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Attending to Religion in Religiously Competent Health Care

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In applying my training in the academic study of religion to my work in health care, I have noticed an ironic development: While cultural competency initiatives have increasingly recognized the importance of religion, the very notion of "religion" is often lost in the discussion. The present article is an appeal to attend to religion in religiously competent health care.

Defining Religion

Scholars struggle to define "religion." As Arnal and McCutcheon put it: "What shall we do with this intractable word and concept that, on the one hand, we seem unable to do without and that, on the other, we are incapable of defining in any coherent way?" [1] But if we cannot define religion in some coherent way, then everything—or nothing—is religious. And if that is the case, then we cannot parse out when and how religion matters in health care.

I understand religion as a particular kind of worldview or *Weltanschauung*, that is, "a way of looking at the cosmos from a particular vantage point," [2] "a comprehensive conception or theory of the world and the place of humanity within it. It is an intellectual construct that provides both a unified method of analysis for and a set of solutions to the problems of existence." [3] What distinguishes a religious worldview from a nonreligious one is its vantage point in viewing the cosmos and humanity's place in it from the perspective of a perceived transcendent reality, a reality beyond or qualitatively unlike ordinary material reality yet imbuing the latter with ultimate significance, an unapparent Real behind the apparently real. Religious adherents deem certain phenomena to be "sacred" or "holy," as in the belief that

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Jesus Christ was an incarnation of God or that Gautama Buddha was an enlightened being. Because a transcendent reality cannot be empirically verified or falsified, what is held as sacred or holy to some people may not appear so to others. "Eyes of faith" perceive what other eyes do not, for instance attributing healing to the intervention of St. Raphael the Archangel of the Catholic tradition or the Medicine Buddha Bhaisajyaguru of the Buddhist tradition.

This perception of a transcendent reality is the key to defining "religion" and distinguishing it from a materialist worldview that denies any such transcendent reality. The philosopher of religion Kevin Schilbrack sees "a belief in superempirical beings or powers" (what I have called a transcendent reality) as the necessary though not sufficient property of a religion, which must also have at least two other properties from the following list in order to qualify: "ethical norms, worship rituals, participation believed to bestow benefits on participants, and those who participate in this form of life see themselves as a distinct community." [4]

This definition covers religions that include all five properties as well as individuals who identify as "spiritual but not religious." Although they may not affiliate with a distinct religious community, if they believe in a transcendent reality and follow ethical norms related in some way to that transcendent reality, deriving benefits thereby, they are "religious" by this definition.

Losing Sight of Religion

Cultural competency comprises "a set of attitudes, perspectives, behaviors, and policies–both individually and organizationally–that promote positive and effective interactions with diverse cultures." [5] What can be called religious competency has become an accepted subset of cultural competency even if the phrase itself is not used, and a plethora of religious competency resources is now available. [6] We can say that religious competency comprises a set of attitudes, perspectives, behaviors, and policies—both individually and organizationally—that promote positive and effective interactions with diverse religious groups and individuals.

Ironically, the increasing recognition of the importance of religiously competent health care has often lost sight of the very notion of "religion" as defined above. The deficiency is most evident in the spirituality literature. Often, spirituality is not understood as a religious worldview that sees the cosmos and humanity's place in it from the perspective of a perceived transcendent reality. Consequently, the notion of spirituality is unhelpfully stretched so far as to include virtually anything in human experience. Many spirituality scales operationalize spirituality "in terms of positive emotional states," such as "acceptance, caring, compassion, harmony, gratitude, mercy, and peace," and "not in terms of anything that is distinctly spiritual or religious." [7] Clarke describes how the nursing profession has created "broad, generic, existential definitions [of spirituality] . . . which have the tendency to result in a type of spiritual care which is indistinguishable from psychosocial care, hard to explain to patients and difficult to put into practice." Clarke suggests that the profession's desire to sever its historical ties to institutional religion has contributed to such insipid understandings of spirituality. [8] To be clear, I am not advocating for a certain type of spirituality but rather for definitional precision. If "spirituality" is defined without reference to a transcendent reality, it is no longer "religious" by definition.

But if we cannot define religion in some coherent way, then everything—or nothing—is religious. And if that is the case, then we cannot parse out when and how religion matters in health care.

Attending to Religion

Religious and nonreligious (materialist) worldviews are different intellectual constructs that patients invoke when facing the inevitable health decisions of human existence. It seems to me that most religious patients will appreciate the affirmation of their own worldviews regardless of their estimation of the legitimacy or veracity of other worldviews.

Paradoxically, nonreligious patients may benefit most from attention to religion because the legitimacy of their worldview will be honored. At times, the health care literature includes both subtle and blatant dismissiveness of nonreligious worldviews. For instance, one resource bemoans the uncoupling of medicine and spirituality in Western history and expresses a bias against "secularistic culture [that] entices people to many isolated, broken commitments," whereas religion "puts them all in perspective by asking the ultimate questions about the sacred that integrate otherwise disconnected and fragmented thoughts and feelings." [9] There is no recognition here that a nonreligious worldview can "integrate otherwise disconnected and fragmented thoughts and feelings" without appealing to the sacred. At other times, the literature assumes—rather, presumes—that all patients are spiritual beings whether they admit it or not since human beings are innately spiritual. [10] This presumption can lead to characterizing atheists as unwittingly or unwillingly spiritual according to the generic psychosocial understanding of spirituality described above [11] or as "psychologically maladjusted or existentially bereft." As Hwang et al. suggest, there is "a need to move beyond outdated pathological stereotypes of atheists [and other materialists, I would add]" in order to see them as potentially "*affirmatively secular* individuals" for whom "a secular world view can *enhance a person's overall health and quality of life.*" [12]

Let us consider how providers can enhance care for both religious and nonreligious patients who refuse standard medical pain palliation. The World Health Organization has declared palliative care a "human right" and "the ethical duty of health care professionals." [13] Given such a view, providers will likely be baffled, annoyed, or frustrated by patients who refuse standard medical palliatives, as in the following hypothetical cases.

Patient A is a stoic humanist who sees pain as fundamental to the human condition and makes "a secular argument for enduring, rather than seeking to alleviate, the travails of body and soul," [14] believing that physical suffering can "become an aid to self-knowledge, a route to philosophical progress." [15] Giving his pain a religious explanation, Patient B, a chronic alcoholic, informs the hospital chaplain in advance of a cholecystectomy that he wants no postoperative pain medication because "God wants me to be in pain—God wants me to suffer through this so I can atone for some of my sins. And God's right—I don't deserve the pain meds and I don't want the pain meds." [16] Patient C refuses pain medication by interpreting the core Buddhist ethical precept against intoxication to cover anything that might interfere with right mindfulness, a key aspect of the path to Nirvana or enlightenment.

In two of these cases, patients invoked a religious worldview, in the other a nonreligious or materialist one in refusing medical palliatives. Providers need to under-

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Consequently, the notion of spirituality is unhelpfully stretched so far as to include virtually anything in human experience.

stand each of these underlying worldviews without privileging or denigrating any of them, especially the religious worldviews that appeal to a transcendent perspective for justification. Providers should also be aware that other patients holding these respective worldviews might choose to take pain medications, which should not be interpreted as evidence of the internal inconsistency or inadequacy of certain worldviews to make acceptable medical decisions. Patients are merely drawing upon different strands or interpretations of internally complex worldviews.

Providers would do well to recognize how their own biases may affect patient care. [17] Some nonreligious providers may experience discomfort in dealing with religious patients, perhaps due to their own anger toward God or an inability to understand the implications of a religious "analytic third" in the therapeutic relationship. [18] Treating the claims of all worldviews (including the providers' own) as equally legitimate can lessen such discomfort. Religious providers who find it difficult to care for patients who do not share their worldview can take a cue from a Christian writer: "Respecting other people's beliefs doesn't mean indiscriminately agreeing with everything you run across. However, it does entail realizing that these sometimes strange beliefs are extremely important to people." [19]

Conclusions

Competent health care must not lose sight of religion's motivating power as well as its potential for both good and ill. "Religious conviction motivates and inspires human behavior like few other forces." [20] A religion scholar summarizes religion's bifurcated potential in individuals: "At a given moment any two religious actors, each possessed of unimpeachable devotion and integrity, might reach diametrically opposed conclusions about the will of God and the path to follow." [21] Pargament applies these insights about religion to health care: "The sacred is for many people, a powerful resource. It can also be a source of seemingly intractable problems. But the sacred is more than a source of solutions and problems, it is a distinctive source of significance. No other human phenomenon has as its focus the sacred." [22]

When consulting the health care literature, it is important to look for awareness of the referent that distinguishes a religious worldview from a materialist worldview and the implications of this difference for providing competent care. If the notions of "sacred," "holy," "transcendent," and the like are not present, then the discussion lacks the essential element of religiously competent care. But if nonreligious (materialist) individuals are dismissed as somehow unwittingly or unwillingly religious or spiritual, then the discussion lacks the necessary sensitivity for competent care.

Competent care occurs when providers (1) understand that everyone involved in a case has a worldview or *Weltanschauung*—"a way of looking at the cosmos from a particular vantage point," "an intellectual construct that provides both a unified method of analysis for and a set of solutions to the problems of existence"—and (2) sensitively consider the implications of religious and nonreligious worldviews, especially when encountering a worldview different from their own.

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