Whither religion in medicine?

doi:10.1136/medethics-2019-105892

Michael Dunn

Few topics in medical ethics stimulate as much heated debate as the question of the proper place of religious beliefs in medical practice. Typically, this debate is orientated towards questions about the religious beliefs held by medical practitioners, and in particular the appropriate limits that ought to be placed on these beliefs shaping care in ways that might impact negatively on patients' interests. In this issue, however, it is the religious beliefs of patients themselves, and how these beliefs ought to be responded to by clinicians, that is the focus of analysis.

In their Feature Article, Greenblum and Hubbard (pages 705–10) articulate a strong position in response to this issue. Their fundamental claim is that clinicians should not deliberate about religious commitments with religious patients when these patients are drawing on these commitments in the medical decision-making process. They present two main arguments in support of this claim: the *public reason argument* and the *fiduciary argument*, and they contend that the discussion of religious considerations should be compartmentalised and farmed out to another appropriately placed person, such as a member of the clergy. Stimulating six commentaries that interrogate aspects of both arguments and the authors' practical proposal, Greenblum and Hubbard's paper gets to the heart of the challenge of reconciling the public role of medical practitioners with the private encounters that substantiate the performance of this role.

PUBLIC REASON AND PRIVATE LIVES

Greenblum and Hubbard's first argument is that clinicians ought to limit their deliberations in decisions made with patients to presenting 'considerations that any reasonable person could recognise as counting in favour of something' (page 707). Drawing on the work of John Rawls and Robert Audi, the authors discount the place of religious reasons in such deliberations when these are inconsistent with, or cannot be translated into, public reasons. Their crucial move here is to connect the public role of doctors to a requirement to exercise public reason alone on the grounds that 'physicians are relevantly akin to public officials' (page 705).

This argument is challenged across a number of the accompanying commentaries. Schuklenk (see page 713), who is supportive of the authors' conclusion, contends that it is not doctors' role as being akin to that of a public official that grounds the argument for excluding religious considerations from medical decision-making, but their duties as *self-governing professionals*, which are uncontroversially secular in nature. Certainly, as Colgrove (see pages 716–18) points out, the mere fact that clinicians' roles intersect with certain public functions (resource allocation, being in receipt of public funds, etc.) does not imply that these clinicians are required to wear the commitments of their 'public officialdom' hats when they are constructing and conducting interpersonal relationships with patients that are focused firmly and solely on meeting their obligations to these individual patients.

Griffin's (see pages 714–15) elegant response to Greenblum and Hubbard's reliance on Rawlsian public reason takes issue with what she sees as the unjustified normative positioning that follows in the wake of foregrounding non-sectarian reasons recognised by 'reasonable people'. Griffin argues that the foundational concept of public reason is an 'empty' and 'hollow' vehicle that functions to enable certain substantive normative commitments (in this case, those advanced within the profession of medicine) to be smuggled into medical practice in ways that lead to a paternalistic shaping of patient care that functions to suppress pluralistic values and to unjustly burden patients and their families, despite its claims to the contrary. This concern is paralleled in a related criticism of public reason expressed by Eberly Jr. and Frush (see pages 719–20), who claim that the 'opposition of 'public reason' to 'religious reason' is simply the preference of one particularist rationality against another' (719).

A FIDUCIARY DUTY TO SET ASIDE PATIENTS' RELIGIOUS COMMITMENTS?

Greenblum and Hubbard's second argument is founded in a particular articulation of the fiduciary demands of the doctor-patient relationship that leads them to claim that clinicians who engage in religious deliberation with their patients will undermine trust in the medical profession. This view of the fiduciary relationship envisages trust as being reliant on clinicians 'making medical decisions based on considerations that are consistent with current medical science' (page 708).

Eberly Jr. and Frush's main counter-argument is that this account of the fiduciary duty that undergirds the doctor-patient relationship is problematically reductive. They take the intuitively persuasive view that 'the 'fiduciary' nature of such a relationship means that sick and suffering patients entrust not merely the facts of their disease process but also a core part of themselves to the physicians caring for them' (page 720). This view does indeed seem to capture something important about what is owed to patients, as a matter of trust, in medical encounters. What would follow from this reformulated view of clinicians' fiduciary duty is a more robust patient-centredness in the delivery of care and the negotiation of medical decisions. A patient-centred approach of this kind would require taking the particular concerns of patients seriously in shaping what clinicians tell and offer patients, and would situate clinicians and patients as equal partners in a dialogical process of responsive care built on established models of shared decision-making.

Being appropriately and sensitively responsive to a patient's religious commitments in the decision-making process would be acceptable on Eberly Jr. and Frush's reformulation of clinicians' fiduciary duty, but would not imply that doctors have free licence to invoke religious considerations in the absence of the patient first expressing relevant religious beliefs and how these are shaping her reflections on the decision at hand. Indeed, Colgrove draws attention to some argumentative slippage in Greenblum and Hubbard's paper, and particularly in their presentation of the case of Mr. Kamala and Dr. Chatterjee, that is relevant to understanding the normatively appropriate structuring of the doctor-patient relationship here.

Even if persuaded by the counter-arguments to Greenblum and Hubbard's formulation of clinicians' fiduciary duty, there might well be residual concern about clinicians' ability to marshal the

religious commitments expressed by patients in ways that advance an appropriately nuanced management of patient-centred decision-making. This competency concern is raised by both Schuklenk and Gill (see page 721) and looks to have significant force. However, whether a pragmatic concern about the religious and spiritual competency of clinicians ought to lead to the conclusion that, as Eberly Jr. and Frush put it, doctors should focus on how they can do theology better in their encounters with their patients, rather than ceasing doing theology at all, will depend on how persuasive readers find the various arguments presented here.

ETHICAL STEWARDSHIP OF NEW AND FUTURE TECHNOLOGIES

Elsewhere in this issue of the journal, a handful of papers place ethical issues arising through the advancement and translation of new technologies into medical practice and research under the microscope.

Kong (see pages 732–37) expresses concerns about the ethical justification for new photographic techniques for facial phenotyping that are increasingly being deployed in psychiatric genomics to observe and examine abnormalities among individuals with neurodevelopmental disorders. For Kong, the historical misuse of photography in this context for eugenic purposes, and the potential for these techniques to exacerbate the stigmatisation of people with impairments given the social meaning and objectification that are associated with, and characteristic of, photographic imagery, mean that new safeguards need to be introduced in this medical research context before these techniques can be embraced more widely.

The other technology examined across two papers in the journal concerns the future use of ectogenesis, or 'artificial wombs'. Being debated here is the distinction between artificial womb technology and the established practice of neonatal intensive care that provides incubation to prematurely born babies. Colgrove (see pages 724–27) argues against this distinction on both conceptual and normative grounds. Romanis (see pages 728–31) defends the conceptual distinction that gestatelings, the human beings being gestated in artificial wombs, are not newborn as they have not yet emerged from the process of gestation. For Romanis, this is significant because the main differentiating feature between a gestateling and a newborn, premature baby is that the gestateling has not completed all of the biological state changes associated with birth. Whether the newborn baby and the gestateling have the same moral status, as Colgrove claims, remains an open question for Romanis, but is obviously one that is likely to provoke further analysis and debate in this rapidly evolving area of reproductive ethics.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.