

# Commentary: A Case for Studying the Relationship Between Religion and the Practice of Medicine

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## Abstract

A growing literature on the religious characteristics of health care professionals raises questions about how clinicians' religious traditions and commitments shape their clinical practices. Because medicine is a moral practice, theological and philosophical ideas are operative in any self-conscious application of medical science. As such, disagreements about morally controversial medical interventions are likely to be particularly visible expressions

of deeper disagreements about the means and ends of medicine. This commentary argues for systematic study of religion-associated variations in clinicians' clinical practices, and it proposes a framework for how that research might be carried out. Increased professional attention to the intersection of religion and the practice of medicine may enrich doctor–patient communication by stimulating physicians to be more self-conscious and candid

about the intersection of their religious commitments and their practices. In addition, by raising such issues from beneath the surface of “evidence-based” or “patient-centered” medicine, such attention may foster policy solutions that permit peaceable and conscientious coexistence of those who disagree.

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**Editor's Note:** *This is a commentary on Catlin EA, Cadge W, Ecklund EH, Gage EA, Zollfrank AA. The spiritual and academic identities, beliefs, and practices of academic pediatricians in the United States. Acad Med. 2008;83:1146–1152.*

In this issue, Catlin and colleagues<sup>1</sup> report on the religious characteristics of 209 pediatricians from the faculty of 13 elite academic health centers. The authors found that compared with the public, these academic pediatricians were significantly less likely to endorse a religious affiliation, attend religious services frequently, or have confidence in the existence of God. Yet, they reported a breadth of religious beliefs and practices nonetheless: majorities believe in God, pray, attend religious services at least on occasion, and endorse some religious affiliation. More importantly, most academic pediatricians, and particularly those who are more religious, are conscious that the religious beliefs they hold influence their interactions with patients and colleagues.

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This study provides a welcome contribution to a small but growing literature on the religious and spiritual characteristics of health care professionals, and by focusing on faculty at leading academic institutions, Catlin et al highlight the belief systems of those who will have disproportionate influence on the future shape of medical practice. Yet, as the authors concede, further research is needed to answer the question begged by this and similar studies: What differences do physicians' religious traditions and commitments make with respect to their clinical practices? In what follows, I outline why such research is needed, how it might be carried out, and what we can reasonably expect as a consequence of greater professional attention to the relationship between religion and the practice of medicine.

### Why Further Study Is Needed

Theory and data both suggest that religious traditions and commitments, and their secular counterparts, substantially influence physicians' clinical practices. To begin, physicians in the United States do not seem to be much less religious than the general population. In 2003, colleagues and I surveyed 1,144 physicians from all specialties.<sup>2</sup> We found that these physicians were just as likely as members of the public to endorse a religious affiliation and were more likely to regularly attend religious services,

though they were somewhat less likely to say that they try to carry their religious beliefs over into other areas of life. In addition, in both our study and that by Catlin et al, the majority of physicians indicated that they were conscious of their religious beliefs influencing their clinical practices.

Moreover, as the authors note, several studies, including our own, have found that religious differences account for much of the variation in physicians' practices related to morally controversial areas such as sexual and reproductive health care practices, end-of-life care, prayer, and other forms of interaction with patients regarding spiritual issues, as well as physicians' judgments about their obligations when patients request morally controversial medical interventions. In these contentious domains, religious characteristics are often stronger predictors of physicians' practices than are any of numerous other demographic and practice variables. Yet, with respect to the influence of religion on the practice of medicine, these overtly controversial issues may be merely the tips of proverbial icebergs.

Indeed, religion-associated variations in physicians' practices highlight the necessary relation of theology to the practice of medicine by drawing attention to theological and philosophical ideas that are operative in any self-conscious

application of medical science. For example, with respect to sexual and reproductive health care, politically charged disagreements about abortion and emergency contraception reflect deeper disagreements about the answers to profound human questions: What is the purpose of human life? What is the proper place of technology in human flourishing? What defines parenthood? Why should humans bear or not bear children? When does human life begin? To whom does one's body belong? What obligations do physicians and society have toward a human embryo or fetus? These are questions to which different religious and secular moral traditions have long offered differing answers, and in light of the totalizing claims made by religions such as Judaism, Christianity, and Islam, it would be surprising if such disagreements did not also lead to differences in physicians' practices in the area of sexual and reproductive health care.

By highlighting the theological issues at stake in the practice of medicine, religion-associated variations among physicians demonstrate the fact that physicians act as practical philosophers in their clinical work. Physicians make prudential judgments about what to do to help their patients, using the technical means available, taking everything else into account—including the scientific evidence, the patients' wishes, and professional expectations, of course, but also including religious and other moral considerations. At times, physicians of different worldviews will disagree about whether a given practice is legitimate. This is often the case with respect to controversial practices in sexual and reproductive health care and end-of-life care. At other times, physicians will agree about the range of legitimate clinical strategies but disagree about which is to be recommended in a given moment. For example, different traditions may agree that the experience of depression can be treated legitimately by pharmacological therapy, referral to a psychologist, or referral to a pastoral counselor, yet physicians formed in one tradition may be much more likely than those formed in another to recommend a particular strategy in a given case.<sup>3</sup> These latter differences are subtler and will go largely unnoticed until well-designed empirical research brings them to light.

Unfortunately, to date, there has been relatively little study of the influence of physicians' worldviews on their clinical decisions. A series of patient-centered movements such as integrative medicine, holistic medicine, culturally competent medicine, narrative medicine, and spirituality and medicine have collectively embraced the influence of patients' histories, cultures, religions, and spiritualities on their experiences of illness and their medical decisions. Yet, medicine has generally preserved an idealized vision of physicians as more or less interchangeable representatives of the one profession, answerable to data and a unitary standard, and steered against the influence of their own "personal values." Indeed, when physicians' practices seem to differ because of their different religious commitments, those commitments are more often seen as a threat to, rather than a resource for, quality medical care. As a consequence, the influence of physicians' religious commitments on their practices often remains unarticulated, unexamined, and underappreciated.

### A Framework for Research

Systematic study of religion-associated variations in physicians' clinical practices will lift the influence of religion from below the surface of "evidence-based" and "patient-centered" medicine out into the arena of public moral deliberation about the ethical practice of medicine. The most fruitful empirical research regarding religion and medicine will incorporate the complementary strengths of qualitative inquiry and quantitative survey methods. Methods of qualitative inquiry such as semistructured interviews invite physicians to answer open-ended questions about how they make clinical decisions (or recommendations to patients) with respect to an array of scenarios that arise in clinical domains of interest. Such a format would allow participants to describe aspects of the clinical domain that seem ambiguous and/or controversial, and how their clinical approaches differ from those of their colleagues. Participants would be encouraged to describe their understanding of whether and how their religious commitments shape their care of patients, and whether they are aware of other physicians whose worldviews lead them to practice differently.

Data from qualitative interviews can be used to ground the development of cross-sectional, self-administered surveys that assess the magnitude and direction of associations between physicians' religious characteristics and their self-reported and self-predicted clinical practices in particular clinical domains. Such survey measures should reflect the language used and explanations given by physicians with clinical experience in the domain of interest. They should be calibrated to reflect points of genuine ambivalence or disagreement within the profession. For example, suppose a researcher wants to know how doctors' religious characteristics are associated with their prescription of narcotics for chronic pain syndromes. An item that asks whether the physician ever prescribes narcotics for chronic pain will be much less helpful than a few carefully crafted clinical vignettes of difficult cases, followed by measures of how likely the physician would be to prescribe narcotics in each case.

Of course, surveys also must include measures of physicians' religious characteristics. Catlin and colleagues thoughtfully chose measures that allowed them to compare the characteristics of pediatricians with those of the general population, and as further research in this area is done, I hope that investigators will gravitate toward a consistent set of religious measures that allow for comparisons across different studies. Which measures are most useful has yet to be decisively determined, but insofar as possible, researchers should include at least one measure of affiliation (Protestant, Jewish, Hindu, etc.) to indicate the substance and content of the subjects' religious tradition, and one or two measures of religious practice and/or commitment to assess the salience of subjects' religious commitments to their self-conscious clinical decision making. To avoid minimizing or neglecting the influence of secular traditions, empirical studies of religion and the practice of medicine would employ a functional definition of religion, in which a person's religion is that set of intellectual and moral commitments (beliefs and values, with their related practices) that the person self-consciously endorses as his or her own worldview. Worldviews may be substantively religious or they may be substantively secular.

Cross-sectional surveys are very useful, but some pertinent questions will only be addressed adequately with longitudinal studies. For example, Catlin and colleagues found that among pediatrician faculty from their study population, 9 out of 10 were religiously affiliated at age 16, but that proportion had declined to 7 out of 10 by the time they were surveyed. In contrast, our study of physicians from all specialties and practice settings<sup>2</sup> found that even among those who work in an academic health center or teaching hospital, 9 out of 10 reported a religious affiliation. These differences raise interesting and, to date, unanswered questions: Do leading academic institutions preferentially attract those who are less religious? Or is there something about the culture at highly competitive medical universities that leads people to discard the religious commitments they once had? In a broader vein, how does the experience of medical training shape, and how is it shaped by, students' religious identities and commitments? How do religious practices shape physician "professionalism," medical ethics, the doctor-patient relationship, and shared decision making? How do religious commitments shape the decisions physicians make regarding specialization, and their motivations for and goals of professional practice? Such questions will be answered best by studies in the tradition of the great longitudinal educational and occupations surveys of past decades (e.g., The National Education Longitudinal Studies) that can evaluate these relationships dynamically over the course of the physician's formative years, from their entrance into medical school to their first years in practice after completing training.

Notwithstanding the importance of empirical research, scholarship regarding religion and medicine will be woefully incomplete without a robust analytic component that invites theological and philosophical interpretation and critique. Religion-associated differences can be measured and described using survey research methods. Yet, to understand why those differences exist, scholars should present the empirical findings back to clinicians, theologians, and others who are formed in and knowledgeable

about particular religious traditions, asking them to interpret the findings in explicit reference to those worldviews. In this way, empirical studies can help to foster public discourse regarding religion and medicine that is theologically informed, relevant to patients and clinicians, and accessible to leaders of the health care professions.

### The Anticipated Consequences of Increased Professional Attention

As medicine pays increased attention to the influence of religion on the practice of medicine, several consequences will likely result. First, patients will become more conscious of the influence of physicians' religious commitments on their clinical practices. Findings from empirical studies will therefore stimulate dialogue between patients and physicians to clarify expectations and to negotiate mutually acceptable accommodations for respectfully working together in light of shared or divergent moral traditions. This dialogue has the potential to enrich the doctor-patient relationship and to allow patients, if they deem necessary, to seek physicians who share their premises or conclusions with respect to how medical science should be applied toward their good.

Physicians will be stirred to greater self-consciousness about the influence of their particular spiritual commitments on their clinical practices. The Association of American Medical Colleges has urged medical educators to teach students how to "incorporate awareness of spirituality, and culture [sic] beliefs and practices, into the care of patients in a variety of clinical contexts . . . [and to] recognize that their own spirituality, and cultural beliefs and practices, might affect the ways they relate to, and provide care to, patients."<sup>4</sup> The research I am advocating will provide an evidence base to make this aim possible. Self-consciousness often yields greater reflection and consideration; initial prejudices and/or judgments can be more fully considered. Moreover, these studies may encourage physicians to be more candid about the reasons for their clinical recommendations, so that they are less likely to couch those recommendations in terms that mask deeper but less visible commitments.

Policy makers, medical ethicists, and all those who seek the common good will find it easier to discover and engage in respectful discourse about the true grounds of disagreements regarding medical practice. Public dialogue that explicitly engages the claims of different worldviews (religious and secular) will, at a minimum, promote mutual understanding in our pluralistic society. Such dialogue may also foster policy solutions that permit peaceable and conscientious coexistence of those who disagree. This would be no small achievement in the face of public conflicts regarding physicians' obligations with respect to morally controversial clinical practices.

In summary, the report by Catlin and colleagues invites systematic study of the relationship between physicians' religious traditions and commitments, and their clinical practices. Such research would draw public and professional attention to the moral and spiritual dimensions of medicine, facilitate development of paradigms for medical education in which students grapple with those dimensions and become conscious of their own reasoned commitments, and invite scholars and physicians from the world's great religions to interpret medical practice in their own tradition-specific terms. One may hope that such study would also catalyze a constructive new engagement between science and religion regarding medicine, arguably the most culturally influential applied science in the modern world.

### References

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