Julian Churcher offers advice on discussing faith with patients

RESPECT, TRUST & CONSENT

key points

- We can no longer assume a shared worldview with patients; this makes raising spiritual matters a minefield.
- A triad of respect, trust and consent is central to a healthy relationship between clinician and patient.
- Love for your patients will mean that you are willing to risk your security for their highest good.

There was a time when a Christian doctor working in the UK could reasonably presume a shared worldview with her or his patients. In *most* areas, *most* people would identify themselves as 'Christian'. The gospel story was familiar, even if not understood, or personally embraced.

Today, competing belief systems, including the atheistic secularism that rejects any supernatural belief, have made raising spiritual matters a minefield. There is lots of potential misunderstanding and offence.

A triad of *respect*, *trust* and *consent* is central to a healthy relationship between clinician and patient. Their presence – or absence – affects every part of a consultation.

Respect

Respect for our patients should be a given, grounded in our understanding that every human is made in the image of God. If I respect someone, I recognise their adult freedom (and responsibility) to choose for themselves, as Jesus demonstrated in his conversation with the rich young ruler.[1]

If we respect our patients then it follows that we should be sensitive to them – sensitive to their attitudes, priorities and unspoken concerns. Our sensitivity will be demonstrated in our dealings with them on the basis of freely given consent and in an environment of mutual trust.

Respect, moreover, extends to fellow professionals. It will for example involve our being careful not to disparage them in conversation with our patients, however tempted or provoked. Respect is due to the authorities to whom we are properly accountable. This includes the General Medical Council (GMC) with its mandate to protect patients from abuse of every kind, by doctors with any and every belief.

Trust

Trust is fragile in any new relationship, not least when the stakes are as high as for someone first meeting a 'new' doctor. They will be asking themselves: 'Can I trust you?' or in other words, 'Do I believe that I can rely on your sincerity, benevolence and truthfulness?' and vitally 'Am I right to cede power to you to act on my behalf and in my best interest?'[2]

A medical indemnity provider has usefully described patient trust as deriving from the combination of the *affection* that results from the care given, and the *respect* that results from the competence demonstrated by the clinician.[3]

We all recognise the powerful effect of that first encounter. If we start on the right foot, for example making an astute diagnosis or giving timely and effective treatment, we may swiftly gain the patient's lasting trust. But if we miss the obvious and the patient suffers unnecessarily, then we may remain 'on trial' for a long time. Often the small 'pebbles' count as much as the 'boulders' of diagnosis and

clinical outcome. 'People build, or lose, their trust in you from the tiny fragments available: the way you listen (or don't), whether you've read the notes … "If they can't get the small things right," patients reason, "What about the big things?".'[4]

Changes in society have made the 'trust' question one for doctors too: 'Can I trust you?' Redressing the traditional power imbalance between doctor and patient has been necessary, but an increasing readiness to take offence damages the bond of trust and is counter-productive. This makes it more difficult for doctors to work with a necessary degree of confidence.

Consent

Consent is 'permission for something to happen or agreement to do something'.[5] Consent in medicine is usually the former. It may be explicit (stated verbally or in writing) or implicit. The act of choosing to see a doctor implies consent to the consultation that follows.

'Consent' is worth distinguishing from 'assent', implying a shared journey of continuing trust. I may grudgingly give assent, but 'grudging consent' is an oxymoron. Consent is the patient's gift to give rather than something for the doctor to take, as argued in a recent essay.[6] A legal description – in the context of sexual intercourse – is 'agreement by choice, having the freedom and capacity to make that choice'.[7]

Most of the questions we ask patients are unique to medicine, whether concerning stiff joints, loss of vision, accusing voices, itching, bowel function, or feelings of panic and despair. Then examination uses all our senses, both from a distance and close up. If our patients don't perceive our actions as professionally clinical, they will see them as either intimately personal or abusively impersonal.

Preparation ensures valid consent and frequently we must offer unhurried explanation of *why* we need to ask this question or perform that examination. Anything less makes our actions intrusive. Problems arise when there isn't a *shared* perception between doctor and patient of the appropriate boundaries for history and examination. If we first offer and explain, respecting the patient's autonomy and integrity, then we can nearly always negotiate our way to an effective and productive encounter. The same goes for conversation about matters of faith and belief.

Discussions of faith

The increasing privatisation of faith means that raising the matter – even in passing – can feel awkward. The power differential in the doctor–patient relationship has sometimes resulted in doctors feeling at liberty to preach without permission. Even when well-intentioned, this can be driven more by the doctor's need to see themselves as a faithful witness than by Christ-like love for the patient.

Even when I am as sure as I can be that I have consent to discuss matters of faith, the patient may subsequently complain. My words or manner may feel intrusive, and be seen as my agenda for the consultation rather than a helpful response to *their* agenda.

Secularists' indignation at discussions about faith *ever* arising in the consultation springs from their belief that transcendental belief is at best misguided and irrelevant, and at worse delusional and destructive. Therefore, they claim, it has no place in 'scientific' medical practice. This is clearly an a *priori* faith position, neither proven nor provable, but it is often vigorously held, with an arrogance that allows no possibility of error and a fervour that betrays its fragility.

The GMC's key document *Good Medical Practice* states: 'You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.'[8]

Ensuring continuing consent is fundamental to the Saline Solution – a day course run by CMF that helps Christian healthcare professionals recognise God-given opportunities and respond effectively to patient enquiries about their faith. 'Permission, sensitivity and respect' are watchwords of the course. Guidance includes: 'Ask permission to speak further… Be sensitive to your listener… Check regularly to see if they are still with you.'

If the gospel offers rescue to the drowning (as we certainly believe it does) we must remain committed to the distribution of lifebelts, deck-chairs and beach-balls – indeed *anything* that floats. We are witnesses of the resurrection, called to testify faithfully to our personal encounter with the once-crucified, forever risen saviour. When another person asks us to 'give the reason for the hope we have'[9] we do just that. Then it is the Holy Spirit's role to convict of sin and open their heart. But we don't cease to be their professional carer at the same time.

Be sure that your attitude is one of unfeigned respect and that you have the patient's freely-given consent when discussing matters of faith. It would be sensible to ask whether someone else – relative, friend or other healthcare professional – might object to such conversation, and find out why. This will tell you about their ego-strength and the dynamics of their relationships; take it all into account. Observe appropriate boundaries: you are their doctor or nurse and not their pastor, best friend or parent-substitute.

All this truly calls for the wisdom of serpents and the innocence of doves. Love will mean that you are willing to risk your security for the patient's highest good. The Holy Spirit's leading, whether prompting or restraining, will be your surest compass.

If you would welcome an opportunity to consider these issues in greater depth, share your experiences and gain confidence in addressing patients' spiritual needs, please contact the CMF office for details of a forthcoming Saline Solution somewhere near you or to help us with future course planning.

***Julian Churcher** is CMF Staffworker, London and South East.*

The increasing privatisation of faith means raising the matter – even in passing – can feel awkward

references

1. Matthew 19:16–30
2. Fugelli P. James Mackenzie Lecture, *BJGP* July 2001, referencing Seligman AB. *The problem of trust*. Princeton, NJ: Princeton University Press, 1997 and Luhmann N. *Trust and power*. New York, NY: John Wiley & Sons, 1979
3. Medical Protection Society
4. Munro J. What I know I owe to patients. *BMJ* 2014;349:g6734
5. Consent. *Oxford dictionaries*. Oxford University Press, 2015 *bit.ly/1KcIv96*
6. Sokol D. Let's stop consenting patients. *BMJ* 2014;348:g2192
7. Rape and sexual offences, chapter 3: Consent. Crown Prosecution Service. *bit.ly/1F4D3Pc*
8. General Medical Council. *Good medical practice*. London: GMC, 2013
9. 1 Peter 3:15