Spirituality, Religion, and the Physician: New Ethical Challenges in Patient Care

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This article presents a case study in faith and medicine that raises numerous ethical concerns regarding physician behaviors. Four areas of concern: physician paternalism, fiduciary responsibility, clinical misdirection, and therapeutic focus are examined. The difference between religion and spirituality and the ethical implications of this distinction are explored as they relate to patient care.

Mental and spiritual food is a crying need. Yet in long illness the mind usually starves or hungers, because man is not so one-sided a creature as our medical treatment assumes... Doctors are beginning to recognize the emotional and spiritual element not only in mental disease but in all disease... but we still have a long way to go in this direction.

(Cabot and Dicks. *The Art of Ministering to the Sick*. 1936)

More than sixty years after spirituality in medical care was given credence by the world-famous physician Richard C. Cabot, *Time* magazine reported, “a broader yearning among patients for a more personal, more spiritual approach to health and healing” (*Time* 1996). *The Journal of Family Practice* reported that seventy-five percent of the general population believes physicians should address spiritual issues as part of their medical care (King and Bushwick 1994). The Gallup Poll reported that sixty-one percent of Americans believe that their faith is the most important aspect of their life (*USA Today*, March 24, 1996).

Over the last several years, educational initiatives in religious faith and spirituality began to appear in medical school curriculums. Grants from the Templeton Foundation and the National Institute of Healthcare Research (NIHR) directly supported or encouraged curricular transformations at dozens of medical schools. Today, many graduates from these schools are striving to enhance patient care by acknowledging and embracing issues in religious faith or spirituality. Sixty years after Cabot’s statement, medical students and doctors are actually “beginning to recognize the emotional and spiritual element in all disease.” This has been perceived as such a remarkable development that it has generated extensive media coverage.

The bioethics profession has also taken notice. Since publication of the SUPPORT studies (The SUPPORT Principal Investigators 1995) and the public debates on assisted suicide, the definition of ethical patient care has focused increasingly on the physician’s addressing of religious or spiritual concerns. However, the ethical content of the act of a physician addressing a patient’s spirituality has escaped this focus. And, most surprisingly, both the bioethics and the medical literature have been silent on such ethical concerns.

In this article, I seek to initiate and stimulate a dialogue on physician spiritual care ethics, beginning with a case written by Dr. Dale Matthews, a national leader and spokesman for integrating religious faith and medicine.
Having a Mid-Life Crisis!

The nurse’s note caught my eye and punctured my spirit. “Mid-life crisis?” I groaned inwardly, glancing at my watch. “I’m already behind schedule as it is!”

I gathered myself… and marched into the office. A young woman sat with her head down, deep in thought, eyebrows knitted with worry and pain.

“How can I help you?” I said, automatically.

“I don’t know,” she whispered and began to sob.

My heart softened and concern about my schedule began to fade. I waited quietly and patiently as she wept, and when she was finished, I inquired gently, “What’s going on?”

She said that she had lost her focus, her purpose in life, and that she didn’t know what to do or where to turn. She had been a successful executive, but she derived little pleasure and much pain from her job. Her father had died a year ago, followed shortly by two close friends.

She was sleeping poorly, felt exhausted, lost her appetite, and dropped a few pounds; she couldn’t concentrate and noticed feelings of guilt and retribution. She was uninterested in her usual activities, which included gardening and cooking, and had lost her sexual desire. She felt as if she were “in a cocoon” and “just going through the motions.” No joy.

I asked her about her family, her friends, her habitual means of coping, her past history, including her previous bout of depression. And then I asked her, “What about God?”

“That’s who I have been looking for!” she exclaimed… “So that is what this is all about!”

She described a childhood in which she attended Mass and read the Bible regularly. “Things were better then,” she said wistfully. She described an adolescence when her life was in tumult and she drifted away from her childhood faith. She described an adulthood, focused on achievement and goals, but empty of connection and meaning, lacking heart and soul.

“Sounds like you’ve made a useful discovery,” I heard myself say. “All of us have spiritual needs. Welcome to the club! Renewing your relationship to God may be an important part of getting better for you. Have you thought about going back to Mass again or speaking with a priest or pastoral counselor about what’s going on with you?”

“No, I haven’t,” she grinned. “But I think I just may be ready to begin!”

I prescribed Prozac to relieve her depressive episode, counseling to manage her grief and pent-up anger, and a daily dose of the Psalms with a weekly dose of worship to strengthen her spirit. Then I shook her hand… murmured, “May God be with you and bless you…” and escorted her to the receptionist. I gazed at my watch… and picked up the next chart. (Matthews 1997)

As a clinic visit for recurrent depression, this is an unusual one because of its religious content. As a medical ethics case, this is unusual because of the apparent absence of conflict. Nonetheless, the religious content in this clinical setting raises significant ethical issues on four topics: physician paternalism, fiduciary responsibility, clinical misdirection, and therapeutic focus.

Physician Paternalism
There is a profound difference between curing and healing, where curing is the correction of aberrant physiology and healing implies a restoration of wholeness. When health care professionals cannot cure, this does not absolve them from the responsibility to foster healing. In the case presented, the physician goes beyond the curing paradigm by refusing to treat the patient’s suffering strictly as a mechanical breakdown requiring a technical fix. In doing so, he redirects his focus from aberrant physiology to that of symptoms and their meaning. This focus is important for pa-
tients who seek empathic understanding and for physicians who seek to release potent forces of change within their patients. But within this shift is an ethical challenge: can it be done without subjecting the patient to value judgments or stereotyping?

"Paternalism" is the term applied to externally imposed restrictions on one's self-determination, which may follow from imbalances of power, maturity, and knowledge. In physician paternalism, the physician's unilateral judgment of benefit or harm can deny a patient the opportunity to participate in decisions that affect his or her life. One insidious form can occur in interviewing. By judging content and constraining the patient's story, the physician can block the patient's opportunity to effectively communicate her story.

Hence, there is need for caution. One must ask: by invoking religious concerns and not following from the patient's cues, is this physician forcibly shaping the patient's experience into a form unrecognizable to her? As Margaret Mohrmmann notes in Medicine as Ministry,

There is much to be learned from the way patients tell their own tales of suffering: what they emphasize, the chronology as they have experienced it, the side events that sound unrelated to us, but are clearly not to them, what they fear it all means. Only when we hear all of this can we dare to insert our own questions . . . so that the answers fit the patient's story. Otherwise, the answers simply create our own story: a description of a patient we have not heard, a human experience we have not touched" (Mohrmmann 1995).

In the case presented, the patient's comment, "So this is what it is all about!" is open to many interpretations. As ethicists, we must ask if her response reflects whether she has been given an answer to a question she has not asked. Has this physician opened doors for this patient? Or has this physician created or imposed his own story in her life?

The answer to this question rests in listening and seeking to understand how others perceive their situation and the meaning it holds for them. In 1927, Frances Weld Peabody wrote that "the significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases, both diagnosis and treatment are directly dependent upon it" (Peabody 1927). Returning to this ideal is the primary challenge of medical practice seventy years later, in which visits are too often encounters between strangers, and time pressures limit development of a relationship in which a patient's story is both heard and understood.

Physicians are trained to give answers rather than raise questions. In this initial interview in which the diagnosis of depression is so clear, the physician asked, "What about God?" and interjected a potentially alien and alienating topic. In doing so, could this physician, in his zeal to rescue, have imposed inappropriate control? Given disparities in power and authority between health professionals and vulnerable patients, there exists a tremendous risk of coercion or inflicting emotional harm. To minimize the risks of physician paternalism, the patient must consent to the possible prescription of religious answers for her clinical concerns.

Hence, two ethical concerns arise when considering physician paternalism in spiritual care. The first is constraining the patient's story by giving answers to questions that have not been asked by the patient. The second concern follows from physicians giving answers to religious or spiritual questions. Religion and theology can offer answers, and a good argument can be made that such answers should not be provided by physicians but by clergy or other religious leaders. Spirituality, in contrast, is not about answers but about questions. When approaching spiritual or existential concerns, physicians must resist their natural temptation to intervene and give answers. Such restraint is, in fact, a powerful means of caring for the patient's integrity and dignity. As the bioethics literature has affirmed many times, in
the realm of values, the patient, not the physician, is the expert. We now need to extend this understanding to include the realm of spiritual concerns, in which the physician is not an expert with sure answers to life’s most troubling and profound concerns. Although the physician arguably should help patients identify spiritual issues and resources, spiritual answers can only be found, they cannot be given.

If physicians give answers to spiritual questions, they may not only be overstepping their clinical competence, they may be moving from being a figurative to a literal priest. This inappropriate transformation is not helped by a physician’s providing Biblical messages, religious sermons, prayers, blessings, and benedictions. The ultimate physician arrogance would be to assert that he or she is speaking on behalf of God. Patients may equate questioning such physicians with challenging God.

Fiduciary Responsibility

The second ethical concern in spiritual care evolves from challenges to widely accepted norms of professional behavior. When one looks outside of physiological parameters, cases are rarely clean. In such cases, defining a patient’s best interest is difficult. For the practitioner addressing spiritual concerns in the clinic, defining fiduciary and personal responsibilities may appear even messier.

For many people, spirituality is associated with dogma, fixed answers given to or forced upon others. As spirituality is about questions, not answers, recognizing the difference between religion and spirituality is critical. One can be profoundly religious, yet not spiritual. Likewise, one can be profoundly spiritual, and not religious.

When these distinctions are blurred, new ethical challenges arise for the physician. All health care professionals should recognize how and when one’s values, attitudes, and spirituality affect patient encounters. However, this requires a commitment to significant reflection on one’s experience in clinical encounters and is rarely addressed in training programs. Such insight does not come easily. Hence, as a person of religious faith, is the physician aware of whether he is addressing this patient’s religious, rather than spiritual, issues? And, if this physician is addressing the patient’s religious issues, what precautions does he take to minimize promotion of his own faith’s answers?

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A physician’s ethical responsibilities are grounded in a covenant of trust based on a fiduciary vow to place the patient’s interest ahead of one’s self-interest. The unique ethical challenge to physicians in addressing a patient’s religious and spiritual concerns is in understanding what is in the patient’s best interest. To paraphrase Kant, what one sees depends upon what window one looks through. If one is looking through a religious window, then might one define a patient’s best interest with religious conversion or revival?

Hence, for some, the ethical challenge of addressing spirituality in clinical care might be defined as how to be a better evangelist in the clinic. If one’s faith includes the belief in a “great commission” or other imperative to proselytize and recruit, then one may, in fact, be driven to write prescriptions for reading Biblical passages and for engaging in other religious practices. Any proselytizing and recruitment, of course, may represent an abuse of the physician’s power and position to serve his or her own self-interested ends. Just as there are clear examples of commercial conflicts of interests in the clinic, a potential religious conflict of interest exists. The ethical physician must be vigilant in avoiding either.

Can such a prohibition interfere with a physician’s deeply held values and beliefs? Yes, it
might. As such, this represents an ethical conflict. However, in the name of preserving trust in the physician-patient relationship, such prohibitions appear to be appropriate. This is not a dilemma. As in other cases in which a physician’s beliefs may be compromised in patient care, the generally accepted response is for the physician to withdraw from the case and to refer the patient to someone who can provide the desired care. The parallel response in this situation would be for the physician to withdraw from a presumably secular setting and practice in a clinic with a clearly stated religious mission. At such a location, informed patient consent for religious recruitment and instruction would be presumed.

Clinical Misdirection

The third ethical concern surrounding spirituality in clinical care derives from the shift in focus. The greatest risk in rushing to address religious or spiritual issues is overlooking clinically relevant information. As all good clinical recommendations must be based upon informed judgments, the focus on spiritual issues may in fact blind physicians and harm patients.

In the case presented here, the prescription for “renewing one’s relationship with God” may, in fact, be helpful for this patient. However, the physician does not describe why this patient “drifted” from her religious practice. Did she consciously leave? Was her religious experience helpful? Hurting? We know that she suffered great losses in her life. Was she mad at God? Did she trust organized religion? Failure to address a spiritual differential diagnosis is as professionally irresponsible as failure to address a medical differential diagnosis. Patient harm may follow from either omission. Offering glib religious prescriptions may in fact recreate previously abusive relationships and undermine a patient’s future ability to enter into therapeutic relationships.

All health professionals must acknowledge the potentially tremendous power for healing, as well as hurting, found in religious faith and spirituality. With such power, as with the health professional’s power to diagnosis and treat, comes tremendous professional responsibility. This responsibility includes the obligation to refer when necessary. For example, health professionals must be aware of how and when religious or spiritual concerns are both the cause of the clinical problem as well as a source of its potential solution.

Focusing the interview on religious or spiritual issues may divert the physician’s attention from important physiological issues. Fatigue and a depressed mood, for example, can be signs of multiple disease processes. The physician’s decision to focus on illness rather than disease can only be done after considering the medical differential diagnosis for the patient’s concerns. In this carefully constructed case, the time-rushed physician did not address his differential diagnosis, his findings on the physical exam or the laboratory tests. We can presume that these were edited out to focus the reader on the religious issues addressed. However, can one truly address spiritual or religious issues in the increasingly briefer clinic appointments? To squeeze into scheduled appointments, the physician must triage among the interview, physical exam, and patient teaching functions of the visit. If one focuses on spiritual concerns, what gets dropped? Such triage decisions have both clinical and ethical importance that we as a society must address.

Therapeutic Focus

The last ethical concern inherent in spiritual care in the clinic is the risk of misunderstanding or misdirecting therapeutic strategies. Many people in this country believe that medicines are not necessary and that they will be healed spiritually, that God will provide and cure their disease. Such people can readily find faith healers proclaiming curative powers. Additionally, Christian Scientists and other faith traditions believe that no disease needs to be addressed by the medical system. As a result, health care professionals’ recognition of religious and spiritual concerns in the clinic may be misinterpreted as grounds for rejecting the need for further medical evaluation and medical treatment.

In this case, prescription anti-depressant
medication and counseling are consistent with the recognized standards of medical care. However, the patient’s “excellent discovery” and the physician’s religious prescriptions might be interpreted by some patients as sufficient therapy. This may be especially true for patients who have an aversion to medications, counseling, or other therapies. This may also be true for those with limited or nonexistent health care insurance. In all cases, the physician’s responsibility is to communicate and to promote the most efficacious therapies. When spiritual issues are addressed in the clinic visit, the physician’s messages on therapeutic strategies may be lost. For practical reasons, health care professionals addressing spiritual concerns might benefit patients by testing for understanding before patients depart and upon their return to clinic.

Conclusion

Because of public interest, doctors have, in fact, “begun to recognize the emotional and spiritual elements in all disease.” However, physicians still have a long way to go in matters of spirituality and practice. This trend in medical education and practice continues despite fundamental gaps in the medical profession’s knowledge and its traditional biomedical focus. Although a MEDLINE search will reveal hundreds upon hundreds of articles on spirituality in the nursing literature published since 1992, very few articles exist in the medical literature. Furthermore, the limited medical literature does not document what spiritual issues patients would want their physician to address. Nor does the medical literature address how and when patients would want such issues to be addressed. No one has measured the learning needs of medical students and residents. And no one has measured yet the quality of a physician’s preparation and competence to address a patient’s spiritual concerns.

We have just begun to recognize the ethical elements in spiritual care. This case study seeks to initiate necessary dialogue on ethical concerns to be considered when physicians address religious faith and spirituality in clinical settings. The four categories of ethical importance (physician paternalism, fiduciary responsibility, clinical misdirection, and therapeutic focus) deserve further analysis so that the role of spirituality in clinical care becomes balanced, useful, and serves the patient’s needs as effectively as possible.

References


