Mark F. Carr, "The Spectrum of Religion and Science in Clinical Encounters," *The Journal of Clinical Ethics* 19, no. 4 (Winter 2008): 360-70.

The Spectrum of Religion and Science in Clinical Encounters

Mark F. Carr

Mark F. Carr, MDiv, PhD, is the Director of the Center for Christian Bioethics, a Member of the Faculty of Graduate Studies, Director of the MA program in biomedical and clinical ethics, and Professor of Ethics in the School of Religion at Loma Linda University in Loma Linda, California, *mcarr@llu.edu.*

INTRODUCTION

Some clinical practitioners may hold biases toward religious beliefs and practices, and some patients may hold biases toward secular medical science and its practitioners. When this happens, the resulting misunderstandings and poor communication can exacerbate biases and contribute to adverse clinical interactions. In this article, I posit a faith-science continuum as an analytical tool to help remedy these problems.

Practitioners and patients/families may come to clinical encounters from widely divergent places on the faith-science continuum, making it more difficult for the parties to grant full credibility to the other, and damaging the relationship at the heart of providing care. This is particularly true when religious practices are seen as causing harm. The following case illustrates this; it includes true and fictional elements.

CASE STUDY

It was rare for Mr. Crockett to bring one of his children to the doctor, but several hours after punishing nine-year-old Jimmy for being lazy, he worried there was something wrong. Jimmy seemed languid and appeared anemic. In Dr. Stapul's office, Mr. Crockett noted that Jimmy "normally responds well to a whuppin'." Mr. Crockett added that he did not much like doctors, and "hoped against hope" that Dr. Stapul would help.

Dr. Stapul noticed some stitches on Jimmy's lower lip, and Jimmy and his father boasted about Momma's fine stitching: "Praise God, she's always been good with a needle and thread." Alarmed, Dr. Stapul asked why Jimmy hadn't been brought to her office for stitches, and Mr. Crockett said, "We don't generally trust you people. Jesus is our healer!"

After a few more questions put to Mr. Crockett, Dr. Stapul asked to examine Jimmy more closely alone. Before leaving the exam room, Mr. Crockett leaned over Jimmy and whispered, "Remember, Daddy loves you." On careful examination, Dr. Stapul found no evidence of any physical damage from the spanking. Dr. Stapul asked Jimmy he if thought his dad ever hit him too hard, maybe when he was angry. Jimmy responded, "No. Mom and Dad never spank me when they're angry. It hurts them more than it hurts me." After more careful examination, Dr. Stapul felt confident that there had been no physical abuse. But she did not agree with spanking in general, and while she considered herself someone who believed in God, she found the Crockett family's attitudes and behaviors strange, even disturbing.

Dr. Stapul asked Jimmy to wait outside the exam room and asked Mr. Crockett to come back in. She asked him about his practice of "whuppin'" his children, and said that she had momentarily considered calling Child Protection Services.

In response, Mr. Crockett turned combative. "I don't raise lazy children Miss Stapul; 'spare the rod, spoil the child.' You go right ahead and call them — and the police too! I can raise my child as me and God see fit." Then Dr. Stapul heard him say, softly, "I knew we shouldn't have come here today."

In a case like this, deeply differing points of reference work against the effort to help the patient get proper care. Due to the gulf between the points of reference of the physician and the patient's parents, future possibilities to treat Jimmy and his siblings, and to aid the Crocketts in finding other ways to discipline their children, may have been foreclosed.[1] I will consider this case using the faith-science continuum. Depending upon where one falls on this continuum, the level of credibility and respect afforded to another may vary significantly. Considering where physicians and their patients may find themselves on the continuum may overcome bias and enhance the healing efforts of the clinical interaction.

THE FAITH-SCIENCE CONTINUUM

Mr. Crockett does not trust physicians. Not because he thinks they are out to get him or his family, rather because he perceives that consulting with physicians runs counter to his faith. He thinks physicians are overly scientific, antireligious, secularly trained, and acculturated agents of a godless society that is against him and his kind. He is not alone. He may be confused, but he is one of a multitude. He relies on a conservative, deeply religious worldview that may assign little to no relevance or authority to science. On the contrary, sources of authority for such people include scripture; church, synagogue or mosque; and the authorities within these structures.[2] In some cases, on points of reference such as corporal punishment of children, there is a high likelihood of difference in values with their physicians. Many conservative religious people feel it is essential to administer corporal punishment to their children in order to raise them properly.[3] One minister told me that had his father not beat him — had he not beat all his children — none of them would have grown up with any measure of decency.

Mr. Crockett upsets Dr. Stapul, not because she thinks he doesn't love his children, or because she doesn't think he has the right to believe whatever he wishes, but rather because she takes him to be ignorant, backward, abusive, and unable to recognize that she has the best interest of his children in mind. She perceives the practice of using corporal punishment based upon religious conviction as a vestige of a bygone era that must be forcefully rejected in the face of scientific data that proves that physical discipline of children is abusive. She is not alone, and she is not confused. The gulf that lies between her and Jimmy and his parents affects her ability to provide care, nonetheless.

Her worldview and its subsequent authorities are very different than those of Mr. Crockett.[4] In the words of Edgar Ledbetter, MD, former director of the Maternal, Child, and Adolescent Health Department of the American Academy of Pediatrics, "A disappointing number of persons rely on theologic or ideologic convictions for personal ethical decisions, appearing to ignore other valuable resources" such as "modern medical care."[5] Thousands of physicians, like our Dr. Stapul, have a worldview that is both religious *and* fundamentally oriented by science. They may deeply value religion and religious practices, but this is balanced with similarly deeply held values of science. When the two sources of value come into conflict, typically it is scientific values that modify religious values, which is certainly true of the issue of corporal punishment. For most religiously devout physicians, primary understanding of corporal punishment will come through a scientific interpretation of data. But data is largely irrelevant to people like Mr. Crockett.

Griffith and Griffith in their article, "Addressing Spirituality in Its Clinical Complexities: Its Potential for Healing, Its Potential for Harm," highlight the sometimes stark differences in worldview that present in the clinical encounter. Their patient, Lutchi, was a deeply religious person whose mother, Thelma, "explained that she watched, because it was her duty to watch, every health professional they met to see if they were treated with respect." Griffith goes on to describe the "two competing paradigms for treating" Lutchi; one from the clinician who "seeks the best-validated scientific facts" and the other from the patient who, in Lutchi's case, needed to pause during a clinical interaction in order to hear, literally, the voice of God.[6]

Before continuing further, it is important that I be clear about the issue of physical discipline of children: religion or its practice can never justify the use of a switch, or one's hand, or anything with such force that it raises a welt on a child.[7] The positive rights of parental autonomy do not trump the negative rights of a child to be free of the personal, physical harm of corporal punishment.[8] But my views, or those of any physician, are unlikely to convince parents like Mr. Crockett, in large part due to our widely differing points of reference — hence the value of what I am calling the faith-science continuum.[9] This remains true regardless of what data set we might use in the effort to convince parents otherwise — true believers of this sort are deeply suspicious of medical science and data.[10]

The faith-science continuum is not complex. Imagine a worldview based solely on faith on one end, and a worldview based solely on science on the other. Place the most stereotypical person you can imagine who might operate at either of these extremes. The person of faith at the extreme end completely rejects the person at the extreme end of science — and vice versa. The person of faith is sure that the person of science is going to burn in hell for unbelief, and the person of science is sure the immoderately devout person is an ignorant buffoon. Now place these two people in an examination room together over the care of a child.

I purposefully highlight the extremes for heuristic purposes. I agree with those who, like Kenneth Hickey and Laurie Lyckholm, see medicine and religion as "allies in their mission of assuaging human suffering."[11] My own faith tradition has dedicated itself to finding a healthy balance of modern medical science with the "healing ministry of Jesus Christ."[12] I am routinely surprised by skeptical attitudes among persons of faith toward modern medical practitioners. Recently, at a meeting with the Health Minister of Afghanistan, we heard that Muslim Afghanis are routinely skeptical of the secular medical scientific orientation of their physicians. In the ideal, medicine and religion are partners in the healing endeavor, yet this is often not the attitude of those present in the clinical encounter.

I am optimistic toward the possibilities of positive alliance between medicine and religion, yet religion and religious practices also routinely cause suffering. This is one of the primary points made by Griffith and Griffith in their seminal article. Using the metaphor of a "flowing, refreshing stream" to represent the positive elements of religion, they further recognize the stream may have pollutants "almost toxic in their effect on people."[13] Clinicians, medical science researchers, and allied religionists have a moral obligation to do all that we can to move religion and its practices away from causing suffering. There are reasons to be hopeful for the future as knowledge increases and spreads throughout communities of faith. For instance, the literature focused on violence toward women is making an impact. One positive example is the work of Daniel C. Maguire and colleagues at the Pilgrim Press and the Religious Consultation on Population, Reproductive Health and Ethics. Production of the book *Violence Against Women in Contemporary World Religion: Roots and Cures* and the DVD "What Harm Is It to Be a Woman?" is encouraging.[14]

To nuance the delineation of points along the faith-science continuum, it is important to note the distinction between the official teachings of a religion and the religious practices of its adherents. It is common to find gaps between the practices of the faithful and the official teachings of any given religion. One of my own experiences is illustrative. Early in my tenure as a professor here at Loma Linda University, a member of a congregation I once served called for help. She needed an official letter supporting her refusal to immunize her child so the state would "leave her alone." Of course, no one at the university would officially recognize the position of objection she was taking. As healthcare practitioners, we strongly support immunizations. Furthermore, clinical practitioners of the same faith working here found this mother's religious convictions on the point rather odd.

ASSIGNING CREDIBILITY ON THE FAITH-SCIENCE CONTINUUM

In establishing this faith-science continuum and asking practitioners to reflect on the credibility granted the religious other, I assume the following.

1. Biases we carry into the clinical encounter, from either side of the continuum, will negatively affect the relationship established in the clinical encounter.

2. Physicians may be more likely to lean toward the science pole, while patients/families may be more likely to lean toward the faith pole of the faith-science continuum.
3. Recognition of one's location on the continuum, whether as patient or practitioner, will enhance the possibilities for a positive healing relationship in the clinical encounter.
4. Enhanced understanding in both parties will likely include increased compliance toward treatment plans.[15]

Placing a Parent on the Credibility Scale

Some physicians may assign different religions different amounts of credibility. Some religious practices are more credible than others. Recall a case in Utah of the "watermelon baby": 21-month-old David Fink's parents, members of a Christian cult, thought him to be the Christ child. For some reason they fell on the idea that the Christ child could be kept pure by feeding him only watermelon and lettuce. The state took the child under protective custody — justifiably so.[16] While Christianity would place high on most people's credibility scale, this particular practice of Christianity has no credibility. Why?

I suggest the following criteria as a way to assess the credibility of a religion.

Age of the religion. The older the religion, the more likely it will carry a higher level of credibility. This and the following criteria – the number of a religion's adherents — work together; the older the religion, the more likely there will be more adherents.

Number of adherents. The larger the religion, the more likely it will carry a higher level of credibility. Again, with the age of the religion and an increased number of adherents, it is more likely that there will be a broad recognition of and agreement with the values of the religion, thus the connection to the next criterion.

Similarity of value systems. The more similar the value system of the patient to the physician, the more likely the physician will rank the patient's religion high on a credibility scale. This is particularly true when focused on the issue of harm. When the religion of the patient — or the patient's parents — is harmful to the patient, the more likely the religion will suffer from low credibility.

Agreement with Western medical practice. The more the patient/parents agree with the medical practices of the physician, the more likely they will have a higher level of credibility in the mind of the physician.[17] On the other side, physicians' openness to alternatives outside the routine practice of Western medicine is often an essential element of the credibility the patient accords the physician.

As noted above, another element that is important in establishing credibility in a clinical encounter is how closely the patient/family follows the routine expression of their stated faith. The practice of their religion may well be at odds or out of step with the official teaching of the religion. The data generated from studies of religious families, primarily Christian religious families in North America, report that the use of corporal punishment is common. The majority of North American Christians indicate, however, that they do have strong confidence in scientific data. Because there is data that spanking has a potential for harm, the Christian community is pushed to address it as problematic.[18] It will take some time, however, to move those on the far end of the faith side of the continuum toward acceptance of these data.

In the case noted at the beginning of this article, Mr. Crockett describes himself as a Christian. Further discussion may reveal more about the specific tradition of Mr. Crockett and his family. In the case above, Dr. Stapul discovered two things that led her to assign lower credibility to Mr. Crockett: corporal punishment and the wound care provided by the mother. It is common for some Christian traditions to allow corporal punishment and of course, physical harm, as a result of such punishment, cannot be tolerated.[19] The fact that the mother used her skills with a needle and thread on her child's lip is an odd aberration. The vast majority of Christians would urge the Crocketts to go to a physician for such wound care. The fact that the family did not is justification for lower placement on the credibility scale. But, in the absence of physical abuse, Dr. Stapul cannot justify calling Child Protection Services merely because she finds the Crockett family to be bizarre.

Placing the Physician on the Credibility Scale

From the perspective of the patient toward the physician, placement on the faith-science continuum will influence the overall effectiveness of the clinical encounter. Should Mr. Crockett perceive that Dr. Stapul does not respect his family's religion and the way they practice it, he is less likely to follow her prescribed treatments.

Patients bring to the clinical encounter an equal number of biases that affect the way they perceive the credibility of the physician. Many people of faith do not immediately trust those who act from a scientifically oriented point of reference. The past includes occasional instances when medical science found to be in error,[20] and some on the far extreme of the faith side of the continuum continue to recall and rehearse those missteps. A settled disposition to distrust medical science and its practitioners characterizes many on the extreme faith side of the continuum.

The clinical encounter may begin from a very challenging place when the patient and/or parents bring such biases with them. Patients and their parents may grant very low levels of credibility to physicians should they intuit that the physician thinks poorly of them for their faith convictions.

Years ago, Robert Veatch noted the benefit of "deep values pairing" in the physician-patient relationship.[21] This deep values pairing would exist if there were "alignments based on the most fundamental worldviews of the lay person and professional." In such cases, argues Veatch, there would be "some hope" of achieving the patient's best interest in clinical interactions. This type of values pairing happens both explicitly and subtly for many in our society. Some who can afford it purposefully seek out clinicians with similar worldviews. Unfortunately, too many in our society have insufficient funds or lack sufficient continuity of medical care for themselves or their families. Consequently, such values pairing may be difficult. Should this type of pairing exist, the distance between physician and patient on the faith-science continuum may be close enough to help rather than hinder the healing effort.

Veatch does not imagine that pairing of clinician and patient with similarly oriented worldviews will eliminate the problems of bias. He does argue, however, that the communication bias found between the two parties is reduced, such that the influence of the clinician's medical knowledge is more likely to persuade the patient: "There will be biases, but they will be less corrupting of the patient's own perspective." In fact, when "unconscious bias and distortion occur" on the part of clinicians, deep values pairing "will tip the decision in the direction of the patient's own system."[22]

Studies more recent than Veatch's have focused on notions of *spirituality* — rather than *religion* — as expressed in specific faith traditions. My assertion here has no specific interest in that body of literature. However, at least one recent study notes the relevance of Veatch's position. Mark Ellis and James Campbell examine data on concordant spiritual orientation in the physician-patient relationship. They cite "differing belief systems and physician attitudes" as possible barriers. Among other things, the barriers result in "adverse impact on medical care."[23]

In the absence of deep values pairing, patients and their parents do bring questions about the credibility of the physician into the clinical interaction. Diplomas mounted on walls do not matter in these instances; certificates of accomplishment are held as meaningless. As stated above, scientific data and evidence-based medicine may not persuade. Let me suggest the following as possible contributing factors that influence the perceptions of physician credibility for those leaning heavily toward the faith side of the continuum.

Expression of openness toward alternative or nonscientific therapies. While physicians may at times remain deeply suspicious of the religion and/or religious practices of their patients, if they are aware of their own biases and stretch themselves to verbalize openness toward their patients' differing values, then their credibility will increase in the minds of these patients.[24]

Explicit effort to find points of common value. Similar to that which lends credibility to the patient in the mind of the physician, points of common value will help patients feel more confident in the credibility of their caregivers. When physicians make the effort to identify with the values of their patients, credibility increases.

DEVELOPING POSITIVE COMMUNICATION PATTERNS

At least three things will enhance clinical interactions over disputed matters such as the religiously inspired practice of corporal punishment.

Place yourself on the faith-science continuum. No doubt, most physicians are not "overly scientific, antireligious, secularly trained, and acculturated agents of a godless society," as Mr. Crockett believes them to be. Nevertheless, faith and religion are sufficiently important elements of our society and its members to merit the time spent pondering where one falls on the continuum. The scientific orientation of Western medicine is ubiquitous in American society. Equally prevalent, however, is belief in God and its expression. Science and religion have clashed in American history, but should we hold such clashes responsible for failed relationships in the clinical encounter? Some physicians have been clear in their opposition to faith.[25] Ellis and Campbell quote one physician: "I was pretty angry about their religious beliefs, because I thought that [those beliefs] stood in the way of them getting [the healthcare] they needed."[26] In pediatric cases, when a parent's faith is not sufficiently accepting of medical science, most physicians are inclined to override parental autonomy and seek the benefit that medical science offers the child.[27]

Be aware of your biases. Knowing where one falls on the faith-science continuum will help offset the effect of these biases.[28] Edmund G. Howe places heavy responsibility on practitioners in his comments on bias: "Seeing others as being different and of less moral worth than ourselves is a tendency to which we all are prone. The degree to which we do this is much greater than we have imagined. . . . It is especially important that careproviders know and accept that we all have this tendency, because, if they do not, it is unlikely that they will be able to overcome it. . . . It is critical for careproviders to do this to acquire patient's trust."[29]

If a physician consciously holds bias against religion and its believers, it behooves her or him to avoid practicing in an area where the majority of the population holds a strong faith orientation. Ideally, physicians are sufficiently open to "the other" such that knowledge of their own biases will push them to practice openness and toleration. Religious practices that are clearly harmful to children can never be acceptable. Physicians who practice in areas where harmful religious practices are more common may be able to find a way to interact with patients and parents in a way that will bring the community slowly forward out of abusive patterns. It may be possible to use local cases of family violence as illustrations that pull families away from practicing corporal punishment.

Minimize causes of conflict. Some contexts and attitudes may exacerbate tendencies to grant only minimal levels of credibility to each other in the clinic. Learning what prompts physicians to assign negative levels of credibility to patients and their parents with regard to religious practices will help if the physician decidedly avoids such prompts. Visual and audio prompts that aggravate should be kept to a minimum. Sometimes the simple expressions that people of faith use in casual conversation will set the physician off in a negative direction — and vice versa. Such prompts were deliberately noted in Mr. Crockett's dialog, with the end that readers might find themselves moved in a negative direction. C. L. Kawada and colleagues call such prompts "priming language," and assert that they may affect communication in the clinical encounter before either party is conscious of their bias or disposition toward the other.[30] As Howe notes in the article cited above on physician-parent interaction, such unconscious priming can exacerbate an initial bias and may prompt a physician to view a parent "with contempt." Without fully realizing what is happening in this adversarial interaction, physicians "may then see the parents as different and so treat them as outsiders, which may irreversibly thwart further meaningful communication."[31]

DISCUSSION

How might the use of the faith-science continuum enhance the analysis and development of the clinical encounter highlighted in the case study? First, clinicians must be more self-aware. Locating oneself on the faith-science continuum and reflecting how one assigns credibility to various religions and religious prac-

tices is essential. Second, awareness of the prompting cues that set the tone for the initial development of the clinical relationship may help avoid negative direction. Finally, helping the patient and/or the patient's family to orient on the faith-science continuum will prove beneficial as well. These three elements are especially important in the early establishment of clinical relationships. More lengthy and established relationships will have already developed positive patterns conducive to the healing relationship, in part because the characters have come to understand where each of them falls on the continuum. These steps are illustrated in the context of the case of Jimmy Crockett.

Self-orientation on the faith-science continuum. Dr. Stapul could work to become more aware of her own sense of religion and religious practice in living a full life. She might place herself somewhere in the middle, moving toward the scientific end of the continuum. When Mr. Crockett slowly reveals his strong bias against those on the science end of the continuum, it serves to aggravate Dr. Stapul's bias.

Despite both sets of biases, Dr. Stapul might attempt to communicate to Mr. Crockett that she also is a believer in God and that she thinks parenting is morally important. Her questions to young Jimmy may or may not change, depending upon her conversation with his father; she needs to find out the true nature of what the father does when he spanks his children. Dr. Stapul might then be able to share studies that report the use of spanking is ultimately more harmful than helpful, and move Mr. Crockett in a positive direction away from using it as a parenting tool. Helping him understand that people of similar religious conviction are at a different place on the faith-science continuum, and that they are equally serious about responsible parenting, may bring him slowly along in a positive direction.

Awareness of relational promptings. Mr. Crockett's comments may exacerbate any bias and differences in perspective between himself and Dr. Stapul. If she is tuned into his words and aware of the religious practices behind them, she may be able to avoid the aggravation. Awareness of and positive response to the promptings that set the tone for the clinical encounter may help Dr. Stapul shape the resulting relationship in positive directions. Rather than allowing herself to characterize the kid's parents as "strange," she may simply recognize that she is dealing with someone who is further to the faith side of the continuum than she is comfortable with. She will need to ask clarifying questions to help place Mr. Crockett's religious practices in context, and this can become a part of the initial history. She should continue to remain vigilant for abuse, but it may help her young patient to seek a commonality with his family's religious practices, rather than focus on what divides her from them. As noted above, one such point could be that parenting is a moral venture that is strongly shaped by religion and science.

Helping others place themselves on the faith-science continuum. In the effort to help Mr. Crockett clarify his own feelings toward seeking the help of medical science, Dr. Stapul can carefully push against Mr. Crockett's bias. Griffith and Griffith, in addressing an effort to move a patient from a "faith/or medicine, to a both/and position," write that it was their responsibility to "hold open an inviting space for him."[32] With subtle and open language that invites Mr. Crockett to explore his understanding of the nature of the scientific care his son will receive, Dr. Stapul can help orient Mr. Crockett toward the clinical encounter. She can enter into a positive conversation about the religious practices of the family and how it can remain open to the medical science that she hopes will help them. In the end, physician and patient may agree to disagree about what helps the healing endeavor, but if the physician can be as open and accommodating as possible, the enhanced credibility this affords in the mind of the patient will help.[33]

If Dr. Stapul recognizes that Mr. Crockett's skepticism and lack of trust is an important obstacle, and that he is a good distance away from her own position on the faith-science continuum, she can adjust her comments appropriately. She may even say something directly to the point of how she can understand his lack of trust in medicine and healthcare in general. His skepticism, however, does not need to get in the way of good care for his child. If the conversation goes well, Dr. Stapul may be able to describe the faith-science continuum to him. The fact that the continuum is simple and easy to understand should make it helpful in earnest dialogue with patients and their families.

After interviewing Jimmy, as she re-engages in dialogue with Mr. Crockett, Dr. Stapul can begin from this point of contact on the faith-science continuum. Mr. Crockett may still become defensive when she

describes for him her responsibility to the boy and to finding out the exact nature of his spanking. He will likely bristle at the idea that she would consider calling Child Protection Services. In response, however, Dr. Stapul can reiterate her agreement with his concern for careful parenting, while remaining firmly opposed to using spanking as a tool to that end. Emphasizing this point of commonality does not negate the differences the two may have over methods of parenting, but it may serve to keep Mr. Crockett closer to the clinic, as opposed to alienating him further from the help found there. If Dr. Stapul had been able to understand her own bias and resist the negative promptings she perceived in Mr. Crockett's statements, she may have been able to keep Mr. Crockett positively engaged in a constructive conversation aimed at helping him eliminate corporal punishment. Perhaps she could affirm his correction of his children without approving of the use of corporal punishment, and so continue the conversation. After finding as many points of commonality as possible, Dr. Stapul's assertion of the inappropriate use of physical correction might become more accessible to Mr. Crockett.

CONCLUSION

The mix of faith and science in the clinical encounter will often be volatile, but they need not clash. Some patients and their parents approach the healing endeavor with faith convictions that cling to skepticism of medical science and its practitioners. Physicians can be the enemy from this perspective. Some physicians run clinics that have little or no patience for religion and religious practices. Some physicians inadvertently or purposefully communicate a bias that is antireligious and derogatory toward persons of faith. Both parties would do well to place themselves on the faith-science continuum in an effort to understand and overcome their bias.

With an enhanced level of understanding, the clinical encounter will be more effective. I posit that the burden of greater effort must fall on physicians, as the level of their education regarding the socio-dynamics of the clinical encounter dictate that they be the ones to shape the nature of the encounter, such that the highest likelihood of benefit to the patient results. Awareness of and attention to points of reference on the faith-science continuum can improve this clinical encounter.

NOTES

1. F.A. Curlin et al., "When Patients Choose Faith Over Medicine: Physician Perspectives on Religiously Related Conflict in the Medical Encounter," *Archives of Internal Medicine* 165 (January 2005): 88-91. In their study of conflict over religiously oriented issues, the authors found disagreements falling into "1 of 3 overlapping domains": "Religious Doctrine vs. Medicine," "Ethical Controversy," and "Faith vs. Medicine." See also R.W. Wolfe and C. Gudorf, ed., *Ethics and World Religions: Cross Cultural Case Studies* (New York: Orbis Books, 1999), 118ff; K. Knott and M. Franks, "Secular values and the location of religion: A spatial analysis of an English medical centre," *Health and Place* 13 (2007): 224-37.

2. Some will argue with the basic assumption that people of deep religious conviction are suspicious of science in general and medical science in particular. I grant there is no natural or necessary reason for suspicion. There is authentic instruction from each of the Abrahamic traditions that urge the faithful to seek the care of medical practitioners when in need. However, today among many — perhaps the majority — of the faithful in these traditions, there is a common and I would argue ignorant attitude of suspicion fed and sustained by bad stories of the clash of religion and science. Additionally, hesitancy to seek medical care may be the result of frustration in previous clinical encounters. On such frustrations see S.K. Hull et al., "A Prevalence Study of Faith-based Healing in the Rural Southeastern United States," *Southern Medical Journal* 99, no. 6 (June 2006): 644-53. Among other things, Hull et al. found that persons who were dissatisfied with their medical care were more likely to use faith-based healers.

3. J.H. Baron, "Corporal Punishment of Children in England and the United States: Current Issues," *Mount Sinai Journal of Medicine* 72, no. 1 (January 2005): 45-6; D.A. Hines and K. Malley-Morrison,

"Cultural Contexts: Religion," in *Family Violence in the United States: Defining, Understanding, and Combating Abuse* (Thousand Oaks, Calif.: Sage Publications, 2005), 55-81; N. King, T. Butt, and L. Green, "Spanking and the corporal punishment of children: The sexual story," *International Journal of Children's Rights* 11 (2003): 199-217; A. Mahoney et al., "Religion in the Home in the 1980s and 1990s: A Meta-Analytic Review and Conceptual Analysis of Links Between Religion, Marriage, and Parenting," *Journal of Family Psychology* 15, no. 4 (2001): 559-96; J.L. Crouch and L.E. Behl, "Relationships among parental beliefs in corporal punishment, reported stress, and physical child abuse potential," *Child Abuse & Neglect* 25 (2001): 413-9; T.L. Dietz, "Disciplining Children: Characteristics Associated with the Use of Corporal Punishment," *Child Abuse & Neglect* 24, no. 12 (2000): 1529-42; E.E. Pinderhughes et al., "Discipline Responses: Influences of Parents' Socioeconomic Status, Ethnicity, Beliefs About Parenting, Stress, and Cognitive-Emotional Processes," *Journal of Family Psychology* 14, no. 3 (2000): 380-400; E.T. Gershoff, P.C. Miller, and G.W. Holden, "Parenting Influences from the Pulpit: Religious Affiliation as a Determinant of Parental Corporal Punishment," *Journal of Family Psychology* 13, no. 3 (1999): 307-20; H. Danso, B. Hunsberger, and M. Pratt, "The Role of Parental Religious Fundamentalism and Right-Wing Authoritarianism in Child-Rearing Goals and Practices," *Journal for the Scientific Study of Religion* 36, no. 4 (1997): 496-511; C.G. Ellison, "Conservative Protestantism and the Corporal Punishment of Children: Clarifying the Issues," *Journal of the Scientific Study of Religion* 35, no. 1 (1996): 1-16; C.P. Flynn, "Regional Differences in Attitudes Toward Corporal Punishment," *Journal of Marriage and the Family* 56 (May 1994): 314-24.

4. For an essay on the effect of worldview in clinical medicine and medical education, see J. Tilburt and G. Geller, "Viewpoint: The Importance of Worldviews for Medical Education," *Academic Medicine* 82, no. 8 (August 2007): 819-22.

5. E.O. Ledbetter, "An Ethical Approach to Intervention/Prevention of Child Maltreatment," *Advances in Pediatrics* 50 (2003): 215-29, p. 224.

6. E.M. Griffith and J.L. Griffith, "Addressing Spirituality in Its Clinical Complexities: Its Potential for Healing, Its Potential for Harm," *Journal of Family Psychotherapy* 13, no. 1/2 (2002): 167-94. The authors go on to assert that these competing paradigms must come together in "therapeutic alliance." "Yet empirical research on clinical practice has emphasized that it is the therapeutic alliance that holds most sway in the success or failure of treatment. The relational rigor needed for a strong therapeutic alliance demands that a clinician begin by understanding the client's or patient's experience and organizing treatment within this framework. These stories of personal experience may have little to do with what science would say about a problem" (p. 173).

7. Physicians' attitudes toward the use of corporal punishment are mixed and somewhat dependent upon practice specialty. See Ledbetter, note 5 above. One study conducted in Israel compares physicians' attitudes toward different types of corporal punishment. Between 82 percent and 97 percent of physicians felt that striking a child with an object that leaves bruises was abusive. E. Tirosh et al., "Attitudes towards corporal punishment and reporting of abuse," *Child Abuse & Neglect* 27 (2003): 929-37.

8. See Articles 9 and 19, Part I, of United Nations, Office of the High Commissioner for Human Rights, "Convention on the Rights of the Child, Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989, entry into force 2 September 1990, in accordance with article 49," *http://www.unhchr.ch/html/menu3/b/k2crc.htm,* accessed 9 October 2008. Additionally, see Article 5 of the Universal Declaration of Human Rights, which states, "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment." United Nations, "Universal Declaration of Human Rights, Adopted and proclaimed by General Assembly resolution 217 A (III) of 10 December 1948," *http://www.un.org/Overview/rights.html,* accessed 9 October 2008.

9. Defining child abuse is of course difficult and dependent to some extent on cultural and religious context. In 2006, Whitney, Tajima, Herrenkohl, and Wang, in the *Child and Adolescent Social Work Journal,* asserted, "There currently is no clear agreement among researchers about what constitutes child abuse." S.D. Whitney et al., "Defining child abuse: Exploring variations in ratings of discipline severity among child welfare practitioners," *Child and Adolescent Social Work Journal* 23, no. 3 (June 2006): 316-42. Federal and

state legislation hold some measure of interpretive flexibility in determining what exactly constitutes child abuse. On the federal level, The Child Abuse Prevention and Treatment Act, as amended by The Keeping Children and Families Safe Act of 2003. Sec. 111. DEFINITIONS. [42 U.S.C. 5106g] offers the following: "the term 'child abuse and neglect' means, at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm," *http://www.acf.hhs.gov/programs/cb/laws_policies/cblaws/capta03/capta_manual.pdf,* accessed 28 July 2007.

10. There are a number of recent efforts to push for new interpretations of scriptural and socio-religious dogma of the past. Three useful sources include the following.

The Faith Trust Institute mission statement reads: "We are a national, multifaith, multicultural organization providing religious communities and advocates with training, consultation and educational materials to address the religious aspects of abuse," *www.faithtrustinstitute.org,* accessed 28 July 2007.

AARDVARC.org (An Abuse, Rape and Domestic Violence Aid and Resource Collection) is a web-based organization with a multitude of resources for helping offset the tide of violence. It includes very helpful information about the "Religious Aspects of Domestic Violence" and includes links to organizations from each of the Abrahamic faiths whose sole purpose is to ease the incidence of family and intimate partner violence among the faithful, *http://www.aardvarc. org/dv/religion.shtml,* accessed 28 July 2007.

Finally, the *Journal of Religion & Abuse* is solely devoted to the issue of religion and family violence. By Hayworth Press, this peer-reviewed journal "uniquely joins theory and practice, encouraging critical thinking about the issues surrounding abuse and its prevention and intervention," *http://www.haworthpress.com/store/product.asp?sku=J154,* accessed 28 July 2007.

11. K.S. Hickey and L. Lyckholm, "Child Welfare Versus Parental Autonomy: Medical Ethics, the Law, and Faith-Based Healing," *Theoretical Medicine* 25 (2004) : 265-76.

12. From Loma Linda University Medical Center's mission statement: "The mission of Loma Linda University Medical Center is to continue the healing ministry of Jesus Christ, to make man whole, in a setting of advancing medical science and to provide a stimulating clinical and research environment for the education of physicians, nurses, and other health professionals," *http://www.llu.edu/mission/mcmission.html,* accessed 28 July 2007. Curlin, Chin, Sellergren, Roach, and Lantos put it this way: "Throughout much of history, medicine and religion have coexisted in uneasy tension. Both confront the most challenging experiences in life — birth, illness, suffering, disability and death — experiences that raise fundamental questions about human nature and human experience," (p. 452). F.A. Curlin et al., "The Association of Physicians' Religious Characteristics with their Attitudes and Self-Reported Behaviors Regarding Religion and Spirituality in the Clinical Encounter," *Medical Care* 44, no. 5 (May 2006): 446-53.

13. Griffith and Griffith, see note 6 above, p. 168.

14. See D.C. Maguire and Sa'diyya Shaikh, ed., *Violence Against Women in Contemporary World Religion: Roots and Cures* (Cleveland, Ohio: Pilgrim Press, 2007); "What Harm Is It to Be a Woman?" produced by the Religious Consultation on Population, Reproductive Health, and Ethics, 2007, *www.religiousconsultation.org,* accessed 28 July 2008.

15. M.R. Ellis and J.D. Campbell, "Concordant Spiritual Orientations as a Factor in Physician-Patient Spiritual Discussions: A Qualitative Study," *Journal of Religion and Health* 44, no. 1 (Spring 2005): 39-53; S. Fainzang, "Religious Attitudes Toward Prescriptions, Medicines, and Doctors in France," *Culture, Medicine and Psychiatry* 29 (2005): 457-76; S.P. Sattar et al., "Inert Medication Ingredients Causing Nonadherence Due to Religious Beliefs," *Annals of Pharmacotherapy* 38 (2004): 621-4; F. Rosner, "Free Will, Autonomy, and Patient Noncompliance in Judaism," *Cancer Investigation* 19, no. 1 (2001): 100-4.

16. "Fugitive Couple and Children Found in Montana," *http://www.cnn.com/US/9810/06/fbi.kidnapped.01/index.html,* accessed 28 September 2008.

17. In fact, some recent studies indicate this is a good assumption to make. Curlin, Roach, Gorawara-Bhat, Lantos, and Chin found that physicians described religious influences as "harmful when they generate psychologic conflict or when they lead patients to decline medical recommendations" (p. 761). F.A. Curlin

et al., "How Are Religion and Spirituality Related to Health? A Study of Physician's Perspectives," *Southern Medical Journal* 98, no. 8 (August 2005): 761-6.

18. See note 3 above.

19. Ibid.

20. While it is difficult for me think along the lines of those who seek to detract from the credibility of medical science, I am nonetheless able, as are they, to come up with a number of illustrations showing how medical science has at least been perceived to be in error. Consider the following examples: the use of Diethylstilbestrol, Thalidomide, and estrogen; exposure to sunlight for vitamin D development versus the negative effects of possible melanoma; and a host of ill effects caused by drug interactions and reports of failure to be completely forthright about the side-effects of many drugs. Add to this the negative press associated with iatrogenic illness, wrongful death, and the staggering number of documented medical errors, and those who are initially skeptical grow even more averse to taking their loved ones to a physician or to the hospital.

21. R.M. Veatch, "Abandoning Informed Consent," Hastings Center Report 25, no. 2 (1995): 5-12. See the more recent study by J.J. Petry and R. Finkel, "Spirituality and Choice of Health Care Practitioner," *Journal of Alternative and Complementary Medicine* 10, no. 6 (2004): 939-45.

22. Ibid.

23. Ellis and Campbell, see note 15 above, p. 45.

24. Griffith and Griffith (see note 6 above) urge clinicians to allow for a "both/and" perspective on this matter. Their patient, Lutchi, "was drawing on meanings that were foundational to his life, meanings far more convincing than any that I, as a family therapist, or Griff as his psychiatrist, could provide. . . . While we could not have convinced Lutchi to step into a both/and position, we do believe we can create an environment for a relaxed, fair, and just dialogue that will hold this space open." This is true for Griffith and Griffith even if there remain keen "potential obstacles to justice and openness" (pp. 170-1).

25. Curlin et al., referenced in note 12 above, present data that report a "majority" of physicians "encourage patients in their own religious/spiritual beliefs and practices" (p. 450-1); 23 percent, however, said that they had a "general discomfort with discussing religion matters" (p. 449). In another report of their findings (see note 1 above), Curlin et al. quote a physician as saying, "There have been frequent conflicts . . . and how I deal with it is I always find out what the [religious] request is and in what belief system it originates, and I accommodate it — provided that I'm not doing any overt harm that I know" (p. 90).

26. Ellis and Campbell, see note 15 above, p. 47.

27. A.R. Jonsen, M. Siegler, and W.J. Winslade, *Clinical Ethics* 6th ed. (New York: McGraw-Hill, 2006). Positioning themselves with regard to medical care for minors when the parents invoke religious reasons for treatment preferences, Jonsen, Siegler, and Winslade assert the following: "In general, clinicians must respect a rather broad view of parental discretion and tolerate parental practices that the clinician would not agree with, up to the point where those practices may be judged abusive and contrary to the best interests of the child" (p. 99). Of course making this judgment in our case here will result in intense levels of dispute. When a physician concludes that a parent's behavior is abusive, Jonsen, Siegler, and Winslade argue that "the well-being of the child takes precedence over the parent's rights" (p. 95). In cases in which parents refuse care and treatment for critically ill children, the authors are decided in their position that "parents . . . should be opposed by clinicians" (p. 79). See also the article by Hickey and Lyckholm, cited in note 11 above, as they take a firm position against the rights of the parents when harm may come to the child: "The right of a sick child to appropriate medical care supersedes the right of a parent to withhold that care for the sake of religious beliefs" (p. 273).

28. F.A. Curlin et al., "Religious Characteristics of U.S. Physicians: A National Survey," *Journal of General Internal Medicine* 20 (2005): 629-34.

29. E.G. Howe, "Criteria for Deceit," *The Journal of Clinical Ethics* 15, no. 2 (Summer 2004): 100-11.

30. C.L. Kawada et al., "The Projection of Implicit and Explicit Goals," *Journal of Personality and Social Psychology* 86, no. 4 (April 2004): 545-9.

31. Howe, see note 29 above, p. 111.

32. Griffith and Griffith, see note 6 above, p. 175.

33. In "When Patients Choose Faith Over Medicine: Physician Perspectives on Religiously Related Conflict in the Medical Encounter," Curlin, Sellergen, Lantos, and Chin report that they found many physicians who made an extra effort to negotiate some way through conflict for the good of the patient: "Rather than striving for illusory neutrality, physicians should practice an ethic of candid, respectful dialogue in which they negotiate accommodations that allow them to respectfully work together with patients, despite their different ways of understanding the world" (p. 91, Curlin et al., see note 1 above). In a study regarding patients' and physicians' attitudes about the issue of medications with religiously forbidden ingredients, the authors found that patients appreciated physicians who paid attention to this issue. The patients saw it to be an ethical issue. The authors note, "Informing patients about this promotes respect for their religious beliefs and may promote therapeutic alliance. . . ." (p. 1830). See S.P. Sattar et al., "Patient and Physician Attitudes to Using Medications with Religiously Forbidden Ingredients," *Annals of Pharmacotherapy* 38 (November 2004): 1830-5.