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BIOETHICS NOTES

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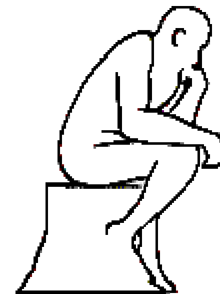

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"When I do good, I feel good; when I do bad, I feel bad. That's my religion."
Abraham Lincoln (1809-1865)

Religion and Clinical Ethics

By Robert Shabanowitz

What role, if any should the religious beliefs of an ethics consultant or an ethics committee member play in their deliberations?

The immediate answer would probably be an emphatic "NO." This response would be predicated upon the generally accepted notion that we live in a pluralistic society, governed by a Constitution, and legitimized by a lengthy history of case law that demonstrates a strong preference for supporting individual liberties and a clear separation of church and state. In our society, a person's individual religious beliefs are mostly free from interference by others, and everyone is free to worship according to his/her personal preference and conception of the good. In the healthcare arena, this freedom to practice will even allow an individual to choose avenues of care, based strictly upon core religious beliefs that may not be in the best interests of suggested and universally accepted clinical care. The refusal of blood transfusions by Jehovah's Witnesses is one example of the protection of such liberties.

Therefore, it would seem entirely inappropriate if an ethics consultant or committee were to use his/her personal religious interpretations of conceptions of the good in their deliberations, especially since these personal religious belief systems and desire for spiritual interaction have been shown to be most influential and invited when the severity of illness is most acute.[1] Attention must be centered upon patient preferences, and not influenced by the consultant's personal views. Do our personal liberties, freedom of choice and the admonitions against mixing religion and science absolutely preclude any discussions of religion at all in our deliberations? If the purpose of an ethics consultant is to help a patient articulate and clarify their conception of the good, how can we completely ignore the significance of religion? What makes these deliberations so difficult is that they often contain elements important to the conversation considered within the private/personal realm, and not the business of medicine. However, a thorough ethics consult does not consist entirely of empiric data. Finding meaning to life, and especially the meaning of suffering occur as we move away from purely technological care; these are issues of transcendence. Compassionate care requires treating the whole person, not simply organs and organ systems, and the clinical ethicist can play an important role in these deliberations, as noted by Puchalski.[2]

> "One of the challenges physicians face is to help people find meaning and acceptance in the midst of suffering and chronic illness. Medical ethicists have reminded us that religion and spirituality form the basis of meaning and purpose for many people."

MEET OUR COMMITTEE MEMBERS
ROBERT SHABANOWITZ

Bob is the Laboratory Director for the Fertility Clinic at Geisinger Medical Center in Danville. He joined Geisinger in 1991, and was previously laboratory director at the University of North Carolina at Chapel Hill. Bob joined the ethics committee in 1996 and became a co-chairman in 2002. In 2001 he earned a Certificate in Clinical Bioethics from the Medical College of Wisconsin, and is currently completing a Master's in Bioethics at the same institution. Bob has published in a variety of professional journals and recently in the American Journal of Bioethics. He hopes to translate his interest in bioethics into greater benefits to the community he serves, through continued education, research and publication.

In our search for a more enriched answer to our question, we must examine the role of religion/spirituality (R/S) in healthcare, the association of R/S in health outcomes and the ethical issues when incorporating R/S into care. We must ask ourselves if we need a more global perspective of healthcare options that includes spiritual factors.

Many physicians are skeptical of such an approach. This is not surprising since most published work on religion and health seems to lack consistency.[3] These inconsistencies in empirical data therefore make it difficult to support specific recommendations for clinical interventions. Furthermore, possible harms can ensue if initiation of these R/S discussions is misinterpreted by patients, leading them to believe their illness is being framed as a judgment of moral failure. As stated by Sloan, et. al.[3],

> "Attempts to link religious and spiritual activities to health are reminiscent of the now discredited research suggesting that different ethnic groups show differing levels of moral probity, intelligence, or other measure of social worth."

However, there is evidence that R/S does play an important role in **decision-making** by patients and is used in an assessment of their quality of life, especially in considerations of mortality, coping and recovery.[2] Being familiar with a patient's R/S may therefore be incumbent upon a physician because it both addresses the patient's desire to talk about spirituality, and can strengthen the patient's trust with the physician. These inquiries become important because a patient's reflections on R/S issues may affect the decisions they make about medical treatments. So even if R/S issues are not directly related to health outcomes, they act indirectly by their influence on health-care decision-making concerning treatments. Health-care providers can understand the spiritual dimensions in patient's lives by respecting these beliefs, and by listening rather than guiding or leading. Helping patients deal with suffering and loss is as important for quality of life as technical decisions are for maintaining life itself.

Are there other ethical concerns associated with such an approach? According to Sloan et. al.[3] physicians can influence patients by virtue of their medical authority. They view the promotion of a non-medical agenda as departing from areas of established medical expertise and therefore an abuse of their professional status. These authors also believe that such discussions are more private and personal, and outside the limit of medical intervention. Just like data that show marriage is associated with lower mortality risk, it is not appropriate discussion for medical intervention. In addition, there is also the worry that a physician's own notions of R/S may affect their interpretation of how patients relate R/S to healthcare.

> "most physicians apply medical science while maintaining a belief that God intervenes in patients' health…religious characteristics may influence the care of patients in clinical contexts like end-of-life care…Compared with their secular colleagues, religious physicians may be more likely to share such hopes and to understand the religious frameworks from which they emerge."[4]

Issues of religion/spirituality are an important consideration for patient decision-making. The role of an ethics consultant, in part, is to help protect a patient's autonomy. At times, this may require the consultant to help patients clarify and articulate their R/S preferences. There is a moral imperative for the consultant to facilitate patients' decisions of what ought to be done to achieve health and healing. The ethical foundations for decision-making requires thorough analysis of the patient's diagnosis, prognosis and treatment options. Therefore, R/S issues may help provide an important ethical foundation for decision-making.

> "Patient agency beliefs may be inclusive of specific tenets of faith or practices from religious traditions."[5]

The ethical use of power within a clinical encounter can be used by the consultant to be fully supportive of what improves patient empowerment, including discussions of R/S. This can be accomplished within a framework that is consistent with good outcomes and inclusive/attentive to an individual patient's goals and interests.

Given all the preceding considerations of the contextual nature of R/S in patient's decision-making, the role of religious beliefs for the ethics consultant should be that of assisting the patient in achieving their desired therapeutic goals. Respectful dialogue, communication and the

understanding that discussions of R/S issues may be critical in a patient's decision-making process is crucial. However, the ethics consultant should make every attempt to insure that a patient's autonomy is clarified such that patients themselves are not unduly or mistakenly influenced by these considerations. Therefore, it becomes incumbent for the ethics consultant to have some knowledge in this area. Not so much as to answer every question, which would be more within the realm of a hospital chaplain or appropriately trained religious representative, but in the least to be aware of when such further consultation would be requisite. The ability for the ethics consultant to engage the patient in such R/S discussions is understood to be an important aspect of their deliberations. For example, the American Society for Bioethics and Humanities (ASBH) Core Competencies for Health Care Ethics Consultation[6] list as core requirements…

> Assess the social and interpersonal dynamics of the case (e.g., power relations, racial, ethnic, cultural, and **religious differences**)
>
> Approaches including **theological/religious** approaches…

The ASBH is not the only institution to address the importance of R/S issues. Recommendations of the Association of American Medical Colleges for a Curriculum on Spirituality state...[7]

> "Students will be aware that spirituality, and cultural beliefs and practices, are important elements of the health and well being of many patients. They will be aware of the need to incorporate awareness of spirituality, and culture beliefs and practices, into the care of patients in a variety of clinical contexts. They will recognize that their own spirituality, and cultural beliefs and practices, might affect the ways they relate to, and provide care to, patients. Students will be aware of the range of end-of-life care issues and when such issues have or should become a focus for the patient, the patient's family, and members of the health care team involved in the care of the patient. They will be aware of the need to respond not only to the physical needs that occur at the end of life, but also the emotional, socio-cultural, and spiritual needs that occur."

This need for what is now termed **"cultural competence" or "cultural sensitivity"** has also been promulgated by the ASBH's Learner's Guide to Ethics Consultation.[8]

> "Over the past decade, "cultural competence" or "cultural sensitivity" has been touted as integral to effective (and ethical) patient care. Cultural diversity may be perceived as a greater challenge in health care today not because of a real increase in the diversity of America (which has always been a culturally diverse country), but because of the emergence of patient autonomy as a leading principle of biomedical practice. Health care providers today are expected to educate patients about their options, engage them in conversations about their values and motivations, and enable patients to make their own treatment choices based on their unique understanding of their best interests. This process of education and partnership is undoubtedly more challenging when patients and caregivers do not share a common language, worldview or belief system."

Even Sloan, et. al.[3], who were most critical of the empiric role of R/S on health agree with the importance of discussion as it relates to understanding what is important in a patient's value system and the impact of R/S on decision-making.

> "We believe therefore that it is premature to promote faith and religion as adjunctive medical treatments. However, between the extremes of rejecting the idea that religion and faith can bring comfort to some people coping with illness and endorsing the view that physicians should actively promote religious activity among patients lies a vast uncharted territory in which guidelines for appropriate behaviour are needed urgently."

The ethics consultant usually arrives in order to help resolve conflicts between physician and patient. Therefore, the role of the ethics consultant is several-fold. The consultant must be able to help both the patient and physician clarify and articulate the ethical dimensions of their respective positions and then assist in creating a common ground that respects each of these individuals core principles. In order to craft this common ground, the consultant must be aware that issues of religion and spirituality are often considered important factors in the decision-making of patients, especially in the case of difficult, life-threatening illness. The consultant may be responsible for opening a dialogue to allow honest discussions in a respectful manner. Understanding the role of R/S in decision making is therefore a required competency for the consultant. The consultant must explore the patient's value

system, and if R/S issues are important, must ensure that the patient, in fact, is not unduly influenced by possible false beliefs and truly subscribes to the relevant tenets of their religion. This may require the services of a religious leader or consultant. In addition, the consultant must also be aware that how physicians themselves interpret whether or not R/S issues influence a patient's health is, in part, a reflection of their own religious beliefs.[4] It stands to reason then, that even an ethic's consultant's personal beliefs on R/S issues will have an influence on their interpretations. Attention to this possible conflict has also been addressed in the ASBH's Learner's Guide.

> "It is not uncommon for individuals participating in clinical ethics consultations to be told that the "problem" in a particular case is the patient's cultural beliefs or identity, only to find it is the health care provider who is struggling to reconcile her personal moral beliefs with her professional obligations to the patient. Individuals participating in ethics consultations have an obligation to recognize how their own cultural identity influences how they perceive, analyze and negotiate ethical dilemmas. They also have a responsibility to recognize how their own expectations and assumptions may hinder free and creative communication with persons from different cultures."

When opening such discussions, the ethics consultant must make every attempt to avoid ethical conflicts by adhering to several rules proposed by Astrow, et. al.[9] There should be no coercion to participate, there should be no proselytizing, and there should be no religious advocacy. However, issues of R/S can not be ignored because they are often enmeshed within the patient's narrative history.

The original assumption that religious beliefs **of an** ethics consultant or an ethics committee member **should not** play a role in their deliberations still holds. However, this does not mean that R/S issues should not be deliberated upon, nor neglected. Religious and spiritual issues may often **inform** and add value to the dialogue. Understanding and appreciating how R/S issues may affect each of us, patient, physician and consultant, as we navigate the rough waters, can not simply be ignored. We must be cognizant of its influence.

Respectfully submitted,
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