

When clinical medicine collides with religion



Daniel E Hall

USA (Rev D E Hall MD, F Curlin MD, H G Koenig MD)
(e-mail: revdocdan@aya.yale.edu)

Daniel Hall is a surgeon, Episcopal priest, and post-doctoral fellow at the Center for Aging at Duke University Medical Center, Durham, NC 27710, USA. Farr Curlin is instructor of medicine, University of Chicago School of Medicine, Chicago, IL 60637, USA. Harold Koenig is associate professor of psychiatry and medicine, Duke University Medical Center, and Geriatric Research, Education and Clinical Center, VA Medical Center, Durham, NC 27710, USA.

The trauma surgeon had seen the situation before: 35-year-old male driver after a crash—tachycardic, hypotensive, obtunded, fluid in Morrison’s pouch by ultrasound, and more than a litre of blood still pouring from the chest tube. While wheeling the man towards the operating room the medical student ran up to the attending doctor saying, “the patient is a Jehovah’s Witness and his wife insists that he not be given any blood”.

Although not always this dramatic, religious perspectives on health can seem extreme whenever they challenge or contradict the prevailing model for standard care. Religious groups at the margin of society—Christian Science, Scientology, New Age—shape people’s lives according to unique worldviews that challenge some of the assumptions of wider cultures. In so doing, these groups may dispute medical standards for appropriate care.

However, this conflict is not always restricted to so-called extreme religions. When people formed by more mainstream religions—such as Christianity, Judaism, or Buddhism—question standard medical care, doctors might perceive these religions as radical. The extremity of a religious view has less to do with a particular belief than it does with how compatible or incompatible that belief is with the secular, scientific, medical perspective.

Fundamentally, the interaction between religious and medical views is a case of applied ethics. Medical science can inform patients and doctors about what can be done, but choosing what ought to be done is moral enterprise. Although doctors often rely on the secular principles of autonomy, beneficence, non-maleficence, and justice, patients are partners in medical decision making, and they are frequently informed by religious views that do not always order moral principles in the same way as do secular medical professionals. So how should doctors navigate the sometimes troubled waters between these separate worldviews?

As with anything in medicine, preparation is important, and doctors should be encouraged to learn as much as possible about their patient’s views (religious or otherwise) so they can understand how their worldview will affect medical decision-making. Campbell (see Further reading) discusses 20 faith traditions and their particular approaches to assisted suicide, feeding tubes, and termination of cure-directed care at the end of life. Unfortunately, outside the area of end-of-life care, we do not know of any comprehensive summaries of medically relevant religious perspectives. However, there are many articles in published medical work that discuss specific religious tenets in great depth. Furthermore, the internet is a rich source of information on more unusual religious practices.

Although preparation is important, because of the diversity of faiths, doctors must learn details of specific religious perspectives by talking to patients. Careful listening is essential. Such inquiry should always show respect for the patient, never demeaning or blindly challenging their views. If the discussion is marked by anything other than mutual respect and trust, the doctor can lose valuable opportunities to assess or facilitate adherence with standard medical care. It is easy to become offended when—on the basis of a religious precept—patients challenge our medical judgment. However, we must remember that when compared with something like “eternal salvation”, use or non-use of a medical technology like blood products can, in the patient’s eyes, be quite trivial. Although medical science is powerful and doctors are respected members of society, patients are generally more influenced by their immediate communities—especially when those communities are formed around counter-cultural religious practice. Doctors have an important part to play in the health care of these patients, but our opinion is usually less influential than we might think.

Although this approach of respectful inquiry is an important first step, the practice of medicine does not end there. After exploring the religious perspectives of the patient, decisions must be made. However, the present climate of medical ethics was formed in reaction to a typically coercive paternalism, and its focus on patients' autonomy generally suggests that the doctor is a neutral party in medical decision-making. The doctor is seen as a provider, whose responsibility is only to supply the services desired by the health-care consumer. Yet those involved in clinical medicine know that the doctor-patient relationship is deeper than the provider-consumer model. The best doctors engage patients in negotiation that persuades, cajoles, and sometimes firmly pushes them to take the medicine they need, even if it is not always what they want.

Careful empirical inventory of clinical practice will reveal that tolerance and autonomy are not always the final arbitrators. Emergency-room doctors will rightly pump the stomachs of patients admitted after a religiously motivated suicide attempt. Likewise, some people's religions foster practices that harm others or themselves in ways that medical professionals have no obligation to tolerate or respect. In our experience, such circumstances are rare.

It is possible for doctors to negotiate agreeable treatment plans within the patient's religious worldview; however, negotiation can sometimes become quite intense. For example, patients with a strong family history of early colon cancer might refuse regular colonoscopic screening because they are confident that God will hear their prayer to prevent cancer. Without violating the patient's trust, the doctor might attempt to persuade the patient that God is, in fact, answering his or her prayer through the miraculous technology now available to detect and remove precancerous polyps before they become a problem. The doctor might even go so far as to enlist the help of the patient's religious minister.

When medical and religious perspectives are opposed, doctors have to discern how to proceed. If the position is clearly articulated by both the religious community and the patient, the professional imperative to respect the patient's autonomy would guide the doctor to pursue non-standard treatment—eg, resuscitation without blood products for Jehovah's Witnesses. Although the choice might seem strange to the doctor, such well-defined positions rarely engender much overt conflict.

Rights were not granted to include this image
in electronic media.
Please refer to the printed journal.

A verger's dream: leg transplantation by Saints Cosmas and Damien

However, doctors can find it difficult to manage these tensions in situations in which the religious community starts to exert its influence over the individual. For example, a woman might choose to carry her unborn child to term even though prenatal ultrasound has diagnosed that child with anencephaly. She herself may be ambivalent with respect to some aspects of this decision but choose to follow the guidance of her religion. This type of decision places the principle of community before the principle of autonomy, and thus can seem extreme to the doctor.

There is no objective or universal set of values that can resolve this tension. The final arbitrator will not be found in scientific facts or abstract principles, but in the wisdom and character of doctors who struggle to offer sound counsel to patients in need. There is no greater privilege; no greater responsibility.

Further reading

Campbell CS. Religious ethics and active euthanasia in a pluralistic society. *Kennedy Inst Ethics J* 1992; **2**: 253–77.