

CASE AND COMMENTARY

How Should Physicians Respond to Patient Requests for Religious Concordance?

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Abstract

In which ways and in which circumstances should institutions and individual physicians facilitate patient-physician religious concordance when requested by a patient? This question suggests not only uncertainty about the relevance of particular traits to physicians' professional roles but also that medical practice can be construed as primarily bureaucratic and technological. This construal is misleading. Using the metaphor of shared language, this article contends that patient-physician concordance is always a question of degree and that greater concordance can, in certain circumstances, help to obtain important goals of medicine.

Case

Ms L is a 78-year-old woman who presents to a primary care clinic to establish care with a new physician, as she has recently moved. She is assigned to a newer physician on staff, Dr O, who chats with her briefly and then begins to interview Ms L. Within a few minutes of Dr O's questions about her health history, Ms L mentions her faith. "I found Jesus a long time ago," she says sincerely. "Do you believe in God?"

Dr O is surprised but doesn't show it. "Yes, I do. Is it okay if we focus on your medical history for now?"

Ms L pauses for a moment and goes on about her faith's importance. "An essential part of who I am is that I believe in God. I believe in Jesus. What God do you follow? Is it Jesus, Allah or another god?" Dr O tries to focus on how to move on to obtain the rest of Ms L's history, and replies, "I believe in Jesus and Allah, too." Ms L straightens her spine and immediately replies, "No, you can't follow both."

Dr O doesn't reply and moves on to her review of systems. "Do you know if there is a Christian doctor here?" Ms L interrupts.

Dr O replies, "I'm new to this clinic and don't really know the religious affiliations of my colleagues." Dr O pauses and considers whether to continue examining Ms L.

Commentary

This case could be approached successfully in a variety of ways. We advocate a case-by-case approach to similar impasses, which call for wisdom and finesse. Accordingly, we caution against policies that would rule out any number of responses (eg, accommodation, partial accommodation, resistance) that might fit a specific clinical environment and patient.

We do recognize, however, that this case invites us to consider a wider set of difficult cases encountered by physicians—namely, cases in which a patient seeks out a physician who is concordant with her along some dimension (in this case, religious affiliation). This wider set of cases prompts an important question: In which ways and in which circumstances should institutions and physicians facilitate patient-physician concordance when such concordance is sought by a patient? This question involves considerations of justice (Are similar patients being treated similarly?), physician duties (Are physicians obligated to accommodate reasonable patient requests?), and the roles of health professionals in a pluralist society (Which aspects of physicians are relevant to their professional roles and why?). (We restrict our commentary to patients' requests for concordance, since physicians' requests for concordance involve additional ethical considerations.)

Are Particular Features of Physicians Relevant to Their Professional Roles?

Requests for religious concordance may stir controversy because of concerns about justice or the understandable desire to preserve strict **professional boundaries**,^{1,2} but each of these motivations may reflect the medical profession's underlying uncertainty about the relevance of individual characteristics to professional roles. Resistance to facilitating religious concordance is consistent with calls for physicians to set aside their particular characteristics (eg, religious affiliation³) when they don their professional role, but such calls are grounded in a false presumption—that the practice of medicine is primarily a bureaucratic and technological venture.⁴

On this construal of medical practice, the physician is characterized as an interchangeable and "anonymous functionary"—a characterization of moral worthiness when associated with "proper procedure," as the intrusion of the physician's particularity becomes a threat to the procedures that preserve the medical bureaucracy's pretense to fairness.^{4,5} The requirements of bureaucracy and technological production conspire to characterize particularity as either corrupting (bureaucracy's concern) or as a threat to predictability and reproducibility (technological production's concern); in this frame, particularity threatens hopes of achieving medical practice that is efficient and fair.^{4,5} Within the bureaucratic imagination, the only relevant features of individuals are those that mark them as holders of bureaucratic offices (ie, physicians) or as clients of such offices (ie, patients).^{4,5} As clients, patients are *assumed* to desire and need representative professionals, not idiosyncratic individuals.

Concerns about efficiency and fairness are appropriate when considering general clinical encounters between “moral strangers,”⁶ but such concerns do not preclude facilitating clinical encounters between *moral friends*. Ms L’s queries suggest that she is seeking a moral friend whom she can trust to promote her health in the context of a particular moral landscape. Accommodating such a request can be accomplished without threatening fairness, whereas refusing such a request is likely to hinder Ms L’s physician from practicing good medicine and Ms L from participating fully in a physician-patient relationship. Thus, reflexive resistance to facilitating religious concordance due to concerns about fairness or efficiency prioritizes the demands of a vision of medicine that may not lead to the best care for some patients. Moreover, in some cases, it seems quite possible to meet the demands of efficiency and fairness while simultaneously facilitating clinical encounters between moral friends.

The possibility of religious concordance promoting the practice of good medicine in some cases alerts us to the reality that the practice of medicine is not primarily a bureaucratic and technological venture and that arguments grounded on such a construal go astray. In contrast, we maintain that each patient and physician is an irreducibly particular individual with a manifold identity, only one aspect of which is described by the role of patient or physician. While these roles certainly entail commitments, these commitments do not require the wholesale repudiation or concealment of one’s manifold identity. It is neither possible nor wise to attempt to strictly separate the personal from the professional; to do so involves eradicating deep, often idiosyncratically grounded, commitments—eg, a personal commitment to serving those in need—that are often prized in those who enter medicine. Setting aside this false dichotomy between the personal and professional, how should physicians navigate concordance or discordance with their patients along different dimensions?^{7,8,9}

Concordance as One Strategy for Realizing Current Ethical Ideals

It seems uncontroversial to say that the competent physician pays attention to psychological and social features that may affect patient care. A physician’s capacity to pay attention—and to facilitate wise decisions in light of what she recognizes—can be enhanced in some cases when there is concordance of one form or another between a physician and a patient.

To select a common example, it may be that any competent physician can, with the help of an interpreter, treat a patient who speaks a different language, but a physician who shares the primary language of the patient has presumably *more capacity* to elicit salient information, understand context, and respond appropriately to what the patient says. The aforementioned “more” is not required by the professional role, but it does seem to facilitate the achievement of goods that medical professionals rightly pursue. Concordance, in this case, enhances the practice of medicine. The example of [language concordance](#) relates to the case described above, as religious discordance can be viewed

as the absence of a “common vocabulary” and context—in short, as the absence of a shared language.¹⁰

Using the example of language concordance as a paradigm case, we suggest that concordance of moral vision and “moral language” may help physicians recognize and respond to salient features of individual patients. While any competent physician can treat Ms L, she might be best served by a physician who speaks her “language,” understands her traditions of thought and practice, and can respond in light of any salient nonphysiological information that emerges due to this shared context.

Of course, a request for concordance can express not a need for a shared moral language but a form of invidious discrimination, such as when a patient insists on being treated by a white physician. Facilitating such requests is obviously unacceptable, and it is possible that Ms L is motivated less by a desire for shared moral language than by a disdain for non-Christians. Distinguishing cases that deserve accommodation from those that should be resisted is no small feat, and it calls for difficult moral discernment in some cases. But, in the present analysis, we presume Ms L is acting in good faith, and this assumption seems fitting as a first response to most patients.

Returning to the notion of moral vision and moral language, each patient and physician enters a clinical encounter steeped in particular traditions of thought and practice, which inform their moral evaluations of available goods (medical and nonmedical) and their judgments about how medicine fits into the pursuit of those goods. Accepted ideals of medical practice, such as shared decision making (SDM), informed consent, and goal-concordant care, recognize this evaluative aspect of clinical encounters.¹¹⁻¹⁶ SDM attempts to rectify asymmetries between patients and physicians by promoting, at a minimum, the transfer of information from physician to patient and the transfer of values and preferences from patient to physician, recognizing that the moral evaluation of courses of action bears heavily on whether they are medically appropriate.^{11,12,14} SDM hopefully leads to a joint decision informed by both medical expertise and patient values. In a similar vein, a primary goal of informed consent—on some readings—is to assist the patient in making treatment choices that accord with her inherent stable values, once again recognizing the importance of the moral evaluation of medical therapies.¹³ Recently, the concept of goal-concordant care has risen to prominence as a way of describing care that accords with a patient’s goals and respects the limitations she desires; some authors have even suggested that failing to achieve goal-concordant care may constitute a medical error.^{15,16} All 3 of these ideals—SDM, informed consent, and goal-concordant care—highlight the reality that health is a real good, but it is not the only good. All patients must eventually decide how to choose among the various available goods and to what extent to cooperate with physicians in doing so.

The physician who attempts to achieve the ideals represented by SDM, informed consent, and goal-concordant care is tasked with attending to the patient's past and present in order to envision and propose clinical care plans that reflect the physician's commitment to the patient's health and accord with the particular characteristics, preferences, and interests of the patient.¹³ In making these proposals, the physician respects the patient's authority to decide whether and to what extent she will cooperate with the physician to pursue various courses of action among the many available (some of which may contradict the physician's medical recommendations). In some cases, the patient's particularity will influence the very proposals the physician offers. This process of mutual accommodation can fail, and some failures will be traceable to blindness on the part of physicians—blindness that might have been overcome by concordance of moral vision and moral language.

Such blindness may be rooted in the medical context. The medical context has been described by Taylor as "a community defined by the shared cultural conviction that its shared convictions [are] not in the least cultural, but, rather, timeless truths."¹⁷ Taylor pithily describes this as "a culture of no culture."¹⁷ In this frame, the physician is presumed to be neutral—as Dr O is characterized—and any discordance is a matter of the neutral medical-scientific perspective (often portrayed as normative) coming into conflict with a particular (in this case, religious) culture. Ms L's reaction to Dr O exposes the weakness of this claim of physician neutrality. Ms L indicates that the religious commitments of her physician matter to her. Dr O might be able to demonstrate respect for Ms L without sharing her values, but Dr O will have to concede that she is not an interchangeable representative of the medical profession. She is, rather, a physician who comes to medicine with convictions that differ from those of her patient, which might make a difference for the care she offers Ms L. Put differently, in the dance that is medical practice, medical facts are not merely given; as Kuczewski writes, uncovering medical facts involves a "value-laden thought process.... Such values may simply come from the standard of care and the clinical culture, but they will sometimes be colored by the physician's own experiences and, quite possibly, personal values."¹⁸

We suggest that proceeding from the predominant cultural commitments of a culture of no culture can hinder physicians from achieving medical goods. To provide one example, Hasnain et al have argued on the basis of their qualitative research that "Muslims ... have in common a religious thread that impacts the entire spectrum of their health-related beliefs and practices."¹⁹ Accordingly, Muslims, particularly Muslim women, have a diverse set of **religious and cultural needs** related to health and, as Hasnain et al note, "lack of providers' attention to these needs compromises the provision of quality care and contributes to Muslim women's reluctance to seek and use healthcare services."¹⁹ In their study, most challenges reported by clinicians in treating Muslim women centered on clinicians failing to understand these patients' religious and cultural needs.¹⁹ While ignorance can be overcome by education, it also can be mitigated by concordance at the

level of religious affiliation and gender. Moreover, the public appears to suspect that physicians' distancing themselves from patients' cultural commitments (ie, proceeding from a culture of no culture) sometimes hinders their care. One survey found that 43% of respondents were "very" or "somewhat" concerned that "medical personnel might not understand how your culture affects the type of treatment you would like to receive."²⁰

Conclusion

The clinical encounter is steeped in and inevitably shaped by the values of both physicians and patients, and concordance is always a question of degree. Physicians who resist requests for concordance may have uncritically accepted a role as an anonymous functionary working in a culture of no culture. We contend that this posture will sometimes prevent a physician from recognizing the goods and values at stake in a request for concordance and in the medical decisions that patients face. This is not to say that all requests should be satisfied, but it is to argue for cultural humility rather than a presumption of neutral cultural competence in assessing such requests.²¹ As Tervalon and Murray-García note, such humility requires that we are "flexible and humble enough to say that [we] do not know when [we] truly do not know and to search for and access resources that might enhance immeasurably the care of the patient."²¹ Occasionally, the best resources we have may be our colleagues, who—because of their concrete particularity—may be able to better provide what the patient needs. A diverse community of physicians makes such accommodations possible; physicians with specific traditions of thought and practice are sometimes best situated to bring to bear what medicine offers and to do so in ways that fit the needs of patients with similar traditions of thought and practice.

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Editor's Note

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