

Virtual Mentor
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Religion, Patients, and Medical Ethics

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FROM THE EDITOR

The Separation of Church and Medicine

The rise of a secular public sphere and the concomitant demand for tolerance of private religious beliefs has marked the development of modern thought. Fields once closely tied to religion, such as government, philosophy, and education, have sought nonsectarian grounding that opens them to members of any religious community or none at all. Medicine and medical ethics have likewise sought to separate themselves from confessional stances. At the same time, medical ethics has demanded a respect for patient religious and spiritual beliefs. To borrow a phrase from government, a separation of church and medicine has become the accepted norm.

This separation, however, frequently breaks down. As two important ways that people respond to human suffering, religion and medicine are bound to intersect. Often this intersection is not problematic. Occasionally, however, the values of secular medicine conflict with the values of religion. This issue of *Virtual Mentor* explores some of the problems and questions that arise when religion and medicine intersect and how we as health care professionals ought to respond to them.

Clinical decision making ideally brings together physician expertise and patient values to arrive at a treatment that maximally benefits the patient. Religion and spirituality often shape patient values in ways that run counter to what physicians might consider best for the patient. Margaret and John Tarpley respond to a case in which a man's faith influences his decision not to undergo treatment for pancreatic cancer. They emphasize the importance of respect for patient autonomy when such situations arise. Sometimes, the differing worldviews of physicians and patients cannot be brought together. Iraqi physician Nabil Al-Khalisi recounts a clinical tragedy in which a child with methanol poisoning dies because the physician cannot convince the child's grandfather that ingesting alcohol ethanol, prohibited by the grandfather's understanding of Islamic law, is an effective therapy.

How patient religious attitudes affect treatment decisions was the focus of a recent *JAMA* article that received widespread attention in the professional and lay press [1]. On the surface, the article seemed to show that terminal cancer patients who are religious receive more aggressive therapy with no added benefit than similar patients who are not religious. In an insightful journal discussion, Kyle B. Brothers discusses this article and its methodology and questions how much it can tell us about the association between religious beliefs and use of aggressive treatment at the end of life.

Patients are not the only parties in the clinical encounter whose spirituality might shape their values. Physicians too have religious views, including agnosticism and atheism, that influence their encounters with patients, especially when patients bring up their own spirituality. In one case in this issue, an agnostic physician adopts religious reasoning to persuade his patient to make medically appropriate lifestyle changes to reduce his risk of stroke. Commentator Keith G. Meador explores some of the problems of both inauthentic use of religious language and use of religion as a means to a medical end. Building on this case, neurologists Derek Riebau and Lisa Hermann have written a clinical pearl that summarizes current recommendations for secondary prevention of stroke.

Clinical encounters in which the faith (or lack thereof) of the physician and that of the patient interface can present quite a challenge. The training of physicians to be cognizant of these dynamics has received increasing interest among medical educators. In an informative essay, Samuel E. Karff draws on his experience as a theologian and educator of medical students to discuss how physicians can be trained to interact with devout patients in constructive and appropriate ways.

Caregiver religious values can also lead to conflict with the secular values of the larger profession. Today, this conflict frequently arises with regard to provision of reproductive health care, such as contraception, abortion, and fertility therapies. In the current debate, the issue is usually framed as a clash between an individual caregiver's right to refuse to provide services of this kind on religious grounds and the profession's larger secular commitment to make these services accessible to all. This dynamic is inverted in one of this month's cases: an individual clinician's commitment to reproductive health care alternatives conflicts with the religious beliefs of the health system in which he is practicing. In their commentary, Frank A. Chervenak and Laurence B. McCullough come down strongly on the side of the clinician's right and obligation to provide what he believes to be appropriate medical care. Robert J. Walter's view of the same case contrasts the physician's covenantal duty to the profession with his contractual obligation to his employer. Looking at this same issue on a societal level, Lynn D. Wardle explores how the medical system could accommodate provider conscience while making provision for availability of services.

The efforts of the Indian Health Service (IHS) to incorporate traditional Indian medicine illustrate some of the challenges in crafting policies that accommodate religious and secular values. In a comprehensive look at the history of the IHS, Everett R. Rhoades, its first American Indian director, details some of the difficulties in making room within the secular, bureaucratic world of a government agency for traditional religious practices.

In the health law section, Kevin Abbott discusses statutory child-neglect laws, exceptions to those laws that allow parents to forgo medical care for their children in accord with religious beliefs, and how courts have dealt with cases where exercise of religious freedom has resulted in death of a child.

These articles demonstrate the manifold ways in which medicine and religion intersect, for better or for worse. In a series of op-ed articles, three authors explore a range of perspectives on the question of whether physicians should engage patients on the topic of spirituality. Stephen G. Post examines the nature of the relationship between medicine and religion and concludes that intersections between them are inevitable. He describes religion and medicine as “brothers under the skin,” intrinsically linked by the reverence in which they each hold life. Christina M. Puchalski articulates some of the important boundaries that providers must maintain between religion and medicine. Richard P. Sloan delivers the view from the opposite end of the spectrum, arguing that much of the current enthusiasm for religion in medicine is misguided and that we need to keep an even stronger separation of church and medicine.

This issue of *Virtual Mentor* leaves many questions unanswered. The variety of viewpoints represented here shows there is no consensus on the right way to handle the intersection of religion and medicine. What does seem to be clear is that the question is not going to go away. As future and current physicians, these are problems that will confront us in our practices. It is my hope that this issue of *VM* gives all of us an opportunity to examine these questions so that when we must confront them, we do so with integrity and thoughtfulness.

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CLINICAL CASE

When Patients Say, “It’s in God’s Hands.”

Commentary by Keith G. Meador, MD, ThM, MPH

Mr. Adams arrived at the hospital by ambulance after the sudden onset of right-sided weakness and difficulty finding words while he was at his construction work site.

By the time Mr. Adams reached the emergency room his deficits had mostly resolved. His medical history was notable for irregular care. He had been told some years earlier that he had diabetes and high cholesterol. He had smoked a pack of cigarettes a day for over 30 years. His physical exam noted BP 190/120 and mild weakness in his right arm. Cranial nerve and mental status exams were normal, and his blood glucose was 202 mg/dl. A head CT showed no acute lesions. Mr. Adams was diagnosed with a transient ischemic attack (TIA) and admitted to the neurology service for overnight observation.

The next day, Dr. Howard, the attending neurologist, came by to have a discussion with Mr. Adams about his care going forward.

“You were very lucky,” said Dr. Howard, “that this mini-stroke seems not to have done any permanent damage. Next time you might not be so lucky, so we need to do some work to prevent you from having a full-blown stroke. You’ve got several stroke risk factors that we’ll want to do something about.”

“Like what?” asked Mr. Adams.

“Well for one thing you’ve got diabetes, so we’ll need to work on getting your blood sugar under control,” said Dr. Howard. “You’ve also got high blood pressure and high cholesterol, both of which put you at further risk for stroke. Plus, smoking puts you at increased risk, so you’ll need to work on quitting.”

“I don’t know about all that,” Mr. Adams responded, somewhat defiantly.

“Well, to reduce your risk of having another stroke you’ll need to change your lifestyle some,” said Dr. Howard. “That’ll mean pills to control the diabetes, cholesterol, and blood pressure, but it’ll also mean eating right, exercising, and quitting smoking as soon as you can.”

“That sounds like a lot,” said Mr. Adams.

“It’s your life we’re talking about,” said Dr. Howard.

“Yeah, well, I handled this stroke OK, and you know, when the Lord wants to take me, He’ll take me whatever I do,” said Mr. Adams. “I don’t see the need to bother with a bunch of new pills.”

Dr. Howard was somewhat taken aback by this line of reasoning. He was adamantly agnostic and thought of belief in a higher power as a coping mechanism. Nevertheless, he responded, “Look, God is in control, but that doesn’t mean we don’t have to take some responsibility for our lives. He gave us free will and allowed us to choose what to do. And now you’ve got a choice whether to save your life, and you can’t just palm that off on God.”

“Well, I guess not,” said Mr. Adams.

“Good,” said Dr. Howard. “I’ll have one of our stroke educators come talk to you more about this, and we’ll get you set up with a doctor to have your diabetes, cholesterol, and blood pressure followed.”

Commentary

The role of religion in health care continues to be a point of contention, while concurrently offering creative possibilities if properly understood and thoughtfully appropriated [1]. This case provides a context for considering at least three core issues relevant to this conversation: (1) the relationship between religion and health, (2) ethical implications for the physician in the practice of medicine, and (3) the role of the chaplain in health care. Each of these merits its own essay, but we will focus our discussion by addressing each one through the particular lens of this case.

The one clear consistent association between religion and health documented in the literature is the association between attendance at religious services and health [2]. Although this finding is consistently present even when controlling for multiple potential confounders such as physical functioning and mobility, it should be noted that this is an association without any presumption or claim to causality. In spite of the lack of scientific evidence of causality between religion and health relevant to clinical practice, statements such as Mr. Adams’ comment attributing his destiny to God are common in medical practice and merit clinical consideration. Cultural sensitivity to the worldview represented by Mr. Adams is a crucial part of establishing a working patient-physician relationship, and consideration of diverse examples of worldviews is an important dimension of clinical competency in medicine.

The breadth of traditions and cultural perspectives represented within the typical pluralistic health care setting frequently challenges us and may well evoke spontaneous responses of incredulity or amazement, but a more considered response is called for if we are to practice responsibly. Dr. Howard is described as having been “taken aback” by Mr. Adams’ response to his illness and particular worldview. One of the challenges for medical education currently is to adequately equip

physicians to interpret and understand the breadth of culturally contingent perceptions of illness and therapeutics, so they can engage patients genuinely and constructively without interjecting a prejudiced view of the patient and while maintaining cultural, philosophical, and religious integrity for the practicing physicians themselves.

Sustaining the ethical integrity of the practicing clinician, while honoring the patient's worldview, is an integral part of the engagement of this issue [3]. While the outcome appears constructive when Dr. Howard uses "God language" to convince Mr. Adams of the importance of lifestyle changes and medication compliance to address his medical problems, we can legitimately ask whether Dr. Howard can make the statement, "God is in control," credibly and with authenticity in light of his self-avowed personal agnosticism. Using the patient's language and worldview constructs to challenge the stated position of the patient and establish a treatment plan—implying these are shared by the physician when they are not—could be interpreted as manipulative and deceptive. Within our accepted views of providing good health care, the health behaviors and medical adherence advocated by Dr. Howard seem laudable at first glance, but we need to consider whether the process by which he got to this outcome was the most ethical or responsible for either Dr. Howard or Mr. Adams.

Can patients legitimately expect honesty from their physicians regarding their own views and beliefs on such matters, especially when the explicit or implied perspective is being used for establishing a therapeutic alliance or fostering compliance with a treatment regimen? Do physicians owe it to themselves to maintain their own integrity concerning their religious and philosophical worldviews when theirs differ from those of their patients? If we are attentive to the power differential inherent to the patient-physician relationship and to the inevitability of differences between the patient and physician with regard to religious and philosophical worldviews in increasingly pluralistic health care settings, the answer to these questions should be a resounding yes. If medical students and physicians are given opportunities to examine their own religious views thoughtfully—while learning about other traditions with attentiveness to implications for the clinical setting—they are less likely to be "taken aback" when confronted with perspectives radically different from their own.

While substantial progress has been made in incorporating spirituality into the curriculum in a growing number of medical schools, the quality and depth of that instruction is quite varied. It can be argued that adequate education of medical students and physicians regarding the religious and cultural traditions represented by their patients is not feasible within the limited time and resources of medical education. This may be true, yet, if physicians are to understand patients informed by varied and distinctive worldviews, they must at least commit time to examine themselves and gain a level of comfort with the diversity of possible religious and philosophical lenses through which their patients may interpret and respond to illness

and suffering. The ethical and optimally competent practice of medicine is dependent on an intentional approach to this self-understanding.

The goal is to develop an ability to understand better how one's patient engages illness and interprets therapeutic interventions, without prejudice and with an appreciation for the particular cultural and religious perspective brought to the clinical encounter by the patient. This "appreciation" does not imply agreement and should not be seen as necessitating that the physician enter into a worldview or use of religious or cultural language other than his or her own. Efforts to do so lack authenticity and imply a potential manipulative coercion that compromises both the integrity of the clinician and respect for the legitimacy of the patient's own worldview.

An important alternative for the physician or other health care professional is consultation with a chaplain colleague. Although all clinical settings do not have chaplains, most hospitals, especially teaching hospitals, have chaplains on staff or available within the community. While it is unrealistic to expect availability of chaplains from all the major religious traditions in all hospitals at all times, chaplains who have completed clinical pastoral education (CPE) training and are members of national chaplaincy associations can be expected to have a breadth of background to provide collegial and informed assistance in dealing with clinically relevant religious issues with most patients. Although chaplains are frequently consulted when approaching end-of-life issues with patients and their families, their potential for service is much broader. Most chaplains would be pleased to advise on more nuanced spiritual and religious dimensions of daily patient care than is typically done.

Good clinical care includes sensitivity and curiosity about the cultural and religious values and beliefs of our patients. We will most likely give proper attentiveness to these issues if we have given some intentional consideration to our own perspectives and have been provided with basic education regarding the impact of cultural and religious worldviews on the interpretation of suffering and response to illness. Opportunities for thoughtful self-examination and clinical strategies for honoring and responding to the worldviews our patients bring to the clinical setting should be part of primary medical education and a component of the continuing medical education of physicians. Authentically engaging patients with a genuine curiosity regarding religion and spirituality in their understandings of health and illness adds a depth and richness, the lack of which we frequently bemoan in the current practice of medicine. Intellectually educating and practically equipping medical students and physicians for this engagement is vital to assure ethical and clinically competent care of our patients, while preserving the personal integrity and sense of authenticity for those providing care.

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Related in VM

[Secondary Management of Ischemic Stroke](#), October 2009

[Physicians and Patients' Spirituality](#), October 2009

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CLINICAL CASE

Can Physicians' Contractual Obligations Limit Their Professional Obligations?

Commentary by Frank A. Chervenak, MD, Laurence B. McCullough, PhD, and Robert J. Walter, MD, DHCE

Dr. Charles, a gastroenterologist, had been volunteering one night per week at a charity clinic that was operated by a group of Roman Catholic physicians and nurses. Although these physicians and nurses started the clinic as a way to live out their Catholic faith, they welcomed volunteer staff members of any faith or no faith who wanted to treat the underserved in their clinic. There were many non-Catholic physicians who volunteered at the clinic, of whom Dr. Charles was one.

For some months he had been treating Ms. Bates, a 23-year-old waitress with no insurance who had Crohn's disease. Together, they were able to keep her disease under control with a drug regimen she could afford. In the process they developed a good patient-physician relationship, and she viewed Dr. Charles as her primary physician since she had no other regular doctor.

At one of her visits, after they had discussed her health status, she said, "Dr. Charles, I've got something else I want to talk to you about. I've got a boyfriend now, and we're having sex. I'm really worried about getting pregnant. I barely have enough money to take care of myself, especially with the Crohn's. I don't think I could manage if I had a baby. I know about condoms, but my boyfriend doesn't always use them. Is there anything you can recommend for me?"

Dr. Charles paused. He believed the Catholic Church's position on birth control could be bent when a woman's health might be compromised by pregnancy, and if Ms. Bates had come to him in his private clinic, he would gladly have counseled her about contraception. Indeed, he felt it to be his obligation as a physician to provide such counseling. He was aware that Ms. Bates did not have access to another physician due to her financial situation. It was this clinic's policy, however, to follow the teaching of the Catholic Church, and it did not allow clinicians to recommend any method of birth control except total abstinence or periodic abstinence (the rhythm method). He had known about this policy, but as a gastroenterologist had not given much thought that the issue would come up in his practice.

Commentary 1

by Frank A. Chervenak, MD, and Laurence B. McCullough, PhD

Whether or not Dr. Charles should provide contraception counseling to Ms. Bates is really two questions. We will address each in turn.

1. Is Dr. Charles ethically obligated to *offer* means of contraception that are not morally permissible in Roman Catholic teaching?

The ethics and law concerning the physician's role in the informed-consent process are well established. The physician is to identify, from among technically possible and physically available alternatives for managing the patient's condition, the diagnostic and therapeutic alternatives that are medically reasonable. In the language of medical ethics "medically reasonable" is beneficence-based: there is an evidence-based expectation that a diagnostic or therapeutic intervention will result in a greater balance of clinical goods over clinical harms for the patient as these are assessed from a clinical perspective. This is a professional obligation that all physicians have [1].

Individual or institutional limitations on this professional responsibility are ethically impermissible because the presentation of information about medically reasonable alternatives is independent of the patient's subsequent decision to accept one of the medically reasonable alternatives, which is a function solely of the patient's autonomy, not the physician's. The individual conscience of a physician or the moral commitments of a health care organization are therefore not threatened by the physician's fulfilling his or her professional responsibilities in the informed-consent process [2].

It follows from the concept of the physician's responsibility in the informed-consent process that the answer to the first version of the question is "yes." As a matter of strict professional responsibility, Dr. Charles is obligated to inform Ms. Bates about possible means of contraception. It should be added that this answer applies to all of the health care professionals employed by or volunteering their services in this clinic. The ethics of informed consent are not somehow distinctive or unique to physicians but also apply to nurses, physician assistants, and other health care professionals.

2. After offering all medically reasonable alternatives, should Dr. Charles *recommend* only those forms of contraception permitted by the clinic's religiously based policies?

In the informed-consent process, after having presented the medically reasonable alternatives (along with information about their clinical benefits and risks), the physician is ethically justified in recommending one of the medically reasonable alternatives when, in evidence-based reasoning, it is clinically superior to the other in its outcomes. In the language of medical ethics, such an alternative is ranked first in beneficence-based clinical judgment [1]. The clinic's policy, however, is based not on evidence but on religious commitments and values. To be sure, these are important and serious moral commitments, but they are not medically evidence-based and therefore should not influence or interfere with what Dr. Charles may or may not recommend. The answer to this second question is therefore "no."

Dr. Charles has a larger question to consider, though. Should he continue working in this clinic if he believes its policies might interfere with his providing optimal care to his patients, even if he expects such interference to be rare?

Organizational policies of the clinic that are not consistent with every physician's professional responsibility to patients in the informed-consent process are ethically impermissible for two reasons. First, the clinic is a moral cofiduciary with its physicians of all patients for whom the clinic assumes responsibility [3]. It follows that, as a cofiduciary, the clinic is ethically bound by the same standards of professional responsibility that its physicians and other health care professionals are, as we described above. Second, the organization is not ethically justified in invoking the moral integrity of the commitments of the Roman Catholic faith community out of concern that fulfilling professional standards of informed consent will somehow make the clinic responsible for the subsequent decisions of patients to use accepted, safe, and effective pharmacologic contraception in violation of the teachings of the Roman Catholic faith community. As we pointed out above, these subsequent decisions are the function solely of the woman's autonomy. It is therefore a mistake for the clinic to assume that there is a straight line between provision of information about pharmacologic contraception and a patient's election of it. After all, some women, having learned of the risks of such contraception, elect against it. Similarly, other women elect against barrier techniques or IUDs because they are not as effective in preventing pregnancy as these women prefer. Still other women will not accept forms of contraception that are inconsistent with their religious or other moral beliefs, including women who are not Roman Catholics.

It follows that, if the clinic does not recognize its cofiduciary responsibilities in the informed-consent process and change its policies, then continuing to work there violates professional integrity. The answer to this question is, therefore, "no." Dr. Charles should not continue to work in a clinic if its policies interfere with his providing optimal care to patients.

Does Dr. Charles have an obligation to advocate for change in policy given that patients at the clinic, such as Ms. Bates, might not have other options due to their poverty?

The counseling policies of the clinic do not pass muster in the professional ethics of medicine and this is the main reason that Dr. Charles should oppose them as a matter of cofiduciary responsibility to all of the patients who seek care at the clinic. It is ethically significant that patients like Ms. Bates are under serious economic constraints in their ability to gain access to medical care. Such patients may, in reality, not be free to seek contraceptive counseling elsewhere, a constraint on their autonomy to which the clinic should be responsive. But this is a buttressing reason for Dr. Charles (and all of the health care professionals in the clinic) to oppose the clinic's counseling policies. The main and unavoidable reason that he has such an obligation to the clinic's patient arises directly from professional integrity, i.e., practicing medicine to standards of intellectual and moral excellence. The standards

of moral excellence in the informed-consent process are not matter for compromise. Otherwise, Dr. Charles destroys his own professional integrity, which, ethically, he is not free to do. The answer to this last question is, therefore, “yes.”

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Commentary 2

by Robert J. Walter, MD, DHCE

Dr. Charles faces a situation in which his personal values conflict with institutional policy. As a physician with a fiduciary relationship to his patient, he seeks to act in the best interests of and in accordance with Ms. Bates' wishes—within the limitations of care for the underserved. Many physicians confront situations in which personal goods or values (religiously or secularly based) conflict with the values either of an institution at which they practice or perhaps even of the profession itself. How one attempts to negotiate such conflicts is not only a matter of moral integrity but of fulfillment of professional, fiduciary, and contractual obligations.

To gain insight into the present case, it may be useful to examine an analogous relationship. Joining a profession (taken from its Latin root *profiteri*, or “to profess”) entails an “an active, conscious declaration, voluntarily entered into and signifying willingness to assume the obligations necessary to make the declaration authentic” [1]. A profession has a code of conduct and values and an expectation that

individuals who enter into the profession will abide by them, sublimating or setting aside personal values in favor of the shared goods promoted by the profession. The key distinguishing feature is a voluntary willingness to assume the shared values upon entry into a specific profession. Such an act has been called a “covenantal relationship” implying a strong obligation and responsibility to uphold the shared goods of the profession [2]. This covenantal relationship contrasts with differing levels of obligation that derive from other types of relationships.

It may be argued that Dr. Charles has entered into a “contractual relationship” to provide services at the charity clinic. He now finds his personal values in conflict, not necessarily with the covenantal values of the medical profession as in our analogy, but with those of an institution that has a narrower set of moral norms than the profession. This conflict exists within the contractual relationship between an individual and an employer. While he may not have anticipated a conflict within his subspecialty of practice, it may be said that Dr. Charles either explicitly or implicitly agreed to abide by this set of moral norms in voluntarily entering into practice within this facility. Hence, it could be argued that direct contraception counseling is construed as a violation of his contractual obligations with this particular institution.

Medical necessity and limited access to resources, however, also play a role in the gravity of the situation. While Ms. Bates’ medical condition (Crohn’s disease) would not directly jeopardize her health or that of the fetus during pregnancy, there is the problem of limited financial resources if pregnancy occurs. Would Ms. Bates have the resources to adequately care for the child and would those demands place a disproportionate burden upon her, perhaps even requiring a diversion of financial resources away from her own medical care to the potential detriment of her health? Ultimately, Dr. Charles must proceed in a manner that is in line with his own conscience and understanding of good medical practice, while recognizing that he is undertaking an act of conscientious objection and may be subject to contractual penalties for diverging from the institution’s established moral code and his obligations to uphold them. It might be argued that the contractual relationship establishes a relative set of obligations and responsibilities that must be carefully analyzed and evaluated, even though they may be of a differing and perhaps less absolute quality than those corresponding to his covenantal relationship with his profession. Dr. Charles must evaluate his potential actions in light of his contractual obligations in the context of his fiduciary responsibilities to the patient at hand.

While the options available for specific action within the charity clinic may be limited, Dr. Charles can arrange continuity of care for Ms. Bates should he deem it medically necessary that she receive contraception counseling and access to resources. Although Ms. Bates’ lack of access to traditional health care and her probable inability to obtain services elsewhere hinders a direct transfer of care, a few options may be proposed. With regard to the procurement of contraceptive methods, Dr. Charles may recommend referral to a facility that provides resources to low-income patients (such as family planning organizations). This recommendation would raise the issue of moral complicity, but, it may be argued, the material

complicity (rather than formal complicity) that results would not necessarily violate his contractual obligation to the clinic. Likewise, should Dr. Charles find it necessary to counsel Ms. Bates directly, such counseling could take place at Dr. Charles' primary institution where these particular restrictions are not in place. It could further be argued that Dr. Charles has no obligation to bill for services rendered at his primary institution given previous billing at the charity clinic. While this might be viewed as more formal than material complicity, such actions would need to be evaluated in light of his contravening contractual obligations.

Having realized the potential for conflict with this case, Dr. Charles is challenged with the question of whether it is acceptable to continue in his employment at the charity clinic. His discussion is contingent on several factors: the institution's reaction to his actions (if the administration becomes aware of them or he makes them aware), the likelihood of similar situations occurring, and an evaluation of the strength of the contractual obligations and responsibilities placed upon him during his employment at the charity clinic. In light of his experience in this situation, Dr. Charles may be inclined to advocate for policy revision to assist patients in similar circumstances. While there may be many barriers to change, given the hierarchical structure of the Roman Catholic Church and adherence of each institution to those shared ethical and religious directives, Dr. Charles must again weigh the potential benefits of rightfully advocating for what he believes is in the best interests of his patients against the potential harms of doing so under penalty of violation of his contractual obligations to the institution.

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Virtual Mentor

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CLINICAL CASE

The Patient Who Says He Is Ready to Die

Commentary by Margaret Tarpley, MLS, and John Tarpley, MD

Mr. Edwards arrived in the emergency room with colicky flank pain and hematuria. A noncontrast CT scan demonstrated an 8 mm stone in his left ureter. He was admitted to the hospital under the care of the urology service. The CT scan also showed a pancreatic head mass. After further work-up during the hospitalization, the mass was diagnosed as pancreatic adenocarcinoma. An oncology surgeon was consulted.

Dr. Sanders, the surgical oncologist, went to Mr. Edwards' room to discuss the diagnosis. He explained that pancreatic cancer was a very deadly disease, and that Mr. Edwards' only real hope for any long-term survival was to undergo pancreatoduodenectomy (Whipple procedure) soon. Even with the operation, Dr. Sanders explained that Mr. Edwards' chances for survival were slim and that the operation carried significant risk for morbidity. Nevertheless, Dr. Sanders reminded him that without the operation his chance for survival was essentially nil and strongly recommended that he undergo the procedure as soon as possible while the tumor was still resectable.

Having heard Dr. Sanders' recommendation, Mr. Edwards, who was 64 years old, responded, "Well, Doc, I think I understand. I've got no shot without the surgery, and a slim shot with it. I appreciate that you think I should have the surgery, but I'm not so sure. You see, I'm a man of faith, and I figure I'm ready to meet my maker. I've lived a full life, and I've got no regrets. I feel safe in the Lord, and I don't want to spend my last days in the hospital recovering from surgery, even if that means losing my shot at living another year or two longer. Nope, I'm going to choose quality over quantity, and live out the rest of my days waiting for the Lord to call me home."

Mr. Edwards' wife and two grown children, who were present, began to argue with him and urge him to reconsider. Nevertheless, Mr. Edwards remained peacefully steadfast that he did not want the operation. Dr. Sanders suggested that they all take some time to think about it and talk it over and told them that he would return the next day to discuss things further. As he was leaving the room, Mr. Edwards' son caught him and told him quietly, "Doc, you've gotta talk him into this tomorrow."

After he had left the room, Dr. Sanders was not sure what he would do the next day. His natural inclination was to be aggressive, especially in tumors found this early. He had had patients in the past who were scared or confused and reluctant to have a

Whipple, but whom he had convinced. But Mr. Edwards was different. He seemed to be at peace with his situation and to have understood everything. Dr. Sanders was not particularly religious, but the strength of Mr. Edwards' convictions and the serenity it brought him impressed him. Dr. Sanders was not so sure that the Whipple was the right thing for him.

Commentary

Respect for patient autonomy is a pillar of medical ethics [1]. In the 21st century physicians no longer tell the patient what to do when a diagnosis is made; rather the physician communicates—in terms suitable for the nonmedically trained person—an interpretation from the findings of the physical examination and various tests. The interpretation includes a diagnosis of the disease, possible courses of action with inherent risks as well as benefits of each action, and sometimes a recommendation, evidence-based if possible. Three terms for medical decision making are shared decision making, informed decision making, and evidence-based patient choice; but all retain strong physician input [2]. Dr. Sanders hopes that Mr. Edwards is capable of processing the information presented in the office, and he knows that many patients seek additional input from family, friends, and research on the Internet or in a library. An additional source of counsel may be related to the patient's cultural background or faith system such as a senior family member, minister, rabbi, imam, or spiritual director. Numerous polls, interviews, and published studies reveal the high percentage of the U.S. public for whom personal faith plays a role in viewpoints on healing and health, especially in a life-threatening or an end-of-life event [3-5].

Once the diagnosis is explained to a patient like Mr. Edwards and perhaps the patient's family, the physician who respects patient autonomy becomes a resource for requested information and advice but does not attempt to force a particular decision. From a physician competency standpoint, professionalism, communication, and interpersonal relations are involved in addition to medical knowledge and patient care. Mr. Edwards appears to be the only person involved who initially does not favor the surgical procedure option. His wife and children want him to agree to the operation, and the son pressures Dr. Sanders to assist them in reversing Mr. Edwards' decision. The clearly articulated reasoning for refusing the Whipple on religious and quality-of-life grounds impresses Dr. Sanders, who appears to respect the decision.

There are an estimated 42,470 new cases of pancreatic cancer in the United States in 2009 that will result in a projected 35,240 deaths. Cancer of the pancreas is one of the most lethal diagnoses. A third of patients who undergo a pancreateoduodenectomy experience a significant morbidity, though mortality is now in the low single digits at major centers [6]. Given the poor but not completely hopeless prognosis of pancreatic cancer, the preceding case study raises several questions.

Any competent adult has the right to invoke his faith in God to justify refusal of treatment, even when an intervention offers the only chance of prolonged life. But, (1) does Dr. Sanders have an obligation to advocate for surgical intervention because

of the slim chance of increased survival? (2) Should the plea from Mr. Edwards' family influence Dr. Sanders' advocacy for intervention if the physician personally can understand and even respect Mr. Edwards' decision? (3) What effect will Dr. Sanders' own personal faith—or lack thereof—have on his respect for and understanding of the patient's faith-based decision making?

One hundred years ago Sir William Osler offered timeless advice to the medical community on recognizing the various expressions of faith involved in health and healing: existential religious faith, faith in the medical system, faith in the doctor, and faith in the specific medical treatment [7]. As the rationale or even wisdom of a faith-based decision to refuse intervention is pondered, examples or precedents come to mind. A modern example is the Jehovah's Witnesses' religious proscription against blood transfusion. While many medical professionals have little or no understanding of the Jehovah's Witnesses' use of the Hebrew Scripture's condemnation of ingesting blood, an almost universal agreement has been reached to respect (or at least accede to) this belief and refer holders of this belief to medical and surgical practitioners who specialize in care that avoids using blood. Any adult whose mind is clear and who has adequate information should be respected for invoking religious beliefs as part of medical decision making, even if the decision runs counter to family or physician opinion. Treating cancer surgically has not stirred up religious controversy, and therefore the respect (grudgingly or otherwise) accorded to the person who refuses an abortion or stem-cell therapy is not automatically conferred on the person who refuses a risky surgical procedure that offers some hope for improvement.

Because any operation has risks, the physician who advocates for tumor resection must be honest about quality of life as well as possible benefits. The physician's obligation is to communicate clearly and honestly, not to "win" a debate. Even if the patient were refusing the operation based on fear of a surgery or the complications, the physician could offer appropriate assurance but no guarantees. Dr. Sanders can offer a possible 10 to 20 percent 5-year survival if the operation is performed versus an almost-certain brief survival period—although the quantity and quality of life is uncertain for both choices. When the physician strongly believes a poor choice is being made, it is his or her responsibility to communicate clearly understandable data, answer questions honestly, and attempt to understand why the patient has made the choice. It is not his or her duty to try to force a change of mind, even if family or others agree with the physician [8].

While the patient's family may be a vital component of the support system, both during and after medical or surgical intervention, the family can only play an advisory role for the competent adult while treatment decisions are made. Faith and beliefs are highly individual, and the physician cannot assume that all family members share the same religious interpretations. If family members accompany the patient to the physician's office, the physician can ask the patient if he wishes to invite the family members into the consultation. The wishes of family members may be heard but should not unduly influence the physician.

A physician such as Dr. Sanders, described as “not particularly religious,” is unlikely to be influenced by his own beliefs. Several studies suggest that a number of physicians hold religious and spiritual beliefs that might affect their practice but the actual influence of these beliefs on their practice is unclear [9].

Edmund Pellegrino, the father and dean of modern medical ethics, says that, in our current pluralistic society, “universal agreement on moral issues between physicians and patients is no longer possible” [10]. While the personal decision to forgo medical intervention may or may not be a moral issue for the patient, the physician who feels strongly that intervention is in the patient’s best interest may feel a moral obligation to communicate that opinion to the patient. The caveat is that all medical and surgical interventions carry risk, and the physician who forces a viewpoint on a reluctant patient—regardless of the patient’s rationale of fear, religious convictions, or family input—not only weakens that patient’s exercise of autonomy but might be assuming responsibility for a poor outcome. The physician makes recommendations, the patient makes the decision. When the physician feels assured that the patient has all the data and understands the benefits and the risks, the physician should respect the patient’s choice.

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THE CODE SAYS

AMA Code of Medical Ethics' Opinion on Respect for Patient Beliefs

Opinion 9.12 – Patient-Physician Relationship: Respect for Law and Human Rights

The creation of the patient-physician relationship is contractual in nature. Generally, both the physician and the patient are free to enter into or decline the relationship. A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination. Furthermore, physicians who are obligated under pre-existing contractual arrangements may not decline to accept patients as provided by those arrangements.

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JOURNAL DISCUSSION

Coping with Religious Coping

Kyle B. Brothers, MD

Phelps AC, Maciejewski PK, Nilsson M, et al. Religious coping and use of intensive life-prolonging care near death in patients with advanced cancer. *JAMA*. 2009;301(11):1140-1147.

The Coping with Cancer Study was a multisite study based in the Dana Farber Institute's Center for Psycho-oncology and Palliative Care Research and designed to examine the relationships between psychosocial factors and end-of-life care [1, 2]. Andrea C. Phelps and colleagues used a subset of the data from this study to explore whether a statistical correlation could be found between patients' religious coping styles and the administration of intensive medical treatment during the last week of their lives. In short, Phelps et al. concluded that those patients who reported using positive religious coping methods on a survey instrument were significantly more likely than others to have undergone invasive life support at the end of their lives and to have died in intensive care units.

Readers or clinicians who wish to apply this finding to medical practice face the tasks of understanding the meaning of the prospective patients' coping styles and the significance of the outcomes being measured and then inferring why these two artifacts should be connected. In this discussion of Phelps' study, I seek this type of understanding with the goal of identifying the value that this article might have for those in graduate and postgraduate medical education.

Religious Coping

The instrument used by Phelps et al. to identify patients who relied on religious coping methods is known as the Brief RCOPE. Pargament et al., who reported on the development and validation of this tool in 2000, designed RCOPE because "coping theory represents one promising perspective from which to understand, study, and work with religious issues" in research and practice related to counseling [3]. Pargament et al. explicitly focused on the functional role of religion (especially Christian religion) in dealing with life stressors, and it is for this reason that they directed their attention to religious *coping* as opposed to religious practice, religious morality, or religious experience.

For the purposes of RCOPE, its designers narrowed the meaning of religion to religious coping. As psychology researchers, they view humans as discrete individuals who function either successfully or unsuccessfully within society; it is because of this perspective that Pargament et al. are able to make normative claims

that some religious coping is positive and some is negative [4]. For these authors, then, the question is not only how religious coping functions in the lives of people undergoing life stressors, but also how religious coping helps or hinders functioning in society [4].

But Pargament et al. are not just interested in clinical psychology; they are interested in psychological research. Although psychology has strong theoretical and empirical traditions, empiricism has come to dominate modern research. For this reason, even researchers interested in developing a theoretically based model for religious coping look for empirical evidence as the most acceptable way to pursue that endeavor. Hence, RCOPE was designed specifically to facilitate the quantitative measurement of the use of religious coping techniques among large groups of individuals.

RCOPE does not allow us to understand religious morality because it focuses on religious coping; it does not allow us to understand the ways communities experience religion because it focuses on individuals and their functioning, and it does not allow us to understand the rich and complex ways that religion affects human flourishing because it attends only to elements that can be quantified. RCOPE is not designed to serve such grand purposes, but by using such a narrow conceptualization, researchers inadvertently create the impression that we are “dealing with religion” [4]. The religious elements of the body, mind, and soul of actual humans who face a terminal disease cannot be packaged so easily.

What, then, can we say of those patients with cancer who enrolled in the Coping with Cancer Study and were categorized through a brief version of RCOPE as employing “positive religious coping methods?” Certainly, they are people who explicitly identify God as playing a role in the way they deal with their diagnosis. From this we can infer that, in general, these are persons who use God language in talking about their experience in the world, including their understanding of morality. But the method employed does not allow us to understand what religion means for each of the 178 persons who were identified by RCOPE as using high levels of positive religious coping methods. In a quantitative study of this type, attaining such understanding would be neither practical nor desired.

Use of Intensive Medical Treatment

Phelps et al. chose intensive, life-prolonging care—defined as receipt of ventilator resuscitation during the last week of life—as their primary outcome. (They also looked at hospice enrollment as a secondary outcome, but I will not address the authors’ discussion of this outcome.) Unlike the categorization of religious coping methods, ventilator resuscitation during the last week of life is an empirical and quantifiable outcome. What is less straightforward, however, is whether this outcome is viewed as desirable or undesirable. The authors state only that, “Because aggressive end-of-life cancer care has been associated with poor quality of death and caregiver bereavement adjustment, intensive end-of-life care might represent a negative outcome for religious copers” [5]. Since both “quality of death” and “caregiver bereavement adjustment” are based on retrospective recall by caregivers

for those who have recently died, we can infer that the authors believe that intensive end-of-life care is desirable or undesirable only insofar as family members (perhaps as surrogates for the deceased patient) perceive that care to have been a positive or negative experience [4].

What is the Connection?

Building from these understandings of religious coping and intensive medical treatment at the end of life, we can begin to fill in the gaps as to why these two variables might show statistical association. The authors are interested in this connection and control for several potential confounders in their statistical model—among them patient preference for heroic measures, patient acknowledgement of having a terminal illness, the assignment of a health care proxy, and the use of nonreligious coping mechanisms—in order to isolate religious coping as a causative factor. After controlling for these variables, the association between religious coping and intensive treatment remained. The authors acknowledge, however, that they are unable to discern between the effects of religious coping and other elements of religiosity, including belief in healing miracles, belief that only God knows when a person will die, and “religiously informed moral positions” [6].

In fact, scientific inquiry of this type can never prove a theory of causation, but can only fail to disprove it and thus increase our confidence that the theory is correct [7]. For this reason, we should not expect this study to provide evidence of direct causation between religious coping and intensive medical treatment at the end of life. We should, however, expect the authors to provide cogent hypotheses for a causative relationship. Instead, theories they offer present religious coping as a marker for some other religious characteristic—e.g., religious copers may decide to undergo therapies with high risks and uncertain benefits because they trust that God could heal them through the proposed treatment, or “high rates of intensive end-of-life care...may be attributable to religiously informed moral positions that place high value on prolonging life” [5]. In the end, they propose further research in order “to determine the mechanisms by which religious coping might influence end-of-life care preferences, decision making, and ultimate care outcomes” [6].

If we cannot establish a direct connection between positive religious coping and intensive medical treatment at the end of life through either empirical or theoretical means, then we must theorize an indirect connection. Such a theory might take the following form: affirmation of the role of God in coping with a terminal illness is a marker for belief in God. Those who believe in God are more likely to express a set of preferences, expectations, or moral stances that would result in explicit or implicit requests for intensive medical treatment even in the face of a lethal illness. In general, physicians are reticent to withhold intensive treatment against patient preferences. Therefore, patients who affirm positive religious coping methods are more likely to receive intensive life-prolonging care near the end of life.

Significance for Practice

Unfortunately, the above conclusions create a dilemma for medical practice. The authors imply that the administration of intensive treatment near the end of life may lead to patient and family experiences that, in retrospect, will be undesirable to those involved. On the other hand, physicians frequently administer intensive medical intervention to those who prospectively prefer such treatments for religious reasons. As a result, it is likely that, on occasion, physicians respond to patient preferences by providing interventions that are not supported by medical indications and that families will later recognize as harmful. How can we as medical providers respond to such a paradox?

One approach is to step back from a focus on survey instruments that allow us to generate aggregate data about religion and end-of-life care. There are many types of expertise and knowledge, and in this case providing care to a terminally ill patient requires understanding of a specific human and his or her needs. This understanding cannot be found in empirical study results; it can only be found at the bedside. And learning how to obtain this understanding cannot be found in a textbook on evidence-based medicine; it can only be learned by observing our mentors, talking with one another and our loved ones, and by listening to our patients. I do not disagree with Phelps and her collaborators that chaplains and mental health providers should be involved in the care of the terminally ill. But I also believe that the most important part of our role as caregivers should not be delegated. We should develop comfort and confidence in discussing religious beliefs and experiences with patients, propose only reasonable interventions that are medically indicated, and provide our presence even when we don't need to perform a procedure.

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CLINICAL PEARL

Secondary Management of Ischemic Stroke

Derek Riebau, MD, and Lisa Hermann, MD

Complex interactions among the 100 billion neurons that form the nervous system not only regulate and maintain basic life-preserving functions, they render us who we are as individuals.

In an instant, any or all of the characteristics that define us can be permanently taken away by an all-too-common disease—*stroke*. Stroke is the sudden death of neurons due to impaired blood flow and oxygenation resulting in neurological deficits. There are two categories of stroke: ischemic stroke, which results from the occlusion of a blood vessel and is responsible for roughly 87 percent of strokes, and hemorrhagic stroke, which results from the rupture of a blood vessel [1]. Stroke is the leading cause of disability and the third leading cause of death (after heart disease and all forms of cancer). The financial burden of stroke to individuals and the U.S. health care system is enormous and growing—with an estimated cost for medical treatment of stroke of \$68.9 billion in 2009 [1]. Approximately 795,000 strokes occur every year; of these, about 185,000 (*more than 20 percent*) are recurrent strokes [1]. This latter statistic underscores the importance of secondary stroke prevention.

In this article, we will focus on prevention of recurrent ischemic stroke, which depends on the specific etiology and associated contributing factors. In general, ischemic strokes can be classified into large-vessel territory strokes and small-vessel territory strokes.

Large-Vessel Territory Ischemic Strokes

Large-vessel territory ischemic strokes are caused by occlusion of a main artery supplying the brain (e.g., internal carotid, middle cerebral, vertebral, basilar, or *posterior communicating artery*) or a prominent branch of a main artery and typically result from thromboembolic events, although focal thrombotic events can also cause main artery occlusion. Blood-vessel injury, stasis/turbulent blood flow, and hypercoagulable state—known as Virchow's Triad—are often sources of thromboembolic strokes. Etiologies include artery-to-artery thromboembolic stroke, cardioembolic stroke, and stroke associated with right-to-left shunts and hypercoagulable states.

Artery-to-artery thromboembolic stroke. Thrombus formation at the site of arterial disease may embolize to intracranial arteries. The most common cause is carotid atherosclerosis. Prevention of recurrent carotid atherosclerosis strokes is guided by degree of stenosis.

- For symptomatic stenosis between 50 and 99 percent, surgical management via carotid endarterectomy is effective for reducing stroke risk, although the benefit is greatest among patients with severe stenosis (70 to 99 percent) [2]. Medical management (e.g., blood pressure reduction, smoking cessation, lipid-lowering treatment, antiplatelet therapy) is also recommended for these patients [3].
- If the patient is not a good candidate for surgery, endovascular interventions (carotid artery angioplasty and/or stenting) may be an option, although clinical trials comparing carotid endarterectomy to endovascular therapy have produced mixed results [4-6].
- For carotid stenosis less than 50 percent, medical management is recommended [2].

Cardioembolic stroke. The most common cause is atrial fibrillation. Other cardiogenic sources include acute myocardial infarction with wall-motion abnormalities, severely depressed ejection fraction, atrial myxomas, and valvular diseases. Secondary prevention usually involves anticoagulation with warfarin, particularly for atrial fibrillation (INR goal, 2 to 3) [7].

Stroke in the setting of right-to-left shunt. In the event of a suspected thromboembolic stroke without identifiable artery-to-artery or cardioembolic etiology, a right-to-left shunt should be considered. The most common right-to-left shunt is a patent foramen ovale (PFO), which allows thromboemboli originating in the venous circulation (e.g., deep venous thrombosis) to gain access to the arterial circulation. The concomitant presence of an interatrial septal aneurysm appears to increase stroke risk, although secondary management in these settings is unclear (e.g., PFO closure versus medical management, antiplatelet versus anticoagulation) [8-11]. Clinical studies to help establish treatment guidelines are currently ongoing.

Stroke in the setting of a hypercoagulable state. This is less common but should be considered if vascular imaging and cardiac evaluation are unrevealing or if the patient has a history of previous thrombotic events. Examples of hypercoagulable states include pregnancy and the early postpartum period, malignancy, and inherited or acquired hypercoagulable disease. Efforts at prevention depend on the likelihood of recurrence and usually entail anticoagulation.

Small-Vessel Territory Ischemic Strokes

Small-vessel territory ischemic strokes are caused by occlusion of small, penetrating cerebral blood vessels (e.g., lenticulostriate branches of the MCA), resulting in lacunar infarcts that commonly occur in the deep subcortical regions of the brain, such as the basal ganglia, thalamus, internal capsule, centrum semiovale, and periventricular area, as well as in the pons.

The main risk factors include hypertension, diabetes mellitus, dyslipidemia, and smoking. Prevention of hypertension mandates appropriate management of the following four pervasive risk factors.

Hypertension. Treatment of hypertension leads to reduction in stroke risk of approximately 30 to 40 percent [12]. While lifestyle modifications (e.g., weight loss, exercise, low-salt diet) should be encouraged in all patients, most require antihypertensive medications. The optimal drug regimen for prevention of recurrence remains unclear and may depend on individual medical circumstances, but data supports the use of thiazide diuretics alone, or in combination with angiotensin-converting enzyme (ACE) inhibitors [3, 13].

Diabetes. Diabetes is a significant risk factor for recurrent stroke [14]. Glucose control to near-normoglycemic levels is recommended with goal hemoglobin A1C less than or equal to 7 percent [3].

Dyslipidemia. Treatment of dyslipidemia involves exercise, dietary guidelines, and medications with goal low-density lipoprotein less than 100 mg/dL and less than 70 mg/dL in patients with multiple vascular risk factors who are at very high risk for vascular disease [15]. Clinical trials have demonstrated that statins reduce stroke risk, and their use is recommended for prevention of recurrent stroke [3, 16, 17].

Smoking. Cigarette smoking increases the risk of stroke, so smoking cessation is crucial [18, 19]. Treatment strategies include counseling, nicotine products, and oral smoking cessation medications.

While these risk factors are discussed in the section on small-vessel territory ischemic stroke, their damaging effects on the vasculature are indiscriminate of vessel size. Thus, secondary management of large-vessel territory strokes would be incomplete without treating the concomitant vascular risk factors of hypertension, diabetes, dyslipidemia, and smoking.

Antiplatelet Therapy

Secondary management of noncardioembolic stroke with an antiplatelet agent has been shown to reduce stroke recurrence [20]. Antiplatelet agents include aspirin, clopidogrel, and extended-release dipyridamole, the last of which is used in combination with low-dose aspirin. Aspirin monotherapy, the combination of aspirin and extended-release dipyridamole, and clopidogrel monotherapy are all acceptable options for secondary stroke prevention [3].

Lifestyle Modification

Prevention of recurrent stroke must also include lifestyle modifications to address habits and conditions that directly or indirectly increase stroke risk.

Alcohol. Heavy drinking is a risk factor for stroke. Patients should be strongly encouraged to eliminate alcohol use or limit consumption to fewer than or equal to 2 drinks per day [21].

Obesity. The relationship between obesity and stroke is complex, inasmuch as many obese people have other associated risk factors for stroke (e.g., diabetes, hypertension, dyslipidemia). Losing weight significantly improves blood pressure

control, fasting glucose and lipid levels, and most likely has a global impact on reducing stroke risk [22].

Inactivity. Regular exercise lowers stroke risk, probably due to the effect of physical activity on blood-pressure reduction and improved glucose tolerance [23].

Sleep apnea. Sleep apnea is an independent risk factor for stroke, and untreated sleep apnea can worsen functional outcomes in stroke patients [24, 25]. Signs and symptoms of sleep apnea include snoring, daily fatigue, and daytime napping. Studies have shown that in patients with stroke and obstructive sleep apnea treatment with continuous positive airway pressure (CPAP) improves well-being and reduces risk of recurrent stroke and mortality [26-28].

While the discussion above encompasses many of the etiologies of stroke, further evaluation and prevention is required when less-common causes of stroke such as vasculitis, arterial dissection, and moya moya are recognized. Overall, appropriate recognition and management of stroke risk factors can not only prevent death and disability, but save the health care system billions.

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HEALTH LAW

Law and Medicine: Pediatric Faith Healing

Kevin Abbott

Prince v. Massachusetts established that adults willing to endanger their health in the name of religion are free to do so, but parents are not at liberty to make that choice for their children [1]. Child-neglect laws vary by state, but in general require parents to provide children with food, shelter, and necessary medical care [2, 3]. Still, certain religious groups subordinate biomedical care to treatment by faith alone [3]. Such “faith healing” is a resignation to divine will for healing that is effectuated through spiritual practices such as prayer, laying hands on, and anointment with oil [3, 4]. Currently, 30 states have exceptions to child-neglect laws that provide shelter from misdemeanor violations to parents who treat their children through prayer in accord with the beliefs of a recognized religion [2]. Sixteen of those states, however, have judicial bypass procedures that allow judges to compel medical treatment when the life of the child is at risk [2]. Yet up to the point of death or serious bodily harm, jurisdictions that provide for religious exceptions generally recognize parents’ rights to raise children in accord with their religious tenets [5, 6].

The first three cases that follow illustrate various approaches to clashes between religion and state law. The fourth is a contemporary case that is still working its way through the court system.

Religious Exception with No Judicial Bypass

California has a religious exception to misdemeanor child neglect with no judicial bypass provision. In *People v. Rippberger*, 8-month-old NM died after 2 weeks of illness and no biomedical intervention in keeping with her parents’ Christian Scientist beliefs [7]. NM suffered flu-like symptoms for the first week, at which point her parents called a Christian Scientist nurse. The next week, NM’s condition worsened: her eyes often rolled to the back of her head, her body became rigid, she suffered heavy convulsions and was often unresponsive. The nurse treated these symptoms with prayer and scripture readings, but NM died at the end of the second week. The autopsy revealed that NM had died of acute purulent meningitis, which medical doctors testified was treatable with antibiotics. The state charged NM’s parents with felony child endangerment under section 273 of the state penal code [7].

California Penal Code 270 requires parents to provide necessary medical care for their children [8]. It has a religious exception, absolving parental liability for treatment through prayer that follows the beliefs of a recognized religion [7]. The parents argued that the 270 exception extended to 273 because the purpose of the former was to provide statutory protection for Christian Scientists who treat children

according to their beliefs. Not extending the exception to 273, they pointed out, would blunt the purpose of the 270 exception. The court rejected this argument and read the religious exception narrowly. It held that the exception only applied to misdemeanor liability and declined to extend it to felony liability. The court reasoned, “we cannot accept the proposition that the Legislature intended to carve out an exception that would permit a small section of our society, with impunity, to endanger the lives of infants who are helpless to act on their own behalf” [7].

Thus, although there is no statutory language allowing courts to order necessary medical treatment, courts have shown a willingness to interpret religious exceptions narrowly and compel treatment via other statutes.

Religious Exception Subject to Judicial Bypass

Colorado has a religious exception with a judicial bypass provision. In *People ex rel D.L.E.*, the state asked the court to declare DLE a neglected child under Colorado law [9]. At age 12, DLE suffered grand mal epileptic seizures linked to brain damage sustained during birth. Because of religious beliefs, neither DLE nor his mother sought medical treatment and instead relied solely on prayer. The first trial court ordered medical treatment, which improved his symptoms. DLE’s mother appealed and the appeals court reversed the trial court’s order, finding that DLE’s prayer treatment fell within the religious exception to the child-neglect statute because his condition was not life-threatening.

Just before the first appeals court ruled, DLE stopped taking his medications and went into *status epilepticus*, which led to a stroke, permanent flaccid paralysis of the left extremities, and a nerve injury that inhibited right-arm movement. His brain functioned only 60 percent of the time, and at rehearing medical experts said he suffered “severe physical impairment” [9]. The state refiled its petition in light of these new developments.

At the second trial, physicians opined that without medication DLE would suffer greater lack of motor coordination and further brain damage [9]. Still, the trial court rejected the state’s petition, reasoning that the religious exception was a complete bar to a felony charge of child neglect. The state won on appeal [9]. The statute read, “No child...who is under treatment by spiritual means...shall, *for that reason alone*, be considered [neglected],” and the court reasoned in its decision that the statement “for that reason alone” did not preclude other reasons for alleging child neglect irrespective of spiritual treatment [9].

Thus, when a child’s life is in imminent danger a court may rule that the child is neglected per Colorado law, bypassing the religious exception statute.

No Religious Exception

Washington does not have a religious exception to its child-neglect law. In *State v. Norman*, the Normans failed to seek medical care for their 10-year-old son, AN, because of the beliefs of their church, No-Name Fellowship [10]. AN lost weight and

excessively drank water and urinated. Following religious protocol, Mr. Norman called the elders to pray over AN in church, at which point some members alerted Mrs. Norman to their suspicions of diabetes. When AN's condition worsened, elders went to the Norman's house for further treatment. They believed the illness was due to the sins of Mrs. Norman (failure to submit to her husband) and AN (masturbation). In order to "get right with God," one elder spanked both of them one evening. Mr. Norman then decided to spank AN through the night and seek medical treatment in the morning if necessary. AN died that night from juvenile diabetes; he weighed 46 pounds. A jury convicted Mr. Norman of manslaughter [10].

Since Washington did not have a religious exception to statutes requiring parents to furnish children medical care, Mr. Norman's appeal relied on broad principles of freedom of religion and expression found in the state and federal constitutions [5, 10, 11]. The defense argued that lack of a religious exception in such laws was unconstitutional [10]. The court rejected this argument, citing a long line of English and American common law precedent, reasoning that federal common law under *Prince* required parents to protect children from serious and fatal injury, even if that included seeking medical care contrary to firmly established religious beliefs. The court concluded that Mr. Norman was free to believe in any particular healing method but that he was not free to act on any particular method that jeopardized the health of his child [10].

Thus, in Washington and other states without religious exceptions, courts may compel parents to seek medical care irrespective of religious beliefs, however strongly they are held.

A Contemporary Case

A tension exists in Wisconsin law regarding faith healing exceptions. For conviction under the state's reckless homicide statute, a court must find that a person created an "unreasonable and substantial risk of death or great bodily harm" and that the person was aware of the risk that led to the death of the victim [12]. There is no religious exception for this statute [12]. There is, however, a religious exception in the Wisconsin child-neglect statute that absolves parents from child-neglect liability if they rely on "prayer or other religious means for treatment of disease or for remedial care of the child" [13]. Wisconsin courts are currently dealing with the tension between the provisions of its reckless-homicide and child-neglect statutes.

Eleven-year-old Madeline "Kara" Neumann died in March 2008 of diabetic ketoacidosis. Her parents, who were unaware that Kara suffered from juvenile diabetes, treated her symptoms with prayer in lieu of medical care, abiding by their religious beliefs [14]. The day before she died, Kara lost the ability to talk and suffered abdominal pains. The state charged the Neumanns with reckless homicide [15]. A Wisconsin jury convicted Mrs. Neumann in 2009 [15]. At trial, Judge Vincent Howard precluded any argument based on religious exceptions because the reckless-homicide statute did not have such an exception and added that the broader freedom of religious principles applies to beliefs, not actions [14].

On appeal, Mrs. Neumann has the option of either challenging her conviction on technical grounds or making a constitutional argument. If she chooses the latter, Mrs. Neumann could claim that compelling medical treatment abrogates the religious exception carved out in the child-neglect statute, which was designed specifically to protect state citizens' constitutional right to religious freedom. The court will likely respond with *Prince*, which said parents are free to risk life and limb in the name of religion, but are not free to subject their children to those risks [1]. It is a well-established principle that constitutionally protected religious freedoms are not absolute, and the government is willing to narrowly limit such freedoms to the extent necessary to protect the welfare of its children [1, 6, 7, 9, 10].

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POLICY FORUM

Access and Conscience: Principles of Practical Reconciliation

Lynn D. Wardle, JD

There are many situations in which conflicts arise between health care professionals who have religious objections to certain medical services and their employers or patients who want them to provide those services. The services that are generally controversial include delivery or support of abortion, sterilization, contraception, assisted reproduction techniques (ART), withdrawal of life support, withdrawal of nutrition and hydration, autopsies, or assisted suicide.

The American health care system can protect the basic rights of both institutional providers and individuals who have religious objections to certain services while still ensuring that patients have effective access to them. It is important to recognize that not all religious objections are categorical but often pertain to providing the service in only *some* situations, such as providing elective abortions but not therapeutic or life-saving abortions, or providing ART for polygamous, same-sex, or unmarried couples. Full respect for the core principles of both religious freedom and health care professionalism can be achieved under two conditions: first, if there is full commitment to protecting both interests, and, second, if there is a willingness to accept practical and reasonably complementary solutions, even if they are less than ideal from either perspective.

Right of Conscience as a Basic Human Right

The U.S. legal system has a deep tradition of protecting and respecting rights of conscience, particularly religious conscience, while endorsing excellence in and access to medical care. Respect for and protection of religious freedom predates the adoption of our Constitution and undergirds the First Amendment.

When our nation was founded, two different views of protection of religious conscience were competing [1]. One view was that protection of conscience was a matter of utilitarian tolerance and prudent political accommodation [2]. Here, respect for conscience and religion was a matter of *toleration*—sound public policy, neighborliness, good will, and expedient politics. If that view had prevailed, only a weak and unreliable civil-rights tradition would have developed. It makes a big difference whether respect for another's moral convictions is simply a matter of expediency and tolerance (to be suspended when outweighed by other political considerations), or whether it is a positive, basic civil right that everyone can exercise.

The founders adopted a positive right of conscience that has prevailed since and was most eloquently articulated by the father of the Bill of Rights, James Madison. Early colonial charters and state constitutions spoke of it as a right [3]. The Virginia Declaration of Rights was initially drafted to guarantee “fullest toleration” of religion but Madison amended it to say that “all men are *entitled* to the full and free exercise of [religion] according to the dictates of conscience.” When an effort to revive the religion tax in Virginia was made after the War of Independence, Madison drafted his famous “Memorial and Remonstrance” using the language of positive rights, not mere toleration: “The equal *right* of every citizen to the free exercise of his Religion according to the dictates of conscience is *held by the same tenure with all our other rights*” [4]. He described it as “an *unalienable right*,” and explained:

The Religion then of every man must be left to the conviction and conscience of every man; and *it is the right of every man to exercise it as these may dictate*. . . . It is the *duty* of every man to render to the Creator such homage, and such only, as he believes to be acceptable to him [5].

Madison explained further why conscience had to be protected in terms that underscored the foundational nature of rights of conscience:

Before any man can be considered as a member of Civil Society, he must be considered as a subject of the Governor of the Universe: And if a member of a Civil Society, who enters into any subordinate Association, must always do it with reservation of his duty to the general authority; much more must every man who becomes a member of any particular Civil Society, do it with a saving of his allegiance to the Universal Sovereign [5].

Madison saw the individual’s right of conscience as tied to and derived from his preexisting and superior duty to God. It was Madison’s view that was adopted by the founders of the American republic.

Today, as in Madison’s day, it is futile to expect citizens in a free democracy to be loyal to public officials and to obey their laws, if the laws do not allow them to be faithful to their God and obedient to His laws. Denying rights of conscience to health care professionals undermines the moral foundation for the claims of others on access to controversial services. If one’s own moral rights of conscience are not protected by law, it seems incongruous to be asked to respect another’s moral claim for access.

Practical Protections of Rights and Access

As Professor Kent Greenawalt writes:

In principle, people should not have to render services that they believe are forbidden directly by God or are deeply immoral. However, any privilege to refuse needs to be compatible with individuals being informed about and being able to acquire standard medical services and drugs, and with health care institutions and pharmacies not having to turn handsprings to have personnel on hand to provide what is needed [6].

Greenawalt counsels further that “people who can get treatment or drugs elsewhere and have adequate information about alternative possibilities have a much less powerful claim that refusal impinges on them to an impermissible degree” [7].

This is a good recipe for balanced accommodation: protection for rights of conscience, protection for the access interests of patients, and practical disclosure of information about conflicts and accessible alternatives to satisfy both values.

This formula has been tried and has worked in practice, showing that it is possible to protect both rights of conscience and rights of patients to controversial medical procedures. For example, the American Pharmaceutical Association adopted a policy in 1998 that protects the rights of conscience of pharmacists while supporting the establishment of “a system to ensure patient access to legally prescribed therapy without compromising the pharmacist’s right of conscientious refusal.” The system supplies free telephone information about pharmacies and pharmacists who will fill controversial prescriptions that may violate the rights of conscience of some pharmacists [8]. The toll-free referral system operates successfully in Washington state [9].

The landmark model for protecting rights of conscience without denying patient access arose from the controversy over requiring physicians to provide abortions and contraception products over their religious objections [10, 11]. Shortly after the Supreme Court of the United States struck down laws restricting abortion in 1973, federal courts forced church-run hospitals to allow sterilization or abortion despite faith-based hospital policy [12, 13]. Congress responded with the Church Amendment which prohibits courts from ordering an institutional health care provider or individual to participate in performing abortions or sterilizations contrary to their religious beliefs or moral convictions [14]. Later, Congress expanded protection for rights of conscience by enacting the Danforth Amendment to bar discrimination against those who declined to participate in abortion training, abortions, or referrals, and the Weldon amendment, barring federal, state, and local agencies or programs from eligibility for certain federal funds if they discriminated against individuals or institutions for failing to provide, pay for, provide coverage of, or referral for abortions [15, 16].

Nearly all states have enacted similar conscience-protection provisions into state laws—only Alabama, New Hampshire, and Vermont currently lack explicit conscience protection covering at least abortion services [17]. While many of the state and federal laws offer protection for rights of conscience that is limited to specific services, procedures, personnel, or institutions and does not extend to or cover many others, these laws have had a powerful symbolic effect in preserving the principle of protection of religious conscience of health care professionals generally, with very little documented evidence of hardship for persons seeking controversial medical procedures [18, 19].

Protection for rights of conscience is not always favored. For example, the 2007 Ethics Opinion Number 385 of the Committee on Ethics of the American College of Obstetricians and Gynecologists entitled “The Limits of Conscientious Refusal in Reproductive Medicine,” would significantly curtail the rights of providers of reproductive medicine to exercise conscientious abstention [20]. While the opinion acknowledges tensions between a physician’s conscience and patient access to controversial services, it fails to recognize that protection of conscience is a fundamental human right, not merely a convenient accessory. Its analysis presents many reasons for facilitating full patient access but fails to present with equal care the reasons for protecting rights of conscience, so the conclusion that physicians’ rights of conscience must nearly always be subordinated to facilitating patients’ access to care reflects flawed analysis. For persons interested in serious analysis of the legal and moral debate, Opinion Number 385 is a disappointingly one-sided.

We Can Do Both

Tensions between religious values and professional obligations can be reconciled by respecting both interests. Preserving protection for rights of conscience while accommodating access takes frustratingly more time, effort, and creativity for those whose goal is maximum ease and efficiency of delivery of particular health care services. The inconvenience factor may be one reason why profit-driven or cost-conscious health care institutions and organizations are impatient with efforts to protect their rights. While protecting rights of conscience and of access to services may sometimes require additional cost or sacrifice on both sides, in the long run it takes less time and expense than the litigation, deep resentment, and backlash that denial of the first American right—the right of religious conscience—inevitably produce.

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MEDICINE AND SOCIETY

Recognizing the Mind/Body/Spirit Connection in Medical Care

Samuel E. Karff, DHL

For many centuries, conventional wisdom proclaimed the healing power in the doctor-patient relationship. In “Precepts,” Hippocrates declared: “...where there is love of man, there is also love of the art. For some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician” [1].

By the middle of the 20th century, with the impressive triumphs of modern biomedicine, a new paradigm declared that, in an age of sophisticated diagnostic tests, pharmaceutical magic bullets, and super surgery, only the quality of the biomedicine physicians mastered and applied determined medical outcome.

But during the past 25 years or so another mindset has emerged which maintains that the clinician/healer must both address the disease and know the patient as person. The physician should seek to know how the medical condition is being experienced by the patient and what impact it has on his or her life and spirit. Because of the mind/body/spirit connection the quality of that understanding can actually affect medical outcome. We have recovered the insight of Hippocrates [2, 3].

As a result, the web surfer will discover a plethora of programs in medical centers bearing such names as medical humanities, spirituality in medicine, and health and the human spirit. Our program at the Center for Health, Humanities and the Human Spirit defines spirit or spirituality as a person’s inner world of values, vital beliefs, strivings, and goals—in other words, all that gives meaning to a human life. Meaning is the sense that there is purpose in my life even when I face its darker side, including serious, chronic, or terminal illness. The human spirit drives the quest for meaning, and meaning sustains our will to live.

There are multiple sources of meaning: the giving and receiving of love; our daily work; feeling connected to the mystery, beauty, and grandeur of nature; love of music, and, for a significant number of people in our nation, the beliefs and spiritual disciplines of a religious community [4]. The majority of patients welcome a physician’s inquiry into their spiritual or religious belief in the context of medical care [5].

Eric Cassell has taught us that there can be pain without suffering. He defines suffering as pain devoid of meaning [6]. A third-year student at our medical school visited with a couple in the hospital immediately after the expectant mother

experienced a miscarriage in her 7th month. Hardly able to contain his bitter tears, the husband explained this was their third miscarriage. “Why is this happening to us doctor? What did we do wrong?” The student physician explained the possible biomedical triggers of a miscarriage without realizing that the couple was also asking a deeper question. This cumulative assault on their hopes shattered their sense of meaning. How could this happen in a world governed by a powerful and gracious God?

Whether religious or not, a sensitive physician should recognize that the biomedical level of understanding may be inadequate. In such instances the physician should connect the couple to an appropriate clergy person for additional counseling.

To ascertain a patient’s spiritual beliefs, Dr. Christina Puchalski suggests that physicians ask a set of questions that can be integrated into the patient’s history. Among the questions, she suggests: “What is your faith or belief? Do you consider yourself spiritual or religious? What things do you believe in that give meaning to your life” [7]?

Such inquiries are best reserved for serious medical situations in which the doctor is likely to be part of the ongoing treatment. The physician may want to begin more nondirectedly by acknowledging that, “This is a difficult time in your life. What helps you get through such times?” If the patient mentions his or her religious faith, the doctor should validate the potential helpfulness of such support; if no indication of religious belief is given, Cynthia Cohen et al. suggest the following: “Some people also find that their religious or spiritual approach to life is a great source of support to them when they are ill. Do you have a religious or spiritual connection that is important to you” [8]? If the response is negative, further inquiry would be inappropriately intrusive.

We seek to help medical students understand that even when their personal attitude toward religion is negative, they should guard against depreciating the patient’s faith by word or body language. Without any violation of conscience, nonreligious physicians should be able to say: “I know that many have found their faith very helpful.” Such validation is important not only because the physician is an authority figure, but as an expression of elemental respect for the patient.

If a physician’s nonbelief is one potential source of conflict with the patient’s values, the devoutly religious physician’s inclination to bear witness to his or her faith is another. Any proselytizing gesture is a gross abuse of the patient’s vulnerability and a serious violation of professional boundaries. Nor should the religious physician initiate prayer with the patient. The most unobjectionable testimony to personal faith I have heard from a physician came in a conversation with Dr. Andrew von Eschenbach, a distinguished urologist at MD Anderson Cancer Hospital and most recently the head of the FDA. He told me that whenever he gives a serious diagnosis he says to the patient: “I promise to get you the best treatments available; I will be

with you through this journey, and, since I am a believer, I will be praying for a positive outcome.”

If the physician and patient share a common faith, an offer to pray together may be appropriate. But periodically, a nonreligious medical student or physician will be asked by a patient to pray at the bedside. How may the clinician be supportive of the patient without violating his or her conscience? He may respond: “Let me hold your hand and be with you, but why don’t you offer the prayer.” That response expresses solidarity and is less distancing than, “Sorry, this is not my thing. I will request that a chaplain come to pray with you.”

Some religiously grounded patient requests may not be accommodatable. When a male resident entered the labor and delivery room, the patient’s mother confronted him: “We are Muslim and it is not fitting for our daughter to be exposed to a male who is not her husband. We need a female doctor to deliver our baby.” The resident validated the mother’s concern and promised he would try to accommodate her, but he cautioned that a female resident might simply not be available at delivery. As it happened, the female residents were involved in other deliveries. The male resident walked into the “lion’s den” with great sensitivity. He affirmed the family’s concern and expressed regret that he could not accommodate their request. He assured the family he would seek to minimize exposure, that members of the family could be present in the delivery room, and that he knew the family’s primary desire was for the delivery of a healthy baby. The family showed appreciation and relief.

In retrospect, the family’s initial objection could have been totally disarmed if the resident had suggested that a chaplain be summoned to visit with the family. Armed with knowledge and spiritual authority, the chaplain could explain to the family that, in all major religious traditions including Islam, when life or health is at stake, normal religious prohibitions may be suspended. Surely this would not be the first time a male physician delivered a Muslim baby.

In most situations of potential conflict between religious and medical values, a chaplain or other clergy can be helpful. A physician faced such a challenge when an elderly woman was judged by the medical team to have crossed the boundary between prolonging life and prolonging dying. For weeks, the woman was confined to bed, totally unresponsive, unable to communicate, and sustained by a respirator. While the medical team determined that this was a case of medical futility and suggested the removal of all artificial support systems, the woman’s daughters steadfastly insisted on “Doing everything to give God time to perform a miracle.”

One daughter acknowledged that some months earlier, her mother had said she would prefer death to what her life had now actually become. At that point, the student physician requested that the daughters speak to a chaplain. Hearing the daughters’ concern, the chaplain explained that, “God heals through the doctors He sends and the medicine and machines He enables us to discover or fashion. Sometimes, God heals in His own special way, and we call that a miracle. If God

wills a miracle, He does not rely on artificial support systems. You may still pray for a miracle, but you should allow your mother to receive palliative care.” In effect, the chaplain explained that the daughters misunderstood the nature of a miracle. After this conversation, the family consented to palliative and hospice care.

A woman told her physician that since her adolescence she had observed a complete fast during the 24-hour period of Yom Kippur, the holiest day in the Jewish year. She insisted on observing the fast without hydration. When the physician admonished that in her condition such observance could endanger her life, she held fast to her intention. Fortunately, the physician asked for a clergy consultation. A Jewish chaplain explained to the patient that in Jewish law it is a sin to fast if doing so endangers your life. The woman agreed to receive hydration.

Whether religious nor not, we live our lives without being fully in control and face an uncertain future. Religious persons seek comfort in the faith that beyond the mystery there is an ultimate source of power and goodness to whom they may turn for strength and healing. At such times they want the best biomedical resources available, but they also seek intimations of God’s presence. Before serious surgery such patients will welcome a visit from both surgeon and clergy.

Suppose a physician knocks on the patient’s door and discovers that a minister is either in discussion or prayer with the patient? Should the physician ask the clergy to leave for a few minutes so he or she may visit with the patient, or should the doctor, wherever possible, excuse himself or herself and return after visiting other patients? In my early ministry, physicians and clergy assumed that the doctor’s visit should always take precedence. Perhaps it is a measure of a cultural shift and of the impact of our health and human spirit program that when we ask this question of our medical students today they almost invariably say: “I would excuse myself and say that I will return after visiting other patients.”

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HISTORY OF MEDICINE

The Indian Health Service and Traditional Indian Medicine

Everett R. Rhoades, MD

The federal government's assumption of responsibility for American Indian health care brought together two fundamentally different systems: centuries-old traditional Indian medicine and modern Western medicine. Early physicians, while acknowledging extensive Indian use of herbal remedies and certain successful therapeutic procedures, generally regarded Indian healing as based primarily on superstition. Even so, recognition of Indian healing successes and patients' insistence on being seen by a traditional healer sometimes resulted in a certain degree of cooperation between physicians and traditional healers [1]. Systematic attention to Indian medicine, however, may be considered to have begun in the mid-20th century with two simultaneous occurrences: (1) the Many Farms Demonstration Project and (2) the 1955 transfer of Indian health services from the Department of Interior to the Department of Health, Education and Welfare (now Health and Human Services).

The Many Farms Demonstration Project

The Many Farms Demonstration Project, a collaboration among the Public Health Service, Indian Health Service (IHS), Cornell University Medical School, the Navajo Nation, and the Many Farms Community, was designed to examine the feasibility of a comprehensive community-oriented system of care in a Navajo community [2]. It was an outgrowth of earlier studies conducted by Cornell University physicians of the newly introduced isoniazid for the treatment of tuberculosis among Navajo Indians. Not surprisingly, the Many Farms Demonstration Project, with its inclusion of an anthropologist, examined the interface of traditional Indian healing and modern medicine. The project's analysis of traditional Indian healing is perhaps the only semiquantitative approach to the subject and provides information that remains useful today. Part of the success of the program lay in the recognition that "First, it must be realized that this is not a situation of compromising alternatives. Rather, there is belief on the part of patients that both systems have something to offer, they both 'work'" [3].

The Indian Health Service

Even before the Many Farms Project and the 1955 transfer referred to above, much of the care provided to Indian people had strong community emphasis, especially in preventive programs. The newly appointed IHS Director, Dr. James R. Shaw, built upon this community orientation and implemented a number of initiatives, one of which was attention to traditional Indian healing. Aware of the important role sometimes played by medicine men in improving community health programs, he recognized the value of inculcating traditional practices in the IHS [4]. For example,

he arranged for tours of IHS clinics and hospitals by medicine men, acquainting them with Western medical procedures and practices [5]. This mark of respect for traditional healing set a positive tone for subsequent IHS policy. An illustration of IHS physicians' calling on the assistance of a traditional healer is related by Dr. Shaw:

The medicine man had come to the hospital in response to urgent appeals by medical officials, who called him in after two patients had fled the hospital and others were preparing to leave. Lightning, which some Indians believe is a cause of illness, twice had struck a tree on the hospital grounds. The hospital and its patients had to be blessed; the spirits concerned had to be placated. When this was done, the patients settled back with confidence that danger had been warded off. The white man's medicine had been reinforced by Indian religious concepts [6].

An intriguing bicultural aspect of this case is that the ceremony, apparently conducted in the laboratory, reached each patient room through use of the public address system. This case also illustrates that, in addition to specific individual healing procedures, cultural consultations are often important elements of successful therapeutic outcomes. I was once asked to consult (at a non-IHS hospital) on the case of an Indian patient who felt compelled, for rather complex and important tribal religious reasons, to leave the hospital against medical advice. The patient was able to relate the reasons for the need to me but not to his own physicians; the result was a successful outcome.

IHS efforts in the 1960s and early 1970s were given impetus by passage of the 1978 American Indian Religious Freedom Act, which, as the title indicates, was designed primarily to protect American Indian religions. Reflecting the importance of religious expression in much Indian healing, the IHS director issued the following policy statement:

The Indian Health Service has continued to recognize the value and efficacy of traditional beliefs, ceremonies and practices of the healing of body, mind and spirit.... It is, therefore the policy of the Indian Health Service to encourage a climate of respect and acceptance in which an individual's private traditional beliefs become a part of the healing and harmonizing force within his/her life [7].

The policy was explicit in regard to Indian patients:

When an Indian Health Service patient (guardian-family member) requests assistance in obtaining the services of a native practitioner, every effort will be made to comply. Such efforts might include contacting a native practitioner, providing space or privacy within a hospital room for a ceremony, and/or the authorization of contract health care funds to pay for native healer consultation when necessary [7].

In accord with this policy, in constructing new health care facilities, the IHS often sets aside a room or, in some instances, a building for use by traditional healers. The IHS also expanded efforts to support traditional Indian medicine through employment of a traditional healer, located in Headquarters West, Albuquerque, New Mexico. This individual served as a liaison with local communities and other traditional healers.

In 1992, the formal Traditional Medicine Program was established, also located in Headquarters West. Its primary purpose is to increase the interface between the two systems of care. A further advance occurred in 1994 with issuance of a policy statement introduced by the following memorandum from the IHS director:

This memorandum is to affirm my commitment to protect and preserve the inherent right of all American Indians and Alaska Natives (AI/AN) to believe, express, and exercise their traditional religions [8].

This statement coincided with the establishment of the Traditional Cultural Advocacy Program (TCAP) as an important means of ensuring that traditional healing practices are respected by IHS employees in all our services and programs. During the next 2 years, roundtables were held throughout Indian country bringing together traditional Indian healers and IHS personnel to seek ways to foster cooperation and collaboration. In general, there were strong expressions that the IHS (and other government agencies) should do more to foster utilization of traditional healers. A number of suggestions were made, unfortunately many of them not clearly feasible within the federal system.

An important ancillary effort on the part of the IHS has been increased orientation of IHS personnel to respective local Indian customs and traditions. Efforts to make newly constructed facilities more attractive to Indian patients through attention to local cultural norms have also increased. As announced by the director in 2007:

Within the IHS, I am especially proud of how all of our newly built health centers and clinics reflect the cultures and traditions of the Tribes we serve. Each new design is created in close consultation and collaboration with the Tribes.... For members of the Navajo Nation, there is special meaning in the new Four Corners Regional Health Center because tribal culture is reflected in such features as the lobby dome, which represents a traditional Hogan with eight cedar panels. Additionally, the main lobby floor incorporates the Navajo four sacred colors in its design, and the building's entrance canopy supports are faced in sandstone to recall the Red Mesa. Traditional Healing programs at facilities such as the Fort Defiance Indian Hospital also combine the proven and accepted ways of Native medicine with the modern technology of the federal Indian health care system [9].

Thus, efforts on the part of the IHS to support traditional healing continue. Presently, the most common interface between IHS practitioners and traditional medicine men and women is in the IHS Alcohol and Mental Health program. It is not uncommon, however, for IHS personnel to participate in certain healing activities such as the increasingly common “sweat” ceremonies used in several healing practices.

A relatively new development that will significantly influence incorporation of traditional healing is the assumption of management of health programs by the tribes themselves. Approximately one-half of health programs are now operated by the tribes through IHS self-determination or self-governance contracts. Notably, tribes are free of many bureaucratic requirements, such as personnel policies, with which the federal agency must comply. The extent to which various tribes incorporate traditional healing is not presently known, but anecdotal information indicates that a number provide for traditional healing.

Given the widely scattered nature of Indian communities and the highly individual nature of medical practice, it is not surprising that a given policy is sometimes unevenly implemented at the local level. In addition, inadequate funding and a number of practical and logistic requirements often pose barriers to full expression of a given policy. In the case of traditional Indian medicine, questions of credentialing, mechanisms of payment, and criteria for federal hiring or consultation by traditional healers as contractors have yet to be satisfactorily resolved. For example, if traditional healers are to become federal employees, they naturally will fall within the extensive civil-service requirements, which they may not be eager to accept. Tribes correctly assert that they are the ones who should designate (i.e., certify) traditional healers. While agreeing, the IHS is still faced with the dilemma of paying for such care, especially given the cumbersome and restrictive federal guidelines for the procurement of medical services, one element of which is the requirement for competitive bidding in the awarding of contracts. In fact, the IHS as a federal bureaucracy has a limited set of mechanisms that can be brought to bear on the subject. Notwithstanding the highest level of desire to be supportive, certain bureaucratic requirements will undoubtedly continue to pose challenges for some time.

Regardless of the several practical considerations, an underlying and fundamental question has not been completely resolved: whether the special sacred nature of much Indian healing might be injured by placing it within the IHS systems of care [10]. As expressed by a young Indian woman to the Task Force on Health of the American Indian Policy Review Commission in 1976, “real traditional Indian healing should not even be talked about too publicly, it is too sacred for that” [11]. Thus, one can appreciate the delicacy with which the IHS, as a federal bureaucracy, must proceed in efforts to provide for traditional Indian medicine. This delicacy is expressed in the 1978 policy noted above:

The goal is that there be respect and complimentary [sic] interface between the two systems of medicine and religion. Care must be taken that apparent Indian Health Service and federal beneficence do

not become a means of destroying a system of healing which has both a long history and contemporary relevance [7].

Each of these systems is affected by modern life and developments, but in different directions. While Western medicine continues dramatic growth, modern pressures are exerting a negative influence on the development of traditional healers and their work. A common concern expressed throughout Indian country is that the number of traditional healers continues to diminish.

It is not possible to predict the future, but it seems clear that support for traditional Indian medicine will continue to occupy the attention of both the IHS and tribal programs and efforts to accommodate each of the systems will continue to evolve. In the meantime, perhaps the most pertinent observation was made more than a half-century ago by the Many Farms leaders: “The two systems then, co-exist, but for any given illness there is no interaction. This situation is very unstable and one of the systems is likely to become dominant—but the outcome will be decided on political grounds, rather than on factors related to the relative efficacy of the two systems” [2].

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MEDICAL NARRATIVE

Sami, the Methanol Guy

Nabil Al-Khalisi, MD

Health is a multistep process that starts with community awareness and ends with patient care. When the community education level is nonexistent, there is little a physician can do to help patients, no matter how skilled he or she is. The following is a story of an after-midnight shift in an Iraqi ER—one where I had a problem that was more cultural than clinical, and one I could not face on my own. I was traumatized, threatened, had flashbacks and deep moral conflicts; I ran away.

It was midnight; the weather, cold and foggy. I sat before the glass door of the pediatrics emergency department main entrance. I was tired and headachy, having spent the day working with a senior colleague. We both worked quickly, discharging as many stable patients as possible. My senior colleague left me alone to face the after-midnight shift so that he could get some rest.

I looked through the glass door, hoping that no one would come. After 16 hours of labor I was ready for a break. Knowing there were 8 hours more made me feel sick, but I tried to be optimistic and take things easy.

A loaded after-midnight shift can bring up to 20 patients; I was hoping for a max of four or five. The good news is only one patient came asking for help that night. The bad news is that after I finished my duty I wished I had had 30 patients screaming and shouting instead of this one.

Sami had brown hair, shiny blue eyes, and a small mouth wide open. He was about 5 years old. He was so drowsy that he was unable to walk for any distance without a stumble. He arched his back a little bit, hanging over his grandfather's big hand. They were both walking in a slow stride that made me follow their every move as they advanced toward the main entrance. Sami looked curious about what was really going on; he had not been into a hospital before I guessed.

As they opened the door I could not face Sami without a smile on my face. His charm threw a spell on me from the very first glance. He was an adorable little fellow who made me feel that every little effort and every drop of sweat for the sake of every child was worth it. I forgot about my headache and started talking to Sami right away. His grandfather appeared worried and anxious and he kept interrupting my conversation with Sami. It was as if he really knew that we were all running out of time. Sami's hands were cold and he was clearly unbalanced; he smelled like alcohol and his clothes were covered in vomit. I asked him what was wrong, but he

replied with a faint smile, saying, “Nothing, I feel sleepy; where is mom?” Just then I turned to the grandfather who was shaking and stuttering. He said, “Doctor, he almost drunk the whole bottle, all of it, thinner, we were painting, the whole bottle!” I suddenly realized that I was dealing with a time bomb here. A “thinner” means methanol; in Iraq it is used to dilute paints.

I fetched my stethoscope and listened to the child’s chest, which was mostly clear with a few scattered wheezes. I ordered Ipecac solution and IV fluids right away and tried to talk with Sami to assess his level of consciousness; he seemed to be oriented but a bit sleepy. Telling Sami that everything would be ok was a joke but I had no other choice. I had to lie; at least it would alleviate his fears.

Treating methanol poisoning is quiet simple. You bring some friendly ethanol molecules that shift hostile methanol molecules away from liver cells and we are all happy and safe—no retinal damage; no liver failure; no nothing. The problem was that the list of 20 generic, commonly used drugs carried by our pharmacy—the pediatric emergency department pharmacy at the medical city complex that is the best health institution in Iraq—did not contain ethanol. My mind raced with thoughts of how I could get some ethanol in Baghdad at midnight. No stores were open; no pharmacies. I remained silent for a while thinking deeply, trying to solve a problem that was 10 times more logistical than medical. I had never run into such a problem during my entire 12-month career. I bent down and looked directly into Sami’s eyes. I touched his cheek and told myself, “this kid must make it.” I was bothered by Sami’s strong aromatic smell with every breath, as if he were an alcoholic. Just then I had an idea—let’s drink some Arak (a traditional colorless Iraqi spirit that contains up to 80 percent ethanol—affordable and at hand. My initial plan was to make the grandfather get a bottle or two of Arak from a nearby shop, as alcohol stores tend to stay open later than pharmacies.

I turned to the grandfather, took him away from Sami, and tried to be assertive and informative at the same time. “Sir, Sami is dying. We have got only one shot. He has methanol poisoning, it is very serious, and we need to act fast. Methanol has only one antidote which is ethanol, and unfortunately we do not have medical ethanol here; do not feel panic please; we can make it. Arak contains ethanol as its main component, and we can use it to cure Sami. Bring me a bottle of Arak and I promise to do my best but please hurry up.”

After this short speech things changed dramatically; the grandfather’s face turned from pale yellow to red; he became obviously angry and aggressive. He attacked me with both his hands, trying to smother me. He was taller and heavier than me so within seconds he grasped my neck. He started shouting “You bastard; you have no mercy; you want me to bribe you? Are you trying to blackmail me? Are you bargaining Sami’s life for alcohol? If he dies, you die too, understand?”

Soon after that the Facility Protection Service (FPS) intervened. Suddenly I was surrounded by guards; they pulled the grandfather away and tried to calm him. On

my hands and knees, I took a few deep breaths. Just then I saw noticed that Sami was looking at me strangely, like he was saying, “What is going on? Grandpa loved you a moment ago? What did you do to make him so angry?” In this moment I felt that time had stopped and it was just me and little Sami looking at each other. I realized that Sami’s life was on the line and I had to convince his grandfather that I was saying the truth or else.

In the other corner of the ER, Sami’s grandfather was forced to sit on the floor. FPS’s attempts at calming him were not successful and he continued shouting and threatening me. He felt so angry that both his hands were shaking—he was hysterical. Convincing such a man is almost impossible, but I had to try no matter what. I slowly advanced and stopped about 1 meter away from him while the guards were still holding him down to the floor. I asked him to listen carefully. He looked at me with disgust and told me that God would punish me for my horrible acts; no one could escape the rage of God. I talked as keenly as I could and tried to be convincing. “I am not asking for a bribe; this is my job and I am doing it in the best way that I can. Arak contains ethanol and we really need it. Bring it and you will see that I will not sip a drop of it. Trust me please; Sami’s life is on the line here.”

He replied in an indignant way, “Drinking alcohol is a sin; God told us that no benefit can be sought from alcohol; God knows what he is doing.” It became obvious that I had failed to convince him. I went to the lobby and called the chief resident immediately; fortunately he was awake and willing to come to the ER right away. Five minutes later the chief was examining Sami and soon after talked to the grandfather, telling him that every word I had said was right and that he should do as I say. At this very moment the grandfather became insane, calling me names and shouting very loudly, “Corruption, you both are corrupted physicians, you do not deserve to live, God help me, if anything happens to Sami I will kill you both, I will tell the minister of health.” The drowsy chief resident whispered a few words in my ears, telling me to discharge Sami. He said we had done all we could, and the grandfather would have to accept the consequences of his actions.

While the grandfather was crying for help and cursing me at the same time, I stood a few meters away, thinking of alternatives. I thought maybe I could go fetch the bottle, but realized that this was impossible because there were too many critically ill patients in the ER that could not be left alone. I thought about waking up an off-duty fellow colleague to do the job, but would the grandfather let us give alcohol to Sami? Why would anyone risk himself at this late time to help a guy who was refusing help in the first place? Feeling hopeless and incapacitated, I decided to wait and see whether Sami’s deterioration would push the grandfather and make him listen to me. This was my last option.

Time passed slowly. I watched Sami fading minute by minute without being able to do anything. First he started vomiting; then he became drowsier and drowsier; a few hours later he became completely unconscious. The grandfather never changed his mind; he continued to blame me for what was happening and promised revenge if

Sami died. I felt sad watching a child's life slipping away in vain. Despite Sami's deteriorating condition, the grandfather decided to stand still, and he was intending to report what happened to the hospital officials the next day. I felt so tired and confused at that time and let my eyes close. Meanwhile, the grandfather tired of shouting and crying too; he became silent, letting out a brief cry every now and then. At 4 a.m. the three of us fell asleep.

Suddenly at 5:30 a.m. a scream broke the silence. The grandfather shouted, "Help me, he is not breathing, his hands are turning into blue, God please save him, he is still so young to die, oh God, help." I rushed to Sami with my stethoscope and checked his vital signs; he was dead. I tried to resuscitate him but to no avail. A few minutes later when I lost hope that I could bring him back I looked into his face and said, "Forgive me dear Sami, I did my best, I hate this world for not giving you another chance, which you really deserve to have." He was cold and pale; his face was still as charming as before but less expressive. I think that he did not even know what had happened to him. The grandfather collapsed soon after that. I spent the next 2 miserable hours remembering every little detail of what had happened. Five minutes before my shift ended the grandfather started weeping and then came straight toward my desk; he looked me into the eye and said "I will kill you, Sami must be revenged, you are corrupted, and I will never feel peace till you are dead." I felt so sorry for everyone, including myself. I also felt scared that this distraught man might really try to kill me.

On my way home, I thought deeply about this event. I realized that medical training alone was not enough to cure people. It is not always about training and equipment; sometimes ignorance, illiteracy, and a chance are all that matter. Putting the pieces of this story together tells us one fact: healing people is a multistep process that starts with education and ends with treatment. I could not oppose societal values on my own. Being a doctor is a doubled-edge sword; you can help sick people more than you can imagine because you are in the middle, surrounded by sickness. On the other hand, providing health care alone is not enough. We should adopt a new way of thinking; humans are so precious, we should cherish our lives, and abandon our disagreements because they simply do not matter anymore.

After the incident, a dozen questions popped up into my exhausted mind; can I keep doing this in Iraq? Should I try harder or just give up? Whose fault is it? Am I doing the right thing? I got home, took off my shoes, and lay down in bed. I closed my eyes and ran away. I could face no more truth. I ran away, far away in my bed.

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OP-ED

Physicians and Patients' Spirituality

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Editor's Note: In this series of op-ed articles, three authors explore a range of perspectives on the question of whether physicians should engage patients on the topic of spirituality.

Ethical Concerns and Boundaries in Spirituality and Health

Christina M. Puchalski, MD, MS

Spirituality has become an increasingly prevalent topic in current models of health care. More than 75 percent of medical schools teach topics related to spirituality and health, and hospitals are beginning to develop spirituality programs to increase the delivery of compassionate care [1, 2]. Spirituality can be defined as “the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred” [3]. Illness can trigger profound existential questions for the patient and family, as well as for health care professionals, and questions about why people suffer, die, or have to deal with unbearable stress are often at the heart of the clinical encounter.

Spirituality and religious beliefs and practices have been shown to have an impact on how people cope with serious illness and life stresses [4, 5]. Spirituality often gives people a sense of well-being, improves quality of life, and provides social support [6, 7]. Spiritual beliefs can also affect health care decision making [8]. Numerous surveys indicate that patients want their clinicians to talk with them about their spiritual needs and integrate spirituality into their treatment plans [9, 10].

Healing Clinical Relationships

An integral part of spiritual care is the focus on the patient-clinician relationship in which care is viewed from a humanistic as well as technical perspective. Differentiation is drawn between cure and healing and between disease and illness. An emphasis on cure or disease relies primarily on the scientific model of care. Focusing on healing or illness brings the patient and the physician into the clinical context. The patient's wishes, beliefs, and values play a role in decision making and in the treatment plan. And the clinician's ability to form a compassionate relationship with the patient is as important as that clinician's ability to diagnose and treat the patient scientifically. Central to this healing relationship is recognition of and attention to the support that is available to patients in the midst of their illness. Studies have shown that ability to support patients in their suffering requires health care professionals to know how to be a compassionate presence, convey dignity, and

attend to spiritual needs of families [11]. If they are to be fully present to the patient, health care professionals must prepare through reflection on their own sense of transcendence, meaning, purpose, call to service, and connectedness to others.

The focus on relationship-centered care implies that both parties are equal partners in the clinical healing relationship. Conversations about existential and spiritual issues transform the clinical encounter and its participants, as the clinician and patient move into a nontechnical and personal domain of experience. Clinicians have to recognize that they have the capacity to be deeply influenced by their patients just as they (clinicians) influence patients. There is an intimacy in these healing relationships and in spiritual care—one that must be engaged in with formality. Ethical guidelines are of paramount importance in relationship-centered care where boundaries are not explicitly clear [12].

Intimacy with Formality

Intimacy with formality recognizes that there is a power differential between the clinician and the patient. Patients feel a sense of vulnerability and lack of control and view the power and control as belonging to the clinician. Clinicians have a moral obligation to never exploit a patient, to be trustworthy, and to use their expertise and power with the best interests of their patients in mind. Conversations about spiritual and existential issues are deeply personal. In this context, the clinician must recognize that she is not an expert in the patient's spiritual beliefs. Therefore, it is best to follow the patient's lead in these conversations. Proselytizing by clinicians or dismissing patients' spiritual or religious beliefs is unethical under all circumstances within the clinical encounter. Forcing a patient to share his or her beliefs or values is also discouraged, and patients' privacy must be respected. Questions should be asked in a manner that conveys openness to all types of beliefs—humanistic, religious, and nonreligious alike. Some patients may have had traumatic experiences with religious or spiritual organizations and may be resistant to disclosing their backgrounds. Thus, a spiritual history or assessment should be sensitive enough to identify concerns in all patients and ask general questions that invite them to share what is important to them and their care [13-15].

Respect, patient-centeredness, and inclusivity are key ethical guidelines for medical practice [16, 17]. Respect means valuing the patient's views even when they differ from more frequently encountered belief systems. Respect also extends to the recognition that individuals are unique—two people with the same religious affiliation do not necessarily treat all dogma of that religion in the same way [18, 19].

Boundaries

Appropriate therapeutic relationships with patients and families adhere to boundaries. This is for the benefit of the patient, family, and clinician.

Boundaries are mutually understood, unspoken, physical, emotional, social, and spiritual limits to the professional relationship. Where the clinician ends, the other person begins. Observing boundaries shows a healthy recognition of the

purpose of the relationship and, at the same time, avoids building walls. Boundaries allow clinicians to be in the present and to passively enable emotional, physical, or social distractions to flow freely, not interrupting the patient-clinician interaction. Suppose, for example, the patient verbalizes thoughts that for some reason make the clinician uncomfortable. Recognizing the professional boundary allows the physician to focus on the clinical issue rather than on the patient's potentially distracting words or emotions, so the encounter can continue. Distancing, which many clinicians use to protect themselves, is based on a fear of entanglement and actually jeopardizes the clinical relationship in that it breaks the potential for a compassionate connection. Respect for boundaries, on the other hand, allows for compassionate presence in the healing encounter. Clinicians are more vulnerable to crossing boundaries when they are overworked, stressed, or have experienced losses or grief, so it is essential that they have avenues for self-care and reflection.

Conclusion

Spiritual care supports the relationship-centered model of health care. Clinicians who open the door to spiritual questions of meaning and purpose, suffering, and issues at the boundaries of life and death gain intimate relationships within the clinical context. To sustain this relationship effectively, ethical guidelines must be honored and boundaries observed for the sake of both patient and clinician.

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The Perennial Collaboration of Medicine and Religion

Stephen G. Post, PhD

From the dawn of civilization spirituality and religion have defined human experience. It is from religious worship, beliefs, rituals, and practices that cultures emerge and that the great majority of lives are still shaped in most parts of the world, especially in times of severe illness or catastrophe when people tend to ask deep questions about their lives. These big questions do not go away: Is there a purpose to life? Is there hope for humanity? Do love and compassion go with or against the grain of the universe? Is there a higher power and can our lives be lived in accordance with it? Are we morally accountable to it? Can we be forgiven in some

ultimate sense? Is our nature merely biological, or is there a nonmaterial soul that points toward eternity?

The intensity and pervasiveness of these and other big questions about human nature and destiny in the cosmos have in no way subsided in our scientific age. Indeed, from New Age spiritualities to the global rise of Christian Pentecostalism, from the undiminished appeal of religious traditionalism to the pervasiveness of faith-based philanthropies, modern times are as defined by spirituality and religion as any other in history, perhaps more so insofar as technological innovations force us to ask questions about our growing capacities to modify the essential nature of humans and to bring our species to an end through massive violence and ecological perils. Physicians who interact empathically with patients understand that such questions are very much a part of the illness experience.

We all know that religions can bring out the very best in people and the very worst, like marriage and parenthood, like corporations, politics, and even the profession of medicine itself. And yet these are all institutions that will remain with us and, at their best, contribute to human flourishing. The spate of neo-atheist best-selling books calling for the end of religion and spirituality in favor of a pure secularism can only be understood as the frustrated gasp of those who observe the continued modern importance of spirituality and religion, despite elite secular philosophies.

Medicine arose in theological contexts. The ancients swore their healing oaths to the gods and goddesses, thereby adding an aura of sacred depth to the task of preserving life and ameliorating suffering. A revolution in medicine occurred with the Abrahamic faiths, all of which gave rise to a more deeply impassioned concern for the ill than had been seen in classical antiquity. From the Prayer of Maimonides to the Christian founding of the first hospitals, from the advances made by Muslim physicians to the establishment of great medical schools in Europe and the Middle East, from Florence Nightingale's founding of modern nursing to Dame Cicely Saunders' establishment of the Hospice movement, from Albert Schweitzer's "reverence for life" to Paul Farmer's "theology of liberation," medicine has never been secularly grounded. Rather, medical science has been energized with the noble religious commitment to healing. In this there has been no contradiction, but rather a great synergy whereby empirical methods devised by Christian Renaissance humanists like Francis Bacon merged with a religious stewardship for human lives. To think that modern medicine can be explained in secular terms is to be neglectful of its spiritual history.

Good healers have always understood that the art of medicine requires empathic attentiveness to patient spirituality. The patient who is loved feels that his or her life has value and significance in the eyes of the nurturer. Compassionate love responds to the deepest of human needs—the need for *significance*. It reflects back to the beloved the significance, dignity, and even sacredness that would otherwise be obscured. The need for significance is not the quest for fame or renown. Rather, in

navigating through life, all people need to feel that their existence is not an error. The affirmation of significance is profoundly important in times of severe illness.

In December 2006, I walked through the Johns Hopkins University Hospital's Broadway entrance in Baltimore. Built in 1889, this historic entrance is breathtaking, in large part because of a 10-foot-high marble statue of Christ entitled *The Divine Healer*—a replica of Danish sculptor Albert Thorvsaldsen's *The Christ*. Donated to the hospital in 1896, its massive base reads, "Come Unto Me All Ye That Are Weary and Heavy Laden and I Will Give You Rest." Bathed in light, the lowered arms depict divine compassion encircling the ill and the grieving, as if to say, "I understand your travail." How many people over more than a century have walked by that statue with a feeling of complete insignificance before the power of illness and death, only to be uplifted by a renewed sense of self worth?

Granted, things have changed over the last century, and many American hospitals that had their origins in the religious promptings of Judaism and Christianity have loosed themselves from these identities. But even in secular settings, whether in the Cleveland Clinic or at Stony Brook, clinical pastoral care is thriving, interfaith chapels can be found, and attentiveness to patient spirituality and religion are considered part of good medical practice. Indeed, much research indicates that health is enhanced when patient spirituality is taken at face value and respected as such. Medical schools such as Duke, the University of Chicago, and Yale University are the norm rather than the exception with their flourishing programs that link to divinity schools. Johns Hopkins University might not wish to build a marble statue of Christ today, but its chapel is open to people of all faiths.

Spirituality and religion are especially important to people with serious diagnoses. This is an existential reality—most people who have to cope with a serious threat to their health or that of a loved one get down on their knees and seek the assistance of a higher power of their own understanding. A surgeon may be a committed atheist, but that does not stop the average patient awaiting major surgery from praying that God will guide that surgeon's hands. Many are the surgeons who report requests from patients to join them in prayer before a major operation, and the best either do so or bow their heads in silence while the patient prays. Spirituality and religion do not "creep in" to the patient-physician encounter, but are constitutive of it now no less than when the first shaman healers walked the earth.

What links healing to the spiritual and religious aspects of patients and physicians lives? Patients need hope and a sense of meaning in life if they are going to cope successfully with a serious illness. Hope and meaning impact treatment decisions and adherence, relationships with caregivers, and even physiology itself, as Dr. Jerome Groopman has summarized in his book *The Anatomy of Hope*. For most people, hope and meaning are not just matters of individual subjectivity or of interpersonal relations—they are contextualized within a spiritual-religious framework. It is one thing to be dispositionally optimistic, a quality that may quickly fade in hard times. But hope is deeper; it endures even the lowest valley. For many

people, such hope requires faith in a higher power. To dismiss the spirituality and religion of a patient is often to dismiss the emotional conditions under which healing optimally occurs.

Respect for patient spirituality should be coupled with respect for physician spirituality at those times when a physician adheres to religious prohibitions against, for example, declaring brain death if the physician is an Orthodox Jew, or performing abortions if he or she is Roman Catholic. Over my 21 years teaching in medical schools at Case Western and Stony Brook, I have encountered many medical students who are deeply shaped by their religious traditions in wanting to practice the healing art. Many of the finest physicians with whom I have worked are deeply faith-based in their lives, although they are rightly not explicit about this in daily practice. They worship regularly, pray for their patients early in the morning, and make every effort to practice with compassion. Virtues such as compassion, commitment, diligence, and self-improvement are rooted in a faith-based perspective on the value of human lives.

Of course the clinic is no place for a physician to be explicit about the importance of spirituality and religion in his or her practice, nor should such faith be imposed in any way on patients. But a general openness toward and appreciation of patient spirituality is likely to flow from a physician who recognizes the importance of spirituality in his or her own life.

Contemporary medical ethics has a decidedly secular tone. Most people who are involved professionally in the field have little or no understanding of the religious traditions that shape the lives and decisions of patients and their families. For this reason, patients and their families usually prefer to discuss significant issues of medical ethics with the appropriate clergy. In many institutions I have engaged in conversation with ethics committee members who are disturbed that patients prefer to consult with clinical pastoral care. But such a preference makes great sense—why would a patient who is religious suppose that anyone on an ethics committee would understand his or her values, much less share them? Oftentimes, legal cases on medical futility or other topics involving medical ethics arise primarily because ethicists have no understanding of religious traditions and perspectives, and may even show some degree of hostility.

How can we do better? First, we need to recognize that religious values are often constitutive of patient identity in fundamental ways. These values therefore cannot be privatized (i.e., left in the purely inner domain of the patient without any actual implementation in the world). Such values need to be taken seriously. Second, clinical pastoral care should, with adequate training, become centrally involved in hospital ethics consultations.

Medicine and religion are as linked today as they ever were. They are brothers under the skin, for at their best both promote a reverence for life as a gift to be cared for, healed when possible, and freed from physical pain.

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Why Patients' Religion Is Not Their Doctor's Business

Richard P. Sloan, PhD

The possibility that religious devotion is associated with better health—a belief held widely by the general public and increasingly within medicine—brings with it a growing demand that physicians address the religious and spiritual concerns of their patients in clinical settings. While no one disputes that religion provides comfort to a great many in times of distress, the question is whether physicians can make any additional contribution to this and if so, how? This brief essay summarizes the evolution of the recent move to reconnect spirituality and medicine and examines the empirical, practical, and ethical implications of physician involvement in the religious lives of patients. I conclude that (1) the evidence supporting a connection between religious devotion and better health is at best weak, (2) physicians lack the time and training to engage in anything more than the most superficial inquiry into their patients' religious and spiritual concerns, and (3) there are significant and unresolved ethical impediments that make physician involvement in the religious and spiritual lives of their patients unjustified, impractical, and misguided.

Many factors have contributed to the growing interest in connecting religion and medicine. They include cyclical waxing and waning of religious sentiment throughout U.S. history, a rise in irrationality over the past 40 years, the influence of advocacy foundations, and patient dissatisfaction with technology in contemporary medicine. Regarding the latter, many see physician attention to the religious and spiritual lives of their patients as a solution to this problem, a way of “humanizing” the medical encounter. But as H.L. Mencken put it, for every complex problem there is a solution that is simple, neat, and wrong.

It is wrong for any number of reasons. First, despite the claims of proponents, the evidence linking religious devotion to better health is weak and inconclusive [1, 2]. The strongest evidence shows associations between increased attendance at religious services and reduced mortality [3]. But even this evidence is mixed and difficult to interpret.

People attend services for a great many reasons—out of religious devotion, certainly. But also out of loneliness or habit, to make business contacts, or to find friends. It is impossible to determine which of these religious or social benefits of church-going is responsible for the association with reduced mortality, assuming the association is

solid. As Garrison Keillor remarked, “Anyone who thinks that sitting in church makes you a Christian must also think that sitting in a garage makes you a car.”

Second, practical constraints make it extremely difficult for physicians to do anything more than determine whether patients’ religious beliefs will influence their care. Advocates recommend conducting a “spiritual history,” a series of questions designed to inform the physician about patients’ religious and spiritual concerns [3, 4]. Different versions of these histories exist, but even the briefest reduces the limited time physicians have with patients. This is a significant problem, since many recent investigations have determined what practicing physicians know too well already: there is far too little time in the day to address all the medical matters that, on the basis of solid empirical support, are considered standard patient care. To take only one example, an *American Journal of Public Health* paper reported that for physicians to provide all services recommended by the U.S. Preventive Services Task Force at the recommended frequency would alone take 7.4 hours per day [5]. Physicians’ valuable time should be devoted to matters they are trained to manage and that make a difference to their patients’ health outcomes.

This leads me to the related point that physicians are untrained in religious and spiritual matters. Largely in response to funding from the John Templeton Foundation, medical schools have added training in these matters. In 1993, fewer than five schools offered some training in religion and spirituality; now 70 percent do [6, 7]. No one has tracked precisely what this training consists of, and there must certainly be considerable variation. Given medical school curriculum requirements, it is unlikely to consist of more than a few hours during the first 2 years. Exposure to such training does not qualify physicians to respond to the often complex religious and spiritual matters that arise for patients when they are ill. Health care chaplains study for years to be qualified to discuss such matters with patients. Indeed, in matters of religion and spirituality, the physician has no more expertise than the patient.

Third, attempts to bring religious matters into clinical medicine raise significant ethical concerns, including manipulation and outright coercion, invasion of privacy, and causing harm. Regarding the first, religious intrusion into medical practice threatens to violate the norm of patient autonomy. For example, the Christian Medical and Dental Association, a professional society with more than 17,000 members, publishes a handbook that instructs physicians on how to use their practices to evangelize. Because medical patients are very often in pain and fearful, they are especially vulnerable to manipulation by physicians who, even in these days of patient consumerism, retain positions of authority in the patient-physician relationship. When doctors capitalize on this authority to pursue a religious rather than medical agenda, they violate ethical standards of patient care.

Religious influence on medicine is pernicious in another way. Recently, the *New England Journal of Medicine* reported that 14 percent of U.S. physicians, representing different regions of the country and different medical specialties,

believe that their personal religious views rather than the needs of their patients should determine which legal medical treatments they offer and, more distressingly, that they are under no particular obligation to disclose this bias to their patients or to refer them to other physicians who will offer the treatment. Ethicists have noted that, because doctors have state licenses that grant them exclusive rights to practice medicine, they have an obligation to deliver medical care to all those who seek it, not just to those who share their religious convictions. That means understanding the best scientific evidence about which factors contribute to health and which don't and practicing medicine accordingly. It means not permitting personal values, religious or otherwise, to supersede the best interests of patients. As epidemiologist Petr Skrabanek noted, allowing doctors' religious values to interfere with the care patients receive is "a social movement dressed up in scientific language" [8].

Proponents of bringing religious practices into medicine frequently claim that patients want their physicians to inquire about their religious and spiritual concerns under the guise of more patient-centered care. Some have remarked that, regardless of the evidence about relationships between religion and health, "we should address [religion in medical practice] because the patient surveys are saying that we should be addressing it" [9]. "Most patients desire to be offered basic spiritual care by their clinicians and censure our professions for ignoring their spiritual needs" [10].

Close inspection indicates that these claims are substantially exaggerated. With a single exception, the studies on which these claims are based ask general questions about patients' interest in having physicians raise religious and spiritual matters in clinical medicine. In one study, for example, 456 patients from primary care clinics in six academic medical centers from North Carolina, Florida, and Vermont were surveyed about a variety of topics including their preferences for religious or spiritual involvement in their own medical encounters [11]. While two-thirds thought that their physician should be aware of their religious or spiritual orientation, only one-third wanted to be asked about it during a routine office visit. Not surprisingly, the more severe the medical condition, the more willing patients were to consider a spiritual or religious interaction. But when asked whether they would want their doctor to discuss spiritual issues *even if it meant spending less time on their medical problems*, the numbers of patients who wanted these discussions plummeted: only 10 percent were willing to make this trade-off while 78 percent were not.

Finally, bringing religious and spiritual matters into medicine raises a more basic question that derives from broader American societal trends: the apparent willingness to subordinate other interests and virtues to religious values. Advocates contend that religion and spirituality are important aspects in the lives of many of their patients and therefore, physicians should engage in discussing them. While it is certainly true that religion and spirituality are important to many patients, they are no more so than many other aspects of our lives: family, friends, work, hobbies, and so on. Religion or spirituality, like sports, or finances, or music, make up one of many essential concerns in the lives of patients [12].

To conclude, no one disputes that for a great many people, religion provides comfort in times of difficulty, illness-related or otherwise. However, because (1) the evidence of a connection between religious devotion and better health is weak and difficult to interpret; (2) there is far too little time in clinical practice to take on religious matters; (3) physicians are not trained to do so; and (4) doing so raises significant, unresolved ethical issues, the best approach for physicians is to respectfully note patients' interests, religious or otherwise, and move on.

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SUGGESTED READINGS AND RESOURCES

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