

Pragmatic ethical approaches to evangelising in the medical encounter

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This paper describes the practical ethical issues and addresses some of the difficulties that arise at the interface between religion and the practice of medicine.

Situations that arise between the physician and the patient concerning religious and spiritual beliefs are described. Approaches and caveats to offering religious opinions, instructions and evangelising in the medical encounter are proposed by the author.

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Since antiquity the practice of medicine has almost always been interwoven with religion. This relationship continued throughout the Middle Ages where treatises on the roles of religion and medicine were further explored.

The physician, Sir William Moore, writing in 1642 in his treatise *Religio Medici* (the Religion of the Doctor), recorded that 'there are infirmities, not only of the body but of the soule, which doe require the merciful hand of our abilities'.^[1] There is now a substantial body of literature reflecting positively on the association of faith with our patients' abilities to cope with and recover from physical and mental illnesses.

As in all ethical proposals it is important to make sure that we base our arguments on the same definitions. Evangelism may be defined as the preaching or promulgation of the Gospel often with a corollary to 'win over to the Christian faith'.^[2]

If it is taken that to evangelise is to attempt to convert another person to a specific faith, then it should normally have no place in the medical encounter. This is more often expressed by the verb *proselytise*, which typically means to 'induce someone to convert to one's faith'.^[3] This is very different to encouraging the patient to continue in their own religious practices, prayers, meditations and with their own specific religious counsellors or provide information where this can be obtained.

This remains a grey area of doctor-patient communication, with differing medical opinions on where to establish clear boundaries. Most physicians believe that religious beliefs can heal, and prayer promotes healing,^[4,5] which was notably highlighted by Sir William Osler,^[6] who wrote about 'the faith that heals'.

Despite these findings, physicians may be uncertain of the advisability of incorporating spirituality or religion into their medical practices.^[7] This was summed up in the *New England Medical Journal* that 'it is not clear that physicians should engage in religious discussions with patients as a way of providing comfort'.^[8]

There is a limited curriculum time allocated for teaching when and how to conduct a spiritual assessment and engage in prayer with a patient. Some medical schools as well as the World Health

Organisation, who have integrated religion and spirituality into their list of goals for health education, now recommend training in this aspect.^[9,10]

The relationship between the physician's religion and beliefs and those of their patients and their illnesses, is intricate. In simplified terms, humans can inhabit three layered syncretic belief systems. First, the wider landscape of the general cultural and religious beliefs of the nation or country in which the patient lives. Second, the commandments or directives of the patient's specific religion or sect. Last, the often-unspoken internal beliefs of one's personal religion. There is then the gradations of agnosticism and atheism and, in addition, the faculty of mankind to hold competing and contradictory beliefs at the same time. These are fields in which sheep may not safely graze.

South Africa is a multicultural country with a broad range of religious beliefs, spanning major world religions from African religious belief systems to animism. In addition, the major Western religions are now also divided up into innumerable sects and disparate religious groupings, often with widely differing doctrinal imperatives and interpretations.

Also, there is now a substantial body of literature exploring the distinctions and interconnections between spirituality and religion, with many people claiming to be spiritual rather than religious.

Our history has partly been influenced by mission hospitals whose primary purpose was the provision of health care but whose *raison d'être* was also integral to and often inseparable from elements of evangelism. In addition, in modern times, there has been a rise in television and media evangelism as well as a proliferation of agencies providing faith healing.

Introducing religion into the medical encounter comes with several important considerations. There is a power, knowledge, and status differential between a physician and his or her patients who may be particularly vulnerable in the circumstances that they find themselves.

There is also the question of uninvited evangelism as opposed to the requested or the open invitation for religious guidance by the

patient. Even with invited advice or opinion, one should proceed cautiously, with permission, respect, and sensitivity. Our personal agendas are rarely fully examined, thoroughly considered, or without bias or prejudice. If patients express discomfort with spiritual or religious discussions, then this should not be pursued.

On the other hand, if the physician (and the patient) is of the opinion that the patient's religious or spiritual beliefs contribute to or cause the patient's physical or mental illness, it becomes relevant to explore further and provide support to the patient. This is often the case in psychiatric practice and with traditional healers, where the cause of illness and religious beliefs are often linked with the patient's mental state. In these instances, it is often difficult to distinguish religious beliefs from psychiatric disorders, such as delusional, psychotic, and obsessive states.

In cases of severe life-threatening illness, end-of-life care, and stressful relationships and life events, it would be reasonable for the physician to conduct a general inquiry about the patient's religious beliefs to obtain additional information and knowledge of the patient's background, which can assist in their management and advice.

Often the physician and the patient are from the same congregation or religious community and therefore have a common basis for care and advice. In some cases, the physician may even be a minister or lay preacher in this community. In these instances, there are appropriate occasions, if requested or judged to be beneficial, to engage in prayer with or for patients, to provide comfort and support but not to evangelise.

Conflicts of interests may arise, though, when the religion, beliefs, or culture of the patient diverge from those of the physician, causing the patient to perceive the physician's religious directives as intrusive and offensive. In this way, under rights-based ethics, it is important to protect the patient's right to privacy, autonomous decision-making, as well as freedom from coercion.

Once the communication between the doctor and patient leaves the medical substance of the consultation, as concerns the diagnosis and treatment of disease and illness, it can become extremely complex.^[5] This moral complexity involves the interaction between the physician's and the patient's inherent characteristics, fundamental beliefs and a slew of background influences, including education, cultural background, and socioeconomic status.

This goes back to the original Aristotelian concept of virtue ethics which concerns the essential character of the physician (from *ethikos* meaning character). It is the pursuit of what ancient philosophers referred to as 'the good'. The creed of good people with good intentions doing good things for a good and just society.

Subjects other than the medical reasons for attending often arise in unguarded moments or in moments when the consultation has, unwittingly, segued into a more familiar and casual conversation. With religious, political, and social commentary one needs to tread warily with measured and considered comments because the advice that we give carries the weight and influence of the status of a physician.

Physicians, on occasions, are directly asked by the patient about their own (the physician's) religious beliefs. This is a legitimate question, and the recommended response is to provide a generic answer of one's religious affiliation. If the physician is an atheist, it would be appropriate to convey that one does not hold any strong

religious beliefs. An unyielding atheistic stance by the physician may hinder further communication with patients who hold religious beliefs. Conversely, the opposite situation can occur when dealing with atheist patients who the physician believes may benefit from advice of a religious or spiritual nature.

The brief, in this case, is then to inquire about the patient's religious and health beliefs to assess the type of advice that would be most appropriate for the patient. The patient may have absolutist or fundamentalist beliefs, or only be searching for meanings and clarity. One can then take a cautious approach with the fundamentalist and a more supportive non-partisan role with those who are lost and searching. To this end, many of these encounters are conducted intuitively by "feeling one's way". The essence of care in these instances is to impartially guide the patients to their own choices.

It is often difficult to phenomenologically bracket out, which means to exclude one's own agendas, beliefs, and educational background, when addressing not only religious issues but also political and personal social views and opinions. The agenda should be of beneficence (the good) in acting in the best interests of the patient without partisan, messianic or invested approaches. For this we need to know exactly where we, ourselves, stand on these issues guided by the Delphic inscription of *Know Thyself*.

In conclusion evangelism or proselytising a specific religion in the medical encounter would be considered unethical unless initiated and explicitly requested by the patient.

Under normal circumstances (*sub communibus*) the physician should not:

- Initiate conversations relating to religious beliefs in order to evangelise.
- Impose his or her religious views on the patient.
- Attempt to draw the patient towards his or her own belief system.

On the other hand, one of the most important and holistic approaches to the care of the patient, especially in psychiatric and general practice, encompasses the pastoral care and the spiritual life of the patient. This is a very complex field of ethics in which to plough. It is important to step cautiously with respect and sensitivity and perhaps we should leave it with Marcus Aurelius who advised us to approach life and others with impartiality and 'keep our principles in readiness for the understanding of things both human and divine.'^[11]

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