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## **Virtual Mentor**

Ethics Journal of the American Medical Association  
May 2005, Volume 7, Number 5

### **From the Editor**

#### **Lord, I Need A Healing: The Uneasy Relationship Between Faith And Medicine**

This month's issue of *Virtual Mentor* explores the ethical issues raised by faith commitments in the patient-physician relationship. On a daily basis, physicians care for patients with strong religious convictions. For many patients, faith forms the core of their value system, bringing meaning both to health and suffering. Religiously devout patients interpret major life events—birth, reproduction, illness, and death—in the context of their relation to God and their faith community [1]. While some physicians view matters of faith as tangential to their scientific practice of medicine, patients often need to converse with their physician about significant health care decisions in the language of belief in the sacred.

In a recent survey of patients, 83 percent of respondents wanted primary care physicians to ask about spiritual beliefs in at least some circumstances, especially in cases of life-threatening illnesses (77 percent), serious medical conditions (74 percent), and the loss of loved ones (70 percent). Among those who wanted to discuss spirituality, the most important reason given was desire for physician-patient understanding (87 percent) [2].

But what happens when this understanding breaks down? When the religious beliefs of patients are brought to bear on a particular medical decision, they often lead to conclusions different from those held by most medical professionals, or even society at large [3]. Two of the 4 cases in this issue highlight just how profoundly patients' worldviews affect their understanding of illness.

Patients are not alone in their strong religious commitments. In a 1999 survey of family physicians, 74 percent of those surveyed reported at least weekly or monthly attendance at religious services, and 79 percent reported a strong religious or spiritual orientation [4]. A 2004 national survey of 1100 physicians by the Jewish Theological Seminary in New York found that 74 percent of doctors believed that miracles have occurred in the past, and 73 percent believed they can occur today, while 72 percent believed that religion is a reliable and necessary guide to life. More than half believed that medical practice should be guided by religious moral teaching [5].

Given these strong personal beliefs and many physicians' conviction that they have a place in medical practice, doctors often find themselves in moral quandaries. From time to time patients request services or procedures that physicians oppose based on

their own religious commitments (Cases 3 and 4 represent 2 examples), and physicians from diverse religious traditions often speak from opposing moral perspectives.

As a result of the globalization of medicine, the clinical dilemmas raised by religion are becoming increasingly diverse and often represent non-Western traditions. Thus in addition to respondents from the particular faith tradition represented in each clinical case, we have invited physicians from different religious backgrounds to comment on the ethically salient issues, highlighting the unique perspective of their tradition.

The April 2005 issue of *The New Physician* featured a cover story on how physicians' personal values should impact their medical practice.

“We are here to serve the patient. Our role is to give the patient the best information and allow the patient to make the decision based on their values,” says Dr Scott Spear, associate professor of pediatrics at the University of Wisconsin (UW) Medical School. It's a lesson future physicians must learn....Not everyone can be trained to openly discuss topics with patients, he says. And for this reason, medical schools need to better screen applicants, asking them, “Can you put your own values aside for the patient's needs?” and “Can you separate your own personal beliefs that are not based on science? [6]”

The logical conclusion of Dr Spear's position, and that of others who share his view, is that physicians who intend to carry strongly held moral beliefs (religious or otherwise) into the clinical setting have no place in the medical profession.

Other ethics educators feel differently. Some argue for a more relaxed interpretation of clinician objectivity [7-8], while still others, such as moral philosopher Alasdair MacIntyre, argue that all ethical decisions are made from within a historical tradition and community, and that moral learning takes place when one examines these ethical convictions in the light of other, possibly conflicting, traditions[9].

The remainder of the May issue of *Virtual Mentor* addresses the questions of faith and medicine from several different angles. Through the policy forum, the section on health law, and medicine and society, we examine some important society-wide questions. Should our government fund religiously based health care institutions or programs? Are these programs even effective? What are the legal rights of patients and physicians to object to a particular medical procedure on religious grounds? A review of the play *Equus* explores the ways existential meaning and illness are constructed within a particular religious framework. The journal discussions and the op-ed pieces review an area of intense debate—the role faith plays in empirical health outcomes. Finally, in the clinical pearl we present the reader with a practical tool for spiritual assessment to be used at the patient's bedside.

Clearly, the ethical questions raised by faith are complex and the answers to them equally difficult, but they are important. They involve our most fundamental ethical values—paternalism, autonomy, and beneficence—and individuals' most cherished beliefs about the nature of reality. As we honestly examine our differences and

respectfully dialogue across traditions, we can learn from each other and constructively fashion moral consensus in the midst of diversity. We trust this issue will contribute to this important discussion.

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## **Virtual Mentor**

Ethics Journal of the American Medical Association  
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### **Clinical Case**

#### **Patau Syndrome and Perinatal Decision Making**

Commentaries by Patrick D. Guinan, MD, and Malika Haque, MD

Mariana López, 18, is 6 months pregnant with her first child. A routine screening ultrasound at 20 weeks demonstrated a constellation of severe fetal defects, including a structural brain anomaly, multiple heart defects, and an abdominal wall defect. Concerned about a possible genetic syndrome, Ms López's obstetrician, Dr Sarah Wilson, scheduled an amniocentesis, which confirmed trisomy 13 (Patau syndrome). Dr Wilson informed Ms López and her parents, with whom she lived, that the fetus had a severe genetic anomaly, and that the prognosis was poor. Eighty percent of affected infants die within the first month of life, only 5 percent survive the first 6 months. Those who survive past the first year have severe mental deficiency and seizures and fail to thrive.

The obstetrician offered the family 2 options: early induction of labor to terminate the pregnancy or term delivery of the child with palliative care after birth. She suggested the family think about these options for a few days, and return for a follow-up visit next week.

When they returned, Mariana's parents tearfully explained to Dr Wilson that they were devout Catholics and that they weren't interested in terminating the pregnancy. After praying about the situation and consulting with their priest, they had decided that Mariana should carry the baby to term, and after delivery, they wanted to provide the best care possible to the infant. "At first, we weren't sure what to do, but after talking with our priest, we've decided that we want you to do everything you can to help our granddaughter live," they said. Dr Wilson asked Mariana if she agreed with her parents, and she tearfully nodded yes.

At this point, Dr Wilson explained to the family that, given the poor prognosis associated with Patau syndrome, she believed the best course of action was conservative management of the pregnancy, with no aggressive measures taken either in the peripartum period or in the neonatal intensive care unit. "For instance," she said, "given the child's multiple malformations, there is a high likelihood of fetal distress during delivery. But I can't in good conscience subject you to a caesarean-section delivery for a fetus that will probably not survive its first month." Dr Wilson asked that they meet again in a few days, suggesting that a neonatologist also be a part of the discussion.

Three days later, the family came to the obstetrics clinic, now accompanied by their priest. Dr Wilson asked Dr John Kim, the director of neonatal intensive care, to join

the discussion. Dr Kim emphasized the poor prognosis of the child's condition, but informed the family that he would be guided by their wishes.

The priest, Father Joe Garcia, explained to both physicians that, as long as the baby was alive, he and the family believe that the best possible care should be provided, especially care that's considered routine for other children. "Trisomy or not, this is a child whose soul is made in the image of God," he says, "and to take the life of this innocent one—before, during, or after delivery—is unthinkable."

### **Commentary 1**

by Patrick D. Guinan, MD

This is a case of an 18-year-old woman, 6 months pregnant with a child with ultrasound-detected congenital defects. Amniocentesis revealed a karyotype diagnostic for trisomy 13 (Patau syndrome). The patient is unmarried but is strongly supported by her Hispanic family that is devoutly Catholic. Her attending doctors are not known to be religious.

There are several dilemmas here. The first involves the delivery of the unborn baby who has a severe congenital anomaly. The second is the management of the child after birth. And the third, and the primary focus of this case, is the interaction between the religious convictions of the parents and the secular medical attitudes of the patient's physicians.

### **Patau Syndrome**

Patau syndrome, otherwise known as trisomy 13, is the fourth most common autosomal disorder. It is characterized by orofacial and limb defects as well as cardiac anomalies. Fifty percent of trisomy 13 patients die in the first week of life, and 90 percent die before their first birthday. The cause of death is probably central apnea [1]. Patients who survive have severe mental deficiency, seizures, and failure to thrive. The mother and family should be informed, as compassionately as possible, of the medical realities involved.

There are 3 options. The first would be a direct abortion, where permitted, at 6 months. This is to be ruled out in the case of this Roman Catholic family, because it is the direct killing of an innocent human person. The second, as mentioned by the obstetrician, would be the early induction of labor to terminate the pregnancy. Presumably death would be the necessary, but unintended, side effect of the therapeutic procedure. The medical staff presumes that the therapeutic effect for the pregnant woman would be the psychological relief of the anxiety of raising a retarded child with the dismal prognosis of an early death. Clearly the induced labor is not to enhance the possibility of survival but rather to guarantee the death of the innocent human being. This, then, is not ethically permissible, either.

The third option would be to proceed with what has been an uneventful pregnancy. This would probably result in normal labor and delivery. The possibility of fetal distress would not justify a planned caesarean section. If fetal distress occurred, a C-

section could then be considered, but given the circumstances, could be considered an extraordinary measure.

It should be noted that the deliberate termination of pregnancies for fetal anomalies does not necessarily eliminate the expectant parents' grief but may even increase it [2,3].

### **Management after Birth**

While most infants with trisomy 13 die relatively soon, some can survive as long as 1 year and should be provided all normal care and affection. The associated congenital malformations are best managed conservatively. The baby should receive the care typically accorded any newborn, but extraordinary efforts are probably not warranted. If terminal apnea intervenes, the child should be allowed to die, possibly in the arms of his or her mother and family, with all of the emotional support that they can be provided. There is strong evidence that mothers bond with their babies and that they should be allowed to grieve appropriately following the death of their children [4].

### **Religious Family and the Secular Medical Staff**

The central focus of this case appears to be the potential clash of the values of the patient's family and those of the medical staff. The doctors offer an option of "termination of pregnancy" and "conservative" peripartum management. The family wants "care that's considered routine for other children." This case is structured to highlight the dichotomy: if the doctors suggest abortion, the family may resist that option and ask for "routine care." This is reasonable and the staff should not deny this request. Principle IV of the AMA *Code of Medical Ethics* requires that physicians respect the rights of patients and certainly the choice of care for their child should, if at all possible, be honored [5].

If experience has taught us anything, it is that the autonomy of the patient and his or her mother must be respected. The staff's opinions should be expressed but are secondary. We as clinicians live in a pragmatic medical world but our patients, while they interact with us for a day, a week, or a month, spend the majority of their lives with their families and in their cultures, and we are obligated to respect that. We should not risk the esteem we receive from our patients, to say nothing about ill will and malpractice possibilities, if we subtly force our cultural beliefs on them.

It should be noted that the majority of physicians do have religious belief systems and are probably open to the reasonable religious concerns of their patients [6].

### **Summary**

In summary, we have a woman pregnant with a child that has Patau syndrome. The medical staff is suggesting induced labor which would result in a direct abortion. The family, consistent with their religious beliefs, resist this. The medically ethical solution is to follow the wishes of the family. Infants with congenital anomalies oftentimes present difficult medical dilemmas. We should support families with these problems, and an abortion is not the way to do this. Physicians should explain the difficult medical realities to patients but then accede to reasonable requests.



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## Commentary 2

by Malika Haque, MD

Islamic medical ethics are based on the Quran, the holy book of Muslims; the Hadith, which are traditions of the Prophet Muhammad, peace be upon him; and clarifying opinions of Islamic scholars and jurists when needed.

### Quranic View on Sanctity of Life

Islam upholds sanctity and protection of human life, which is clearly manifested in the Quranic verse “whoever kills a human being not in lieu of another human being nor because of mischief on earth, it is as if he has killed all mankind, and whoever saves the life of a human being, it is as if he has saved the life of all mankind” [1]. Muslims believe that God is the creator of life [2], and many Islamic jurists believe that life starts at conception. The Quran states, “We created man from a quintessence (of clay). Then we placed him as (a drop) sperm in a place of rest firmly fixed. Then we made the sperm into a clot of congealed blood. Then out of the clot we made a lump. Then we made out of the lump, bones, clothed the bones with flesh. Then we developed out of it another creature. So blessed be Allah (God) the best creator” [3].

While most Islamic scholars and jurists believe that life starts at conception, some believe that the intrauterine life is divided into 2 stages. The first stage occurs as plant life, when growth and nourishment take place. The second stage occurs as human life, which is introduced into the fetus when the spirit is breathed into it [4]. This view is supported by the Hadith, narrated by the Islamic scholar Ibn Masud. “The creation of each one of you is brought into the belly of his mother for 40 days, then for a similar period he is a germ cell, then for another 40 days he is an embryonic lump, then an angel is sent to him and ordered to write down his career, his livelihood, his life’s duration, whether he is to be miserable or happy, and the angel breathes spirit into

him” [4]. This “breathing of spirit” is interpreted as the beginning of human life. This is said to occur at 120 days after conception, according to Islamic scholar Ibn al-Qayyim al-Jawziyah [5].

Abortion is not permissible in Islam, unless to save a mother’s life as set forth by Islamic teachings and scholars. The Quran is clear on abortion or infanticide in its verse “kill not your children for fear of want, we will provide sustenance for them as well as for you, verily killing of them is a great sin” [6].

### **Recent Developments in Islamic Medical Ethics**

The majority of Islamic scholars believe that the only indication for termination of pregnancy is a danger to the mother’s life, and, even in those cases, termination needs to occur before 120 days. In some rare cases when a mother’s life is in serious danger, termination can occur at any time, even if after 120 days. In Islamic Shariah (Islamic Law), termination of pregnancy to save a mother’s life is accepting the lesser of 2 harms.

The medical ethics committee of the Islamic Medical Association of North America (IMANA), of which I am a member, has recently composed position papers on Islamic medical ethics wherein it is stated that “abortion may be permitted if continuation of pregnancy may cause the pregnant woman to die or cause serious deterioration of her health, both medical (physical) and mental” [7].

In this case of trisomy 13, diagnosed at 20 weeks of gestation, despite poor chances of survival, poor prognosis for life and functions, I agree that the pregnancy needs to continue with the best appropriate care both for the mother and the baby. There is no question of termination because there is no danger or harm to the mother’s life by continuation of pregnancy. Moreover the pregnancy has advanced to 20 weeks, when the baby is endowed with life and soul. Prior to 120 days, termination would have been considered for a valid reason if it had affected the mother’s life.

Prayers and faith in the will of God empowers a Muslim patient to accept any illness, for everything occurs with the knowledge of God and there is always wisdom in his creation. Muslims also believe that the rewards are greater for caring for a child born with serious health problems.

With regard to the care of a newborn with multiple life-threatening congenital anomalies such as trisomy 13 or Patau syndrome, it’s preferable to provide the care available and let the baby take the natural course if symptoms worsen despite the medical care. Parents of severely handicapped children are best able to make appropriate decisions for them when given not only good medical care but also support by medical experts who are truly conscious of parental religious beliefs and values [8]. There are many medical and ethical dilemmas in the management of a severely handicapped baby. The optimum management can be achieved not only with the best medical technology and treatment but also with significant awareness of parental religious beliefs and values in caring for the patient and the family.

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## **Virtual Mentor**

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### **Clinical Case**

#### **End of Life and Sanctity of Life**

Commentaries by Rabbi Edward Reichman, MD, Sandra Gadson, MD,  
Lerwut Wongsarnpigoon, MD, Nihal S. Gooneratne, MD, and  
Ananda Wickremaratne, DPhil

Ethel Jones is an 82-year-old nursing home resident with a longstanding history of heart failure, who is now hospitalized in the cardiac ICU for the third time this year. She is a retired teacher, with 4 children and 8 grandchildren. She did not list a religious preference when admitted to the hospital. The attending cardiologist, Dr David Rosenberg, is a heart failure specialist, and is an active member of an Orthodox Jewish congregation.

On day 3 of her hospitalization, Mrs Jones developed a fever, which was subsequently determined to be caused by a MRSA line infection from a venous catheter. On day 4, her renal function began steadily deteriorating, until her serum potassium reached dangerous levels.

She has been unconscious for 2 days, and, according to hospital records and her children, she has no advance directives to guide end-of-life care. Dr Rosenberg requests a family conference with Mrs Jones's children (her husband is deceased) to discuss their mother's prognosis and the appropriate next steps in treatment. "I'm afraid that your mother's health is steadily deteriorating," Dr. Rosenberg tells Mrs Jones's family. "She has a serious infection that has failed to respond to traditional antibiotics."

"How did she get this infection, doctor?" Mrs Jones's daughter Jennifer asks. "That's a good question. It's likely the result of an IV line we placed during her admission," Dr Rosenberg replies. "Your mother's infection is caused by a resistant strain of staphylococcus that is common in intensive care units and hospitals, but we have more aggressive antibiotics we can use. I should also tell you that her kidneys are failing, and we'll need to begin dialysis to ensure that her electrolytes and fluid status are kept at normal levels. Despite this, I think there's a strong possibility she'll pull through."

At this point, Mrs Jones's eldest son Franklin interrupts. "Look, doctor," he says, "My cousin was on dialysis for years, and, until he died, he was really miserable. I don't want my mom to have to go through that at this age. I think enough is enough. She's been in the hospital 3 times this year alone."

"I understand your concern," Dr Rosenberg says, "but you should realize that your mother may not require long-term dialysis. Her kidneys may recover, but at this stage,

dialysis is the only solution left to correct her electrolyte imbalances. If we don't lower her potassium, she'll likely develop a fatal arrhythmia."

Franklin looks at the rest of the family, who are shaking their heads. "Honestly, I think you shouldn't treat her any further. Even if it's not permanent, starting dialysis just isn't a path we want her to start on. And the 'aggressive antibiotics'—I don't see any reason to pour more substances into her already tired body. It's obviously her time to go. Can't you just give her something to make her comfortable?"

Dr Rosenberg pauses for a moment and then tells Franklin. "We fully intend to keep her comfortable and continue treating her pain. As you know, I'm committed to doing what's best for your mother. But in good conscience, I can't stop treating your mother as long as there are reasonable courses of action that I could take to preserve her life. According to the principles that guide my practice of medicine, I cannot withhold life-saving treatment from any patient—especially antibiotic therapy and temporary dialysis, both treatments with uncontroversial efficacy."

### **Commentary 1**

by Rabbi Edward Reichman, MD

*One who sustains the life of but one human being is considered as if he has saved an entire world.*  
? Babylonian Talmud, Tractate Sanhedrin, 37a.

As Dr Rosenberg invokes Jewish law in his approach to his patient, it behooves us to discuss how Jewish law would address this case.

- 1) Would Jewish law indeed require dialysis for Mrs Jones?
- 2) If the law requires dialysis for Mrs Jones, can Dr Rosenberg, according to Jewish law, impose his religious beliefs on others?
- 3) Does it matter that this patient is not of the same faith as Dr Rosenberg and does not subscribe to the same religious teachings?

While the voice of Orthodox Judaism is not monolithic and, indeed, a plurality of approaches within accepted boundaries is the norm, one can nevertheless distill immutable principles and values deriving from the Bible, Talmud, and legal codes, which inform the discussion and guide the decisions of rabbinic authorities. Debate and nuanced textual interpretation are hallmarks of Jewish legal discourse. While herein we discuss particulars of a fictional case, any actual case of Jewish medical ethics must be presented to the proper rabbinic authority.

A number of legal principles serve as the foundation for decisions in the field of Jewish medical ethics. One such principle is the sanctity of life and the obligation to preserve it. The concept of quality of life has different meaning in the Jewish tradition, and life, be it sentient or not, is of infinite value. This does not mean that life need be perpetuated at all times and at all cost. According to many rabbinic authorities, there are limited circumstances where specific treatments may be withheld. A full treatment of this area of law is beyond the scope of this essay, but the discussions of withholding treatment are generally restricted to patients suffering from terminal, untreatable

conditions, who are enduring intractable suffering. The specific treatments that can be withheld are debated, but all agree that nutrition, hydration, and oxygen (not necessarily intubation) should be provided to all patients and are not subject to refusal. One is therefore not permitted to withhold food, even if insertion of a feeding tube is required for its delivery, as this is considered basic human sustenance to be provided to all people. Terri Schaivo, for example, according to Jewish law, would not be considered to have a lesser quality of life than this writer. She did not suffer from a terminal, incurable disease, and withholding food would clearly not have been permitted according to orthodox Jewish tradition.

Mrs Jones's medical condition is not discussed in great detail, but for our purposes, I will assume that Mrs Jones has an acute, potentially reversible infection complicated by renal failure, which could theoretically be reversed with antibiotics and temporary dialysis. In such a case, Jewish law would likely require that dialysis be performed, inasmuch as Mrs Jones would surely die without it. If Mrs Jones were suffering from end-stage metastatic cancer and developed irreversible renal failure, a strong case could be made according to Jewish law to refrain from dialysis.

Having established that according to Jewish law dialysis would be indicated, is Dr Rosenberg obligated, according to this same law, to impose his beliefs on others? The answer here is a decided "no." Even if the patient were of the same faith and subscribed to his religious beliefs, Dr Rosenberg would not be required to coerce therapy. The reason is clear from another exercise in legal analysis: American law forbids treatment against a patient's will, and Dr Rosenberg could theoretically receive legal, ethical, and professional censure (not to mention the criminal consequences) for violating a patient's rights and bodily integrity. This could lead to the loss of livelihood and profession for Dr Rosenberg, and would preclude him from assisting in the aid and treatment of future patients. Furthermore, Jewish law places great emphasis on respect for the law of the land where one lives and would disapprove of the violation of American law, with some theoretical exceptions.

As stated above, Jewish law does not require a physician to coerce therapy, if it would result in the loss of profession and livelihood. This concept applies, however, only in a situation where Dr Rosenberg performs no Jewish-legally prohibited actions that would lead to the demise of the patient. In this case, Dr Rosenberg is simply refraining from performing dialysis, but performs no specific action that leads to the hastening of the patient's death. He is permitted the nonaction to preserve his profession and livelihood.

One could envision a theoretical circumstance where Dr Rosenberg is asked to perform an action to hasten the patient's death. For example, if the family wishes to disconnect a patient from a ventilator, that is an action which will lead to the patient's demise. Here, too, one might argue that Dr Rosenberg should not impose his religious beliefs on the family, and he should therefore accede to the request and disconnect the ventilator. In this case, however, Jewish law would not allow Dr Rosenberg to disconnect the ventilator, even if his profession were at risk, because this scenario requires Dr Rosenberg to perform a Jewish-legally prohibited act. (While one could

argue that disconnecting the ventilator is not hastening death but rather allowing nature to take its course, Jewish law thinks otherwise, and focuses on the causality. This action will undoubtedly lead to the death of the patient.)

Although coercion would be out of the question according to Jewish law, Dr Rosenberg could suggest a compromise approach, whereby he encourages the family to allow antibiotics and dialysis on a trial basis. As the antibiotic therapy and the dialysis are discrete treatments, and not continuous, as is a respirator, there would be no problem for Dr Rosenberg, as established above, to discontinue them if the family later requested such. Indeed, if the family is told that there is a chance of recovery with this regimen, but, if it fails, they will have the option to later discontinue the treatments, there might be greater chance of agreement between Dr Rosenberg and the family. The family may take great comfort in the assurance that all efforts were made to treat their loved one, and the possible subsequent guilt of withholding potentially life-saving treatment would be alleviated.

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## **Commentary 2**

by Sandra Gadson, MD

This case is that of an 82-year-old woman who resides in a nursing home. She has a history of congestive heart failure and severe cardiac disease with 3 hospitalizations in 1 year for similar complaints.

During the last admission she developed line sepsis with methicillin-resistant staphylococcal aureus, is now starting to develop acute renal failure, and is unconscious.

The doctor wishes to continue with different antibiotics along with temporary dialysis. There is one son who relates the past experiences of a relative on dialysis, and he seems to feel that antibiotics and dialysis are futile. It is clear that this conflicts with the treatment recommendations, but it is unclear whether he has the authority to make decisions that could terminate his mother's life prematurely.

### **Advance Directives?**

All too often cases like this are complicated by the lack of an advance directive. "Advance directive" is a term that refers to an individual's spoken and written instructions about future medical care and treatment. Advance directives can be used if the patient is unable to make his or her own decisions. Stating health care choices in an advance directive helps family and physicians understand a person's wishes about his or her medical care. In some cases advance directives list individuals who will serve as health care agents.

With all of our training and expertise as doctors, we are first to do no harm. In this case a change of antibiotics and a temporary dialysis does no harm. It could potentially

make a difference in Mrs Jones's outcome. In a case with no advance directives, health care choices are usually made by the family member whom the physician is able to contact. In situations such as this, where several family members are involved, the best approach is to gather all the siblings together and ask them to decide on 1 person to serve as spokesperson for the family. From that point on, talk only with that individual.

The physician should explain to the family that their mother has congestive heart failure, complicated now by line sepsis and acute renal failure. He or she should say that the suggested plan of treatment is short-term and will cause no discomfort and should try to make the family understand that congestive heart failure, sepsis, and acute renal failure are not necessarily long-term and are treatable with antibiotics. Short-term hemodialysis is needed to cleanse the blood of toxins and to remove excess fluid that contributes to congestive heart failure.

A primary goal of hemodialysis in this case is the resolution of Mrs Jones's altered mental status, in order to get her to directly participate in the decision making process. If Mrs Jones does not respond after this treatment, then a neurological consult is in order. If her clinical condition continues to deteriorate, bringing about clinical brain death, then options for withdrawal of treatment would be appropriately discussed with the family.

Clinical medicine more and more is becoming an issue of the value of life. How do we define "value"? How can a physician put a value on a life? We cannot and should not decide who lives and who dies. There are many temptations: medical care can become costly; insurance companies want to keep costs down; many people cannot afford health insurance. There are also pressures from outside the house of medicine. Yet, life is sacred and important, and our mission as physicians is to give the best possible care to our patients without judgment of race, financial background, education, or gender.

In our years of training, we must develop a sense of compassion, a sense of concern and empathy. A good thing to do is remember the Golden Rule, *Do unto others as you would have them do unto you* (Luke 6:31).

If you put medical expertise, knowledge, and skill together with compassion, your outcomes will be acceptable. In the case at hand, if you have followed this patient and feel that she can improve with additional treatment, then that should be considered.

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### **Commentary 3**

by Lerwut Wongsarnpigoon, MD

The conflict between the family and the physician in decision making concerning the end-of-life care for Mrs Jones is a common occurrence in medical practice. A



psychologist colleague told me of the problems she and her siblings had with her mother's attending physician when she was hospitalized for multiple complications of terminal cancer. Her mother and the children had requested that further treatments be discontinued. The attending physician insisted on continuing aggressive treatments to combat the infections and other organ failures.

### **The Family's Decision**

It is common for physicians and patients to disagree over when treatment can appropriately be withheld or withdrawn if they come from different faith traditions that have different ways of viewing life and death. Because faith traditions view the sanctity of life and the meaning of death differently, physicians and patients who do not share the same religion often disagree over medical treatment near the end of life.

Let us consider the case of Mrs Jones from a Buddhist's perspective, for example. A Buddhist is by definition an individual who aspires to live his or her life according to the teaching of the Buddha. Mrs Jones and her family are not known to be particularly religious, so let's suppose that they are Buddhists in the same sense as people who profess to be Christians, but do not actively participate in church attendance or activities. They would at least be familiar with some of the basic tenets, or Dhamma, of Buddhism. They would see "death as a normal process, a reality that will occur as long as ones remain in this earthly existence" [1].

Death can be perceived as a process resulting from the impermanence of life itself. For those who believe in rebirth, death is not the end of life, but simply a transition [2]. Death is the last of the "Three Messengers": Old Age, Sickness, and Death, [3] that one will encounter along the course of one's life. Buddhists are admonished to constantly contemplate the facts that:

1. We are subject to old age and cannot escape it.
2. We are subject to disease and cannot escape it.
3. We are subject to death and cannot escape it.
4. There will always be dissolution and separation from all that we cherish.
5. We are owners of our deed (karma), whatever deed we do, whether good or bad, we shall become heirs to it [4].

Mrs Jones's children seem to be assessing her condition in a manner consistent with the principles described above. In Buddhist terms, they are holding to the "Right View," the first aspect of the Noble Eightfold Path that understands the true nature of existence as consisting of suffering, impermanence, and non-self (insubstantiality) [5]. This does not mean that they are fatalistic or nihilistic, only that they see things as what they truly are in a more detached way.

### **The Physician's Decision**

The dilemma facing Dr Rosenberg is much more daunting and complex. Let us consider what a Buddhist doctor would do, assuming that he is fully aware of a Buddhist's beliefs and subscribes to the Dhamma.

Any physician endeavors to treat his patients with compassion, a concept essential to Buddhism. His goal is “to overcome sickness and relieve suffering. The Hippocratic philosophy of medicine declares that nothing should be more important to a physician than the best interest of the patient who came to him for care” [6]. A Buddhist physician in Dr Rosenberg’s shoes would be aware of the same principles we discussed earlier. He may be struggling with a major question, however? whether withholding further treatments for Mrs Jones constitutes a violation of the First Precept, which exhorts us to abstain from killing or destroying life. There are additional important criteria that a Buddhist physician needs to consider regarding the First Precept. It is noted that for a killing to be considered a *fait accompli*, it has to meet 5 criteria:

1. There is a living being, in this case, the patient.
2. An awareness that it is a living creature.
3. There is an intention to kill.
4. One must make an effort to kill.
5. The living being dies [7].

There is no doubt that criteria 1, 2, and 5 would be met if further treatments were withheld. One can forcefully argue that a physician in Dr Rosenberg’s circumstances harbors no intention to destroy the life of Mrs Jones, and indeed, he strives to treat her with compassion. If he chooses to stop treatment now, he is actually not making any effort to harm or to prolong the suffering of the patient. He probably makes the dying and passing of Mrs Jones more humane. It appears from this reasoning that the First Precept is most likely not being violated.

There are yet other relevant criteria to guide and determine the degree of karmic demerit stemming from the action of destroying a life. One has to consider whether the living being is big or small; useful to others or dangerous and offensive; whether the intention (to kill) is full of hatred, malice, or good will; whether there is an elaborate preparation and deep conviction to harm with no consideration of outcome and consequences, or whether the deed is done in a blind rage [8]. A critical point of which a Buddhist physician needs to be fully cognizant when he decides to continue treating Mrs Jones is whether he is really concerned about what his colleagues think or any criticism he may face. This situation is succinctly described by physician-author Sherwin Nuland in the final chapter of his book *How We Die* [6].

Finally there comes a time when the physician in Dr Rosenberg’s situation has to take a step back and wonder why he does not follow the “Middle Path,” one of the most important practices that enabled the Buddha to attain enlightenment. In such practice he needs to avoid all extremes in the care of Mrs Jones? that of total neglect on one end and ceaseless efforts to keep her alive at the other. He could then assume an attitude of “equanimity,” a gracious state of poise and neutrality, where one admits that it is thus beyond one’s power to do anything to avoid the inevitable death of Mrs Jones.

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## Commentary 4

by Dr Nihal S. Gooneratne, MD, and Ananda Wickremaratne, DPhil.

As a physician and a philosopher raised in the Buddhist way of life our thoughts are as follows:

When life begins and the precise point of its termination have been subjects of much debate and ethical concern these days. In Buddhism, life begins not at the point of birth, but in the act of copulation successfully accomplished. The fetus however incomplete is viewed as life *in posse*, in the most ample sense of that term. There is no difference in the gradually unfolding life processes and their potential, and the achieved fact. One leads to the other. Consciousness is part of the potential.

In relation to this particular patient, the larger Buddhist idea of karma also comes into play. In Buddhism, karma is not action per-se but the thought (*cetana*), which is the parent of all actions, good or bad. The baby that has achieved birth, is a product of a positive wholesome thought the parents entertained. Considering all of the above, there is a sanctity attached to all living beings, be they human or animals or even microscopic organisms, which according to Buddhism have a right to live, regardless of scientific taxonomies about single, multiple, or complex order of cells in life forms. A number of implications follow. First that all life is, to use a religious word, sacred, and worthy of respect. Much as each one of us is a member of a family, according to Buddhism each person is a separate individual in terms of previous karmic conditioning. Secondly, given the intrinsic sanctity of life and the implications that follow, nobody has the right to take away life, since karmically each person's life is his own. It follows that third parties, whether they are friends or family of a person who is gravely ill, must exercise great ethical care in coming to a decision. Ideally, in ancient societies and until recent times, what we call life, namely the natural progression and

degeneration of any organism, took as it were a preordained course. Death was a natural expectation in traditional premodern cultures, east or west, accepted with commendable fortitude and grace. We wish to emphasize that in this age of spellbinding medical technologies and their potential, it is easy to forget that death is a natural eventuality which has traditionally been accepted by the dying person as well as by the family, relations, and friends. In eastern religious philosophies as well as in medieval Christian Europe before modernization, the process of life itself was a calibrated preparation for death. A famous Christian saying in medieval time was “Memento Mori,” remember that you must die.

These 2 emerging elements seem to be paradoxical. First, there is the natural inclination of all organisms toward the perpetuation of life and, secondly, the acceptance of death as a natural process.

How does all this affect the choice we have at hand—whether to artificially prolong the life of a sick person by modern methods or to let nature take its course?

In many cultures this would be a new question, calling for redefinition of existing religio-cultural norms. It puts a grave burden of enormous ethical implications on those who have the responsibility of coming to this difficult decision. For a relative at the bedside to decide that life support systems should be discontinued is, in terms of Buddhism, an arbitrary and ethically indefensible position. The idea that by doing so, we end the prolongation of suffering is subjective and is not altogether a scientifically defensible position. In this particular case and in recent cases highlighted by the media, there seems to be a sharp division in professional opinion among those who have the competence to come to some form of judgment. Indeed, from a Buddhist point of view the resolve to terminate life is a paradoxical, violent act of taking away someone’s life, especially when that person is a human being.

In Buddhism, to be born a human person without the debit of physical or mental handicap, is a privilege which should not be taken for granted. As a result of negative karma, a being may be born in cosmic worlds of woe, in situations of limbo, or as an animal, conditions which the being concerned has no power to alter or abbreviate until the karmic force is expended. There are 2 reasons why great value is placed on the human condition and its potentialities. First it is only as human beings that we can fully understand the central problem of *dukkha*, or suffering, in all its deep existential dimensions. Secondly, it is only in the human condition that we can work out our salvation to end suffering and achieve nirvanic transcendence to break the cycle of birth, and death, and birth again, in an endless, remorseless samsaric round.

In a finely balanced conundrum such as this, the better ethical decision might be to continue with life support systems until nature takes its course. By our phrase “nature takes its course,” we mean the natural end of the patient’s karmic continuity force. In fact what rationally seems to be a matter of decisions is, one way or another, a reflection on how karma works. The very people who take these decisions are, unbeknown to themselves, agents of karma, according to Buddhism. Logically in the Buddhist paradigm, those who take such decisions create karma for themselves.

The difficulty here is one of trying to integrate 2 virtually incongruent worldviews into a single meaningful synthesis or paradigm. For example, in a natural Buddhist context the dying person, as a result of a lifetime habituation, accepts death as a part of the process of the volatility and impermanence of all things. Life support technologies in themselves cannot be blamed or thought to be the key player in dramas of this nature. The key players are those who consciously, deliberately, and volitionally take decisions one way or other. Compassion in Buddhism is naturally associated with the support and perpetuation of life organisms, conditioned, of course, by the impermanence of all things. In no way can it be argued from a Buddhist perspective that taking the decision to withhold treatment is somehow deeply ethical or compassionate and is in the best interest of the patient.

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## **Virtual Mentor**

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### **Clinical Case**

#### **Patient Counseling and Matters of Conscience**

Commentaries by Farr Curlin, MD, and Rev Russell Burck, PhD

Amber Whittaker went to see her family physician about a sore throat. Amber, 19, and her family have been patients of Dr Christine Nowak for 15 years. The Whittakers and Dr Nowak are members of the same evangelical church, Riverwood Community Church, and they have grown to be friends over the past few years.

Dr Nowak examined Amber, performed a rapid strep test, which was positive, and informed her that she had a streptococcal pharyngitis. "Try not to kiss any boys this week," Dr Nowak said with a smile.

"Actually, now that you mention it," Amber said, "that's something I wanted to ask you about. My boyfriend and I have been together for more than a year now, and we've been talking seriously about marriage."

"That's great! I'm glad to hear things are going well," Dr Nowak said.

"Well, that's not all: we feel we're ready to start having sex, and I need to ask you to write me a prescription for birth control pills."

Dr Nowak paused for a moment, then explained, "You know, Amber, I appreciate you sharing this with me, but I imagine you know how I feel about premarital sex. As your doctor, friend, and fellow Christian, I think this is an unwise decision, and I can't in good conscience help you do something I think is wrong."

"But doctor, we've both thought about it, and we love each other, so why put it off any longer?"

"As a physician," Dr Nowak replied, "I'm committed to doing what's in my patients' best interest. And I believe, based on the Scriptures we both read and on our common understanding of God's nature and purposes for us, that sex is the consummation of a spiritual union between husband and wife. Sex is created by God to be enjoyed in the context of marriage, and saving it for that moment makes it all the more special. I realize that's difficult, and it's not what our culture at large believes. But if we call ourselves Christians, we need to carry our beliefs into every aspect of our identity? including something as personal as our sexuality."

#### **Commentary 1**

by Farr Curlin, MD

This case is particularly relevant in light of recent controversies regarding physicians and pharmacies who refuse to prescribe or dispense one or more types of contraceptives. The moral questions are similar in both cases.

In my experience, most within the medical profession would judge Dr Nowak's actions as unethical. In the medical literature, 3 reasons are typically invoked to justify the conclusion that Dr Nowak and others like her ought not to engage in this sort of dialogue with patients. I will briefly outline those here and point to a forthcoming essay [1] which considers them more thoroughly. First, physicians are thought to be insufficiently *competent* to discuss religion with patients. Dr Nowak may be familiar with Ms Whitaker's church, but she is neither a theologian nor a pastor, and it is not clear that she has the requisite knowledge to do justice to the complexities of faith and sexuality. Second, because physicians interact with patients from a position of unequal power, statements like those made by Dr Nowak are thought to be inherently coercive and threatening to patients' right to *autonomy*. Third, statements such as Dr Nowak's violate the commitment to religious *neutrality* which a physician's professional position requires. Presumably, Ms Whitaker seeks out Dr Nowak as a physician, not as a moral counselor. As such, Dr Nowak, by raising religious issues, crosses professional boundaries which require her to remain professional neutral as regards religion [2].

In the end, these arguments are insufficient to justify the conclusion that Dr Nowak actions are unethical. Parts of her actions may be less prudent than they could otherwise be, and a longer conversation could be had about the details of how to navigate situations of moral disagreement. Yet it remains that physicians have the moral freedom, and at times the moral obligation, to respectfully and candidly decline to participate in that which they judge to be immoral or otherwise not conducive to their patients' good. To explain why, it is helpful to return to the question posed to us.

We are asked, "How should physicians respond to patients who are engaged in behaviors that the physician believes to be immoral?" That is the question for the ethicist who necessarily stands at a critical distance from this scenario, but it is derivative of the more primary question which faces Dr Nowak, "How should I as a physician respond to patients who are engaged in behaviors that *are* immoral?" Here I hope it is self-evident that, whatever their legal obligations, physicians are not *morally* obligated to facilitate or otherwise participate in patient actions that are themselves immoral. Such an obligation would be logically self-defeating and would, to the extent that the right and the good mutually coinhere, profoundly undermine physicians' primary commitment to patients' good.

If Dr Nowak is not morally required to facilitate those patient behaviors that are not good, the relevant moral questions are whether it is good for Ms Whitaker to engage in premarital sex, and, if not, whether the prescription of oral contraceptives facilitates or participates in that behavior. Yet, I gather that the questions as I have just phrased them will strike some as beside the point because they suggest that Dr Nowak (or anyone for that matter) could somehow know that another person's sexual behavior is immoral. Indeed, in our day most seem to believe that religious notions about sexual

immorality are not notions about something real which is subject to discursive reason but rather belong in the private realm of “personal values.”

The problems with such ideas require more attention than I give in this setting, but I will clarify 2 points. First, ethical deliberation depends on the confidence that we can, even if only partially and imperfectly, discern that which is good (moral) and that which is not (immoral). If there can be no knowledge about what is good, then venues and dialogues such as this one become meaningless. Second, any real choice, such as that facing Dr Nowak regarding the prescription of contraceptives, is a moral choice which implicitly or explicitly expresses a moral judgment. One very important question is *how* Dr Nowak could know whether or not premarital sex is good for Ms Whitaker. That question requires a great deal of consideration, but regardless of *how* one makes such a judgment, it is clear that the judgment must and will be made.

All of this points clearly to a fundamental challenge of living in a plural society, namely that we do not all agree about what is right and good. What then should physicians like Dr Nowak do in contexts of moral disagreement with their patients? My rather unoriginal proposal is that physicians should respectfully engage in discourse with patients to discern the good and then seek to negotiate accommodations that do not require either to violate their consciences. Because it is moral discourse that is required, we see that concerns about competency, autonomy, and neutrality are misplaced. Competency is a term that refers to technique, but moral deliberation is not a technique. What is needed in cases such as these is the wisdom to discern how best to act given all of the contextual complications.

For example, although physicians are not required to participate in that which they believe is not good, it does not necessarily follow that the most prudent course of action is to try to persuade patients of the physician’s point of view. In a similar way, a physician may judge premarital sex to be immoral but judge the prescription of contraceptives to be moral because the latter may reduce the harms of the former. In regard to autonomy, Dr Nowak’s refusal to prescribe oral contraceptives cannot be a violation of patient autonomy unless autonomy requires physicians to provide whatever their patients request. If autonomy does not require physician participation in all cases, and I think it obvious that it cannot, then one must ask why it requires participation in this case.

Finally, the pretense of neutrality cannot be sustained in any case where a physician is asked to make a judgment, and such judgments are implicit in all deliberate human actions, such as the decision to prescribe contraceptives, or, for that matter, to prescribe anti-hypertensives. Rather than seeking an illusory neutrality, physicians like Dr Nowak should be candid about their own commitments and how those commitments influence their recommendations. For example, it would have been unethical for Dr Nowak to hide her religious convictions by telling Ms Whitaker that she could not prescribe an oral contraceptive because she was worried about its side effects. Respect for persons requires candor about the reasons for our recommendations.



Given the events of the past few weeks in the State of Illinois, I will take advantage of an opportunity to encourage fellow ethicists, clinicians, patients, and policymakers to exercise restraint in formulating policies that would require others to participate in that which violates their consciences [3]. We rightly challenge one another, argue with one another, and even persistently and respectfully badger one another in efforts to discern and persuade each other of the truth. But invoking the coercive power of the law necessarily does violence to any robust concept of religious freedom. Dr Nowak in this case has not imposed her values upon Ms Whitaker simply because values cannot be imposed. Ms Whitaker remains free to value that which she will and retains the legal right to seek to obtain contraceptives from another physician. On the other hand, if the law or the governing powers in the medical profession require Dr Nowak to prescribe contraceptives, they in effect coerce her to make a choice between violating her religious commitments or quitting the practice of medicine. Such policies would constitute grave and unprecedented restraints on religious freedom and would effectively preclude substantial segments of the US population from entering the medical profession.

Those who disagree with us (whether religious or secular) pose very real obstacles and introduce unavoidable inconveniences which complicate our efforts to live our individual and common lives according to the good as we understand it. The answer is not to coercively require some to participate in the aspirations of others, but for all to peaceably tolerate the disagreements and differences that cannot be avoided in a plural culture. In such a world as ours, it is the responsibility of physicians to respectfully and candidly seek the good of their patients, even when that good is something about which they and their patients disagree.

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### **Commentary 2**

by Rev Russell Burck, PhD

This case poses 2 specific questions, each of which introduces a far broader ethical inquiry. The questions, “Is Dr Nowak’s response to Amber ethical?” and “Why or why not?” force us to ask, “What is the good or not so good?” and “How do we determine what the good is?” [1]. The case also asks us, “How should physicians respond to patients who are engaged in behaviors that the physician believes are immoral?” That is a question about other people’s ethics, which my commentary addresses implicitly.

The Hippocratic Oath and the Oath of Maimonides recognize that physicians can exploit patients for their personal “needs.” When Dr Nowak talks about the teaching of their church about premarital sex, is that about herself or Ms Whitaker? Whether she brings her beliefs, her experience as a mature woman, and her membership in the same church into her care of her patient or leaves them at the door, whom is she serving?

Maimonides says, “Grant me the strength, time and opportunity always to correct what I have acquired, always to extend its domain; for knowledge is immense and the spirit of man can extend indefinitely to enrich itself daily with new requirements.” Does this particular encounter with Ms Whitaker confirm the ethical guidance, the “established solutions” Dr Nowak has received? Or does it ask her to examine those established solutions with the possibility of changing them to develop “novel solutions” [1]?

Custom contributes to medical ethics by establishing solutions to common problems. Custom doesn't, however, prepare clinicians well to identify or resolve new ethics problems. Dr Nowak may therefore have to break new ethical ground for herself. That will be a trial and error process.

John Stuart Mill observes in *Utilitarianism* that the absence of an agreed-upon first principle has made ethics not so much a guide as a consecration of a man's actual sentiments [2]. We get beyond consecrating our opinions about the good by testing them.

A customary test of Dr Nowak's response asks about her rights. She has a right to express her views appropriately to her patients and to decide whether to fulfill their requests. As a physician, she voluntarily defers some autonomy to patients, but patient autonomy (self-rule) doesn't entail physician heteronomy (rule by others).

We are finished testing our solutions when they do not require us to address new problems either within ourselves or with others. Simply saying that Dr Nowak has the right to decline Ms Whitaker's request does not end the inquiry. We have to revise the original question and ask, “Is her action “ethically preferable”?”

Many other tests are available. I prefer *Clinical Ethics*, by Jonsen, Siegler, and Winslade [3]. They identify 7 goals of medicine. These goals make Beauchamp and Childress's principles (beneficence, nonmaleficence, respect for autonomy, and justice) specific [4]. Some of these goals of medicine pertain to Ms Whitaker's request, some don't. Promoting health and preventing disease (goal 1) and educating and counseling patients (goal 6) pertain, as does relief of symptoms, pain, and suffering (goal 2). Ms Whitaker is suffering from unconsummated love. Less pertinent are cure of disease (goal 3), preventing untimely death (goal 4), and improving functional status or maintaining compromised status (goal 5). Despite its prominence in medicine, avoiding harm in the course of care (goal 7) is at risk. If Dr Nowak prescribes the pills,

she will harm Ms Whitaker from her point of view, and if she doesn't, she will harm her from Ms Whitaker's point of view.

Regardless of Dr Nowak's beliefs about premarital sex, promoting health and preventing disease are paramount. That links directly to educating and counseling. In the sense of *educare*. Educating is more than telling. It "draws from" the other. Not drawing from Ms Whitaker, Dr Nowak inhibits her ability to educate and counsel. Instead she preaches.

Educating patients by asking, not just telling, leads to Jonsen, Siegler, and Winslade's next major category, *patient preferences*—what the patient consents to. We know Ms Whitaker's preferences. But why does she make *this* request of *Dr Nowak*? This question expands "*patient preferences*" to "*patient perspectives*." By inquiring into Ms Whitaker's perspectives on making love with her boyfriend, Dr Nowak would have been more able to prevent disease, promote health, and relieve suffering and to postpone the standoff between Ms Whitaker's request and her own conscience.

What is she asking of Dr Nowak? A different "gospel," "good news" from medicine that trumps the church's teaching about premarital sex? Permission to act out? Help stiffening her spine against an insistent boyfriend? Reconciliation of her church's messages with those of her own body? Questions like these could have opened the door for a deep conversation that could have integrated Dr Nowak's experience and her medical, religious, and personal convictions into her education and counseling of her patient and fellow church member.

A fundamental goal of medicine, Jonsen, Siegel, and Winslade say, is to improve or maintain the patient's quality of life (QoL). Concern about quality of life could easily prompt Dr Nowak to ask whether the 2 of them could talk about the pros and cons of this decision for Ms Whitaker's QoL. This conversation could include things that could go wrong with Ms Whitaker's plan, such as, sexually transmitted diseases or the effect of premarital sex on her relationship with her parents and her church.

*Contextual features* concern the good of stakeholders other than the patient. In this case, it is important to give explicit attention to Dr Nowak's own good. Here, when her integrity is at stake, it is important for Dr Nowak to be clear in her own mind where she stands and what her responsibilities are to her patient. For quite a while, she wouldn't have to tell Ms Whitaker anything. But there's a lot that she can ask. For example, "Could we talk about how are you thinking about our church's teaching concerning making love before marriage? Are you thinking about not staying in our church? (Remember—this conversation is confidential.) Another question that comes to my mind can be a little touchy, but it would be very understandable if you thought that a doctor might have an opinion that differs from the minister's. Could I ask if you had a thought like that?" And so on. What happens in that conversation will determine whether she needs to tell Ms Whitaker her point of view. Dr Nowak's relationship with others in the church may be at stake along with the church's teaching about sex and marriage. Dr Nowak's professional integrity may also be at stake: Is the physician-believer a tool of the church? Or a closet hypocrite?

The goals of preventing disease and educating and counseling commend deep dialogue with Ms Whitaker about the perspectives behind the preferences. Dr Nowak's professional preparation could have helped her inquire, listen, and still retain her right to say, perhaps a bit later in the conversation and more gently, everything that she said in this scenario. She had an opportunity to consider and test a novel solution for integrating her person values into her care of patients. The main problem of this encounter is less with Dr Nowak's response than with her lack of preparation to review a custom, and be open to revising it. Ethical deliberation can help with that.

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## **Virtual Mentor**

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### **Clinical Case**

#### **The Evangelizing Patient**

Commentaries by J. Wesley Boyd, MD, PhD, John Dunlop, MD, and  
Harold Koenig, MD, MHSc

Michael Washington is a 38-year-old electrician. He arrives at the office of Dr Richard Martin, his psychiatrist, after a recent hospitalization for his first episode of mania. He describes a history of several depressive episodes in the past (though he never sought treatment). He says he has never abused drugs and has had no psychotic episodes. Seven years ago, Mr Washington reports, he experienced a dramatic conversion. Before this conversion, he was a heavy gambler and often abused his wife and 2 children. "Ever since I got saved, I haven't gambled, and I've been trying to be good to my family," Mr Washington says. His wife, significantly less religious than he, agrees that the change was dramatic, but his heavy involvement with a local Pentecostal church since that time has been a source of tension in their marriage.

The manic episode occurred 3 weeks before, when Mr Washington gradually noticed himself feeling energetic, very optimistic, "like I could take on the world." He began several projects at home, working long into the night, "but I still felt great in the morning and had no problem going to work." He also describes praying long into the night, and, on more than 1 occasion, he believes he heard God telling him to follow certain courses of action. For example, he sensed God directing him to give a large sum of money to a single mother in his church, and, when his wife discovered the money missing from their bank account, she was alarmed and insisted he see a doctor—"You've gone way too far this time," she said.

He was hospitalized for several days and started on a regimen of a mood stabilizer and antipsychotic medication. During his third day in the hospital, one of the nurses heard him repeating unintelligible syllables for several hours. After discussion with his wife, Mr Washington was discharged with orders to follow up at a clinic.

At Dr Martin's office, Mr Washington appears significantly subdued. He makes good eye contact, and is candid and cooperative, not displaying any pressured speech or tangentiality. In attempting to assess Mr Washington's insight, Dr Martin asks, "So tell me, Mr Washington, what do you understand about why you were hospitalized?"

"You know, doctor, this is something I've been thinking and praying a lot about, and, to tell you the truth, I realize this might sound kind of weird, but I think God allowed me to get sick so that I could share the gospel with you. In talking with you, it doesn't sound like you know the Lord. I may be sick, but I've gotta tell you! Jesus has made all the difference in my life. He's made me happy and given me peace inside, and I

haven't wanted to gamble or hurt my wife or kids ever since I gave my life to Him. Tell me, Mr Washington, have you ever accepted Jesus as your Savior?"

### **Commentary 1**

by J. Wesley Boyd, MD, PhD

Mr Washington's conversion brought about a dramatic change in his abusive behavior. Following in the pragmatic tradition of William James who said that the only good measure of the truth of any religious belief is whether or not its effects in the world are beneficial and healthy [1], I must support Mr Washington's religious beliefs regardless of their ontological status or whether I would embrace similar beliefs for myself.

I see Mr Washington's religious beliefs over the last 7 years as distinct from the manic episode that has recently led him to be hospitalized, though I certainly do not know what caused the manic episode. It may simply have been bad neurochemistry, a call from God, or something else.

The fact that the episode was replete with religious grandiosity and delusions is not surprising given the place religion occupies in his everyday life. In manic states, individuals often take their everyday concerns and issues and amplify them in some dramatic way. A musician in such a state, for example, might lock himself in his studio for days, producing little of worth but convinced he's making brilliant music that will instantly bring the music world to its knees.

### **Ethical Issues and Concerns**

When patients agree with psychiatrists' recommendations for treatment, we rarely raise concerns about informed consent. The implicit thinking seems to be, "My patient is conforming to my recommendations and wishes, therefore he or she must be properly informed and thinking clearly." But, when a patient believes that God gave him an illness so that he might convert his psychiatrist to fundamentalist Christianity, we certainly ought to raise the issue of whether this patient understands his illness and, additionally, whether he has the ability to give informed consent about receiving treatment.

If pressed, I'd probably conclude that Mr Washington does *not* fully understand the nature of his illness and therefore is not able to give true informed consent about his treatment. Even so, his understanding of the nature of his illness probably is not too much different from that of many individuals because many people ascribe religious or supernatural meaning to their suffering (or their successes, for that matter). Many of my depressed patients, for example, see every ill that befalls them as deserved because they perceive of their own nature as inherently evil. Analogously, many manic patients see any good that comes their way (whether real or imagined) as something deserved because of how special and wonderful they are.

The fact, though, that Mr Washington's understanding of his illness jibes (to some extent) with that of the majority of humanity does not, of course, mean he is correct in

his understanding? recall that most of the world used to think the earth was flat and that slavery was acceptable? but it does put Mr Washington's beliefs into a broader context.

Although I question Mr Washington's ability to act autonomously and give meaningful informed consent, I do not see autonomy as an all or nothing proposition because, in theory, full autonomy would require *complete* knowledge, something none of us ever has. Instead, I see us as existing along a continuum between full autonomy and no autonomy whatsoever, with some of us closer to one end and some closer to the other.

Should I refuse to treat Mr Washington because he does not understand the nature of his illness and, moreover, is pushing his religion on me? Absolutely not! Patients are often pushy in all kinds of ways. Besides, psychiatric illness often if not always strikes at the core of one's being and in its insidious way often compromises one's ability to act reasonably and make informed decisions. Since this is the very nature of psychiatric illness, I would be forsaking my duty as a physician if I were to stop seeing Mr Washington and reject him as a patient based on these reasons.

### **Handling the Question about Religion**

The final ethical concern I'll raise is one of maintaining proper boundaries with patients. What should we be willing to tell our patients about ourselves? Specifically, should I answer Mr Washington's question about my own religious belief? Besides, is my faith status even directly relevant to our work together?

It would be disingenuous of me to answer his inquiry with the standard psychiatric question, "Why are you asking?" because any remotely aware individual knows that evangelicals care a lot about the religious beliefs of those around them. More often than not our patients know far more about us than we might imagine. Whether due to our conversations with them, a Google search, or merely examining the art on our walls or the books on our shelves, patients often make highly accurate guesses about our religious or political beliefs as well as our dietary and exercise habits.

### **How I Would Proceed Clinically**

Even though I would never take Mr Washington's religion for myself, I would strongly support his religious belief because it has kept him from abusing his wife and away from the bottle. That same religion has him convinced he has an illness (many psychiatric patients want to deny any illness) and will probably keep him coming to appointments and taking his medication. The pragmatic utilitarian in me thus supports his belief system.

At some point I would probably tell Mr Washington that I doubt he'd ever convert me, even though I don't think that would deter him in his mission. And that would be just fine with me, because I assume that his ongoing hope of converting me would be one of the reasons he might continue our relationship.

In some sense, Mr Washington and I would both be using one another for our own ends. I'd be looking to keep him healthy and, in the process, feel good about my own psychiatric abilities, and Mr Washington would be looking to convert me. This view might appear a bit cynical, but as long as we are both fairly honest about our intentions, our interactions with one another will be both more above board and more respectful than most relationships, professional or personal.

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### **Commentary 2**

by John Dunlop, MD

Dr Martin has no control over Mr Washington's initiation of a conversation about faith. Thus the ethical question we must address has to do with Dr Martin's response? with the appropriateness of allowing this patient to share his faith with his therapist. Simply put, "Is there room for religious discussion within the practice of medicine?"

### **Responding to Patients Who Share Their Faith**

Dr Martin could ethically choose between several options:

1. He could say, "Mr Washington, you need to understand that I am a psychiatry professional. I am happy to treat your mental health, but I will not get involved in your religion."
2. He could say, "Mr Washington, I recognize that your faith is very important to you and that it has been of significant help to you. You should understand that I, too, have my own faith (or I am not a man of faith) and just as I am not trying to change your faith, I would request that you not try to influence mine. I see the value of your faith to you and would encourage you to continue to practice it."
3. Alternatively, "Thank you. I suspect I am not personally interested in your faith, but it would help me understand you better and therefore better care for you if you did take a few minutes to explain your faith to me."
4. Finally, "Thank you. I, too, have been on a personal search for further meaning in life and I would be interested in hearing about your beliefs. It is not appropriate, however, for that to be part of our professional relationship, especially when your insurance company is paying for our time together. I would prefer to talk to your pastor to learn more about your beliefs."

Some preliminary observations are foundational to this physician's choice.



- Any response must be grounded in truth. Dr Martin must be honest and straightforward in his response. He must not feign interest in Mr Washington's faith in a way designed to manipulate. If he has no interest he must refuse to pursue the discussion. If he feels that Mr Washington's church involvement is harmful to his planned treatment program, he must candidly state that. Mr Washington may find that grounds to request a transfer of care and, in that case, Dr Martin must comply.
- A treatment plan will, when possible, utilize many of the people and institutions influential in the patient's life. Dr Martin should recognize that, after his conversion experience, Mr Washington's life has significantly improved. It has not all been positive, however, inasmuch as it was through the church that the present exacerbation occurred.

It would appear likely that no matter how Dr Martin responds to Mr Washington's request, Mr Washington will continue to be involved in the church. It would seem advantageous therefore to consider how to make Mr Washington's church involvement be positive. Many churches employ counselors or have members of the pastoral staff trained in counseling. Dr Martin may find them a useful adjunct within his therapeutic plan. Other churches foster "men's accountability relationships" for people with a variety of behavioral or social problems.

It also seems clear that there is growing tension between Mr Washington's church and his wife. These are apparently the major influences in his life, and, for both of them to continue to have optimal beneficial effect, this tension must be dealt with. Dr Martin should try to help Mr Washington recognize that, though his wife does not share his faith, she can be a reality check for him.

- It is increasingly difficult to distinguish between matters of body (neurochemistry), soul (the traditional domain of the psychiatric analyst), and spirit (matters of faith). Multiple studies show a genetic or biochemical basis for an interest in religion (the religion gene). Recently Koenig et al have published a twin study demonstrating a genetic influence on religious choices [1]. Do those studies contradict the validity of religious experience? No more so than would the certainty that one is genetically equipped to excel in math exclude someone as a Nobel laureate for discoveries made. Mr Washington's biochemical imbalance may have predisposed him toward religion, but that should have no bearing on the validity of his experience with his religion. An area like this of genetic predisposition may be viewed as an asset in constructing a therapeutic plan for any patient. Without question, genetic predispositions can also lead to destructive involvements, and that is where discernment is needed.

If Dr Martin is sincerely interested in pursuing Mr Washington's faith for his own sake, he must be careful not to do this "on company time." He would

also be well advised to speak to someone other than his patient about this to avoid any conflict of interest within their professional relationship.

### **Recommendations**

Dr Martin must decide whether, in his professional judgment, Mr Washington's church involvement offers more positives than negatives. If he feels that it is essentially harmful for Mr Washington, he must candidly say so and indicate that he will not be supportive. If Dr Martin is open to the possibility that Mr Washington's church involvement is helpful to him, he may choose then to find out more about the church and be able to work within the church structure to help Mr Washington. Dr Martin should also try to smooth out the relationship between Mrs Washington, Mr Washington, and the church. If Dr Martin has a sincere interest in Mr Washington's faith, he needs to pursue that outside of business hours.

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### **Commentary 3**

by Harold Koenig, MD, MHSc

Mr Washington does appear to have had a manic episode, but his symptoms do not sound all that severe when one considers his religious background. Mr Washington had experienced elevated mood, increased energy, and decreased need for sleep. He made some rather poor decisions? particularly with regard to giving a large sum of money without first conferring with his wife. Nevertheless, many of his symptoms or implied pathology may have been a direct result of his religious beliefs.

Giving to the poor and needy is certainly consistent with his religious teachings and is not that bizarre. Had there been no conflict with his wife about this, and depending on his financial situation, such a decision could have been quite reasonable, especially if his wife had been as religious as he. Similarly, hearing God's voice telling him to do things could easily be consistent with his Pentecostal beliefs, as could the glossolalia or "speaking in tongues," which accounts for the unintelligible nonsense syllables overheard by the nurse. Moreover, hearing God's voice is something that is actively encouraged in fundamentalist Christian circles. This is also true concerning his explanation for needing hospitalization, expressed during the follow-up visit with his doctor, and his attempt to evangelize his psychiatrist. Many Pentecostals would explain such an episode this way, reasoning that this was part of God's plan and that God allowed this so that some good might result—an explanation that indeed may help the patient psychologically integrate and cope with the illness.

In fact, this person may not have come to the attention of health care professionals at all had it not been for the conflict between his and his wife's religious beliefs. There is

no doubt that the patient has mania, but there are certainly manic people on the streets who never come to the attention of mental health professionals, particularly if their cycles and symptoms are not severe and if they haven't bothered family members or come into conflict with the law. In this case, neither the patient nor his church community would probably have brought him in for treatment. Without treatment, he may have cycled back to normal or into a mild depression (especially since there is no history of severe mania or depression).

I believe that the patient needed treatment. It sounds, though, like he was cooperative about it and in fact improved after only a few days. This is unlike many of the manic patients whom I have encountered in practice, whom we all know can be extremely resistant and combative, with bizarre delusions and hallucinations, and who may take several weeks to come under full control. Thus, my sense is that this was a mild case of mania that was largely expressed in terms of the patient's religious tradition.

The challenge here will be to make sure Mr Washington is taking his medication. The medication no doubt will have unpleasant side effects, interfere with his functioning, perhaps prevent euphoric religious experiences, and may be expensive for him. Since the patient does not acknowledge that he has a mental illness, he may not comply with treatment. Some rational therapists might even argue against the need for treatment, or at least against the need for as aggressive a treatment plan as might be pursued for someone with an agitated psychotic mania or severe episodes of suicidal depression (neither of which this patient has). Both doctor and patient must come to some agreement on what is and what is not pathological, and until there is common ground here, treatment will not go well.

What is considered "acceptable irrationality"? That may depend on what part of the world one is in, and in what period of history. In non-Western cultures, both now and especially in the past, societies have been much more accepting of irrational behavior than we are in the United States today. Many of these cultures normalized aberrant behavior, and the mentally ill in some societies were highly respected and valued (eg, considered to be shamans or spiritual guides) for their ability to "see" into the spiritual world that others could not. This may have enabled such persons to function better because these views preserved their self-esteem and often increased their social support. This approach to the mentally ill likely conferred benefits that such persons in our society do not have. Instead, we label such persons as crazy, often isolate them in institutions, and then treat them with powerful drugs that have disabling side effects that interfere with their functioning and quality of life.

How does a physician address a patient who reports that he or she has insight or communicates with the supernatural? It is essential that the physician determine if the symptom is truly psychotic or part of the religious or cultural beliefs of the patient's subculture. Carefully observing the patient, evaluating him or her over time and gathering information from family members is essential. In addition, however, information may need to be obtained from the patient's pastor or other members of his church, after requesting permission from the patient. If someone is psychotic or mentally ill, usually persons familiar with that patient's culture can readily tell. Friends

and associates may have noticed a change in the person's behavior, subtle excesses or insensitivities not consistent with usual behavior, and knowing the person over time would enable them to make judgments that a psychiatrist could simply not make unless he or she were familiar with the culture or social group and had seen the patient more than once or twice.

Where does religious belief begin and mental illness end? That may be difficult to determine, as Mr Washington's case illustrates. Until the mental health professional has become thoroughly familiar with the religious beliefs and culture of the patient, such determinations are often not possible without collateral information. Even that collateral information, especially if coming from family members with their own agendas and conflicts with the patient, needs to be further confirmed by gathering information from persons in the patient's religious or social community. And, as noted above, where religious belief ends and mental illness begins is likely determined by how each is defined within a given culture.

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## Virtual Mentor

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### Journal Discussion

#### Clinical Issues and the Empirical Dimensions of the Religion and Health Connection

by Justin List, MAR

**Sloan RP, Bagiella E, VandeCreek L, et al. Should physicians prescribe religious activities? *N Engl J Med.* 2000;342:1913-1916.**

**Koenig HG, Idler E, Kasl S, et al. Editorial: religion, spirituality, and medicine: a rebuttal to skeptics. *Int J Psychiatry Med.* 1999;29:123-131.**

**McCullough ME, Larson DB, Hoyt WT, Koenig HG, Thoresen C. Religious involvement and mortality: a meta-analytic review. *Health Psychol.* 2000; 19: 211-222.**

Religious beliefs and spirituality are situated often in the most private spheres of our lives. At the same time, religion and spirituality pervade many public dimensions, including that of health. Studies that combine these deeply held beliefs with health capture public attention because of the ramifications that they may hold for the health profession and patients. Not surprisingly then, controversy accompanies these studies. This journal discussion explores some of the clinical, empirical, and religious issues that surround an inquiry into a faith-health connection.

Consider a meta-analysis conducted by Michael McCullough et al [1] that concluded “religious involvement was significantly associated with lower mortality, indicating that people with high religious involvement were more likely to be alive at follow-up than people with lower religious involvement” [2]. Richard Sloan and Emilia Bagiella replied to this conclusion that, controlled for relevant covariates, the data analyzed by McCullough et al suggested a statistically *nonsignificant* relationship between religious involvement and mortality [3]. In response, McCullough et al argued back that one of the most important findings from their research was that a religious involvement–mortality *association* persisted despite the researchers’ attempt to eliminate it by controlling for covariates rendering the association statistically nonsignificant [4].

#### Data Interpretation

As demonstrated by the exchange cited in the preceding paragraph, data from studies that explore religion and health raise questions of interpretation and application. From a statistical perspective, interpretation and study design need acute consideration. For example, the criterion validity of variants of “religiosity” is often a concern for researchers and their critics at the outset of a study. Effect modifiers pose additional complexities for understanding a religion-health connection. Demographic, behavioral, and psychosocial variables such as age, gender, race, physical activity, coping mechanisms, and income status are possible effect modifiers of a religion-health association that can, when included in a multivariate regression model, leave a religion-

health association nonsignificant. To what degree religious involvement and practice are mediating factors between exposure to illness and a particular health outcome represents one of the central questions for more research.

The variable of “religious involvement” includes actions such as prayer and attendance at religious services. Recall bias (survey respondents’ selective memory or forgetfulness in answering retrospective questions) and social desirability bias (response given based on respondent’s perception of a socially desirable answer) are frequent problems in many types of survey-based studies, and they make it more difficult to draw conclusions from these studies. Difficulties also arise in measuring and explaining *how* religion and health may be associated, given the diversity of religious experience and variables that shape it. Gordon Allport refers to the distinctions of “extrinsic” and “intrinsic” religiosity [5], the former referring to the personal motivation to practice religious activities as a means to attaining another good, eg, health. Conversely, “intrinsic religiosity” refers to a personal engagement in religious activities out of beliefs and concerns in themselves, rather than as a means for a desirable worldly benefit. Given new studies and media involvement in projecting the issue, it is plausible that a combination of these ideas may be in flux in a religious person’s life. Despite pressing concerns for research and data analysis for a statistical association between religion and health, there are many physiological and psychological research studies and experiments that have produced fascinating observations relating them. Emotions associated with, but not limited to, spirituality, religious activity, and belief likely confer health benefits as many scientists have noted [6]. The physiological pathways involved with these activities promote responses that mediate and reduce stress. While their precise causal mechanisms remain unknown, the elucidation of these pathways poses exciting new questions for further research.

### **Clinical Application**

If reliable research suggests an association between religion and health, then studying how clinicians approach and use this empirical data in patient care requires the utmost attention. In the clinical area, there is wide disagreement as to the level and type of role, if any, physicians should take in discussing possible health benefits associated with religious involvement with patients based on currently available data. Sloan et al argue, for example, that current physician efforts to integrate religious interests into medical practice are not as well justified or as simple as the literature suggests [7]. To them, religious attendance is the only variable of religious involvement that *may* suggest a significant religion-health association. Other researchers argue, on the contrary, that some studies that incorporate variables such as prayer and denominational affiliation may suggest a strong religion-health association as well. Koenig et al [8] articulate the current fundamental divide among researchers in this area:

We all agree that physicians should “take account of” their patients’ religious beliefs, but then so do Sloan et al. We differ among ourselves about whether physicians should or can effectively take the lead in providing spiritual guidance to patients. Nevertheless, we are strongly convinced, as Sloan et al are not, that the evidence regarding religion

and health, while still emerging, is neither weak nor inconsistent, and that religion is a factor that should not be overlooked in the describing influences on the health of populations [9].

At least 2 questions, then, stand out in this ongoing debate on the health benefits of religion. First, does empirical data suggest a relationship between religion and health? Second, if so, should physicians prescribe or engage in a therapeutic discussion about religious practices and beliefs with patients?

Answering either of these questions ultimately lies beyond the scope of this particular journal discussion. However, answering the question of what is at stake for medicine and religion in clinical discussions of religion is not. Studies that suggest greater health benefits of one religion or denomination compared to another are ripe for social critique. Since scientific research does not occur in a vacuum, warranted or not, the idea of “healthy” religions troubles many religious and nonreligious persons alike. Studies that seek to test the efficacy of prayer or meditation may be informative, even useful, on some level, but taken in social context, these “results” pose potentially polemic consequences. This does not necessarily suggest that studies in this field should not be conducted, but rather, that conclusions drawn from them must be interdisciplinary and extremely sensitive in their approach.

Should physicians *prescribe* religion or religious behavior? Should they educate patients on the relationship between them? Joel Shuman and Keith Meador contend, “In spite of what empirical studies show about the correlation between religion and health, it is from the perspective of faithful Christian discipleship fundamentally wrongheaded to suggest—as our colleagues sometimes seem to do—that religious belief or behavior are in some sense the efficient *cause* of better health” [10]. They go on to argue that today’s religious medicine is transforming itself more into a product of a North American consumerist ethos yearning for the commodity of individual health rather than a mutual concern for the care of the sick and suffering intrinsic to many religious traditions. This argument suggests that clinical care based on a religion-health association may be theologically suspect in some of its dimensions, if not suspect on clinical grounds already.

The articles referenced here highlight difficulties in the interpretation of data relevant to religion, spirituality, and health. Today’s American popular culture shows no dearth of references to connections between faith and health. Religion and medicine can and have complemented one another in important ways in areas such as end-of-life care, coping with illness, and behavior modifications [11]. However, once religion is seen as a *means for achieving* (eg, a prescription for) health rather than as an end in and of itself, all involved parties may have much to be concerned about, as Sloan et al point out [7]. Innovative clinical practice and the unique shaping of religious identity in contemporary society will require reflection, further scrupulous research, and ongoing dialogue over religion and its association with health in order to best understand its applicability to the clinical encounter.

## **Questions for Discussion**

1. Some physicians and patients incorporate religious expression in the clinical encounter. For example, some physicians and patients with concordant beliefs pray together. Is there an ethical difference between *engaging* in religious rituals and activities with patients and *prescribing* religious rituals and activities? If so, what are some of the potential strengths and weaknesses of either in the clinical encounter?
2. Some physicians take religious and spirituality histories as part of new patient histories. What may be some appropriate or inappropriate uses of information obtained from these histories?
3. Patients and physicians may encounter situations where discordant religious or spiritual beliefs become known. At what points in the clinical encounter can conflict arise between patient and physician beliefs? How might physicians respond in a way that respects patient beliefs when discordance appears to be a problem?

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## Virtual Mentor

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### Clinical Pearl

#### **Doing a Culturally Sensitive Spiritual Assessment: Recognizing Spiritual Themes and Using The HOPE Questions**

by Gowri Anandarajah, MD

During the last 10 years there has been a considerable increase in the number of studies showing positive associations between spirituality and health [1, 2]. Incorporating spirituality into medical practice, however, continues to pose many challenges [3]. These include the multicultural milieu in which medicine is practiced and the deeply personal meaning these issues carry for both patients and health care providers. A culturally sensitive spiritual assessment is a first step towards addressing the spiritual needs of patients [4]. It also provides a tool through which health professionals can understand their own beliefs, biases, values, and needs as related to health care.

#### **Terminology**

Words such as spirituality and religion carry a variety of meanings for different people. For some these terms evoke positive feelings and for others they may trigger negative responses. Although debate continues regarding the exact meaning of these and related words, it is helpful to have some common ground from which to start.

A. Whole person—Human beings are complex, with physical, mental, and spiritual aspects. Suffering can result from issues pertaining to any of these aspects.

B. Spirituality—Pertains to people's understanding of and beliefs about the meaning of life and their sense of connection to the world around them. It is multidimensional and can encompass both secular and religious perspectives [4].

1. *Cognitive aspects* have to do with the way we make sense of the world around us. They include the big picture questions such as: "What is the nature of the universe?" "Is there a God?" "Why do bad things happen to good people?" "What happens after death?" "What beliefs and values are most important to me?"
2. *Experiential aspects* have to do with connection and inner resilience. They encompass questions such as: "Am I alone or am I connected to something bigger?" "Am I able to give and receive love?" "Do I feel an inner sense of peace and resilience?" "Can I find hope in this difficult situation?"
3. *Behavioral aspects* have to do with ways in which a person's spiritual beliefs and inner spiritual state affect his or her behavior and life choices.

C. Religion—organized or institutionalized belief systems that attempt to provide specific answers to mankind’s general spiritual needs and questions. For many people, religion provides an important foundation from which to meet the numerous challenges that life presents. For others religion may be associated with negative experiences.

D. Faith—can mean a person’s belief and trust in something (eg, God) and may or may not pertain directly to religion (as in “What is your faith?”).

E. Spiritual distress/crisis—This is a state of suffering due to spiritual causes. For example: (1) a mother having difficulty understanding why a loving God would allow her child to die; or (2) a dying patient feeling cut off from sources of spiritual love.

F. Spiritual Assessment—Methods to identify a patient’s spiritual suffering and spiritual needs related to medical care.

G. Spiritual Care—Therapeutic aspects of spirituality and medicine.

1. General spiritual care—bringing presence, compassion, understanding, and listening to each encounter. This can be provided by anyone at any time. It can traverse all cultural barriers by meeting a universal spiritual need without specific discussion about beliefs or God.

2. Specific or specialized spiritual care—addressing the individual needs of the patient. Simple issues may be addressed by physicians. More complex issues will likely require the expertise of well-trained spiritual care counselors such as chaplains trained in Clinical Pastoral Education.

### **Ethical and Boundary Considerations**

There has been a great deal of discussion in the literature regarding the ethical and boundary issues involved in incorporating spirituality into medical care [5]. In a multicultural society, it is important to keep in mind that physicians and patients frequently do not come from the same cultural background or belief system. Since patients in medical and spiritual distress are often in a vulnerable position, it is critical that health care providers be sensitive and careful in their approach to patients. Physicians should also be aware of their limitations in training and expertise in spiritual care and should utilize the help of trained chaplains in complex or difficult situations.

### **Providing a Spiritual Assessment**

A. Goals

1. Provide a safe, therapeutic setting for patients to discuss their spiritual needs related to medical care.
2. Use an approach that will be acceptable and helpful for any patient regardless of religious or cultural background.
3. Keep patient’s needs as the primary focus.

4. Use self-understanding, self-care, and reflection skills to help negotiate through ethical and boundary challenges.
5. Maintain compassionate care as the foundation to every interaction.

## B. Methods

1. *Informal spiritual assessment* – Perhaps the most valuable way to gain an appreciation of a patient's spiritual beliefs and concerns is to listen carefully to the patient's stories and narrative and recognize spiritual themes as they arise. Often, spiritual values and beliefs present in the form of metaphors and stories rather than in response to direct questions. Recognizing these themes (such as search for meaning, or connection versus isolation) and following with open-ended and specific questions about patients' beliefs may reveal a great deal about a patient's source of suffering.
2. *Formal spiritual assessment* – This involves asking specific questions during the course of a medical encounter in order to determine if spiritual issues play a role in the patient's illness or recovery.

C. The HOPE questions are an example of one approach to spiritual assessment [4]. These questions were designed as a starting place for health care professionals interested in the spiritual health of their patients. They may open the door for more in-depth discussion when needed. The HOPE approach asks about:

1. **H**—The sources of hope, meaning, comfort, strength, peace, love and connection.  
By focusing on a patient's basic spiritual resources without immediately introducing the words religion or spirituality, these questions allow for conversations with people from a wide variety of backgrounds and beliefs.
2. **O**—Organized religion's role for the patient.
3. **P**—Personal spirituality and practices.
4. **E**—Effects of the patient's beliefs and values on medical care and end-of-life decisions.

Examples of questions for each of these domains can be found online in an article describing the HOPE tool [4] at [www.aafp.org](http://www.aafp.org).

### **Spiritual Care**

Once a patient's spiritual needs have been assessed, there are several possible options for health care professionals not specifically trained as clinical chaplains.

1. Do no more—sometimes just giving the patient the opportunity to express his or her concerns in a safe, compassionate environment is enough.

2. Incorporate the patient's *own* spiritual resources into preventive care or as adjuvant care.
3. Modify the treatment plan based on the patient's identified spiritual needs; eg, continue or stop heroic life sustaining measures; refer a patient in spiritual distress to a trained clinical chaplain; teach simple relaxation or meditation techniques to patients interested in this approach; consider alternatives to blood products for patients who are Jehovah's Witnesses.

### **Summary**

The spiritual assessment is the first step towards addressing the spiritual as well as mental and physical well-being of patients. If done in a compassionate, culturally sensitive way, it can help provide a great deal of relief to our suffering patients.

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## **Virtual Mentor**

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### **Case in Health Law**

#### **When a Parent's Religious Belief Endangers Her Unborn Child**

by Faith Lagay, PhD

Competent adults can refuse medical treatment, even life-sustaining treatment. This has long been recognized as a common law right, bolstered by the liberty rights granted in the US Constitution. Despite this assumed right, however, physicians often approach the courts when non-terminally ill patients refuse basic, life-saving medical treatments on religious grounds. As a result of such cases, the courts have now established patients' clear rights to refuse treatments that conflict with their religious beliefs.

Case law is less definite when a parent wishes to withhold life-sustaining treatment from a child who is not old enough to confirm his or her belief in the faith that forbids the treatment. Generally, the courts have agreed that, while a competent adult can sacrifice his or her life for religious beliefs, as a parent he or she cannot refuse life-sustaining treatment for a child who has not reached the age of consent and has not chosen to adhere to the religion. The case at hand, *In re Fetus Brown*, concerns the decision of a pregnant woman to refuse transfusions necessary to save her life and that of her fetus.

Darlene Brown, 34 and 3/7-weeks pregnant, was admitted to the hospital by her physician because of urinary tract discomfort. Following a cystoscopy that revealed a urethral mass, her physician, Robert Walsh, ordered surgery to remove the mass. During the surgery, Brown lost almost 1500 cc of blood, and her hemoglobin fell to less than one-third of the value normal for women at her stage of pregnancy.

During the operation—when her blood loss had reached about 700 cc—Walsh called for 2 units of blood for transfusion. Brown, who was conscious during the procedure, refused the transfusion, declaring that she was a Jehovah's Witness, information she had not previously disclosed. Walsh completed the surgery without administering any blood, but, subsequently, when Brown's hemoglobin continued to decline, he asked the hospital to seek court approval for transfusions to save the life of Brown and her fetus. Walsh explained that transfusing Mrs Brown was the only way to get oxygen through the placenta to the fetus. Without transfusion, he estimated that Mrs Brown and her fetus had a 5 percent likelihood of survival.

A hearing was held immediately in an Illinois circuit court, during which the state asked that a temporary custodian be appointed for Fetus Brown with the right to consent to 1 or more transfusions for Darlene Brown when the necessity arose. The court appointed the hospital administrator as temporary custodian, and, over the next day-and-one-half, Darlene Brown received 6 units of packed red blood cells over her violent objections—she had to be restrained and sedated for the transfusions to take

place. Three days later Darlene Brown delivered a healthy baby and was subsequently discharged from the hospital. One week after the baby's birth, the court vacated the temporary custody order and dismissed the case.

Darlene Brown appealed the circuit court order that had appointed the temporary custodian for her unborn fetus, contending that, under federal and Illinois law, she had the right as a competent adult to refuse medical treatment. The state responded that its substantial interest in the life of the viable fetus outweighed the minimal invasion posed by the blood transfusion [1]. Notwithstanding that “the factual issues [were] moot”—that is, the circuit court's decision no longer pertained because the fetus was now a living baby and the custodianship had been revoked—the court considered the appeal because it believed the issue should be determined “for the future guidance of public officials” [2].

The circuit court had based its decision on 2 earlier opinions: the Illinois appellate court's decision *In re Baby Boy Doe* (1994) and the Illinois Supreme Court decision in *Stallman v Youngquist* (1988) [3,4]. In its review, the appeals court looked at the same cases.

The chronologically earlier case, *Stallman v Youngquist*, had asked the court to decide whether a fetus could advance a tort cause of action against its mother for unintentional infliction of prenatal injuries. That court held that “a fetus cannot have rights superior to those of its mother” [5] and that a pregnant woman “owes no legally recognized duty to her developing fetus” [6].

*In re Baby Boy Doe* concerned maternal refusal of delivery by caesarean section that was deemed necessary to save the life of the fetus. The Baby Boy Doe court, balancing fetal against maternal rights as the Stallman court had done, held that a woman's right to refuse invasive medical treatment was not diminished during pregnancy [7] and that the impact upon the fetus was not legally relevant [7].

The court distinguished *In re Fetus Brown* from the precedent cases on 2 points—first, the blood transfusions were not considered to be “invasive,” certainly not in the way that a caesarean delivery is. Second, *In re Fetus Brown* weighed the state's interest against the mother's rather than trying to balance the fetus's interest with the mother's as the 2 prior cases had done.

In attempting to override an individual's right to refuse life-sustaining treatment, the state traditionally invokes 4 interests: (1) the preservation of life, (2) the prevention of suicide, (3) the protection of third parties, and (4) the ethical integrity of the medical profession. Interest (2) was not at issue here, inasmuch as Darlene Brown agreed to medical treatment other than blood transfusion. Interest (4), which seeks to protect the role of hospitals in fully caring for patients and promoting the prevailing medical standards, was deemed not to affect the disposition of Brown's appeal.

In the initial hearing brought by the hospital, the circuit court used the remaining 2 interests. It decided that the transfusion was necessary to preserve the lives of Darlene Brown and her fetus. On point (3) the court claimed an interest in preventing harm to Darlene Brown's 8- and 10-year-old daughters who would be left motherless should Darlene die. But the appeals court disagreed. Moreover it raised the state's fundamental interest in protecting the liberty and autonomy of its citizens. In the appeals court's reckoning, the state's interest in protecting Darlene Brown's autonomy outweighed its interest in protecting her life. Neither was state interest in preventing harm to Brown's 2 existing daughters determinative, inasmuch as her husband had assured the court that he and the girls' maternal grandparents would assume their care.

Remaining, then, was whether the state's interest in Brown's viable fetus could load the scales in the state's favor. The state's interest in protecting the life of a fetus becomes compelling at viability [8]. This interest is the foundation for laws that limit late-stage abortion. But the Illinois appeals court in *In re Fetus Brown* decided that the state's interest in the viable fetus did not outweigh the mother's common law and constitutionally based right to refuse treatment for herself. As the 2 precedent cases had established, a woman's right to refuse treatment does not diminish during pregnancy. The court also disagreed with the earlier court's opinion that a blood transfusion was not an invasive procedure. On these bases, then, the appeals court ruled that the circuit court had erred in appointing a guardian for Darlene Brown's fetus for the purpose of imposing unwanted treatment on Darlene Brown.

### **Implications for Physicians**

This case has been recounted in some detail here because it represents current federal and state case law. While states allow physicians to intervene as soon as an infant is born to administer life-sustaining treatment over parents' religious objections, they prohibit physicians' doing so in the case of pregnant women who refuse treatment on religious grounds. To do so, under current jurisprudential thinking, violates not only of the woman's right to refuse treatment but also her right to exercise her religious beliefs.

The refusal of blood transfusions by members of the Jehovah's Witness denomination is by now fairly well-known among clinicians and others who are likely to be involved in their emergency care. The American Medical Association's *Code of Medical Ethics* states in Opinion 10.01, Fundamental Elements of the Patient-Physician Relationship, that "...patients may accept or refuse any recommended medical treatment" [9]. Nevertheless, this knowledge of the law and professional ethics does not always make it easy for physicians to accept treatment refusals when standard interventions would save a patient's life.

### **Questions for Discussion**

1. What do you think of the legal distinction between a woman's right to refuse treatment that could save the life of her fetus and the state's right to overrule that refusal as soon as the fetus is delivered as a live infant? Does that legal distinction stand up to ethical scrutiny?

2. How do you think the courts might react if a woman's reason for refusing life-sustaining treatment for her late-stage fetus was not based on her religious beliefs?

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## **Virtual Mentor**

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### **Policy Forum**

#### **The Other Side of Complexity: Faith, Health, and Humility**

by Rev Gary R. Gunderson, DMin

*I would not give a fig for the simplicity this side of complexity, but I would give my life for the simplicity on the other side of complexity. —Oliver Wendell Holmes*

The challenge at the intersection of faith and health is that the experts on either side tend to think that the other is relatively simple, while *their* field is full of complex nuances. This is true at the bedside and, more dangerously, in Congress. Only a very young physician can avoid humility in the face of the mysteries of healing and death. And only a very young preacher can stand in a pulpit, look at the congregation and not be astonished by the patterns of tragedy, stupidity, and fortune that emerge in any group of more than a dozen human beings. Each knows that health and illness, meaning and incoherence reflect complex interactions and decades of small choices that cannot be explained, much less fixed with a pill or a sermon.

In recent years nearly every health science journal has seen a growing tide of articles linking faith and health in mostly positive ways. Sociologist Ellen Idler reviewed articles resulting from NIH-funded research that included a religion variable and found 1373 papers published between 1980 and 2002. Found in journals ranging across the health sciences, the religion variable was usually simplistically conceived, while the health issue was the subject of an entire journal and thus deeply nuanced. Religion was usually measured by attendance at worship, or, worse, by denominational affiliation [1].

The most common religious traditions have developed over at least 1 or 2 millennia. They have a multicultural literature in which the most well-educated people of their time reflected deeply about the most complex human dilemmas. Those thoughts proved helpful to enough generations to become embedded in ritual and song, and eventually came to be regarded as sacred. (Think of the process as a highly extended peer review.) The result, as one would expect of any living phenomenon, is great complexity within apparent similarity. In the US today there are roughly 4000 denominations, mostly within the loosely defined boundaries of Christian tradition, but increasingly sharing communities rural and urban with nearly every religious group in the world. This only describes the superficial complexity. When one encounters a single patient, the complexity goes to another scale entirely. If one even begins to probe the layers of coherence that operate within any one modern mind today one is amazed: astrology, Jesus, superstition, electrons, and pharmaceuticals all in one head.

The research corollary of “do no harm” is “do not make me any dumber than I already am.” The quickest way to violate that rule is to count something before you

understand it. The second quickest way is to ignore something just because you know you don't understand it. From patient to polity, physicians find themselves swimming in a religious sea whether they understand it or not. The first myth to dispel is that there is a necessary separation between science, religion, or politics. Replace it with constant negotiation, some of it at the bedside with the patient and family, other aspects of it in court, as a number of state and federal judges (most recently in Western District of Wisconsin) [2] find themselves part of a 300-year effort to identify the appropriate line beyond which is "excessive entanglement" of state with religion. Life is an evolving tangle of meaning and method in which science, religion, and policy are all inextricably involved. The moving edge of science and communications makes the tangle more inevitable as our opportunities for medical *and political* intervention become enhanced.

The physician's first move into the confluence of faith and health should be one of humility guided by 2 questions that are somewhat novel for those schooled to look for disease. Illness and death are relatively simple, inasmuch as they signal that some vital process has been disrupted. Faith is more like health than it is like disease, so it requires different kinds of questions: First, "What do you think is the cause of your life, of your thriving and vitality?" The Interfaith Health Program, a project of Emory University's Rollins School of Public Health, is conducting research into the "leading causes of life" by interviewing a wide number of individuals. We are finding that the question itself tends toward a pattern of connection, coherence, agency, blessing, and hope [3]. People place their struggles—including those of health—in the context of stories of adaptation, resilience, choice, and strength. Religious language is much better with such subjects, but little of the discussion is "religious" in the sense that it talks about extrinsic behavior. It is a language of life that illuminates what the doctor is working *with*, not just *against*.

The second question moves to a policy level. "In what ways are religious-social networks and structures assets for health?" Like physicians, policy makers often take 15 minutes to focus on what is wrong at the moment so they tend toward simple, quick, and cheap interventions. In recent years politicians have hoped that religious networks would be willing to replace expensive and inconveniently complicated government services with volunteers and charity. Needless to say the dismantling of government services has moved much more quickly than the research into the actual capacities of nongovernmental entities. In Africa where all philosophies and strategies have been humbled by the deadly weave of AIDS and intractable poverty, leaders are forced to the fundamental question: "What do we have to work with?" And part of the answer is the tangible and intangible assets found in religion. The Africa Religious Health Assets Program conducted by Emory University and the University of Cape Town is finding through case studies and quantitative mapping that faith has multiple proximal and distal affects on which programs of scale could be built once policy makers and program designers think creatively about assets. The findings suggest collaboration with government, not hand-off.

Having argued for humility, let me finish with a plea for intellectual courage. Faith and health are utterly inseparable because both deal with the lifespan developmental

processes that inevitably reflect physical, mental, social, and, yes, spiritual, determinants and outcomes. It would be bad science to avoid the complexities of how patterns of coherence and meaning contribute to health outcomes on all scales. And it would be terrible theology to try to contain faith apart from the physical and mental dynamics that physicians deal with daily. We will simply have to learn to talk to each other about what matters most—life.

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## **Virtual Mentor**

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### **Medicine and Society**

#### **A Faith-based Clinic in Chicago**

by Meme Wang, MPH

*Of all the forms of inequality, injustice in health care is the most shocking and inhuman.* – Rev. Dr. Martin Luther King Jr. (1966)

At first glance, it appears bleak and desperate. North Lawndale of Chicago possesses all the problems of an inner city neighborhood—inadequate and dilapidated housing, abandoned storefronts, vacant, weed-clogged lots, high unemployment, violent crime, and widespread poverty. In the 1950s, its black population grew as the flight of the white population began and the industrial base eroded. By 1960, 91 percent of its population was black [1]. Dr Martin Luther King, Jr, who believed that North Lawndale epitomized the plight of urban America, moved into a tenement here to highlight segregation and impoverished living conditions in his campaign against slums in 1966. Then in 1968, race riots, sparked by Dr King's assassination, set businesses ablaze and further devastated the economy [2]. Today, just under half of North Lawndale's population still lives below the poverty line [3].

But look closer and you will find churches and faith-based social service organizations dotted along the streets in North Lawndale. Churches, traditionally at the heart of a black community, provide support, relief, and an anchor through turbulent times; and it was one such church that formed the Lawndale Christian Health Center (LCHC), an establishment housed in a large white building that has never been marred by the faintest trace of graffiti. LCHC is the realization of faith-inspired strength and hope for a community of survivors.

#### **Role of Faith in Establishing the Health Center**

This health center's story began a little over 25 years ago, when a young white man named Wayne Gordon became assistant football coach at Farragut High School and moved to North Lawndale to break down racial barriers and spread the gospel. With several of his high school students, he formed the Lawndale Community Church [4]. His wife had been a college roommate of the wife of a medical student, a coincidence that would prove to be meaningful and significant to their lives and to the community of North Lawndale. The medical student, Art Jones, would later form the Lawndale Christian Health Center. The couples became friends and Wayne soon asked Art for assistance in establishing the church. At that time, Jones believed that becoming involved presented an opportunity to prepare for his future plans of traveling overseas on faith-based missions. So despite the rigorous demands of being a third-year medical student at the University of Illinois at Chicago and rotating through a surgery clerkship at Cook County Hospital, Jones agreed to lend a hand; he had no intention of staying.

One day, Reverend Gordon asked his congregation to list the needs of the community. “He got a blackboard out and said we need to do more than just preach on Sunday morning, we need to meet the needs of the neighborhood and express our faith through meeting those needs,” Jones recalled in a recent interview [5]. The first item on the list was a secure place to do laundry because the laundromats were overrun with gang activity. So the Lawndale Community Church set up a laundromat in its own basement with donated equipment. The second item on the blackboard was affordable health care. All eyes turned to Art Jones, the young medical student. It was a moment that transformed his life.

Dr Jones was aware of the problems caused from the lack of primary care in the neighborhood. “At that time, the county [health] system was such that if you were uninsured and poor and you got sick, you went to the county’s ER, but the waiting time to get into the general medical clinic if you weren’t already part of the system was 6 months. So once they diagnosed your heart failure or diabetes or whatever, you literally had a 6-month wait” [5].

After much reflection and praying for guidance, Jones and his wife decided to stay and moved to North Lawndale. Jones worked with a group of people from the church and several other churches in the community to establish the health center over the next 6 years. At the same time, he went on to the University of Chicago, completed his residency in internal medicine, and then continued on for a cardiology fellowship.

With an 8-year grant from the Robert Wood Johnson Foundation, and matching dollars from Chicago foundations such as MacArthur and Amoco, the health center received funding of around \$100,000 a year. With an additional grant from the Chicago Community Trust and help from Christian contractors and neighborhood volunteers, the Lawndale Christian Health Center finally opened in a rehabilitated former Cadillac dealership in September 1984.

### **Role of Faith in Patient Care**

If you walk into the Lawndale Christian Health Center as a patient, its differences from nonreligious community health clinics do not strike you immediately—until you receive the patient questionnaire that asks whether you go to church, and, if so, where and how often. This is for the purpose of recording patient demographics.

LCHC mainly serves the neighborhoods of North and South Lawndale, which differ considerably in their demographic makeup. While North Lawndale is 93 percent African American [3], South Lawndale’s population is 83 percent Hispanic and 12.9 percent black [6]. Representative patients from North Lawndale are single moms, and the problems of obesity and diabetes prevail, along with substance abuse and HIV/AIDS. Patients from South Lawndale generally face a different set of health concerns. South Lawndale, often called Little Village, is Chicago’s largest Mexican neighborhood and essentially serves as an entryway for Mexican-American immigrants to the Midwest [7]. Physicians frequently treat depression and anxiety in the community’s first generation women. “That’s a big part of what they [physicians] see—somatic complaints related to suddenly being in a totally different culture, and

then also just having left their support structure, family or friends in Mexico [5],” Jones says.

Whatever the illness, faith plays a role in its treatment through the health center’s holistic approach of meeting the patients’ spiritual, emotional, and physical needs. “Ultimately,” Jones expresses, “we believe a healthy person is somebody who is physically healthy, emotionally healthy, and also spiritually healthy [5].”

Patients from the health center can be referred to the Lawndale Community Church’s residential program called the Hope House that helps adult men successfully reenter society after prison or substance abuse [8]. Or they can enroll in the employment training or youth education programs offered at the Lawndale Christian Development Corporation. The development corporation also purchases abandoned houses in North Lawndale, renovates them, and makes them available to low-income families through no-security, low-interest loans [9]. This organization and the Lawndale Christian Health Center both grew out of the Lawndale Community Church, because the congregation recognized that the health problems in North Lawndale are entrenched in poverty.

“When a mom comes in and she says, ‘I have a headache,’ instead of just writing a prescription for Tylenol or Motrin, you could say, ‘what’s causing the headaches?’ ‘Well, my kids are being recruited by the gangs.’ How do you deal with that? Most medical practices cannot address this. Here you can get them into church programs and activities that give the kids an alternative to the gangs. You can get them into relationships with other people who have been in that same situation and have dealt with it successfully,” Jones said [5]. Finally, Jones and the other physicians at the health center also act as the initial link for patients to receive more in-depth spiritual and emotional support from the pastoral staff at the health center.

The health center itself offers a full range of services in addition to primary medical care: dental and optometric care, obstetrical services, well-child care and immunizations, x-ray and ultrasounds, laboratory services, aerobic classes, and various case management and comprehensive team-based services for maternal and child health, nutrition, asthma, diabetes, HIV/AIDS, and tuberculosis [10].

In accord with its holistic approach, the health center formed a sexual abstinence program that is true to its faith. But it also provides contraceptive services to teenagers who choose to be sexually active. Jones explains, “The abstinence program is to really work with kids who then turn around and work with other kids to promote the idea that it [abstinence] is an acceptable thing to do because too often, it’s not acceptable to be sexually abstinent.” LCHC does not refer for abortions or perform them, but does offer counseling for those who seek it.

### **Role of Faith in Art Jones’s Patient-Physician Relationships**

While the Lawndale Community Church’s strong presence in the community contributed to Lawndale Christian Health Center’s tremendous success, Art Jones’s personal involvement in the church formed deeper ties to the neighborhood and

helped gain the trust of his patients. Faith plays a consistent and key role in Jones's individual relationships with his patients. Their trust allows them to reveal troubles and circumstances that may have contributed to their illness, and this information often leads to prayer. "After I've taken care of them for a long time, they know where I stand as far as my faith. You'll start to get into what they are struggling with and we'll talk about issues of faith. We'll pray together if that's what they want to do [5]."

Most importantly, faith gives Jones strength to endure and persist through the difficulties and hardships he faces at the health center. "There are frustrating times, there are disappointing times, there are setbacks. I don't want to act like it's all a bed of roses, but when something difficult happens, you've got to say, 'why am I here?' and if faith is driving you, that's going to sustain you through those difficult times. So if I didn't have my faith, I wouldn't be here – I can tell you for sure [5]."

### **Conclusion**

Faith, the foundation of the Lawndale Christian Health Center, plays a continuing role in the challenges that the Lawndale Christian Health Center will face in obtaining funding. In the early days when the Robert Wood Johnson Foundation grant came to an end, the center encountered the daunting task of seeking a different source of financial support. Its faith, however, sustained hope and the conviction that it would survive. Then a series of events occurred unexpectedly. A community health clinic in the north of Chicago, was accused of fraud and forced to shut down. That clinic had received federal dollars that were now offered to the Lawndale Christian Health Center. LCHC accepted the proposal, but only on the condition that it could continue its affiliation with the church and maintain its identity. The federal government agreed and recognized it as a Federally Qualified Health Center, and the health center received section 330 funding that enabled it to expand.

Now, both government and private donors support the center, which has become one of the largest providers of health care for the whole area. Funding shortages plague the health center, however, in its need to serve the ever-growing population of those who require its services. In the last few years, the number of uninsured has skyrocketed. The health center will provide approximately 100 000 medical visits through its 3 locations this year, but the volume continues to rise with the uninsured becoming a larger portion of the patient population. But clearly, what started for faith reasons serves a growing medical need, and, as the health center faces future difficulties, its faith will sustain it as it had in the past.

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### **Op-Ed**

#### **Spirituality and Health in a Therapeutic Culture**

by Keith G. Meador, MD, ThM, MPH

Some have expressed the hope that the recent increased interest in spirituality and health would offer new and creative opportunities for the practice of medicine. While this vision is alluring, the conversation to date has frequently reflected a spirituality that is used as one more tool to fulfill the consumerist expectations of our current therapeutic culture. Rather than offering a distinctive voice for reforming our practices of caring within health care, the prevalence of this therapeutic adaptation of spirituality has distorted and limited the potential contribution of the spirituality and health movement within the practice of American medicine.

The illusion of our therapeutic culture? that the obsessive pursuit of cure and self-enhancement is always an unambiguous good? too often frames our understanding of spirituality and its role in health. Spirituality becomes a means to the end of an individualistic sense of well-being and health, an end to which the contemporary health care consumer presumes to be entitled. This understanding of a therapeutic spirituality increasingly has become detached from religious practices and communities of faith. Spirituality is understood as an individualized expression of desire and expectation to be fulfilled through a contractual exchange with God or whatever the object of one's spiritual inclinations might be. The deal that is implied within this exchange reduces both spirituality and health to commodities. This reductionism distorts our traditional theological understandings of prayer and worship within spirituality as well as our understanding of medicine as a practice of service. In *Heal Thyself: Spirituality, Medicine and the Distortion of Christianity*, Shuman and I commented, "If the human relation to God is essentially contractual? that is, technical and instrumental? then God becomes obligated to fulfill the contract providing health in exchange for devotion.... Improvements in the health of persons notwithstanding, something is lost when the interrelationship of faithfulness and healthfulness is reduced to exchange" [1]. The notion of covenant as a basis for interpreting relationships in both spirituality and medicine is lost when contractual exchange becomes the prevailing paradigm. Entitlement, rather than gratitude, becomes our framework for expressing and interpreting both spirituality and health. This presumption of entitlement within a commodified understanding of spirituality and health limits the potential for gratitude in forming both the human spirit and our understanding of transcendent spirituality.

Utilizing spirituality as a therapeutic technique also contributes to the excessive expectations of patients who frequently ask medicine to provide unmitigated cure and self-enhancement. Interjecting God, or whatever spiritual surrogate for God the patient may choose, into the formula as a therapeutic intervention for negotiating their

expectations—potentially already inflated expectations—sets up both the patient and the clinical providers for distrust and disillusionment. This understanding of spirituality misguides patients and physicians leading to distortion and confusion regarding the relationship of spirituality and health. While therapeutic uses of spirituality are most likely well-intended when attempted by practitioners, they can divert us from a more vital and theologically cogent appropriation of spirituality within health care. We lose sight of the more substantive offerings of a community of practice and caring formed in particular practices of caring that reflect a serious engagement of medicine with the spirituality of patients. Without presuming to use spirituality as some therapeutic technique, attentiveness to spirituality can help interpret and re-narrate illness, so we can see more clearly how our patients might flourish and to what ends we provide care in spite of the suffering and illness common to us all. The inevitability and mutuality of suffering as part of human existence is something we try to deny through the lens of “technological utopianism” as part of our therapeutic culture [2]. Spirituality in health care should offer an antidote to this illusion rather than propagate its presumptuous implications. Rather than seeing spirituality’s relationship to medicine as a therapeutic tool or technique, perhaps we might envision it as an alternative lens, one through which we can see and interpret the hopes and expectations of those for whom we care, regarding human flourishing in relation to God.

Crucial to gaining more clarity regarding spirituality and health in both research and practice is a more careful consideration of what we mean by “spirituality” and by “health.” In concert with our need to reconsider the depths of our captivity to a therapeutic utopianism, Wendell Berry challenges us regarding the individualism of our understanding of health. He comments, “Health is not just a sense of completeness in ourselves but also is the sense of belonging to others and to our place; it is an unconscious awareness of community, of having in common” [3]. Berry will not allow us to reduce health to a private, individualized sense of well-being and contentment while ignoring the sustenance and care of the communities surrounding us and our patients. While challenging our definition of health in this context, we also need to consider a problematic conflation that occurs consistently regarding spirituality. In both research and practice the language of “spirituality” is used interchangeably between dimensions of the human spirit that might most accurately be described as psychological or existential and a notion of spirituality connoting some relationship to God or some clear sense of self-transcendence. Even though this use of spirituality may be common in our current cultural milieu, it does not contribute to clarity or rigor in either research or practice within the spirituality and health conversation.

As we seek to refine this conversation in order to improve the quality of our research and better serve our patients, the challenges are considerable. A pivotal contingency is the clarity with which we persevere in questioning the presumptions of our therapeutic culture and strive to formulate a true prophetic voice within the conversation about spirituality and health. The outcome may very well determine whether the spirituality and health movement of the last decade or so becomes a blip on the trajectory of

American medicine or a force for transforming the practices of caring in American medicine.

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## **Virtual Mentor**

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### **Op-Ed**

#### **Spirituality, Prayer, and Medicine: What Is the Fuss Really About?**

by Larry Dossey, MD

The idea that prayer can affect living organisms is an ancient belief spanning ideology, religion, culture, and race. As anthropologist Stephan A. Schwartz states, “The shamanic cave art of Altamira, Tres Frères, and Lascaux presents compelling testimony that our genetic forebears had a complex view of spiritual and physical renewal, one that has survived to the present unchanged in at least one fundamental respect. The intent to heal, either oneself or another, whether expressed as God, a force, an energy, or one of many gods, has consistently been believed to be capable of producing a therapeutic result” [1].

For at least 50 000 years, shamans and healers have believed that it is their duty to engage the spiritual beliefs of sick persons in the task of restoring health. This fact alone? the enduring centrality of spiritual interventions in the healer’s repertoire? should make us modern physicians pause before rejecting this form of therapy.

What is spirituality? I consider it a felt sense of connectedness with “something higher,” a presence that transcends the individual sense of self. I distinguish spirituality from religion, which is a codified system of beliefs, practices, and behaviors that usually take place in a community of like-minded believers. Religion may or may not include a sense of the spiritual, and spiritual individuals may or may not be religious. I regard prayer as communication with the Absolute, however named, no matter what form this communication may take. Prayer may or may not be addressed to a Supreme Being. Buddhism, for instance, is not a theistic religion, yet prayer, addressed to the universe, is a vital part of the Buddhist tradition.

#### **Prayer Experiments**

Even if prayer connects us with the Absolute, does it work in an empirical sense? Rudolf Otto, the eminent theologian and scholar of comparative religions, asserted that it is “a fundamental conviction of all religions” that “the holy” intervenes “actively in the phenomenal world” [2]. This is an empirical claim, and science is the most widely accepted method of adjudicating such claims. The earliest modern attempt to test prayer’s efficacy was Sir Francis Galton’s innovative but flawed survey in 1872 [3]. The field languished until the 1960s, when several researchers began clinical and laboratory studies designed to answer 2 fundamental questions: (1) Do the prayerful, compassionate, healing intentions of humans affect biological functions in remote individuals who may be unaware of these efforts? And (2) can these effects be demonstrated in nonhuman processes, such as microbial growth, specific biochemical reactions, or the function of inanimate objects?

What has been accomplished? In a 2003 analysis, Jonas and Crawford found "over 2200 published reports, including books, articles, dissertations, abstracts and other writings on spiritual healing, energy medicine, and mental intention effects. This included 122 laboratory studies, 80 randomized controlled trials, 128 summaries or reviews, 95 reports of observational studies and nonrandomized trials, 271 descriptive studies, case reports, and surveys, 1286 other writings including opinions, claims, anecdotes, letters to editors, commentaries, critiques and meeting reports, and 259 selected books" [4].

How good are the clinical and laboratory studies? Using strict CONSORT criteria, Jonas and Crawford gave an "A," the highest possible grade, to studies involving the effects of intentions on inanimate objects such as sophisticated random number generators [4]. They gave a "B" to the intercessory prayer studies involving humans, as well as to laboratory experiments involving nonhumans such as plants, cells, and animals. Religion-and-health studies, which assess the impact of religious behaviors such as church attendance on health, were graded "D," because nearly all of them are observational studies, with no high-quality randomized controlled trials.

The depth and breadth of healing research remains little known among health care professionals, including many of those who have offered critiques and analyses of it. Unfortunately, these critiques are almost never comprehensive, but rely on philosophical and theological propositions about whether remote healing and prayer *ought* to work or not, and whether prayer experiments are heretical or blasphemous [6,7]. Are these studies legitimate? Should they be done? Dossey and Hufford recently examined this question, and critiqued the 20 most common criticisms directed toward this field [8].

It is true that healing research is immature, and anyone hoping to find perfect studies will have to go elsewhere. Yet, this field has already matured greatly and can be expected to continue doing so.

Why do these studies evoke such sharp criticism? It is an article of faith in most scientific circles that human consciousness is derived from the brain, and that its effects are confined to the brain and body of an individual. Accordingly, it is widely assumed that conscious intentions cannot act remotely in space and time. The above healing studies call this assumption into question? and this challenge, I suspect, underlies much of the visceral response this field evokes.

What do we really know about the origins and nature of consciousness? As philosopher Jerry Fodor says, "Nobody has the slightest idea how anything material could be conscious. Nobody even knows what it would be like to have the slightest idea about how anything material could be conscious. So much for the philosophy of consciousness" [9]. And philosopher John Searle states, "At the present state of the investigation of consciousness we *don't know* how it works and we need to try all kinds of different ideas" [10].

Are prayer-and-healing studies blasphemous? These experiments are not an attempt to prove or test God, as many critics charge; and, as far as I know, they never involve an attempt to advance anyone's personal religious agenda. Above all, *these studies are explorations of the nature of consciousness*. In view of our appalling ignorance on this subject, it would seem prudent that these investigations go forward, for they might fill in some of the massive blank spots on the current scientific map.

Another frequent criticism of these studies is that they are so theoretically implausible that they should not be done. In other words, they radically violate the accepted canons of science and the known laws of consciousness, and this places them so completely off the scientific map that they do not deserve consideration. Yet, there are no inviolable laws of consciousness. As Sir John Maddox, the former editor of *Nature*, has said, "What consciousness consists of...is...a puzzle. Despite the marvelous successes of neuroscience in the past century,...we seem as far from understanding cognitive process as we were a century ago" [11]. These studies violate *not* laws of consciousness, but, it often seems, deep-seated, largely unconscious prejudices.

Another common criticism is that these studies are metaphysical; they invoke a transcendent agency or higher power, which places them outside the domain of empirical science. This is a straw-man argument, because researchers in this field make no assertions about entelechies, gods, or metaphysical agents in interpreting their findings. They are searching for correlations between intentions and observable effects in the world. Nearly always they defer on the question of mechanism, which is an accepted strategy within science. Harris et al, for example, in their 1999 study of prayer in patients with coronary heart disease, concluded, "We have not proven that God answers prayers or even that God exists.... All we have observed is that when individuals outside the hospital speak (or think) the first names of hospitalized patients with an attitude of prayer, the latter appear to have a 'better' CCU experience" [12,13].

### **Spiritual Lives of Patients**

Should physicians concern themselves with the spiritual lives of their patients? Should they pray for them? These questions are unanswerable without first becoming aware of the data in this field. What are the correlations between prayer and other religious behaviors, and health and longevity? What is the effect size? What about risk, cost, availability, and patient acceptance? If penicillin instead of prayer were being considered, we would not answer the question of use before asking key questions such as these.

Even if it is conceded that prayer and religious behaviors affect health outcomes positively, what then? Should physicians become involved with spirituality? I believe we can decide these questions by means similar to those we have used to approach other sensitive issues in the past. For example, not long ago many physicians believed they should not query patients about their sex lives. Doing so was too personal and disrespectful of privacy. Then the epidemic of sexually transmitted diseases and AIDS arose, and overnight physicians began to see the issue differently. As a result, most physicians have learned to inquire about their patients' sexual behaviors with respect and sensitivity. Inquiries into peoples' spiritual and religious practices can be done

with comparable delicacy. Codes of ethics and conduct already exist among hospital chaplains that prohibit evangelization, heavy-handedness, and crass intrusiveness, and similar guidelines can help physicians navigate this territory. Indeed, this is already taking place, as medical students around the country are learning to take spiritual histories from patients in ways that honor privacy and personal choice [14,15]. Moreover, consultation is always an option, and physicians can refer patients who voice spiritual concerns to a religious professional. That said, physicians who are not comfortable with spiritual inquiry may sit on the sidelines.

No one expects physicians to be as expert as clergy in these matters, but that does not mean we cannot develop a basic level of expertise. We teach laypersons basic CPR without expecting them to be cardiologists or heart surgeons; just so, physicians can learn the rudiments of spiritual inquiry without becoming as skilled as clergy or hospital chaplains.

This area can also be viewed as a matter of public education. Physicians routinely convey to patients the facts surrounding smoking, the use of seat belts, and protected sex. They can also matter-of-factly deliver information about the latest findings on spirituality and health, and encourage patients to make their own choices in these matters.

Sensitivity and delicacy are eminently achievable if physicians remain patient-centered. An internist friend of mine became interested in the prayer-and-healing studies, and eventually decided that he had an obligation to pray for his patients. He developed a 3-sentence handout that his receptionist gave to each patient as they entered the waiting room. It simply said, "I have reviewed the evidence surrounding prayer and health, and I believe that prayer might be of benefit to you. As your physician, I choose to pray for you. However, if you are uncomfortable with this, sign this sheet below, return it to the receptionist, and I will not add you to my prayer list." Over many years, *no one* signed the sheet.

Researchers are currently exploring hypotheses from several areas of science that are cordial to the remote effects of prayer and intentionality [16,17]. As a theoretical framework gradually emerges, spirituality and the remote effects of healing will begin to seem less foreign, and future physicians may well wonder why we experienced such indigestion over these issues.

The game is early; this field of research hardly existed a few years ago. It took the British Navy around 200 years to require the use of citrus fruit in preventing scurvy aboard its ships, in spite of overwhelming evidence of its effectiveness. The idea that a mere teaspoonful of lime juice a day could prevent such a lethal disease was considered lunacy: theoretical implausibility writ large.

Where spirituality is concerned, let us hope we won't be as obstinate [18].

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## Virtual Mentor

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### Medical Humanities

#### ***Equus* and the Relationship of Religion and Medicine**

by Allison Grady

The play *Equus* by Peter Shaffer is an example of the complex and sometimes adversarial relationship between medicine and religion. The play's main character, 17-year-old Alan Strang, is sent to psychiatrist Martin Dysart, after he gouges out the eyes of 6 horses that were previously the object of his most sincere emotions. Despite Alan's heinous actions, Dysart is not convinced that conventional medicine is the best solution for his problems. Dysart recognizes the centrality of the horses in Alan's life, the passion that they've inspired, and the simple fact that, even though Alan is living outside the bounds of convention, his life is more complete than that of the average person—even Dysart's. Throughout the play, Dysart struggles with the possibility of "curing" Alan through traditional medicine, leaving him void of the passion and purpose that make him unique.

In fact it is Alan's passion that most captivates Dysart. Alan's zeal is directed towards his gods, the horses, and, even though he savagely destroys them, the rituals and worship prior to the act are the most intense that Dysart has ever encountered. "Words like reins. Stirrup. Flank... 'Dashing his spurs against his charger's flanks!'... *Even the words made me feel* [1]." In this passage Alan describes the thrill of horses and horseback riding, and he is clearly moved by even the simplest of words. Just hearing their pronunciation, forming them in his mouth, and speaking them aloud arouses him. Alan's devotion to the horses creates a swelling of emotion that exposes Dysart's emptiness. Dysart laments, "I wish there was one person in my life I could show. One instinctive, absolutely unbrisk person I could take to Greece... I'd say to them 'worship as many as you can see—and more will appear'" [2]. Dysart's lack of fulfillment is as tangible as Alan's enthusiasm, and this creates one of the most striking juxtaposition in the play. Alan has a personal religion that demands all of his soul, defines who he is, and inspires an emotional response that is not found in any other sphere of his life. His religion is composed simply of his relationship to the gods he chose to worship. No one told him whom to worship or the best way to carry out these actions. This sense of empowerment and connectedness highlights Dysart's desperate longing for something and some *one* to share his religion with.

Entangled with the idea of passion is the notion of a purposeful life. Worship allows people to make a connection in a world where many feel utterly alone, and it also allows someone to feel as though he has a purpose in the larger world. In *Equus*, Dysart is acutely aware that Alan does not have many of the traditional ties to other individuals or the general community. Instead, Alan devotes his full attention and energy to the horses who, in turn, give shape and purpose to his life. "I only know it's the core of his life. What else has he got?... He's a modern citizen for whom society doesn't exist. He lives one *hour* every three weeks... and after the service kneels to a

slave who stands over him obviously and unthrowably his master. With my body I thee worship! [3].” Based on this passage, Dysart understands that Alan is not anyone’s average teenager, but he nevertheless has a purpose—a higher calling—that if disturbed by modern medicine, will be destroyed and rendered unrecoverable.

As abstractions, passion and purpose appear to be positive ideals. But when these ideas manifest violently and dangerously as they did in Alan’s mutilating the horses, medicine is called in to help remedy the situation. The distinction between curing a person and stripping him of his personal identity poses a challenge for Dysart. He knows that there will be a “loss in a cure,” and he must decide if those consequences are worth the potential benefits. “My achievement, however, is likely to make him a ghost... *I doubt, however, with much passion!* Passion, you see, can be destroyed by a doctor. It cannot be created” [4]. For Dysart, the only thing that is worse than Alan’s loss of passion is being the person responsible for inflicting this metamorphosis. “The Normal is the indispensable, murderous god of Health, and I am his priest” [5]. Dysart is enslaved to his profession—his personal calling—and despite his reluctance he will use the tools of his craft to “fix” Alan.

Dysart is also torn because he knows the qualities that make us human—emotion, attraction, and pain—are all things that his remedy will quell. “To go through life and call it yours—*your* life—you first have to get your own pain,” Dysart says. “Pain that’s unique to you... that boy has known a passion more ferocious than I have felt in any second of my life. And let me tell you something: I envy it [6].” Feeling—even pain—reminds us that we are human, and by seeking to numb Alan to those feelings, Dysart makes Alan less than human. Complicating the situation is that, with the medical approach, there is no guarantee that Alan will be “cured.” It is certain that Alan will be radically altered, but it is unknown whether or not his problems will be solved. Dysart acknowledges that, “When Equus leaves—if he leaves at all—it will be with your intestines in his teeth. And I don’t stock replacements... if you knew anything, you’d get up this minute and run from me as fast as you could” [7]. Again, it is the intersection of medicine and religion that troubles Dysart most. When he becomes introspective, Dysart realizes that he is just an agent for something much bigger than himself, and, while he respects the power that he wields, he knows that he does not understand all of the potential consequences: “All right—I surrender! I say it... In an ultimate sense I cannot know what I do in this place—yet I do ultimate things. Essentially I cannot know what I do—yet I do essential things. Irreversible, terminal things. I stand in the dark with a pick in my hand, striking at heads” [8].

The final outcome of Dysart’s attempt to cure Alan Strang is not disclosed in the play. While convinced that Alan will lose his passion and his objects of worship and become a complacent and average member of society, Dysart also knows that there are benefits to being assimilated into society. By becoming an average citizen, Alan will avoid the scrutiny, pain, and lack of acceptance that comes with being outside of the norm. Dysart must make the most ethical decision that he can by recognizing that destroying horses is inappropriate and must be addressed but also simultaneously acknowledging that by “curing” Alan, he is also sacrificing the person who *is* Alan Strang.

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