

## CASE WITH COMMENTARY

### What Should Physicians and Chaplains Do When a Patient Believes God Wants Him to Suffer?

Commentary by Benjamin W. Frush, MD, MA, John Brewer Eberly Jr, MD, MA, and Farr A. Curlin, MD

#### Abstract

When physicians encounter a patient who gives religious reasons for wanting to suffer, physicians should maintain their commitment to the patient's health while making room for religiously informed understandings of suffering and respecting the patient's authority to refuse medically indicated interventions. Respecting the patient can include challenging the patient's reasoning, and physicians can decline to participate in interventions that they believe contradict their professional commitments. Chaplains likewise should both support and possibly respectfully challenge a patient in instances that involve desire to suffer for religious reasons, and physicians should draw on chaplains' expertise in these situations to attend to the patient's spiritual concerns. Finally, conversations involving spiritual and existential suffering might include members of the patient's religious community when the patient is open to this option.

#### Case

Mr. L is a 47-year-old father of 2 who has a history of alcohol abuse but has been sober for over a year. He was admitted from the emergency department, where he presented earlier this morning with acute abdominal pain. He was diagnosed with pancreatitis and biliary colic, indicating the need for a cholecystectomy (a laparoscopic procedure to remove the gallbladder to prevent gall stones, pain, and infection). However, before the procedure could take place, Mr. L stated that he did not want pain medication after the surgery because, as he said, "God wants me to be in pain." The medical team, unsure how to proceed, delayed the surgery.

Dr. J, a fourth-year surgery resident, met with Mr. L to discuss his request and quickly reach a resolution, as the medical team did not want to delay the procedure for more than 24 hours. After Mr. L explained why he did not want pain medication, Dr. J stated, "You are going to feel a lot of pain after this surgery. Sometimes the pain is so extreme that patients have difficulty breathing. So the pain medication helps you be able to take

full breaths, which reduces the likelihood of getting pneumonia.” Dr. J then asked Mr. L if he would be willing to speak with a chaplain about his ideas of what God wants for him, and Mr. L agreed.

Dr. J consulted with the chaplain on call, Mr. K, and explained Mr. L’s case. “We can’t, in good conscience, not give him pain medication,” she said. “It’s just bad care. I respect his beliefs, but I can’t be forced to give him what I know to be bad care because of his beliefs. We need to manage the pain to help him heal, if not to be compassionate.” Mr. K suggested, “I’ll speak with him to get a better understanding of his spiritual concerns. Why don’t we talk after I meet with him?”

Mr. K visited Mr. L. They spent some time getting to know each other and, eventually, Mr. K asked, “So would you tell me more about why you think God wants you to be in pain after your surgery?” Mr. L nodded his head and lifted his hand. “I’ve done a lot of wrong in my life and hurt a lot of people. I haven’t been a good father to my kids. And from the way I see it, God wants me to be in pain—God wants me to suffer through this so I can atone for some of my sins. And God’s right—I don’t deserve the pain meds and I don’t want the pain meds.”

Dr. J and Mr. K now meet and consider how to proceed.

### **Commentary**

Recent research has indicated that religious identity and practice can impact health outcomes at the population level as well as individual clinical decisions of patients.<sup>1,2</sup> This research has spurred discussion over how to properly attend to the religious concerns of patients, particularly when such concerns influence clinical decision making.<sup>2</sup> Although physicians often engage with patients’ religious beliefs to support clinical recommendations and to help patients cope with illness and the burdens of medical treatment, sometimes patients give religious reasons for resisting or refusing medical recommendations.<sup>3</sup> Conflicts about medical decision making that involve religion and spirituality can be particularly fraught due to the seriousness and the deeply personal nature of religious belief and practice. The vignette involving a patient (Mr. L), his physician (Dr. J), and his chaplain (Chaplain K), offers such an instance.

Specifically, this scenario pits the patient’s desire to forego postoperative pain medication against the physician’s judgment that not treating postoperative pain constitutes bad medical care. For Dr. J, the proper course of action must conform to “good care,” which, in her judgment, entails administering [effective pain medication](#) after a major surgery. For Mr. L, the patient, the proper course of action requires refusing this pain medication under the religiously informed conviction that the pain to be suffered might “atone” for past sins. This commentary explores the conflict between the patient’s and physician’s views—first, through a reflection on the purpose of medicine, then

through an analysis of the particularities of accommodating religious belief in a clinical context, and finally by addressing the role of a chaplain and the wisdom of a community.

### **Suffering, Health, and Medicine's Purpose**

First, this case raises a critical moral question: namely, what does good care entail for those who practice medicine? The traditional understanding of medicine holds that its *telos* ("purpose" or "end") is health, which Leon Kass famously defined as "the 'well-working' of the organism as a whole."<sup>4</sup> This traditional delineation of medicine's purpose differs starkly from a contemporary vision that does not promote an objective definition of health as the end of medicine but rather champions the relief of suffering as medicine's purpose, an evolution whose roots lie in the philosophy of Francis Bacon.<sup>5</sup> These two rival accounts of what medicine is for lead to different approaches with respect to the present vignette specifically and medical praxis and decision making more generally.

As the third author (F.A.C.) has argued elsewhere, preserving and restoring the health of the patient has been understood for centuries as the constitutive purpose of medicine.<sup>6</sup> Under this traditional approach, physicians seek to relieve suffering, not as an end in itself, but insofar as the relief of suffering is part of attending to the patient's health. For example, the physician might readily prescribe narcotics for a patient whose health is diminished by wracking pain from metastatic cancer, but the same physician might refuse such narcotics for a patient suffering chronic pain when short-term relief of suffering is not proportionate to the long-term health-diminishing effects of dependence on narcotics. In the latter situation, the physician adhering to the traditional approach to medicine might prescribe an alternative regimen that is more conducive to the patient's health, even though doing so brings about less relief from suffering, at least in the short term. In contrast, a contemporary approach that champions the relief of suffering as the proper goal of medicine might struggle to distinguish between different types of patient suffering, potentially compromising the patient's health as a consequence. The authors contend that in order to discern when and how to relieve patient suffering, physicians need to maintain the profession's traditional orientation toward the patient's health.

Importantly, with respect to our analysis of the case, the traditional approach allows room for accommodating a [spiritual or theological understanding of suffering](#) as long as doing so does not contradict the physician's commitment to the patient's health, whereas the alternative approach leaves little room for such an understanding as it views suffering strictly as something to be eliminated.

### **Physician-Patient Accommodation in Engaging with Patients Who Invoke Religious Beliefs**

On the traditional understanding of medicine as oriented toward the patient's health, the question is not, "How should Dr. J reconcile Mr. L's religious beliefs with her professional

beliefs?," but rather, "Does accommodating Mr. L's desire to forego pain medication compromise Dr. J's commitment to the patient's health?" Concern for Mr. L's health circumscribes which decisions are acceptable from Dr. J's point of view; it defines what can and cannot be done. Within the boundaries set by this professional commitment, Dr. J can search out with Mr. L a course of action that respects his religious concerns. What Dr. J is looking for is what Mark Siegler has described as "a physician-patient accommodation," a way forward in which both the physician and the patient are acting with integrity.<sup>7</sup>

In the current scenario, if evidence suggests that withholding pain medicine would unduly reduce the chances of a successful operation, compromise the patient's recovery, or otherwise threaten Mr. L's health, then Dr. J should refuse to offer this course of action, regardless of the religious rationale for such a request. Clearly, there are circumstances in which such refusals are warranted; Dr. J would have clear reason to refuse, for example, if the patient wanted surgery but would not consent to anesthesia.

Conversely, if Dr. J concludes that foregoing postoperative pain medication in this case would not otherwise unduly threaten the health of the patient, then she should feel free to accommodate Mr. L's religiously informed wishes, even if she disagrees with them. Once again, it does not matter so much whether Mr. L's refusal is religiously informed or not, although it is worth noting that physicians tend to be more accommodating of religiously informed requests, perhaps out of respect for the seriousness of religious convictions.<sup>8</sup>

Whatever Dr. J decides, she should explain her reasoning to Mr. L candidly and make clear that her rationale is based upon her professional judgment, not scorn for his religious ideas. If possible, Dr. J should take time to listen to Mr. L in order to better understand his reasoning and how his religious beliefs inform his desired course of action. Such listening opens up the possibility that Dr. J and Mr. L will find an accommodation that will allow Dr. J to do what she thinks is medically necessary. Instead of treating conversation about religious matters as out of bounds, Dr. J should freely inquire about how Mr. L understands the decisions he faces in light of his religious (or other) beliefs. This approach conveys respect, builds trust, and opens up the possibility of finding an accommodation that both patient and physician can pursue with integrity.

In the context of such respectful listening, Dr. J should also feel empowered to respectfully challenge Mr. L's beliefs about suffering. Indeed, as part of their professional commitment to the patient's health, physicians have some obligation to respectfully challenge [patients' refusals of medical care](#) that the physician believes is needed. A sincere discussion—even a respectful debate—in no way denigrates Mr. L's religious beliefs. Rather it treats religious concerns with the seriousness that Mr. L ascribes to them and so treats Mr. L with the respect he deserves. Such conversations do not

require physicians to get into theological arguments with patients. Simply asking patients whether there are alternative understandings within their faith tradition regarding the issue at hand might circumvent an impasse.

### **The Role of the Chaplain**

We now turn to the role of Chaplain K in this dilemma. While chaplains are not health care practitioners per se, they are generally considered members of the health care team.<sup>9</sup> Within that team, chaplains focus on the religious and spiritual care of patients, even when they are employed by secular institutions.<sup>10,11</sup>

Ideally, Dr. J would involve Chaplain K early in this scenario—when it first becomes apparent that Mr. L's faith is important to him. In the course of these conversations, the chaplain, like Dr. J, may also seek to understand and potentially to challenge Mr. L's religious reasoning. He might, for example, encourage Mr. L to consider whether there are alternative understandings of suffering, guilt, or grief found within his religious tradition.

The chaplain should not, however, seek to bring about a predetermined outcome on behalf of the medical institution (such as changing the patient's mind about pain medication). The chaplain is not an instrument subordinated to the health care enterprise but rather a co-contributor to the flourishing of the patient. The commitment of the physician to the patient's health and of the chaplain to the patient's spiritual care are distinct commitments, but both should ultimately be expressed in a caring and respectful stance toward Mr. L throughout his treatment process. For Dr. J, this commitment means providing the best medical care possible within the constraints posed by what Mr. L is willing to consent to, all while exploring and even challenging his refusals. For Chaplain K, this commitment means continuing to attend to Mr. L's spiritual good and observing whether and how Mr. L's religious reasoning about his own suffering changes in the course of his treatment.

It is entirely possible that, in the current situation, no accommodation can be found. Dr. J might conclude that she cannot operate safely without knowing she can give adequate postoperative pain medication. Meanwhile, Chaplain K's presence, prayer, and conversation with Mr. L could result in Mr. L becoming more entrenched in his refusal of such pain medication. Such conflicts are sometimes inevitable, and respect for patients' authority means allowing them to refuse medical care that we believe they desperately need. However things turn out, the chaplain is there to provide spiritual care, not simply to persuade the patient to go along with medical recommendations.

### **The Wisdom of a Community**

In the case of Mr. L, and in other related cases, it can be helpful to broaden the conversation beyond the confines of the hospital and the medical team. Toward this end,

Dr. J or Chaplain K might encourage Mr. L to invite his family, friends, and members of his faith community into further clinical discussions. Mr. L may decline to do so, of course, but, in our experience, many patients have more confidence in their own clergy or other religious counselors than they do in hospital chaplains, and inviting faith communities into these conversations can allow for more meaningful and effective spiritual care in such cases.

Inviting members of an outside religious community into clinical discussions is not without risk; in the present case, the faith community might fortify Mr. L's refusal of pain medication. However, the faith community might instead qualify or alter his understanding of suffering and atonement for sin while affirming the [theological truths](#) important to Mr. L's religious framework. For example, Mr. L's faith leaders might suggest that his refusal to accept pain medication will further burden his loved ones who will watch him suffer. They might help him explore the difference between pursuing suffering and patiently enduring suffering or how the work of reconciliation, repentance, and forgiveness can offer more peace than his current understanding allows.

### **Conclusion**

Ultimately, when religious reasoning leads patients to disagree with or refuse their physicians' recommendations, physicians must seek to understand patients' reasoning and respectfully try to find an accommodation that neither undermines patients' authority to refuse medical interventions nor contradicts their professional commitment to patients' health.

In such encounters, the virtues of humility and patience are essential for physicians. They must have the humility to acknowledge the limits of their knowledge, expertise, and authority, and to ask for help from chaplains or religious leaders from the patient's community who have much more experience with spiritual concerns. They must have the patience to respectfully seek an accommodation with a patient whom they might be tempted to dismiss as simply irrational, and, even when it might not bring about the outcome they desire, they must give chaplains and clergy the freedom to do their work.

Such health care can be arduous and time consuming. However, if we are truly to respect and respond appropriately to patients' religious and spiritual beliefs, it is health care we must practice.

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**Benjamin W. Frush, MD, MA**, is a resident in internal medicine-pediatrics at Vanderbilt University Medical Center in Nashville, Tennessee, and a recent graduate of UNC School of Medicine in Chapel Hill. His scholarly interests involve exploring how both theology and moral philosophy can inform contemporary bioethical conversations, particularly those involving disability, end-of-life care, and moral formation in medicine.

**John Brewer Eberly Jr, MD, MA**, is a recent graduate of the University of South Carolina School of Medicine in Columbia, South Carolina, who will be joining the UNC School of Medicine's Maternal-Fetal Medicine Units Network as a research assistant. His scholarly interests include medical student formation, theological bioethics, the medical humanities, and the philosophy of beauty.

**Farr A. Curlin, MD**, is the Josiah C. Trent Professor of Medical Humanities and co-director of the Theology, Medicine, and Culture (TMC) Initiative at Duke University in Durham, North Carolina. He is an active palliative medicine physician and holds appointments in both the Duke University School of Medicine and the Duke Divinity School, where he is working with colleagues to develop a new interdisciplinary community of scholarship and

training focused on the intersection of theology, medicine, and culture. Dr. Curlin's ethics scholarship takes up moral questions that are raised by religion-associated differences in physicians' practices.

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