allowing spirituality into the healing process," pages 616–624.)

### ■ SPIRITUALITY IGNORED DIMINISHES MEDICAL ENCOUNTER

Suffering has a way of pointing patients toward the transcendent, and the discussions that accompany this inner process require a vocabulary beyond that of physiology and pathology. The artificial neutrality of enforced secularism inevitably leads to a discussion that is conceptually impoverished, lacking the language to address the existential questions of suffering in ways that are meaningful to the patient. By hon-

The inner process of suffering requires a vocabulary beyond that of physiology and pathology

estly sharing their own experiences and perspectives, and sensitively inquiring about the patient's worldview, physicians can raise the level of discussion and create a powerful experience of shared humanity.

This enriched dialectic will enable sensitive and appropriate care for religiously devout patients, ensuring that their concerns are addressed more than superficially. In this way, the clinical encounter will be defined neither by the bland commendation of a generic religion for its salutary effects, nor by the enforced secularism of modernity, but by the contextualization of a patient's illness against the particularities of her life commitments. When a Muslim with diabetes inquires about fasting during Ramadan, when a Catholic grandfather speaks of divine healing of his cancer, and when a Buddhist teenager explains the role that ulcerative colitis has played in her spiritual development, the relationship between physician and patient will deepen, transforming the medical encounter into an "interhuman event."<sup>23</sup>

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