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Increasing diversity at the cost of decreasing equity? Issues raised by the establishment of Australia's first religiously affiliated medical school

Ian H Kerridge, Rachel A X Ankeny, Christopher F C Jordens and Wendy L Lipworth

Medical education in Australia is about to undergo major changes, with the founding of six new medical schools, including the first private medical school and the first religiously affiliated medical school in Australia. The establishment of medical schools at Bond University on the Gold Coast, Queensland, and the University of Notre Dame in Fremantle, Western Australia, are particularly noteworthy developments. A recent article in the *Journal* claimed the new medical schools will foster diversity and are committed to fill "particular workforce needs".¹ We argue that increasing the range of options for medical education is not an unquestionable good, as it may threaten academic freedom and equity in medical education as well as just provision of health care. This article aims to stimulate awareness, conversation and debate on these issues, not only within the medical community but in the wider Australian community.

While there are no *prima facie* reasons why religiously affiliated or private medical schools should not exist, in practice there are a series of curricular and administrative concerns that should be addressed before the establishment of any medical school — religiously affiliated, private or otherwise. There are important ethical and sociocultural issues associated with establishing religiously affiliated medical schools, and the principles underlying such schools must be made clear, particularly as interest may develop in establishing additional religiously affiliated medical schools (eg, based in the Islamic, Jewish or Hindu faiths).

The recent article in the *Journal* outlined concerns raised about the Notre Dame program, including the inclusion of a mandatory theology course, and more generally how the institution's Catholic ethos may affect the medical education provided and the skills and attitudes of physicians being trained.¹ While many factors, including postgraduate education and clinical experience, may influence a doctor's values or practice, it is undeniable that medical education is formative. Thus we concentrate here primarily on the issues raised by the establishment of religiously affiliated medical schools, and the University of Notre Dame's medical school in particular.

The important issue is not whether spirituality and religion are valid fields of enquiry within medical teaching, as there would seem to be little argument about including consideration of these in medical education.^{2,3} Both have been increasingly recognised as

determinants of the values that people attach to their lives, the manner in which they understand and cope with illness, the health care decisions they make and the care they receive.⁴ Nor do we deny that values have a central role in medical education. Indeed, a general consensus has emerged over the past decade that examining values is fundamental to developing an understanding of ethics and professional responsibility in medicine.^{5,6} All Australian medical schools in fact now incorporate study of professionalism, values and ethics within their medical curricula.⁵ Furthermore, it is clear that different medical schools will have special emphases depending, in part, on their student and local populations. For instance, the private medical school at Bond University will emphasise organisation, administration, and information technology skills, along with communication, law, and ethics.¹ Indeed, provided there are structural safeguards, it may be desirable for different schools to produce graduates with not only core attributes necessary for the practice of medicine, but also additional specialised skills suited to particular fields of practice or sociocultural contexts.

There are, however, at least three major areas of concern with regard to religiously affiliated medical schools: (1) the adequacy of the medical education provided and potential resulting limitations on patient access to health services and provision of comprehensive care; (2) equitable access to medical education in an increasingly competitive environment; and (3) issues associated with academic freedom and tolerance of diverse beliefs. In theory, none of these problems are insurmountable, but all should be acknowledged and addressed.

First, it has been well documented that patient access to health care services can be limited either directly (because of explicit religious concerns) or indirectly (by inadequate postgraduate education provided to health care practitioners).^{7,8} The restriction of health care services and the limitation of exposure to the full range of health care services required for professional competency have been major issues worldwide, particularly in obstetrics and gynaecology, and have resulted in legal action in the United States.^{9,10} Although individual physicians can conscientiously object to involvement in procedures that violate their own religious/moral values, it is reasonable to assume that all physicians should receive appropriate education about the range of health care services publicly available in Australia, including termination of pregnancy, provision of contraception, assisted reproductive technologies, genetic counselling, prenatal diagnosis and end-of-life care, as well as about the mechanisms for and limits to expressing conscientious objections. The existence of conscience clauses in codes of professional conduct is indicative of the fact that guidance is needed to mitigate the impact of religious beliefs on medical judgement and the delivery of care. Although Notre Dame officials have stated that their graduates will be educated to discuss these issues in a "non-judgemental, respectful and ethical manner . . . in relation to [the patient's] needs and circumstances",¹

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they also note¹ that use of contraception is an immoral act according to Catholic doctrine (as, of course, are termination of pregnancy and many forms of cessation of life-sustaining treatment, particularly in light of the recent Papal allocution that artificial nutrition should not be withdrawn from patients in a persistent vegetative state except where it is of insufficient therapeutic benefit or overly burdensome to them).¹¹

It is important to acknowledge that there may be a difference, or disjunction, between Catholic teaching and the behaviour and beliefs of many Catholics, including Catholic doctors, and that this may provide some reassurance to non-Catholics that their own beliefs and needs may be respected. Similarly, many religious hospitals often demonstrate a deep commitment to care, equity, social justice and service that may seem to be lacking in many secular institutions, as evidenced by the care of the indigent, the dying and those with HIV/AIDS in this country by religious hospitals and clinics. But, despite the evident commitment to care by many Catholic institutions and clinicians, it remains the case that there is a problematic tension between the teachings of the Church and the services and information provided by medical institutions and practitioners. Physicians may limit the health care options available to their patients (even those services that Australian society has determined should be publicly available), especially in rural and remote areas, where choice of medical practitioner is extremely limited. Doctors are the gatekeepers of all medical services and, as such, their knowledge, training, experience, values and beliefs, as well as the manner in which they resolve tensions between their own moral standpoints and their professional obligations, should be a central concern for the Australian public and any medical school seeking to train medical practitioners able to meet the diverse needs of Australian society. Simple assertions that a religious medical school or other tertiary institution will offer training according to the needs of the community do not adequately acknowledge the potential for conflict with religious teachings or mission, or the impact of such conflict. Nor do they acknowledge that there are multiple communities in which graduates may eventually practise.

Second, although it is recognised that religious beliefs may contribute to or influence medical judgement, they are not required for clinical practice. Religious influence in education may discriminate against those who do not share those beliefs. Incorporating religious traditions into medical education, for instance through obligatory courses in Catholic theology (with limited discussion of contemporary ethics, secular moral philosophy, or comparative religious perspectives, and no options for substitution of other courses), or promotion of the work of the Catholic and other Christian churches as a core institutional value, may create an alienating atmosphere for potential students from divergent religious backgrounds. It may also influence access and choice to pursue medical education at such institutions. The assumption that students who hold conflicting values simply will not apply to religiously affiliated medical schools is fundamentally discriminatory, particularly where such schools include federal government-subsidised places. Moreover, the assumption that differences or conflicts could not arise is naive and inconsistent with recognition of the moral and religious pluralism that is a central feature of Australian society.

There appears to be at least the possibility for discrimination along these lines at Notre Dame. While admission is open to students of any denomination (or presumably those with no

religious affiliation), it is specifically noted that applicants should manifest personal qualities consistent with the mission of the University, which is “the advancement of learning, knowledge, and the professions, and the provision of university education, within a context of Catholic faith and values”.¹² It is unclear how this could be assessed or enforced in a non-discriminatory manner. Given that discrimination against applicants to medical school has been documented to occur even at secular medical schools, in our view it is highly likely that such issues will arise more frequently in a religiously affiliated tertiary institution.^{13,14}

The question of access to medical education is an important one, particularly as there are always more applicants to medical schools than there are places available in Australia, and as there is a desire to create a medical workforce able to meet the diverse needs of our multicultural community. The question that any proposal for a religiously affiliated medical school should address is not only whether its education is likely to increase the number of medical students and physicians in Australia, but also whether it will truly diversify the physician pool in terms of values, beliefs and professional behaviours. For instance, a selection process that may be intimidating for non-Catholic students and a mandatory curriculum emphasising Catholic beliefs, moral philosophy and values suggests that diversity may not be fostered and may well be reduced, which is ethically problematic.

Finally, in a secular, pluralist society, there are well founded fears that rigid institutional commitment to a particular religious tradition can encourage discrimination and bias, as well as limiting academic and scientific freedom. These concerns are affirmed by well publicised instances of academics being dismissed by religious institutions because of theological or philosophical differences (eg, Hans Küng from the Catholic University at Tübingen, Gerd Lüdemann from the Protestant University at Göttingen, and Debora Diniz from the Catholic University of Brasilia).¹⁵⁻¹⁷ In the event of conflicts arising between Catholic ethos/values and the medical curriculum, it is unclear how a Catholic medical school would react to intervention by the university or the Church seeking to silence or remove a student or staff member because of beliefs that diverge from accepted Catholic doctrine or the university’s mission. It is of note that one of the goals of the University of Notre Dame is “. . . to support the role and work of the Catholic and other Christian churches”.¹⁸

Therefore, the question is not whether there can be any involvement of the Catholic church or other religious institutions in medical education, but what structural safeguards should be required for religious involvement in medical education to be morally, educationally and sociopolitically justifiable, particularly where student positions are to be subsidised by the federal government. Education at secular as well as religious medical schools should always be grounded in dominant and morally-justifiable societal norms, such as tolerance, equity, justice and care, the importance of which can be seen in our laws and practices. Australians live with relative ease with religious hospitals and schools (although there is ongoing debate as to whether these institutions should receive public funding). The value that Australian society attaches to religious tolerance is reflected in Section 116 of the Constitution, which prohibits the federal government from making any law prohibiting the free exercise of any religion.¹⁹ While, as a community, we acknowledge that religiously affiliated hospitals and schools may create tensions, we also believe that their existence does not, in principle, undermine society. Indeed,

the potential value of a religious medical school may lie in the fact that its values and norms are more transparent and more clearly articulated than those of a secular medical school.

But, in order to put safeguards in place to mitigate the concerns outlined above, the following issues should be addressed. First, religiously affiliated medical schools must actively recognise that conflicts are possible (and even likely) as a result of differences in religious beliefs or values. Accordingly, processes should be in place to identify and manage differences and conflicts arising between a medical school and its founder institution (for instance, the broader university or the Church), between the medical school and its staff or students, and within the medical school itself. There should be clear policies stating that expressing views inconsistent with the institution's religious values will not prejudice a student's continuing education or a staff member's employment. Second, selection of applicants should proceed in a manner that is non-discriminatory and that actively seeks to promote diversity of beliefs and values. Third, the adequacy of the education provided should be assessed by independent observers in terms of the abilities of graduates to deliver care that is consistent with the varying needs, beliefs, and values of the broader Australian community. This is a valid expectation, particularly in view of the significant number of federal government-subsidised student positions that will be available (50 of 80 positions at Notre Dame will be funded by HECS [the Higher Education Contribution Scheme]).¹ These processes are essential for any medical school to deal effectively with moral and religious pluralism and to ensure academic, scientific and religious/moral freedom. The Australian Medical Council (AMC), through its accreditation processes, has responsibility for the adequacy and quality of medical education. However, assessment of the impact of medical education on the delivery of health care services sufficient to meet the needs of Australians, and in accordance with their values, falls outside the remit of the AMC, and so should be of concern to the wider Australian community.

While religiously affiliated medical schools may increase the range of options available for some students, they may narrow the diversity of values expressed and therapeutic options made available by physicians, thus reducing options for patients. Religious involvement in medical education in a pluralistic society is only morally and socially acceptable where it emphasises the rights of others to have and choose different beliefs, and be no less worthy of compassionate and skilled medical care as a result; where it demonstrates respect for other accepted and morally justifiable beliefs and practices within the community; and where it provides cultural security not only to members of its own religion, but to those with differing or no religious affiliation. All medical schools should seek to foster and attract the trust and respect of anyone who may need the services of their graduates. We do not have any objection, in principle, to religiously affiliated medical schools. What we seek is awareness, discussion and debate among members of the Australian public, particularly patients and policymakers.

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Competing interests

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