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### e-Ethics, 2002 June

Advocate Aurora Health

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## Can't See the Forest: Hospitals as Foreign Culture

**D**iscussion of cultural sensitivity in medicine frequently focuses on confusion and conflict that arise when patients from non-Western backgrounds hold beliefs or maintain practices that impede recommended treatment plans. Consideration of these cases is important. Greater understanding of how diverse cultures perceive and care for disease equips healthcare professionals to communicate better with patients and find ways to accommodate important healing rituals and interpretations of illness. However, behind the "trees" of difference represented by various customs or religions lies the "forest" of medicine itself. Taking for granted our own familiarity with the culture of medicine may result in behaviors that offend or frighten patients and their families, irrespective of their particular values or traditions.

Through education and practice, providers become acculturated to the environment, language, and customs of medicine, which, over time, become second nature. Professional competence depends in part on one's ability to interpret and respond to environmental cues (such as "code blues"), speak the language (for example, "The patient presents with a chief complaint of pain in the lower right quadrant"), and participate skillfully in routine rituals (making unit rounds or caring for patients whose bodies are exposed). Some

medical schools include practicums in which students become patients for a day, thus gaining a sense of what hospitals are like from the other side of the bed. However, such encounters cannot recreate the personal vulnerability engendered by actual disease or injury, as a number of gifted writers have recounted after their own experiences as patients.

Describing the lupus that affected most of her adult life, Flannery O'Connor wrote, "In a sense sickness is a place, more instructive than a long trip to Europe, and it's always a place where there's no company, where nobody can follow."<sup>1</sup> The isolation imposed by illness itself can be exacerbated by the experience of hospitalization, during which patients retain few tangible reminders of who they are and how they usually present themselves to the world.

Imagine entering another country and being required to remove all of your clothing right down to your shoes in exchange for a single garment identical to that worn by fellow tourists. Accommodations are guaranteed, but you have no say in choosing your fellow lodgers, and little or no control over personal habits such as eating, sleeping, or bathing. Because these aspects of inpatient care are routine, we forget the very real but unspoken way an absence of one's own *things* and the disruption of familiar routines con-

tribute to a sense of depersonalization and isolation.

Patients have also described how alienated they feel when staff fail to address them by name, or do so casually, as by calling adult patients by their first names. Busy staff sometimes fail to introduce themselves or colleagues to patients, and develop a manner of bedside consultation that includes little or no direct communication with patients. As Anatole Broyard described it, "I had a very curious relationship with the doctors. They came in groups of six. . . . They looked at me. They shook their heads, and they left me lying in a pool of sweat. . . . To the typical physician, my illness is a routine incident in his rounds, while for me it's the crisis of my life."<sup>2</sup> The challenge of Broyard's observation lies not in acknowledging its accuracy, but in allowing its truth to shape our practices regarding when, where, and how we communicate with colleagues—and especially with patients and their families, who should be the principal beneficiaries of our professional education and training.

Reynolds Price's account of the initial diagnosis of his spinal tumor illustrates how inurement to the seeming necessities of medical culture may cause staff to forget distinctions between public and private space in the hospital:  
*. . . I was lying on a stretcher in*



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*a crowded hallway, wearing only one of those backless hip-length gowns designed by the standard medical-warehouse sadist. Like all such wearers I was passed and stared at by the usual throng of stunned pedestrians who swarm hospitals round the world. . . . The initial internist would show his concern through years to come; but all I recall the two [original doctors] saying that instant, then and there in the hallway mob scene, was "The upper ten or twelve inches of your spinal cord have swelled and are crowding the available space. The cause could be a tumor, a large cyst or something else. We recommend immediate surgery." . . . Then they moved on, leaving me and my brother empty as wind socks, stared at by strangers. . . . What would those two splendidly trained men have lost if they'd waited to play their trump till I was back in [my] private room? . . . At least on private ground, with the door shut, the inevitable shock of awful news could have been absorbed, apart from the eyes of alien gawkers, by the only two human beings involved. It might have taken the doctors five minutes longer; and minutes are scarce, I understand, in their crowded days. I also know that for doctors who work, from dawn to*

*night, in the same drab halls, it all no doubt feels like one room. But any patient can tell them it's not, and I've often wondered how many other such devastating messages they bore that day to actual humans as thoroughly unready as I for the news.<sup>3</sup>*

Price's discomfiture did not result from "culture-clash" as frequently understood. If anything, he probably had more in common with his physicians than many other patients, since he was a well-educated, well-known professional who was also a native of the region where he was hospitalized.

Whether patients are from across the globe or across the street, understanding our role as guides through and interpreters of the "forest"—medical care and practice—can ease patients' vulnerability and fearfulness, and thus make the inpatient experience one of genuine care as well as healing.

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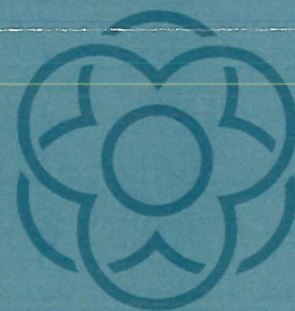
1. Flannery O'Connor, *The Habit of Being: Letters of Flannery O'Connor*, ed. Sally Fitzgerald (NY: Farrar, Straus and Giroux, 1988), p. 163.

2. Anatole Broyard, *Intoxicated by My Illness and Other Writings on Life and Death* (NY: Fawcett Columbine, 1992), pp. 33, 43.

3. Reynolds Price, *A Whole New Life: An Illness and a Healing* (NY: Atheneum, 1994), pp. 13-14.

**e-Ethics** provides discussion of important ethical issues in clinical care and organizational life. In specific cases, fuller ethical analysis may be required. The discussions in *e-Ethics* should not be construed as legal advice and do not necessarily represent official positions of Advocate Health Care.

**For information** about *e-Ethics* or the Park Ridge Center, contact David McCurdy at (312) 266-2222 ext. 225 or [dbm@parkridgecenter.org](mailto:dbm@parkridgecenter.org).



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# e-Ethics

## Children and Religious Objections to Treatment

**W**e've all read the newspaper accounts: because of religious beliefs, some parent refuses to allow her sick child to be operated on, or to have a blood transfusion, or to undergo chemotherapy. The hospital staff becomes alarmed at the prospect of a child dying unnecessarily (in their eyes, anyway), and they ask the courts to intervene. A judge then must decide, but rancor and bewilderment often ensue. Both sides wind up understanding the other less than before the conflict. Looking at a few case studies may help clear up the legal issues.

■ Mrs. Jones, a Jehovah's Witness, was seven months pregnant when a truck smashed into her car, resulting in internal hemorrhaging. Her doctors insisted on giving her a blood transfusion to protect not only her health, but the health of her unborn child. Mrs. Jones refused.

■ Tom, a mature 15 year old Christian Scientist, was diagnosed with inoperative cancer. When physicians told him the best course of action was chemotherapy, Tom and his parents said they preferred to discontinue treatment and pursue therapy with a spiritual healer, believing that he could be cured by faith alone.

Should the doctors and nurses

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in these cases intervene and try to force these patients to accept treatment? These complex and morally ambiguous situations both feature religiously devout individuals relying on their faith to make a healthcare decision. The healthcare professionals in each case must decide whether to respect that decision or try to go against the believers' wishes and have a legal guardian appointed, someone who will ensure that the latest medical techniques will be brought to bear.

Millions of religious Americans, like Jehovah's Witnesses and Christian Scientists, eschew some or all forms of conventional medicine and have battled for the right to refuse treatment in life-threatening situations. Courts have nearly all agreed that any adult "of sound mind" can refuse medical treatment on religious grounds.

This does not mean religious belief represents an exception to the general rules of ethics and law. In fact, one of the fundamental principles of medical ethics is

that a patient has the right to decide whether or not to consent to treatment. This is known as the principle of autonomy, the bedrock principle of secular medical ethics, which includes the right to refuse treatment, so long as the patient is mentally capable of making the decision. An individual patient's particular reasons for refusing treatment, whether based on reason or revelation, are irrelevant.

As with the general principle, in the specific situations of Mrs. Jones and Tom, religion is not, in fact, a crucial issue. The real questions are: Who is empowered to make a healthcare decision affecting a minor? On what basis can they make it?

In the case of Mrs. Jones, the central issue is whether or not she is entitled to refuse medical treatment for herself and/or for her unborn child. Though still a source of widespread controversy, a woman's legal right to control her body trumps the interests (or potential interests) of her unborn fetus. Outside of a few states that mandate drug treatment for pregnant addicts, women have no legal obligation to accept treatment either for themselves or for their unborn child. Much as they might not like it, doctors and nurses are expected to accept Mrs. Jones' refusal of a blood

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transfusion, whether that refusal is based upon religious or non-religious grounds. The law is on her side.

Tom's case is a little more complex. If Tom were six or seven years old, he would be legally incapable of making a major life decision such as accepting or rejecting necessary medical treatment. Normally, parents in such cases make treatment decisions for their children. However, courts expect the parents to act in the "best interests of the child," a legal standard that does not allow rejecting medically necessary treatment on religious grounds.

When an adult makes a decision to risk her life or health because of her religious faith, society must ultimately respect that as a value judgment she has made with respect to the meaning of her life and faith. The state of her soul may be more important to her than the state of her body. However, the law does not accept a parent risking the life of a minor child for that belief. In a common phrase, the parents cannot make the child a martyr for their faith. The parents cannot refuse treatment to a very young child on religious grounds, and healthcare providers are expected to seek a legal guardian to authorize

appropriate medical treatment.

The difficulty in Tom's case is that he is identified as a mature 15 year old. While he is still considered a legal minor, in most situations, healthcare providers allow mature, youthful patients to participate in their treatment plan. This may include allowing Tom to reject further medical treatment if the odds of success are low. The more mature Tom is, the more likely it is that the healthcare providers would defer to him and his preferences. The fact that Tom bases his decision on religious rather than secular grounds should not alter how his physicians treat him.

One last factor is the particular procedure's chances of success. The more likely a procedure will result in a cure, the more likely a court will mandate the treatment. If a treatment has only a small chance of success, the court is likely to defer to the parent.

Respecting a person's religious belief is simply one aspect of respecting the autonomy of that individual. Insofar as individuals are competent to make important life decisions for themselves, the principle of respecting autonomy requires that society honor patients' right to make such decisions.

## Calendar of Events June - August

June 18

### **Ethical Issues in Research**

Elizabeth Gordon  
at Christ Hospital  
4440 W. 95th Street  
Oak Lawn  
in the Percy-Hopkins  
Auditorium, Room B  
at noon  
Cost: Free

June 24-25

### **The Ethical in the Everyday: Care at Home and in the Community**

at the Park Ridge Center  
Cost: \$250

August 5-6

### **7th Annual Chicago Conference on Healthcare Ethics**

Sponsored by Rush North Shore  
Medical Center, Chicago Clinical  
Ethics Program in Cooperation  
with Valpariso University and the  
Park Ridge Center.  
Information: 847-933-6434  
Will take place at  
Doubletree Hotel and  
Rush North Shore Medical Center,  
Skokie, Illinois  
Cost: \$195

August 18-20

### **Organizational Ethics for Faith-Based Institutions**

at the Park Ridge Center  
Cost: \$350

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information about Park Ridge  
Center events, call Bernice  
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