E Pluribus

Volume 3
Numbers 1 and 2
Spring and Fall 2006

Newsletter of the Pluralism Project, Department of Philosophy and Religious Studies, Youngstown State University

Editor's Note: This issue of E Pluribus *takes the interaction of religion and medicine as its theme. Two part-time faculty members in the Department of Philosophy and Religious Studies at YSU graciously agreed to pen articles for this issue. Dr. Donna J. Sloan provides a brief survey of the notable developments in the relationship between religion and medicine, and Dr. Julie M. Aultman discusses some of the ethical concerns that arise when religious beliefs are incorporated into medical practice. We thank Drs. Sloan and Aultman for their contributions.*

Some Perspectives on Faith and Medicine

By Dr. Donna J. Sloan

Although religion and medicine had their origins as a single entity, the emphasis on science that led to a split between them eventually resulted in alienation and an ever-widening chasm, the likes of which continue to this day. Contemporary authors covering the topics of faith and medicine seek to rediscover the inner relationship between the two disciplines, which are explicated variously as religion and science, religion and health, religion and medicine, theology and science, biomedical ethics, and numerous other perspectives in theology and medicine. While some discourses are devoted to debating this relationship, many accept it as a given, and still others elucidate the rationale for their belief in a competitive manner. In this essay, I examine some perspectives of the ways religion and health have been seen as coming together or as failing in that effort in today's medical and religious communities.

Efforts at reuniting the disciplines of religion/theology/faith with theories and practices in science/medicine/health have been extant in curricula of the religious academic community for a number of years and have become increasingly popular in medical schools and nursing programs.

Probably the first attempt at introducing an interdisciplinary approach to the study of religion and medicine was suggested in 1913 at the General Convention of the Protestant Episcopal Church by Rev. William Palmer Ladd, who suggested that providing seminarians with clinical experience would benefit both ministers and patients. Although no action was apparently taken on this suggestion, Dr. William Keller, a Cincinnati physician, reintroduced the idea in 1922. Subsequently, theology students were accepted into the Cincinnati School of Social Work under Keller's supervision. The students used the casework method in a mental hospital, a public welfare program, and a social hygiene society.

These early beginnings laid the groundwork for the Clinical Pastoral Education program (a required aspect of theological education), which had its origin in Massachusetts in 1925, when the superintendent of Worcester State Hospital hired clergyman Anton Boisen as a chaplain. At that time, four theological students went to that hospital for clinical training with Boisen. The students conducted recreational programs, wrote letters for patients, took walks with them, learned about psychiatry, psychology, and religion; they attended psychiatric staff meetings and had special meetings with the medical staff, patients, and Boisen. They also made records of their observations.

Boisen would later write, "We are beginning to recognize that these maladies of the personality are not to be explained merely in physiological terms. . . . The problem seems to be in the strict sense of the term 'a spiritual problem.'"[1]

One of the earliest attempts in modern times to bring medicine and theology together to establish a working relationship took place in April 1967 at the Convocation on Medicine and Theology held at the Mayo Clinic and Rochester Methodist Hospital. The purpose of the convocation was to foster more and better communication between physicians and clerics. The proceedings of that conference, reported in *Dialogue in Medicine and Theology*, edited by Dale White, offer a glimpse of the relationship between medicine and theology at that time and have served as a benchmark for future deliberations on the topic. White acknowledges previous disparate perceptions of the relationship between medicine and theology and lauds the process of change brought about by new possibilities in these fields that bring physicians and clerics together in mutual respect as they recognize their mutual responsibilities in dealing with human beings in a manner that fosters unity. He states:

> Traditionally we have supposed that the clergyman attacked evil and the physician attacked disease. One of the fascinating new areas of thought is the advocacy of new definitions of the sacred and the secular, which sees human life as a whole and recognizes that its treatment must be whole.[2]

In support of that view, Francis Braceland and Robert Nelson suggest that a major premise of the American Medical Association's Medicine and Religion Program, founded in 1961, is that ministers and physicians have come to realize that they "need each other." The actual relation of theology and medicine, according to Braceland and Nelson, is between the whole Christian community, the church, and the whole complex field of human pathology and therapy because the church includes the theologian or pastor as one of its members in addition to medical doctors and those in numerous other allied fields.[3]

Many perspectives that elucidate the relationship of health and religion are devoted to linking health and spiritual care and/or including spirituality in the health-care situation. This has been described by Frederic C. Craigie, Jr., who acknowledges a "clear link" between health and spirituality, while admitting the challenge of "weaving spirituality into organizational life and [making] it an integral component of clinical care." To affect this, three dimensions of spirituality are seen as essential: "spiritual well-being of patients and families, of workers and of the organization."[4]

J. W. Ehman et al. have studied the issue of physicians' including questions about spirituality and religion when investigating their patients' medical histories. According to their findings, "many but not all patients surveyed welcome a carefully worded inquiry about their spiritual or religious beliefs in the event that they become gravely ill." However, the proper wording "remains unknown."[5]

An issue in health and spirituality raised by ministers and health-care workers concerns the question of the appropriate person(s) to provide spiritual care. While health-care workers believe everyone should be involved in spiritual care, chaplains lament that they are not invited to be involved. Interdisciplinary health-care workers often neglect professional chaplaincy when they discuss spirituality. Possible reasons for this neglect "include the continuing negative fallout from the historic religion-science conflicts, the perception that both religion and clergy are irrelevant, and the belief that interdisciplinary professionals themselves can improve their patient services by giving attention to spirituality without the involvement of chaplains."[6]

Still other studies in this genre are devoted to spiritual healing and its association with physical healing. Such has been indicated by Laurence H. Blackburn, who asserts, "the relation between religion and health is real. In the practice of medicine, it is expressed by the psychosomatic approach to pathology and therapy. From a religious perspective it [takes] the form of the ministry of spiritual healing in the churches."[7] However, there continues to be "much apprehension and skepticism about spiritual healing." Definitions of spiritual healing tend to focus more on what it is *not*, than on what it *is*: "[It] is not Christian Science under another name . . . not mental adjustment or positive thinking . . . not just relief from pain or freedom from a handicap." It is "God's loving action in all and every part of our nature . . . the healing of the spirit."[8]

Harmon L. Smith claims that many obstacles must be overcome before clergy and medical doctors can work together as a team. Foremost among them is that doctors historically have considered the practice of medicine to be off limits to other professionals, and within the hallowed walls of the hospital, a prevailing hierarchy created by a "white-coat mystique" warns everyone that physicians are uppermost in importance. This exclusive closed-shop system of organization often makes other professionals (especially clergy) feel inferior to members of the hospital staff.[9] Verification of the superior attitude demonstrated by physicians is indicated by some physicians' implications that clerics' interactions with patients are inept or damaging to patients and by physicians' reluctance, opposition, or indifference to seeking out the advice and assistance of clerics. On the other hand, many clerics believe that doctors have usurped a prominent position that was previously theirs among the public. As a result, hospitals are the modern equivalent of cathedrals with medicine as the religion and doctors as the priests.[10]

John Polkinghorne suggests that there is no simple dichotomy between science and theology because they interact with each other in various ways. Science, concerned with questions of mechanism, poses the question "How?" Theology, concerned with questions of purpose, poses the question, "Why?" Though there are times when theology and science appear to be in direct conflict, make rival assertions, and contradict each other, there are points of interaction that could be perceived as areas of conflict.[11]

Ted Peters debunks the idea of a long-standing warfare between science and religion as "historical fiction" invented in the late nineteenth century. Although warfare might be part of the picture, it is by no means the whole picture, and the ways in which science and religion relate to each other fill a much larger picture. Another metaphor depicting the relationship between science and theology is that of revolution. However, it is no longer accurate to see science and theology as enemies because the revolution is being led by an intellectual trend, a reasking of the "God question" within the construct of scientific exploration about the natural world. The current situation is best described as a truce, as the wall of separation is gradually being disassembled and each discipline has become dissatisfied with consigning differences to separate areas of knowledge. Science and theology are engaged in a common search for shared understanding, not for a shared discipline but for increased knowledge, and advancement in humanity's understanding of reality. Since the 1960s, many groups involved in the revolution have been searching for points of contact and parallels.[12]

Ernan McMullin suggests that the question of how science and religion should interrelate is neither a scientific or theological issue nor a historical or sociological issue. Rather, the question is primarily epistemological: it is about how two different sorts of claims to knowledge are to be related. However, this is not to suggest that the philosopher is necessarily the person best qualified to discuss the issue, for historical and sociological perspectives may contribute relevant observations

on the question. At its basis, the question is about the nature of knowledge rather than about history or sociology or about science or theology.[13]

Finally, although positive relationships between religion and health are apparent, and religious ideas of salvation may be interrelated with medical concepts of well-being, religious beliefs and practices might also have a negative impact on physical and mental health. Among these are fanatical violence, mortifying asceticism, and oppressive traditionalism (e.g., sexism).[14]

In spite of new perspectives attesting to the need for an inclusive approach to the practices of medicine and religion, the disciplines continue to be thought of and practiced as distinct entities. As a result, contemporary ruminations regarding their interrelatedness continue to exist more in the broad arena of discourse rather than as actual practice. Conceptualizing a practice that is inclusive of both medicine and religion or implementing such an approach have often been defined as quackery, magic, or, in somewhat more positive contemporary terms, complementary medicine. To move beyond our propensity to place practices into distinct categories as either religion or medicine might require the use of a more inclusive term, such as "theomedicine." The reality of that possibility may be upon us sooner rather than later if present trends continue.

Notes

[1] "CPE-50 Yrs. Learning with Living Human Documents," *Association for Clinical Pastoral Education, Inc. News* 8 (1975), 1:1.

[2] Dale White, ed., *Dialogue in Medicine and Theology* (Nashville: Abingdon Press, 1968), 5–7.

[3] Francis Braceland and Robert Nelson, "Contributions of Medicine and Theology to the Health of Man: A Dialogue," in *Dialogue in Medicine and Theology*, 19–50.

[4] Frederic C. Craigie, Jr., "Weaving Spirituality into Organizational Life: Suggestions for Processes and Programs," *Health Progress* 79 (1998), 2:25–28, 32.

[5] J. W. Ehman, B. B. Ott, T. H. Short, R. C. Ciampa, and J. Hansen-Flaschen, "Do Patients Want Physicians to Inquire about Their Spiritual or Religious Beliefs If They Become Gravely Ill?" *Archives of Internal Medicine* 159 (1999), 15:1803–06.

[6] L. VandeCreek, "Professional Chaplaincy: An Absent Profession?" *Journal of Pastoral Care* 53 (1999), 4:417–32.

[7] Laurence H. Blackburn, "Spiritual Healing," *Journal of Religion and Health* 15 (1976), 1:34–37.

[8] Ibid., 34

[9] Harmon L. Smith, "The Minister as Consultant to the Medical Team," *Journal of Religion and Health* 14 (1975), 1:7–13.

[10] Ibid.

[11] John Polkinghorne, *One World: The Interaction of Science and Theology* (Princeton, NJ: Princeton University Press, 1986), 62–85.

[12] Ted Peters, ed. *Science and Theology: The New Consonance* (Boulder, CO: Westview Press, 1998), 1–10.

[13] Ernan McMullin, "How Should Cosmology Relate to Theology?" in *The Sciences and Theology in the Twentieth Century*, ed. A. R. Peacocke (Notre Dame: University of Notre Dame Press, 1981), 17–57.

[14] Peter H. Van Ness, "Religion and Public Health," *Journal of Religion and Health* 38 (1999), 1:15–26.

Author's Bio

Donna J. Sloan holds a PhD in interdisciplinary arts and sciences with a concentration in religious studies and health-care systems from Union Institute and University and teaches courses in religion, ethics, and Africana studies at YSU. Prior to joining the faculty at YSU, Sloan had a career in nursing, and her specialty was public health; she holds a master's degree in public health from Harvard University. She is also an ordained minister in the Swedenborgian Church and has more than thirty years of experience in nursing and ministry. Sloan's research interests focus on the interface of liberation theology, biomedical ethics, and alternative medicine.

Segregating Medicine along Religious Lines: An Ethical Perspective

By Dr. Julie M. Aultman

In a recent editorial, "Medical Practices Blend Health and Faith" (31 August 2006), Rob Stein from the *Washington Post* investigates the growing number of clinicians who incorporate their faith in their health-care practices.[1] By practicing their faith in conjunction with delivering health care to those in need, clinicians believe they protect not only their patients but themselves from having to provide services or prescribe pharmaceuticals they see as negative or unhealthy.

As a medical educator, trained in the disciplines of science and philosophy, I explore this controversial issue from the perspective of a secular ethicist, posing the question, "*Should* clinicians practice medicine that conforms to patients' and their own personal religious values?" Practicing medicine in the United States is not an easy task for most clinicians, given the complexity and limitations of the health-care system. Clinicians working in both public and private sectors are not always able to meet the rising demands for personalized patient care due to the restrictions and regulations set forth by the health-care institution the clinician serves or by insurance companies, HMOs, Medicare, Medicaid, and other state and federal agencies and administrations (e.g., the FDA). While several restrictions and regulations are warranted, they can be overwhelming to a clinician whose primary goal is to give patients the best care possible.

One may argue that clinicians who blend health and faith are delivering the best care possible by providing something additional to the healing process. The added element of faith may make patients feel as though they are receiving holistic care, especially when pharmaceuticals, technology, specialized medicine, and other limited resources may be inaccessible to patients due to age, financial status, health-care plan, etc. That is, practicing medicine in ways that cohere with patients' religious values may meet some of the demands for personalized patient care. Also, by knowing and understanding patients' spiritual needs, arguably clinicians are better prepared to meet patients' physical and emotional needs. This sentiment is echoed by many religious health-care practitioners who believe blending health and faith not only preserves their own conceptions of medicine and how it should be practiced, but also engenders an automatic connection with their patients who hold similar religious values.

While there may be several benefits to integrating religious values within a medical practice, there are significant ethical and social limitations worth considering. One of these limitations involves the amount of information delivered to patients. That is, religious practitioners, biased by their own values, may not fully inform patients about their health-care options, and may persuade, even coerce, patients to follow recommended procedures and regimens that may not be valued by the patient. This is not to say that religious practitioners intentionally coerce patients or fail to inform them of their options, but since their religious values are so strongly connected to the powerful, authoritative positions they assume as clinicians, patients may feel compelled to "follow the doctor's orders," even if they do not hold the same religious values. In secular medical practices, in fact, we find some patients blindly following a clinician's advice. Thus, medical educators continually emphasize the necessity of clinicians communicating all options to their patients in a noncercive manner while encouraging them to make the ultimate decision for themselves. Another notable limitation of integrating religious values within a medical practice becomes salient when clinicians do not want to perform a procedure or treatment plan (e.g., abortion) because it is against their religious beliefs; they may refuse to perform it so long as they provide patients with referrals and seek out other clinicians who will deliver the desired procedure or plan.

In Stein's report, however, one clinician stated, "If you refer a patient, it makes you as responsible as the one who does the procedure." This particular clinician felt as though she would be responsible if a patient goes to another clinician for a procedure that does not cohere with her religious values. But responsibility should be understood as a universal value that extends into both secular and nonsecular discourse and practice. Thus, this clinician would be acting irresponsibly by not referring this patient and informing her of the options available. By not referring this patient, this clinician would be imposing her values on the patient, failing to respect her patient as a person in the Kantian sense of the word, that is, a self-determining, autonomous agent able to make her own decisions. And if this clinician or any clinician feels as responsible as the one who does the procedure, he or she should remember that respect is also an important value in many religious circles and often outweighs personal responsibility. In this case, by respecting the patient as a person, the clinician is acting more responsibly than if having intervened to fulfill personal religious values.

In developing institutional guidelines and policies while dealing with differences in the clinical setting, Baruch Brody suggests using the "conscience clause," which "allows members of a religious community who object to certain actions because they violate rule-based constraints accepted in their community to refuse to perform those actions or to have those actions performed on them."[2] The conscience clause may not be introduced into the clinical setting without difficulties, especially when considering whether this clause applies to all patients, including minors who have not yet developed a system of beliefs, which may or may not reflect their parents' beliefs. The conscience clause can be especially problematic if all providers invoke it, thus compromising certain patients' rights, such as the right to an abortion. In any given community, if there are no clinicians willing to practice medicine that goes beyond their personal, religious beliefs, patients may not be getting the care that they need and want.

Another limitation which is more pragmatic than ethical involves the nature of the health-care practitioner's religiosity. That is, even if a clinician follows a particular faith, he or she cannot expect all patients to conform to every belief that the clinician holds. While clinicians and patients may share the same religion, this is not to say that they interpret or follow the rules and teachings of that religion in similar ways. Therefore, even though many patients may be drawn to a health-care clinic or institution that emphasizes religious values within medical practice, clinicians should fully inform their patients about their religious values that are relevant to the medical situation at hand, regardless of their patients' suspected religious beliefs. Clinicians must also consider their patients' secular moral beliefs as well as their social situations. Clinicians must remember that even the most devoted religious patients may not follow their religious values when confronted with a personal, clinical, and ethical dilemma (e.g., a patient wanting an abortion because she was raped by a family member).

Going back to the original question posed, "*Should* clinicians practice medicine that conforms to patients' and their own personal religious values?" the short answer is "yes, so long as both the clinician and the patient have an understanding of each others' secular and nonsecular values and are able to collectively reach a decision that respects the patient as a person." However, given the ethical and pragmatic difficulties of blending faith and health practices, clinicians who practice in this manner must realize that, regardless of the faith(s) involved, communication is one of the most important values between clinicians and patients. Furthermore, as health-care *professionals*, clinicians commit to a particular set of moral, legal, and social obligations and must fulfill this commitment. So, if a patient is in need of a particular procedure or prescription that a clinician considers

unhealthy or negative based on personal religious standards, the clinician is professionally and morally obligated to refer the patient to another health-care practitioner if he or she is unwilling to provide the treatment or procedure requested. In the end, secular ethics and religion must work together in meeting the pluralistic needs of patients.

Notes

[1] Rob Stein, "Medical Practices Blend Health and Faith: Doctors, Patients Distance Themselves from Care They Consider Immoral," *Washington Post*, 31 August 2006, http://www.washingtonpost.com/wp-dyn/content/article/2006/08/30/AR2006083003290_pf.html.

[2] Baruch Brody, "Religion and Bioethics," in *A Companion to Bioethics*, ed. Helga Kuhse and Peter Singer (Oxford: Blackwell Publishers, 1998), 45–46.

Author's Bio

Julie M. Aultman, PhD, is coordinator for bioethics and assistant professor of behavioral sciences at Northeastern Ohio Universities College of Medicine, where she teaches courses on bioethics, philosophy of medicine, philosophy of science, and other topics. She also serves as a part-time instructor in the YSU Department of Philosophy and Religious Studies, for which she teaches courses on biomedical ethics, professional ethics, and critical thinking. She holds a doctorate in philosophy with a concentration in health-care ethics and a specialization in cognitive science from Michigan State University. She also holds a master's degree in bioethics from Case Western Reserve University. In addition to the aforementioned fields, her research interests extend to health-care justice, psychiatric ethics, international studies in health-care systems and community-based rehabilitation programs, and moral development in medical education. Along with Delese Wear, she is editor of *Professionalism in Medicine: Critical Perspectives* (New York: Springer, 2006).

Article Summaries

Brown, Anthony E., Simon N. Whitney, and James D. Duffy. "The Physician's Role in the Assessment and Treatment of Spiritual Distress at the End of Life." *Palliative and Supportive Care* 4 (2006): 81–86.

The authors provide a brief survey of the literature related to the physician's role in the spiritual lives of terminally ill patients and conclude that physicians should be attentive to their patients' spiritual needs and prepared to address them with compassion. The article suggests that doctors invite patients to discuss their religious beliefs and rituals and how they want them to be incorporated into their end-of-life decisions. The article reports that the vast majority (94 percent, according to one source) of patients want their doctors to inquire about their spiritual beliefs. Doctors are cautioned not to interject their own religious viewpoints in discussions with their patients and are, instead, encouraged to speak in generalities about spiritual issues, focusing on how their patients find meaning in their lives and on how patients reconcile their beliefs with their suffering. Physicians who address their patients' spiritual needs and/or distress at the end of life can help their patients achieve a measure of peace.

Olson, Michael M., M. Kay Sandor, Victor S. Sierpina, Harold Y. Vanderpool, and Patricia Dayao. "Mind, Body, and Spirit: Family Physicians' Beliefs, Attitudes, and Practices Regarding the Integration of Patient Spirituality into Medical Care." *Journal of Religion and Health* 45 (2006): 234–47.

With the goal of collecting doctors' narratives about their beliefs, attitudes, and practices surrounding the integration of spirituality into health care, the authors conducted interviews with seventeen third-year family medicine residents in training at an American medical school. Four themes emerged from the data collected: (1) assessing patients' spirituality in clinical practice, (2) connections between spirituality and medicine, (3) barriers to addressing spirituality in clinical practice, and (4) strengths of integrating spirituality and medicine. Most of the physicians in the study acknowledged addressing their patients' spirituality; those that do not assess this aspect of their patients' lives also identified themselves as not being religious or spiritual. Many of the residents said that they take their cue from patients as to whether the patients want their physicians to involve the spiritual dimensions of their lives (e.g., praying with and/or for the patients). Some of the barriers to integrating spirituality and health care identified by the physicians included their own "spiritual place" and the lack of time, training, and appropriate language. All the physicians interviewed provided reasons for why integrating the two areas would be beneficial to patients' health.

The authors suggest that medical students be taught to regard themselves as part of their patients' therapy toward health and wellness and that physicians remain cognizant that their perceptions of the world are affected by their values and beliefs, religious and otherwise, such that neutrality toward religion and spirituality is not possible.

Call for Contributions

All YSU faculty, staff, students, and alumni are invited to contribute articles and announcements about religious pluralism and interfaith activities and events in the Mahoning Valley to *E Pluribus*. Pieces that treat religion more generally are also welcome. Submissions intended to proselytize will not be accepted.

In addition, we are seeking reviews of books related to religious pluralism and/or interfaith relations. We encourage members of the YSU community to submit personal narratives detailing their spiritual paths for possible inclusion in the Reflections on My Faith series. We hope that *E Pluribus* will grow to become known as a forum for the exchange of ideas related to religion.

To submit your article or suggestion to *E Pluribus*, please contact James Sacco at the Center for Islamic Studies at 330-941-1625 or at jjsacco@ysu.edu.

Department of Philosophy and Religious Studies
Youngstown State University
One University Plaza
Youngstown, OH 44555

Telephone: 330-941-3448
Fax: 330-941-1600
Web: http://www.as.ysu.edu/~philrel/

Dr. Bruce N. Waller, Chair
Dr. Mustansir Mir, Coordinator, Pluralism Project
Mr. James J. Sacco, Editor

Submissions may be sent to jjsacco@ysu.edu or, via campus mail, to James Sacco, Center for Islamic Studies.

Publication of this newsletter is sponsored by the Center for Islamic Studies, Youngstown State University.