“Religious Perspectives”  
Lecture Transcript  
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SLIDE 1 INTRODUCTION

Religious belief is a highly significant reality in the lives of many people. Even those who do not consider themselves religious are affected by the moral convictions of religious people, as well as by laws and traditions that may have been influenced by religious convictions.

Treatment decisions can be affected by patients who have dietary restrictions, strong feelings about modesty, touch, and personal space, all based on their religious beliefs. Patients who are not connected to formal religious traditions may still be more familiar and more comfortable with spiritual approaches to health.

Religion has always put a great deal of energy exploring issues at the beginning of life and at the end of life. It is, therefore, no surprise that many religious people hold strong convictions over matters of birth and death. Consciously or unconsciously these religious convictions have been at the foundation of both public and personal morality and lie at the core of some of the strongest disagreements in medicine.

SLIDE 2

Issues of religion, spirituality, and faith regularly intersect with medicine and medical practices. Neither patients nor providers check their religious beliefs and their spiritual values at the clinic door. Some of these will be members of organized faiths with rules and traditions that influence decisions. Others will bring with them values and convictions based on individual spiritual commitments. This means that religious values can potentially affect the decisional considerations of patients and providers alike.

Healthcare professionals not only need to be sensitive to the religious beliefs of their patients, but also need to be self-aware of how their own attitudes toward religion and religious values intersect with their professional duties.

Three areas where religion commonly intersects with treatment decisions:

1. The right of adults to refuse treatment on religious considerations.
2. The limits of parental authority in refusing treatment for children based on religious considerations.
3. The rights of providers to refuse to treat patients based on religious considerations.

SLIDE 3 RIGHT TO REFUSE TREATMENT BASED ON RELIGIOUS GROUNDS

Adults are considered to be autonomous when it comes to choices about their treatment. Patient autonomy takes precedence over the healthcare provider’s desire to act in the patient’s best interest as long as the adults have decisional capacity. The patient can choose to forego treatment, even life sustaining treatment, for personal, economic, religious, or any other reason whatsoever, as long as the decision does not endanger public health or welfare.
SLIDE 4 LIMITS OF PARENTAL AUTHORITY

In 2009, 13 year old Daniel Hauser of Sleepy Eye Minnesota was diagnosed with Hodgkin’s lymphoma. Hodgkin’s lymphoma is usually fatal but has a treatment success rate of about 90%. Daniel took the first of six recommended chemotherapy treatments but decided to refuse additional treatment on the basis of religious grounds.

The family belongs to a religious group which advocates the use of natural remedies. Daniel’s mother began treating Daniel through a natural diet she found on the internet in place of the physician recommended chemotherapy. She claimed that Daniel was feeling better and better every day. X-rays showed that the tumor was growing. The mother claimed that the x-rays were wrong.

Eventually a judge ruled that the parents had “medically neglected” their 13 year old son and ordered Daniel to continue chemotherapy.

While adults are considered competent to make their own decisions about medical treatments, in many cases children lack the decisional capacity required, especially in life threatening situations. In most cases, the proper authority to make such decisions falls on the parents. It is assumed that parents have their children’s best interest in mind when they make decisions concerning them. Furthermore, parents know their children better than others giving parents insights that others would not usually have. Therefore, it is normally presumed that parents are the proper decision makers for their children.

This does not mean that parental authority is absolute. Parents have a duty to provide life-sustaining care, including medical care. Failing to provide children with life-sustaining care can amount to neglect and abuse. In such cases, the court may exercise its legal duty to protect its citizens (parens patriae). The state has a duty to care for vulnerable persons as protector of those who cannot protect themselves. In this role, the state may claim the authority of decision maker for the child.

Finally, age alone is not the best criteria for determining the decisional capacity of minors. The American Academy of Pediatrics (AAP) has recommended that children over 7 years old should be involved in the decision making process and that mature children over 14 should be encouraged to expresses their interests in their medical care and in some cases be the primary decision maker. (American Academy of Pediatrics, (1995). Pediatrics, 95:314.)

SLIDE 5 CONSCIENTIOUS OBJECTION

Conscience is more than moral intuition. Conscience is commonly understood as a form of practical reason that guides choices of right and wrong actions, based on thoughtful consideration of deeply held values and beliefs. Conscience involves the inner movement from general knowledge about right and wrong based on one’s core values and beliefs to application in particular circumstances. The result of this movement from inner values to practical application is a judgement that a particular action is right or wrong for me to do.

One would be expected to experience negative consequences if she were to make a choice in opposition to a deeply held value or core belief. Such a choice would create an inner conflict, a betrayal of one’s
own identity. In this sense the basis of conscientious objection affirms the principle of autonomy, the right of a person to have the final say over his or her own life. It can also be understood in terms on non-maleficence: acting in contrast to one’s core values could cause serious harm.

SLIDE 6 THE CHURCH AMENDMENTS

In response to the Supreme Court ruling in *Roe v. Wade* legalizing abortion, Congress, enacted legislation protecting healthcare workers from being forced to provide abortion or sterilization services that were in conflict with their moral or religious beliefs.

Any institution that receives federal funding is required to honor a worker’s objection to participating in abortion and sterilization procedures, if they have objections based on moral or religious convictions. In addition, healthcare workers cannot be fired, demoted, passed denied promotion, or discriminated against, because they have participated or because they have refused to participate in lawful abortions or sterilizations as a matter of moral or religious beliefs.

Finally, the Church Amendment protects individuals who participate in programs or research projects funded by the United States Department of Health and Human Services (HHS). Both those who choose to participate and those who refuse can refuse based on religious beliefs cannot be discriminated against. This final provision establishes protection for conscientious objectors in cases other than abortion or sterilization.

SLIDE 7 ACOG

The American College of Obstetricians and Gynecologists (ACOG) support the right of doctors to refuse to participate in abortions on grounds of conscience. Nevertheless, because they are professionals, they should be required to refer patients for abortions and in extreme emergencies, to perform abortions in spite of their own objections. ACOG affirms a physician’s right of conscientious objection to participating in abortions, but holds that conscience is not absolute. The implication is that in some cases professionalism can override conscience.

SLIDE 8 DON’T FORGET

Though much of the debate about the relationship between religion and medicine has taken place within the Western tradition where Christianity dominates religious dialogue, within the Christian tradition there is great diversity. Therefore, it cannot be assumed that all Christians hold similar values and beliefs.

The ethical issues that arise with the interaction of religion and medicine are not uniquely Christian and it is not at all surprising that there are many instances where members of different religions agree while members of the same religion disagree.

Healthcare professionals should approach issues of religion in the same way that they would approach issues of culture. They should ask open questions, aimed at understanding the other person’s values, goals and priorities. Engaging in conversation and actively listening create the best chance for understanding.