

## *Virtual Mentor*

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### PERSONAL NARRATIVE

#### **Through the Student's Eyes: Questions about Religion as a Category of Diversity in Medicine**

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Considering religious affiliation as a category of difference enhances the expanding discussion of diversity in medical care. However, describing religious diversity as a relevant difference is potentially costly to physician and patient rights. Difficult restrictions may be placed on both physicians and patients to protect expression of religious differences, and the ability of physicians to function as patient advocates may be compromised.

If one goal of increasing diversity in the health care system is to decrease the feeling that a physician doesn't or can't understand the patient, then it is important to look at one of the major ways in which we construct understanding. Religion is such a means, serving to help us figure out what we want to do. In structuring understanding, religious beliefs can act as an important feature of decision making and communication. Distinguishing between right and wrong also applies to how we understand states of health and disease. Furthermore, patients report that they want their physician to ask about religious beliefs in certain situations<sup>1</sup>. In this light, religious differences are differences that matter.

#### **Moral Discrimination?**

If religion is a relevant difference, it is important to ask if it is a morally relevant difference. That is, does it deserve a protected and privileged place in medicine, and is it then appropriate to allow people to discriminate on the basis of religion? Under most circumstances, patients are already free to choose a physician and to accept or refuse treatment. Would it be appropriate for a patient to refuse treatment by a particular physician on the basis of that physician's religion? Should a patient's request for a physician of a certain religious affiliation be honored?

Similar questions are in play for physicians. While the AMA's *Code of Medical Ethics* provides that, under most circumstances, physicians are free to choose whom they will serve as patients, physicians are also instructed to be non-discriminatory in many regards<sup>2</sup>. It would seem, then, that it would be unethical for a physician to refuse to treat a patient on the basis of that patient's religious beliefs, but it would be permissible for a physician to set up a practice which is intended to treat only patients of a specific faith.

### **Special Autonomy?**

If respect for religious beliefs occupies a protected position under the auspices of diversity, then do religious reasons warrant increased clout in decision making and treatment negotiation? Do they constitute a special form of autonomy that trumps other reasons? In the balance of patient autonomy, physician autonomy, and physician beneficence, refusal of treatment is already well protected and could not be strengthened by religious beliefs. On the subject of patient requests for otherwise inappropriate treatment on religious grounds, Orr and Genesen argue (without clearly defining "inappropriate") that such requests should usually be honored<sup>3</sup>. The authors contend that religious decisions are more than personal preferences, in that they reflect rational extensions of extrinsic values. When religious reasons are given for seeking inappropriate treatment, Orr and Genesen recommend that physicians engage patients using tenets and principles from the patient's own religion. They further suggest the use of a religious interpreter if necessary in order to "balance the reasons behind the requests" with arguments from the patient's own beliefs. Additionally, the authors invite the difficult situation of physicians telling patients that they (the patients) are wrong about their religious beliefs. This is an inappropriate use of reduction according to religious theory, as well as being at odds with the authors' own premises<sup>4</sup>. Orr and Genesen, using Wreen<sup>5</sup>, state that the holder of the belief is more important than its truth state, but then they ask physicians or their interpreters to discover the truth or falsity of the claim. More importantly, this inappropriate use of reduction ends up in a type of "true for me" relativism that dissolves any hope of meaningful conversation in decision making.

### **Scientists or Shamans?**

Who is to win the day when patients request treatment that is not medically indicated in the professional judgment of the physician? Although consensus could be reached on the issue of a treatment that could bring unnecessary risk or harm to the patient, the issue appears murkier if the procedure requested is seen by the physician as neither dangerous nor beneficial. A physician providing a treatment known to be ineffective could be seen as a shaman rather than a scientist. This is even more troubling if the treatment is not associated with appreciable harm. Apart from the idea of medicine as its own type of healing ritual, the identity of a physician may be at stake. To provide a treatment with the expectation that nothing will happen is outside of the limits of scientific medicine. On the other hand, the hope of some sort of placebo-like effect could argue for therapeutic privilege to be invoked in this situation.

### **What to do?**

The above confusion suggests that religious beliefs hold a problematic place in the medical world. That need not be the case. If we ease the imperatives of religious protection and acquiescence to patient-requested treatment, perhaps religion can slide into a more beneficial, less adversarial, and properly integral position in decision making and communication.

Difference matters, and religion is a difference that matters as a general rule. However, in the realm of patient-physician communication, what is important is that physicians recognize that religion is a difference that *might* matter to this particular patient. To do this, physicians must gain comfort with the idea of religion playing a role in decision making. Religious beliefs should be a communication issue, not part of a card game. In a medical setting, the process can be as important as the outcome, so sensitivity is more tenable and beneficial than competency or adversity. Just as it is important for patients to work out their understanding of belief, health, and disease, it is useful for physicians to seek understanding of their own feelings about religion, their beliefs, and their personal relationship to treatment issues. In this model of constructing understanding, the emphasis is on asking the questions, not winning the day or finding the truth.

### References

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