THE INFLUENCE OF RELIGIOUS BELIEFS ON HEALTH CARE:
BETWEEN MEDICAL FUTILITY AND REFUSAL OF TREATMENT

Department of Philosophy and Pedagogy, Silesian Medical University, Katowice, Poland

The problem of respecting the patients’ religious-based decisions seems to play increasingly important role in medical practice. Most probably it happens because: (i) bioethical standards accentuate the principle of the respect for autonomy (the departure from medical paternalism) and (ii) the contacts between people belonging to different religious traditions are becoming more and more frequent (the process of globalization). Toleration, in particular toleration of patients’ religious convictions, needs to be considered as a vital issue for the pluralistic societies. A four-principle approach to medical ethics is assumed as a theoretical base for this study. The main methodological steps could be described as: (i) identification of a ‘considered judgment’ (proper to the problem in concern), (ii) its specification, and (iii) balancing/overriding. According to the internationally accepted proclamations of human rights, the positive obligation to tolerate religious beliefs is indicated as the principle which should govern the process of dealing with the patients’ religiously motivated decisions. The special status of patients’ religious-based decisions as well as the ‘obliging force’ of them is considered. The article concludes with guidelines on how to help doctors resolve moral dilemma related to tolerance of patients’ religious-based decisions.

Key words: globalization, medical ethics, pluralism, religion, tolerance

INTRODUCTION

Undoubtedly, the date signaling a breakthrough in the history of Christianity is October 31, 1517, when Martin Luther nailed the protest entitled “Disputation on the Power and Efficacy of Indulgences”, better known as “Ninety-Five Theses”, to the church door of Wittenberg (1). H. Tristram Engelhardt is ready to state that this date could and should be considered not only as a turning point in
the history of one, even if one of the most influential, religious tradition, but also as a beginning of a new era in the history of the Western Civilization (2). In a certain sense, Engelhardt considers Luther’s protest as a starting point for the pluralistic society. The main consequence of the Reformation was that “one could no longer hope to live in faith, governed by a single supreme religious moral authority” (2, p. 4). It appeared to announce a decrease in the role of religion in the ‘modern’ world. Surprisingly, however, the development of pluralistic societies seems to have led to rediscovering and even putting emphasis on the significance of religious convictions (3).

In contemporary medical ethics two main driving forces behind an increase in importance of religious beliefs could be distinguished. One of them is related to the very process of the development of bioethical standards which has been occurring since the second half of the 20th century (4). The second one finds its roots in the process of globalization which appears to change the way of life of the entire world population.

Emphasis on the human rights, as a certain form of reaction against cruel experience of World War II, and in particular, against comportment of Nazi doctors and their “research practices”, made it necessary to reconsider the standards of medical ethics (5). The main stream of changes in these standards can be described as a radical or even ‘revolutionary’ departure from medical paternalism to the promotion of the respect for the patient’s autonomy (6).

Globalization is understood widely “as an openness: openness to trade, to ideas, to investment, to people, and to culture” (7, p. 504). Although a discussion about the moral value of this process and rationally predictable consequences which it would have over, in particular, poor or minority populations (8), remains controversial (9, 10), the very fact of globalization seems to be something inevitable (11).

Accentuating patients’ autonomy obviously leads to the reinforcing of the significance of their religious beliefs. As Beauchamp and Childress observe “to respect an autonomous agent is, at the minimum, to acknowledge that person’s right to hold views, to make choices, and to take actions based on personal values and beliefs” (4, p. 125). The influence of globalization on the role which religious convictions play in medical ethics is based on the two essential facts: (i) nowadays contacts between people belonging to different religious traditions are becoming more and more frequent, and (ii) multiculturalism of contemporary societies causes the appearance of new religious traditions or, at least, very serious changes in the old ones (evolution of religious traditions) (12, 13).

The general purpose of this article is to indicate the ethical norms which in pluralistic societies should govern the conduct of health care professionals dealing with the patients’ religious-based decisions about medical treatment. In order to realize the purpose it seems necessary to determine (i) what is understood by ‘religious conviction’, or – more precisely - what the identity of these
convictions is, and (ii) if they stand as a special kind of convictions, meaning that they are of particular importance and/or should be guarded with special care.

MATERIAL AND METHODS

A four-principle approach to medical ethics, also known as ‘principlism’, is assumed as a theoretical base of the points under consideration. Bearing in mind that in a popular use, as Childress and Beauchamp observe (4), the term ‘principlism’ seems to express some disparage, it should be emphasized that the reason why this term is used in this article is a matter of convenience, it is simply shorter than the whole expression ‘four-principle approach to medical ethics’.

According to the rules of moral justification accepted by principlism (so called coherentism) (4), the main methodological steps of considerations undertaken in this article could be described as: (i) identification of a ‘considered judgment’ (the notion known from works of John Rawls) (14, 15) related to righteousness/wrongness of morally relevant conduct with reference to decision(s) and/or action(s) based on religious beliefs; (ii) specification of the indicated judgment(s), and (iii) balancing and/or overriding it/them to avoid conflicts with others moral norms. By “considered judgment” Beauchamp and Childress understand the statement expressing moral convictions “in which we have the highest confidence and believe to have the lowest level of bias” (4, p. 20). The processes of specification and balancing are mutually interrelated. Beauchamp defines specification as “a process of reducing the indeterminateness of general norms to give them increased action guiding capacity, while retaining the moral commitments in the original norms” (16, p. 269). The process of balancing aims to determine the weight that a certain norm has in relation to other norms, especially these which are potentially or actually in conflict with the balanced norm.

Principlism and its method of justification of moral norms have been chosen as a theoretical background due to the fact that it seems to “provide a sound and useful way of analyzing moral dilemmas” (17, p. 275) and still remain “the most influential approach to bioethics” (18). In particular, this theoretical approach, due to its universality, makes it possible to formulate inter- and crosscultural moral judgments (16). Although several arguments were presented against the possibility of using principlism as the approach to biomedical ethics in the multicultural societies (18), the in-depth considerations of the nature of pluralism and the possibility of justification of the universal ethical principles in pluralistic societies seem to be very promising (19, 20).

RESULTS AND DISCUSSION

The identification of the universal ethical norm regulating human comportment in a multi-religious setting which could be recognized as a ‘considered judgment’, is – seemingly – an extremely easy issue. In fact, such a norm/principle serves as an example of what should be considered as the ‘considered judgment’ (21). The wording of this judgment could be accepted according to the 18 Article of the Universal Declaration of Human Rights which states that: “Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance” (22).
Though apparently the above quotation can serve as a formulation of the considered judgment, it is worth noticing that both Rawls (15, 23) and the principlists as Beauchamp and Childress (4) speak rather of the wrongness of religious intolerance than of the righteousness of religious tolerance. The negative (only) or positive character of this judgment should be the subject of a separate study.

The obligation to reject any form of religious intolerance and promote tolerance needs to undergo the process of specification. Beauchamp poses the two questions which seem to be a perfect starting point for consideration aimed at reducing the indeterminateness of the general rule of tolerance (16). Namely, it should be explained whether religious convictions stand/ought to be considered as a special (the most important) form of beliefs and, secondly, if/in what degree it is important that a certain conviction expresses beliefs of a given, established denomination or only individual (personal) opinions which are not associated with any ‘officially’ recognized denomination. These two questions serve here both to (i) indicate the direction of and (ii) limit the process of specification.

Even very superficial study of the role which religion played and still is playing in different cultures around the world seems to prove the special position of religiously based convictions in relation to other – politically, esthetically or ethically – based beliefs. Elementary knowledge of the history of mankind clearly demonstrates ‘the fact’ that religions (understood as “sets of beliefs” and “institutions”) have been playing extremely important role, and, in particular, have been able to significantly influence the political, ethical, and esthetical convictions. The in-depth considerations permit to show the role that religions play in history not only as a purely ‘fact’, but also provide the justification of this ‘fact’ (24, 25).

A special position of religious convictions could be also demonstrated using ‘an axiological argument’. It could be said, simplifying the problem, that human convictions are related to the given values. Assuming that some values are or, at least, are recognized as higher/lower than others, it would be reasonable to accept that convictions related to higher or lower values are, adequately, of higher or lower importance than other convictions. Joseph Tischner (26), basically sharing Max Scheler’s philosophy (27), indicates the three main “signs of superiority” of values: (i) their durability, (ii) being a source of profound gladness, (iii) the ability to give the sense to others values. These “signs” confirm the structure of the hierarchy of values which consists of four kinds (modalities) (28) of values known from Scheler’s axiology. Hedonistic or agreeable values are the lowest ones (short durability, source of joy, lack of ability to give the sense to others values). Vital or biological values have a longer durability than the hedonistic ones. Moreover, they are the source of a more profound joy and make sense of hedonistic values. The two others kind of values – spiritual or mental/psychic and sacred - are eternal. Both of them are the source of profound gladness, but only the sacred value is able to give the ultimate sense
to all human aspirations and endeavors. The sacred value is bound up almost exclusively with religion in Scheler’s philosophy. Tischner writes with disapproval of a tendency to sanctify “humanity”, “nation”, “fatherland” or “history” (26). On the other hand, the very existence of this tendency proves that spiritual (mental/psychic) values need to find their sense in something which is absolute, in the value of the sacred.

What makes a certain conviction particularly important is its relation to the value of the sacred. And if it is so, it seems that denominational/individual (nondenominational) character of a certain belief does not create any, at least any substantial, difference. Beauchamp observes, however, that nondenominational and even denominational convictions could be, and sometimes in fact they really are, outlandish, for instance the “messianic views held by serial murderers” (16, p. 271).

It seems necessary to distinguish clearly between the “special status” and “the obliging force” of such convictions. The relation to the highest value gives them special status. It does not mean, however, that patients’ demands based on such convictions should always be honored. The problem which of them should and which should not be honored is a matter of the process of balancing rather than specification of judgments. The very expression “outlandish/bizarre convictions” seems to indicate that they are not/not yet balanced or, even more, that they are, due to their nature, the unbalanced (unable to be balanced) ones.

When starting the process of balancing the norm of tolerance with the essential bioethical principles, it should be emphasized that having and expressing religious convictions is recognized as a manifestation of the patients’ autonomy. It should be highlighted that accepting the authority of the dogmas of a certain religion, or the authority of the church, does not constitute a renunciation of autonomy (4, 16). Thus, even if the fact of yielding to an authority actually seems to require the adoption of a certain passive attitude, this is still accompanied by an activity on the meta-objective level, i.e., the very act of one’s choice to yield to this influence (29).

Religious convictions can be expressed by: (i) actually autonomous patients, (ii) patients, who, although at the very moment when the decision regarding medical treatment should be undertaken, are not autonomous, but previously have announced their will to be/not to be cured in a certain way, (iii) patients who are actually unable to decide autonomously upon the medical conduct and have never before announced their will, in particular it occurs in the case of very young children, especially newborns. Taking into account the very special status of religious beliefs and respecting the principle of autonomy as a rule, the decision based on religious convictions should be honored. The exceptions ought to be limited to cases in which a vital social (state’s) interest is at stake (for instance the treatment of infectious diseases).

Indicating the guidelines which should regulate health care professionals’ conduct in the case of religious-based decision of the autonomous patient, it could
be stated that their moral obligation seems to be restricted to ensuring that the
decision is really an autonomous one. It means that the patient, when making the
decision, fulfils the criteria (acting intentionally, with understanding and without
controlling influences) of being an autonomous subject (4).

The latter of the situations mentioned above seems to be more complicated.
The patient is unable to decide at the moment but his/her preferences are known
(through advanced directives or proxy consent expressed by the person who
knows the patient’s will). Before acting/withholding action in this case, the
health care professionals should consider if the patient has fulfilled the criteria
of being an autonomous subject when he was expressing his will and if the
person giving the proxy consent and/or legal document (advanced directives) is
dependable.

To refuse, even if religiously motivated, a recommended medical treatment
for a young child constitutes overreaching of parental authority. Sharing the
Martin Buber philosophy of education, it could be assumed that the proper aim
of parental power is to protect and help their children to actualize their
autonomy. Buber obliges the parents to consider their child as “predisposed to
becoming an exceptional and unique person and thereby the subject of a
specific form of existence – understood as the task that can be fulfilled by this
person only” (30, p.149). The purpose of the child’s education is to be realized
by the holistic development of children in their biological, psychological,
social, and spiritual dimension. Refusing a necessary medical treatment could
be recognized as a decision which makes it extremely difficult/impossible to
comply with the realization of biological development of the child. And
obstacles in biological development obviously interfere with the child’s
development in other dimensions of human life. Therefore, it could be
concluded that parents who deny their children an effective treatment, no matter
if such a decision is based on religious convictions or – for instance –
philosophical views, have overridden their parental rights (31). It should be
emphasized than that in this case health care professionals deal with the
decision which – regarding its foundation – is not based on parental rights, and
– regarding its content – is harmful for the child. Health care professionals are
obliged, therefore, not to obey the parents’ decision but to act according to the
norm of a so called ‘justified paternalism’ (4).

Balancing the principle of the respect for autonomy with the principles of the
beneficence/ nonmaleficence is probably one of the main issues in contemporary
bioethics. Taking into account that religious traditions usually define what
“goodness” is and what “evil” really means, but the understanding of these ideas
differs from one tradition to another, it seems reasonable to claim that the
principles of beneficence/nonmaleficence should be considered only “inside”
traditions (32). It does not mean, however, that there are no “commonly”
recognizable goods/evils.
Refusal on the base of religious convictions, of certain methods of treatment - perhaps surprisingly - has led to a new knowledge and elaboration of new medical procedures which are undoubtedly advantageous form the point of view of the principles of beneficence/nonmaleficence. Jehovah Witnesses’ refusal to blood transfusion is considered as a driving force to promote the development of blood-saving methods of treatment (33, 34, 35, 36, 37). These methods are important not only from the point of view of the principles of beneficence (elaboration/developing of new beneficial medical treatments) and nonmaleficence (avoiding risks related to transfusion), but also from the point of view of the principle of justice (the problem of allocation of scarce resources of blood and blood products) (35). However, at least some of religiously motivated decisions regarding medical treatment can be conflicted with the principle of justice. It occurs when a patient demands an excessive (also in economical terms) (16) and, in particular, a futile treatment (38, 39).

It should be emphasized that the very notion “futile treatment” remains ambiguous. How should futility be measured? (40, 41) Halliday observes that the concept of futility could be useful only if it were understood in the social context (42). Such an understanding has to include a social consensus regarding the fundamental issues of the philosophy of medicine: purpose(s) of medicine, understanding of health and illness, etc. It would also probably be necessary to reconsider some questions related to the social and political philosophy, for instance if the state, which pays for religious education (as it takes place in Poland), should also provide for free medicines and methods of therapy needed from the point of view of Jehovah’s Witnesses. Dwelling on these issues well exceeds the scope of this article.

Conclusions

Multiculturalism or rather pluralism of contemporary societies poses the fundamental philosophical, in particular ethical, questions with a new force. What do “true”, “goodness”, and “beauty” really mean? Moral communities which constitute pluralistic society seem to have given different but at the same time equivalent answers (43). Understanding the notion of “tolerance”/ “intolerance” is becoming more and more the crucial issue (44, 45). Undoubtedly, religious diversity and tolerance are among the key elements of cultural pluralism. Health care have to face a challenge of providing ethically acceptable medical treatment for patients belonging to different cultural (religious) traditions. When “ethically acceptable” means first and foremost: acting in accordance with the patients’ informed consent or rather informed choice between alternative therapeutic options (46). Taking into account that the processes which have led to the pluralization of contemporary societies will continue to operate in the predictable future, it seems necessary to prepare health care professionals and medical students to deal with the moral challenges of the pluralistic world (8, 47).
REFERENCES


Author’s address: L. T. Niebrój, Department of Philosophy and Pedagogy, Silesian Medical University, Medyków 12 St., 40-752 Katowice, Poland; phone: +48 32 2088628, e-mail: lniebroj@wp.pl