e -Cases in Ethics

Religious Diversity:
The Limits of Accommodation

- A Hmong husband refuses a brain operation for his wife who must have blood drained from a brain stem herniation that is on the brink of rupturing. He would rather that a Hmong priest heal her with chants and prayers because, he believes, “one of her souls is lost.”

- A seven-month pregnant Jehovah’s Witness involved in a car accident is hemorrhaging internally, but she refuses blood products based on religious convictions. After she lapses into unconsciousness her husband repeats the request of his wife using the same religious rationale.

- Amy, a mature 15-year-old Christian Scientist, skips her normally scheduled dialysis with her parent’s permission. When called by the nurse at the hemodialysis center, she stated that she has “decided to seek healing though faith alone. My family supports me and believes in God’s power to heal my kidneys.”

- A middle-aged resident suffering from a debilitating illness in Catholic long-term care requests that a Reiki Master be allowed to provide her “energy therapy.”

- A Jehovah’s Witness after a normal vaginal birth has the placenta surgically removed; however, she hemorrhages. She refuses blood products. She is a single parent. As her situation worsens she is placed on a ventilator but continues to refuse blood products. The hospital asks the court for an emergency hearing and the judge grants them the authority to give her blood products.

If an ethics committee explored these scenarios it would most likely discover that healthcare professionals handle patients’ religiously-motivated treatment requests and refusals in inconsistent ways. A professional may be willing to accommodate some requests based on religious motivations and reasons, but not all. While a professional may not have the time or resources to reflect on consistency of action, it is the responsibility of power bodies, such as healthcare institutions, to examine with publicly defensible reasons whether similarly situated patients are treated in a similar fashion. If an institution allows its employees to accommodate some, but not all religiously motivated treatment requests, the institution would need to address the inconsistency to ensure patients were treated in a fair and equitable manner.

As soon as an ethics committee scrutinizes the issue, it will likely confront the peculiarities and challenges of religious diversity. Institutions have made great strides in accommodating many forms of diversity: racial, cultural, ethnic, and gender. However, an ethics committee would have to ask why it is acceptable to accommodate only some religious reasons and not others? Sorting out this question becomes all the more complex because of medical and cultural trends. Currently there is a convergence of two trends in healthcare that fosters religious accommodation, namely, the rise of complementary and alternative medicine, which in some cases utilize some practices taken from non-Western religions, and the desire of healthcare institutions to promote spirituality in healthcare. In addition, the U.S. culture, based on constitutional guarantees to religious freedom, manifests an everyday willingness to tolerate a person’s religious preference no matter how different it may be from our own. This “live and let live” attitude is based on the fairness expressed in the golden rule—“do unto others…” However, religious healthcare institutions sometimes find themselves being publicly questioned when there is a perception that they have exceeded the bounds of accommodation. Catholic institutions for example, have been criticized for offering complimentary and alternative forms of healing such as Reiki. Such disapproval prompts ethics committees to inquire whether there are any boundaries to accommodating religious preference, and if so, on what basis would the religious institution honor some religious preferences and not others? What should guide practice?

One way to handle these types of issues in the above scenarios is to avoid considering the limits of accommodating religious diversity all together. One way would be to simply frame the question as a patient’s rights issue. In this case, whatever religious preference a patient/resident espouses would be honored, as in the cases of the Jehovah Witness’ blood refusal. However, this framing evades exploring what religious preferences should be accommodated. In fact, the resolution implies that all religious preferences should be accommodated by an institution; however, accommodating this practice might force an institution to act against its moral commitment articulated in its mission and values.

Another but inadequate resolution would be to label others’ religious preferences, as seen from a Western medical perspective as superstitious and quackery, and then to dismiss them out of hand, as might be the case in considering the Hmong husband’s reasons. This resolution epitomizes an arbitrary and dangerous handling of religious accommodation. Staff member’s idiosyncratic labeling of a religious view as incomprehensible fundamentally implies a disregard for protecting patients’ religiously-based preferences.

Preferable to these two extreme approaches would be to investigate whether the accommodation is in fact religious. Some preferences that seem religious at first blush might, after inspection, be cultural preferences, not religious. For instance, some religious healthcare institutions have recently faced allegations that they should not be permitting Reiki within their wellness programs. In fact, Reiki is a Japanese medical practice created in the late-nineteenth century by a practicing...
A more complicated resolution that becomes thoroughly mired in the thick of religious accommodation is to investigate whether the patient’s treatment request, or refusal, is based on an accurate understanding of his or her religious tradition. Does the adherent to a religious tradition accurately understand the religious doctrine? If it is a misinterpretation, should the institution nonetheless honor the patient’s request simply because it is religious? Such an exploration requires developing cultural competency about what different religious traditions believe. Pastoral counseling, sensitive to these beliefs, can be used to clarify the divergence between the tradition and the patient’s understanding. This might press the ethics committee and pastoral counselors to better understand another religious tradition by exploring, for example, whether the tradition’s teaching on this admits any exceptions?

An important avenue of investigation for an ethics committee is to uncover whether the law places any boundaries on religious accommodation. The courts have set up some guideposts for when treatments can be accommodated or limited based on religious reasons. One limitation on religious reasons applies to parents who refuse life-sustaining treatment for children. The Supreme Court has reasoned that you can martyr yourself, but you cannot martyr your children. For example, Christian Scientist parents could refuse life-sustaining treatment for themselves on religious convictions, but they could not make the same decision for a child. In the above case an individual assessment is necessary to determine whether a mature adolescent like Amy may have a mature enough understanding of her faith to assess whether she is being mislead or martyred by her parents. The restriction for making decisions based on religious reasons becomes all the more complicated when applied to the Jehovah’s Witness who is pregnant and is refusing blood transfusion to save her life and that of the fetus. State courts have varied widely on these maternal-fetal conflicts; however, many ask some of the flowing questions to determine whether intervention is warranted: Is the intervention the last resort? Has every alternative been exhausted? Is there a high probability that they will be successful in saving the life of the fetus?

The courts will also not allow a sole-surviving parent to forego life-sustaining treatment on religious grounds, or any other grounds for that matter, if that would make the state responsible for the children. Thus, the Jehovah’s Witness who was hemorrhaging after a normal delivery could be forced by the courts to accept treatment since she is the sole-surviving parent. However troubling this outcome, it would be worth exploring whether the institution took the steps necessary to provide for alternative blood products to assure adequate levels of volume replacement.

The ethics of religious accommodation are complicated by the need to balance the tension of honoring different religious traditions while protecting the integrity of the healthcare institution. To more fully explore the guideposts, ethics committees might consider not only focusing on individual cases of accommodation, but also tracking trends of cases in which religious preferences were not accommodated. With that data in hand, they might then explore whether there is consistency both in reason and action for not accommodating them. Second, ethics committees would want to know where to turn for resources on how different religious traditions think about health matters, for example, by tapping internets resources (see http://www.che.org/ethics/index.php?id=5 or http://www.che.org/ethics/topics.php?id=103). Third, since new immigrant religions are on the rise especially in urban settings, ethics committees might want to consider how they are preparing their hospital colleagues to face the burgeoning challenge of religious and cultural competency.