

## PERSPECTIVES

## Strangers or Friends?

## A Proposal for a New Spirituality-in-Medicine Ethic

Farr A. Curlin, MD,<sup>1</sup> Daniel E. Hall, MD, MDiv<sup>2,3</sup><sup>1</sup>Section of General Internal Medicine, Department of Medicine, University of Chicago, Chicago, IL, USA; <sup>2</sup>Department of Surgery, University of Pittsburgh, Pittsburgh, PA, USA; <sup>3</sup>Duke University Medical Center, Durham, NC, USA.

We argue that debate regarding whether and how physicians should engage religious concerns has proceeded under inadequate terms. The prevailing paradigm approaches dialogue regarding religion as a form of therapeutic technique, engaged by one stranger, the physician, upon another stranger, the patient. This stranger-technique framework focuses the debate on questions of physicians' competence, threats to patients' autonomy, and neutrality regarding religion, and in so doing, it too greatly circumscribes the scope of physician-patient dialogue. In contrast, we argue that dialogue regarding religion is better approached as a form of philosophical discourse about ultimate human concerns. Such moral discourse is often essential to the patient-physician relationship, and rather than shrinking from such discourse, physicians might engage patients regarding religious concerns guided by an ethic of moral friendship that seeks the patient's good through wisdom, candor, and respect.

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Both professional<sup>1-6</sup> and popular<sup>7</sup> literature document revitalized interest in the intersection between faith and health. A growing body of evidence in medicine,<sup>8</sup> psychology,<sup>9</sup> and sociology<sup>10</sup> describes empirical associations between faith and health, and although this "faith-health connection" remains controversial,<sup>8, 11-13</sup> there is emerging consensus that religion is important to many patients, particularly in the context of suffering and illness.<sup>13-15</sup> In response, the medical literature has supported a lively debate about how physicians should and should not address the religious commitments of their patients.<sup>13,16-18</sup> Although not always acknowledged as such, this debate is ultimately a *moral* debate because it concerns what physicians should and should not do. We suggest that thus far the debate has focused only on a limited range of the possible moral questions, and in this article we will attempt to expand the debate to better encompass the experience of both patients and physicians.

## Reviewing the Current Debate

Despite the widespread consensus that physicians should be attentive to and respectful of the religious commitments of

their patients, there is little agreement on how physicians should ascertain or address religious concerns. Should a physician try to discern them passively or should she actively inquire? Should she simply acknowledge and respect religious commitments or should she go further and attempt to clarify their implications? And if clarified should they be validated, taken into account, supported, or challenged? Should a physician ever suggest or even recommend alternative ways of understanding religious commitments? Should she proselytize? At some point along this spectrum, most physicians grow uncomfortable saying "yes," but there is no agreement on where the line should be drawn.

Proponents of what is called "spiritual inquiry"<sup>1-3</sup> argue that questions about religion are simply a matter of taking the actual person into account, building rapport, and discerning those factors that may be relevant to a patient's experience of illness and medical decision making. Critics counter that spiritual inquiry is misdirected and meddlesome, invading patients' privacy, crossing professional boundaries, and raising the threat of coercion or proselytism.<sup>4-7</sup>

Although they come to different conclusions, proponents and critics of spiritual inquiry share a similar conceptual framework that both defines the relevant moral questions and constrains the possible answers. In that shared framework, dialogue regarding religion is approached as if it were a form of therapeutic technique applied by physicians to patients, who interact clinically as strangers to one another. Alvan Feinstein noted and critiqued the ways that medicine is increasingly practiced and assessed as if it were merely a "technical performance."<sup>8</sup> By this Feinstein meant that medicine is now idealized as a practice that is based on empirical evidence, ordered by practice guidelines and algorithms, refined through techniques of Continuous Quality Improvement, and judged in reference to discrete performance-based indicators.<sup>8</sup> Unfortunately, this technical paradigm also inadvertently devalues the role of relationship in the clinical encounter, a process which has led some to argue that the entire practice of medicine is now "understood and regulated as if it were a practice among strangers."<sup>9</sup> This framework which emphasizes technique over relationship gives rise to three particular questions for moral inquiry, summarized in Table 1.

The first question asks, "Are physicians *competent* to engage patients in dialogue regarding religious concerns?" Competency is the first act of kindness, and in our medical tradition, it is demonstrated and governed through accredited certification, but because physicians are unlikely to have any professional training in religious matters, most authors do not consider them competent to address religion.<sup>5,10-12</sup> Critics note that even if a physician had some religious training, such training would not likely encompass the enormous diversity of

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Address correspondence and requests for reprints to Dr. Curlin: The University of Chicago Hospitals, MC 2007, 5841 S. Maryland Avenue, Chicago, IL 60637 (e-mail: fcurlin@medicine.bsd.uchicago.edu).

See editorial by Sheurich, p. 379

Table 1. Current and Proposed Approaches to Dialogue Regarding Religion

Current Approach		Proposed Approach	
Ideal	Question	Ideal	Question
Competence	Are physicians competent to engage patients in dialogue regarding religious concerns?	Wisdom	How might a physician learn to wisely navigate discourse regarding religion?
Autonomy	Is patient autonomy threatened when a physician engages a patient regarding religion?	Respect	How might a physician engage in discourse which seeks to clarify and promote the patient's flourishing while demonstrating deep respect for the patient?
Neutrality	Is it possible for physicians to dialogue with patients regarding religion while maintaining the neutrality that their professional position requires?	Candor	How should a responsible physician address genuine disagreements regarding religious matters in such a way that he and the patient can respectfully negotiate a mutually acceptable accommodation?

religious traditions found among patients.<sup>5,7</sup> Others have noted that even with training, physicians would still be *relatively* incompetent compared to pastoral care professionals,<sup>3,11,13</sup> and they would be much less likely to have the time necessary to adequately address religious concerns.<sup>7</sup> Fearing incompetence, some critics conclude that physicians' attempts to engage patients will lead to erroneous ideas, ill-conceived recommendations,<sup>10</sup> and potentially harmful results.<sup>4</sup> Therefore, the argument goes, physicians should refer religious dialogue to religious professionals.<sup>5-7,10,12,13</sup>

The second question asks, "Is patient autonomy threatened when a physician engages a patient regarding religion?" Physicians' words carry inordinate weight because of the peculiar authority that travels with the profession.<sup>3</sup> Because of this unequal power,<sup>12</sup> it is argued that coercion inheres in any effort that moves beyond "taking note" of a patient's religious concerns toward "taking on" those concerns or the commitments in which they are rooted.<sup>6</sup> Although a physician will not always agree with her patients, some suggest that it would be an unjust "imposition" for the physician to "expound" her own values to an unwitting patient.<sup>11</sup> Patients, it is argued, have a right to "find their own solutions"<sup>11</sup> without the "undue influence"<sup>10,12</sup> of a physician. Therefore, physicians should neither recommend nor critique religious ideas, unless such ideas conflict with "rational, evidence-based medicine,"<sup>1</sup> in which case a physician may have an obligation to challenge the ideas out of her commitment to beneficence.<sup>3</sup>

The third question asks, "Is it possible for physicians to dialogue with patients regarding religion while maintaining the neutrality that their professional position requires?" Some argue that professional boundaries mitigate against any inquiry into religious matters,<sup>4</sup> but if physicians do inquire, it is agreed that they should not take sides, because patients consult physicians for medical advice—not for dubious and unregulated religious opinions.<sup>13,14</sup> In addition, it is thought that the languages of religion and science are immiscible,<sup>5,7</sup> such that trying to add one to the other will only weaken both. For these reasons, Scheurich recently suggested that the medical profession should adopt an approach parallel to the political doctrine of the separation of church and state. To do so physicians would have to remain carefully neutral regarding religious matters.<sup>6</sup>

These three core questions emerge from three moral ideals: competency, autonomy, and neutrality. If these are the right questions, then the only relevant issues involve determining whether and how physicians might engage patients regarding religious concerns in ways that are professionally

competent, do not violate patient autonomy, and are carefully neutral regarding religion. However, we contend that a different set of questions, derived from different ideals, will provide a framework better suited for approaching dialogue regarding religion within clinical medicine.

## A Critique and a Proposal

Suppose for a moment that dialogue regarding religious concerns is not so much a technique enacted by a powerful stranger upon a weaker one, but rather is a moral discourse governed by an ethic of friendship. By moral discourse we mean a dialogue ordered to clarifying "the good" and negotiating the right ways to pursue that good.<sup>15</sup> By "an ethic of friendship" we are not so much referring to emotional connection as to *moral friendship* whereby a physician would act toward her patient out of desire for the patient's good.<sup>9,16,17</sup> Although related to beneficence, moral friendship is a richer concept that aims beyond narrowly defined "goods" toward a more complete sense of human flourishing. To flesh out the ways this new framework would shape interactions between physicians and patients, we will consider again the three questions typically raised about dialogue regarding religion, and then propose alternate questions that follow from the premises of "friendly moral discourse" (Table 1).

## Competence Versus Wisdom

Competence is an important aspect of any technique, but when dialogue regarding religion is understood as technique, it is misunderstood. When patients raise religious concerns with their physicians, do we suppose they are looking for professionally certified spiritual therapy? When a patient with newly diagnosed breast cancer says, "Doctor, I think I will just trust God about this and call you in a few months to check in," is the range of appropriate physician responses limited to silence, simple acknowledgement, or referral to trained "religious professionals"? Do we imagine that the patient expects technical competence from her physician's words in the way she will expect competence from the surgeon who will perform her axillary node dissection? No. In such situations a physician appropriately engages in further dialogue with the patient—not because the physician is a certified religious professional nor because his words will be therapeutic, but because the physician must clarify the way his patient comes to her conclusion, and attempt to negotiate a way forward that

contributes to the patient's flourishing as the physician understands it.<sup>18,19</sup>

If the question is not one of competence, then what is it? We suggest it is more a question of, "How might a physician learn to wisely navigate discourse regarding religion?" Aristotle described *phronesis*, or practical wisdom, as the ability to discern which action, among several imperfect options, will best approximate the ultimate good. For Aristotle all choices about how to act are moral choices about which there can be no empirical knowledge.<sup>20</sup> Whereas the intellect allows the physician to learn medical data and the theologian to learn theology, wisdom guides both in discerning when and how such knowledge should be applied in seeking patients' good. Unlike competence, which can be mediated through scientific ways of knowing and technical instruction, wisdom must be developed through experience in a tradition and a way of life.<sup>15,21</sup> In the medical tradition such wisdom is manifest as "good clinical judgment" in figures such as Sir William Osler. Certainly the wise physician must recognize the limitations of her knowledge, lest in engaging patients' religious concerns she do so badly. Yet, particularly in the case of religious dialogue, it would be naive to assume that a person gains the necessary wisdom solely from professional training. In practice, wise counsel is often given by lay persons who have been shaped and formed by faithful life.

Critics have expressed concern that discourse regarding religion would violate professional boundaries. However, such professional compartmentalization has been challenged by other critics in their search for a more culturally sensitive,<sup>22</sup> patient-centered,<sup>23</sup> integrated,<sup>24</sup> and holistic<sup>25</sup> medicine. These critics note that the divisions of labor that reinforce many professional boundaries can yield an impersonal, technical, fragmented, bureaucratic, and ultimately dehumanizing practice of medicine that undermines genuine interpersonal care and connection. Without doubt, some professional boundaries will always remain essential to medical practice, and forging interpersonal connections will always pose some risk to those boundaries. However, if physicians limit their communication to those areas in which they are professional experts, they will neglect large parts of the human condition including religious and other moral commitments, relationships with family and coworkers, dreams and aspirations, joys and sorrows. It is hard for us to imagine how such sterilization would improve the clinical encounter. It seems, rather, another step down the road toward a sort of medicine that is deeply unsatisfying to patients and clinicians alike.

### Autonomy Versus Respect

The second issue concerns the purported threats of religion to patient autonomy. Although the literature carefully notes the dangers of religious coercion, it is easy to forget that physicians engage in moral persuasion on a daily basis. For example, physicians frequently take pains to persuade patients to continue difficult but promising therapies, or to make yet another effort to stop smoking. In these situations, it is apparently appropriate for physicians to use their unequal power judiciously to persuade patients to pursue the goals judged best by the physician. With respect to the principle of patient autonomy, there is a double standard and a secular bias within the current recommendation against engaging religious concerns. On the one hand, discussions regarding religious

concerns are considered *prima facie* violations of autonomy, but on the other hand, physicians are encouraged to challenge those religious beliefs that run counter to "evidence-based medicine."<sup>1</sup> Contemporary bioethics often insists that patients have the autonomous right to determine their own values without the meddlesome influence of government, church, family, or friends. However, moral decisions are never made in a vacuum. Whenever a patient says, "I understand the options, Doc, but what do you recommend?" the patient is asking for *moral* counsel. In such cases, it is the physician's privilege and responsibility to deliberate about the patient's good so as to offer the wisest counsel possible.

If dialogue regarding religious concerns is discourse ordered by an ethic of friendship, the question is not, "Does dialogue threaten autonomy?" but "How might a physician engage in discourse which seeks to clarify and promote the patient's flourishing while demonstrating deep respect for the patient?" Such discourse requires both trust and judgment lest it become patronizing and paternalistic. However, physicians regularly walk this fine line as they persuade patients to follow medical recommendations. Physicians may be less comfortable clarifying the wider goals that contribute to a patient's flourishing, but with practice and care, such discourse is possible. Physicians should never coerce patients to do anything against their will, but neither should they ignore patients' deepest commitments. To take those commitments seriously will at times call for persuasive negotiation, frequently requires an exchange of perspectives, and always requires respect.

### Neutrality Versus Candor

Two problematic assumptions are bound up in the final question, "Can physicians engage religious matters with their patients while maintaining the neutrality that their professional position requires?" The first problem is the assumption that physicians can and should be neutral regarding religion. Neutrality is an attractive idea to some,<sup>6,13,14</sup> particularly in a secular society which is understandably concerned about tolerance among diverse religious traditions. That concern undergirds the growing preference for addressing "spirituality" rather than "religion," a move which emphasizes commonalities over differences. However, as argued elsewhere, spirituality will not effectively bridge the differences that divide religions because no matter the language used, moral neutrality is not possible.<sup>26</sup> It is *never* possible for individuals to divorce themselves from the specific traditions of knowledge and the moral commitments that shape their lives.<sup>15,21,26</sup> Furthermore, feigned neutrality will never be comfortable to the devout person, for whom "setting aside" ones religious commitments would be a form of unfaithfulness.

The second problem is the assumption that religious commitments are private and as such should not influence the professional sphere. Max Weber noted,<sup>27</sup> some say with melancholy,<sup>28</sup> that the modern world fosters the differentiation of distinct social spheres, each of which requires its participants to check their "private" ethics at the door. He concluded that it would therefore be extraordinarily difficult in the modern world for the religious person to live out his commitments publicly.<sup>27</sup> It may indeed be difficult, yet religions such as Christianity, Judaism, and Islam each make totalizing claims, calling the faithful to put God first in every aspect of their lives. Our culture exerts a steady pressure to privatize and relativize

religious commitments, but it is a pressure that the faithful are called to resist.<sup>29</sup> We are not suggesting that the profession of medicine give official or unofficial endorsement to a particular religious tradition. We argue rather that neutrality is an ideal that is rooted in secularism and is impossible to achieve.<sup>29</sup> Secularism is not neutral as regards religion.<sup>30</sup>

If the question is not how to maintain professional neutrality, what is it? The wise physician must still ask, "How should a responsible physician address genuine disagreements regarding religious matters in such a way that he and the patient can respectfully negotiate a mutually acceptable accommodation?" Without doubt a generous measure of creativity and good will is necessary to find a way that violates neither the integrity of the physician nor that of the patient. Whatever else it requires, it will certainly require dialogue—the sort of dialogue that is generally unacceptable within the ethical framework that currently prevails. The relevant moral concept is *candor*. A physician need not "tell all to all," but she must seek to be conscious of which judgments are part of professional consensus and which follow from her own moral convictions, and she must take pains to make that distinction clear to patients.<sup>11,18</sup>

## Caveats

The framework we have proposed opens up possibilities that some will find troubling. Some may fear that "Pandora's box" will open and physicians everywhere will persuade, manipulate, or even coerce patients to abandon or change their religious creeds. Although we concede that such is possible, for the moment we would contend that overbearing religious zealots are more populous as specters than as practicing physicians. Others may contend, "I do not want *my* doctor to talk to *me* about religion; my religion is none of his business." Well and good. We do not propose any *obligation* for physicians and patients to engage in dialogue regarding religion. However, research does suggest that a substantial proportion of patients would welcome greater dialogue with their physicians about their religious concerns.<sup>31–33</sup> If so, we might turn an earlier concern on its head and ask, "Why should the preferences of those who do not want discourse be imposed upon those who do?" In addition, some will be troubled by the real possibility that relationships between physicians and patients who have differing religious commitments may at times be undermined by discourse that draws attention to those differences. Although they would likely be uncommon, such occasions would not be surprising. This is where the rubber of diversity meets the road of physician-patient communication. If a patient believes that the difference between his own and his physician's fundamental commitments warrants seeking another physician, such an accommodation, however extreme it may seem, is preferable to a paternalism (secular or religious) which would mask the very difference that the patient finds so important.

## Where Do We Go from Here?

Medical education aims to teach the science and art of medicine, but it is not clear that a curriculum for wisdom can be realistically developed. Changes in the economics and practice of medicine are squeezing out the already limited opportunities for senior physicians to mentor medical students and resi-

dents in the moral discourse that deliberates about the good and offers wise counsel. In addition, mentorship in practical wisdom depends upon what Aristotle calls *moral virtue*: "Virtue makes us aim at the right target [i.e., the patient's good], and practical wisdom makes us use the right means."<sup>20</sup> Unfortunately, much of medical training still consists of a "hidden curriculum"<sup>34</sup> which does anything but foster the virtue characterized by wisdom, candor, and respect. Given such obstacles, there will be no simple solution or magic bullet. However, we suggest that as medicine endeavors to recover a discipline of moral discourse, such deliberation is likely to be sustained by those communities, both secular and religious, that preserve a vibrant tradition of moral discourse. We remain hopeful that physicians at every level of training might step back from the pressure of daily practice to identify the ways in which wisdom, candor, and respect are fostered, and then make choices to encounter those ways.

## Conclusion

In the end we propose a simple approach. Physicians who engage patients in discourse regarding religion should do so in an ethic of friendship, marked by wisdom, candor, and respect. Whether a particular conversation is ethical will depend on the character of those involved and the context of their engagement. In the meantime, the medical profession should exercise restraint in formulating both prescriptions and proscriptions regarding the content of physician-patient discourse. Neutrality is not an option. Physicians must and regularly do make moral choices according to their consciences. To make such choices wisely, physicians will at times need to engage with patients in dialogue regarding religious commitments and concerns.

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