The Secular Physician and the Religious Patient: Overcoming Religious Discordance in the Clinical Setting

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ABSTRACT

Deciding how best to respond to a patient's spiritual devotion can raise complex ethical challenges. This is particularly true for medical students and residents who may have little formal training in the area of religion and spirituality. This article explores the challenges inherent to the encounter between a secular physician or medical trainee and a religious patient. A clinical vignette is used to highlight common mistakes made by medical trainees and to suggest more optimal communication strategies when these trainees deal with a patient who raises religious issues. First, the medical trainee or professional can follow the patient's lead in delving into how these issues shape their decisions about medical care. Second, by appreciating the limits of their training and role, physicians can appropriately listen, ask questions, and explore the patient's feelings in a manner that avoids "converting" patients, engaging in theological discourse, or inviting patients to partake in religious rituals. Third, physicians need to uphold their integrity and not engage in actions that infringe upon their own spiritual or religious views.

"I know that you will do fine because God and your hands are working together," I said to the doctor just before she went ahead with the tap. She rolled her eyes and said that what she was about to do had nothing to do with God. I felt sick to my stomach." These were the words of Y, a young HIV positive patient that our team had admitted the night before for work-up of a non-resolving pneumonia. He had come to cope with HIV and all of its devastating complications through his church and through God. He seemed to have placated his apprehension about the thoracentesis he was about to undergo by expressing his faith in God. Yet the senior resident, Dr. L., had managed to dismiss what seemed to be the very crux of his coping with one disapproving phrase.

As I listened to Y's grievances the next morning, I found myself caught in a personal dilemma. Religion had never been an important driving force in my life. In some ways I could identify with Dr. L. – I had no reason to believe that the procedures I performed on patients were influenced whatsoever by a higher power. But it was obvious to me that this young man's faith in our care went hand in hand with his faith in God… How could I, as a responsible medical student, reconcile my obligation to tell the truth the best I knew it without contradicting his spirituality? As a team, we could not guarantee that God would ensure the best outcome. Indeed, I was not even sure if this is what he meant – perhaps he was content knowing that God was with him regardless of the outcome. I simply did not understand.

My uncertainty allowed me to stay neutral and somewhat distant. I listened as Y pointed towards his church through the hospital room window with a peaceful smile. As I left the room, the discordance in our religiosity culminated in a request: he asked me if I would pray for him. Stumbling over my words, I apologetically told Y that I would not feel comfortable doing so, quickly changed the subject to his upcoming ultrasound-guided thoracentesis, and left the room discontented by my elusiveness…

It is not uncommon for patients to draw on theological logic with its concomitant religious language when discussing medical care (Lo, 1). Deciding how best to respond to a patient's spiritual devotion can raise complex ethical challenges in a system that seems to place religion and spirituality at odds with the tenets of scientifically sound, evidence-based clinical decision-making. (Post et al, 2000). The challenges placed on the patient-physician relationship are particularly profound when the patient's religious beliefs lead to clinically unfounded demands for medical care (Astrow et al, 2001).

As a medical student, I felt helpless to deal with Y's spiritual commitments. I was ill-equipped to address his faith without feeling dishonest or without the sense that I was crossing fragile boundaries.

I am not alone. Overall, physicians tend to be less religious than their patients. (Astrow et al, 2001). One US study showed that 95 percent of patients in the US profess a belief in God, while 65 percent of American physicians profess the same beliefs (Astrow et al, 2001). Many of those physicians do not actually practice a religion (Astrow et al, 2001). Evidence also points to religion as playing a significant role in the patient's illness experience. For example, a survey of 203 inpatients at two family practice services found that, regardless of religious service attendance, over two-thirds of patients believed that physicians should consider their spiritual commitments and almost half (48 percent) wanted their

physicians to pray for them (Astrow and Sulmasy, 2004). In a sample of patients facing serious illness, Hebert et al. found that the majority of patients saw the role of spirituality in medical encounters as crucial to the interpersonal relationship and psychosocial care given by physicians (Hebert et al., 2001). Indeed, when patients sense that their spiritual concerns are ignored in clinical environments, many of them are compelled to turn away from effective medical treatment (Post et al, 2000). Despite this, physicians rarely discuss spirituality with patients or consult the services of pastoral professionals (McCord et al., 2004). This is not surprising since responding to a patient's spiritual needs evokes a myriad of professional ethical issues and perhaps the easiest way to stay within professional boundaries is to elude the issue of spirituality altogether.

Yet what is easiest is undoubtedly not always conducive to an effective physician-patient relationship, as exemplified by the above vignette. With the risk of reducing the complexity of patient spirituality to medical terms, it may in fact be detrimental to patient outcome to overlook the spiritual dimension (McCord et al., 2004). Patient spirituality and religiosity have been shown to be correlated with "reduced morbidity and mortality, better physical and mental health, healthier lifestyles, fewer required health services, improved coping skills, enhanced well-being, reduced stress, and illness prevention" (McCord et al., 2004).

Dr. L.'s Approach, Its Pitfalls, and An Alternative Approach

The detrimental effect of Dr. L.'s dismissal of Y's comment, *"I know that you will do fine because God and your hands are working together,"* made it clear to me that the ability to deal sensitively with the spiritual needs of patients would not be bestowed on me effortlessly via the natural virtue of medical training. How could I avoid, in the future, creating a rift between myself and the patient due to discordant religious views? My goal was first to dissect what may have been at the root of Dr. L.'s discomfort with Y's comment and subsequently to define ways in which Dr. L. could have reached a feasible resolution.

Dr. L. recognized that professional boundaries were blurred by Y's belief that she was working through God. She wanted to clarify that her actions had "nothing to do with God," which was perhaps a natural reaction to Y's perception of her having "even a greater power than would occur without a religious sanction" (Astrow et al, 2001). Dr. L.'s reaction coincides in many ways with the attempt of biomedical ethics in the past few decades to focus on "demystifying" the physician's authority and "priestliness" of the past, thereby permitting "greater patient empowerment through autonomy and self-determination" (Curlin and Moschovis, 2004). Thus, the argument goes that since physicians occupy a distinctive position of power, it is an abuse of power and a threat to patient autonomy to use that position to provide spiritual care (Curlin and Moschovis, 2004).

The thrust of this reasoning disregards that, for the religiously devout, very few facets of life are untouched by their religious beliefs. A devout patient's religious principles may be relevant to all aspects of medical care that he seeks (Curlin and Moschovis, 2004). To gain insight into the ways such tradition shapes the patient's life enriches the doctor's care for the patient (Astrow et al, 2001). Indeed, as Curlin states, the beneficent physician who is devoted to the patient's best interests must contemplate how best to support the spiritual commitments of the patient, if and when the patient deems it is important. To respect the patient's spirituality in the patient's terms is in fact to respect the patient's autonomy (Curlin and Moschovis, 2004). By rejecting Y's spirituality, Dr. L. did not accomplish asserting her fallibility as a fellow, non-divine human being as she may have intended. Instead, she inadvertently reinforced an ethos of paternalism with a subtext of "what-you-are-saying-is-ridiculous." Thus, it follows that Y felt "sick to [his] stomach."

So how, in practical terms, could Dr. L. have resolved this conflict ie. clarifying her own need to be deemed separate from divine intervention or association without disrespecting Y's devout existence? By reframing Y's statement as an expression of hope rather than as a statement of an imagined religious ideal, Dr. L. may have recognized the underlying function of Y's statement. In many ways his statement resembles expressions of hope by nonreligious counterparts of Y that Dr. L. may have encountered during her clinical career. Thus, instead of dismissing Y's statement, increasing his anxiety about the thoracentesis and diminishing his sense of self worth, Dr. L. may have chosen to make a statement such as this:

I understand that you may be nervous about the tap and I am happy that you are optimistic that I will be able to do a good job and I hope for the same as well. There are risks to the procedure, however, that I do need to clarify…

As Post et al. point out, in circumstances of suffering, faith in a higher being in the universe often serves as a source of assurance and hope which is not dissimilar in concept to a secular patient expressing optimism, as long as clinicians "attend closely to the informational needs of the patient" (Post et al, 2000). By identifying a common goal (that she "do a good job"), framing the statement as her "hope for the same," and clarifying the risks of the procedure, Dr. L. would have avoided dismissing Y's statement in a clinically consistent way without diminishing the clinical encounter (Lo et al., 2002).

My Approach, Its Pitfalls and An Alternative Approach

In response to Y's comment on the importance of his

church to his illness experience, I stayed silent. By disregarding Y's spiritual concerns, I inadvertently supported the "secularist critique" which purports that "once a physician acknowledges a patient's spiritual concerns, a professional boundary has been reached. Any attempt to engage the patient in further dialogue is out of place" (Curlin and Moschovis, 2004). Indeed, there were several reasons it was easier to take this approach and according to the secularist critique, it was ethically sound. This view suggests that there is little in the training of most physicians that qualifies or enables them to engage in spiritual discourse (Curlin and Moschovis, 2004). My own paucity of understanding and knowledge precluded my ability to engage with Y in any productive discourse. A deeper sense of discomfort manifested when Y requested that I pray for him. Indeed, not being used to prayer in terms of its meaning or purpose, I was afraid that by engaging in prayer I would be deceiving both myself and the patient into believing that somehow we could evoke a better outcome over and above which medical intervention could achieve.

Post et al. suggests that physician-led prayer is within acceptable limits when pastoral care is not easily accessible, when the patient requests and is intent on prayer with the physician, and when the physician is capable of praying without the pretense of faith and without the risk of patient deception, manipulation, or coercion (Post et al, 2000). Under these circumstances, one suggestion that may be acceptable to the secular physician is to "simply listen respectfully as a patient prays" (Post et al, 2000).

At the time of this encounter, I had not thought of tapping into a resource that is often overlooked: the hospital chaplain. As Handzo et al. emphasize, doctors are no more sufficiently trained to be spiritual care experts than they are for other medical specialties (Handzo et al., 2004). Handzo states that board-certified chaplains have graduate-level theological and clinical training that allows them to evaluate a patient's "faith system" and to assist the patient to channel their faith appropriately when coping with an illness. Similar to medical specialists, chaplains can consult with physicians, who can utilize this advice to deal directly with patients' spiritual concerns (Mobeireek, 2004).

Thus, without compromising my own views and maintaining compassionate neutrality, there were various avenues by which I could have maintained a cohesive, non-adversarial relationship with Y: first, by simply listening, and second, by consulting the expertise of the hospital chaplain.

CONCLUSION

Despite the blunders of my clinical encounter with Y, I am grateful that the encounter, and the concomitant shortfalls of my skill in this area, effected this inquiry. I have learned that providing the empathy, compassion, and hope that are hallmarks of a good physician, are not necessarily contingent on faith (McCord et al., 2004). For the secular or agnostic health professional, religion does not have to represent an incomprehensible sphere unworthy or irrelevant to the clinical assessment. There are practical ways of approaching the patient who asserts a need for spiritual concerns. First, the physician should value the patient's views and follow the patient's lead in delving into how these issues shape their decisions about medical care, cause anguish, or provide solace (Post et al, 2000). Second, by appreciating the limits of their training and role, physicians can appropriately listen, ask questions, and explore the patient's feelings in a manner that avoids "converting" patients, engaging in theological discourse, or inviting patients to partake in religious rituals. Third, physicians need to uphold their integrity and to not engage in actions that infringe upon their own spiritual or religious views (Post et al, 2000). Indeed, addressing a patient's religiosity or spirituality creates the potential to traverse fragile boundaries in the patient-physician relationship. However, to ignore the patient who expresses an existential framework based on religion and spirituality may be even more toxic in an era of medicine that aims to treat the patient in a context that includes beliefs and values system and not just the disease.

NOTE

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