Rebuttal From Drs Poole and Richardson

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Invited contribution:

"Counterpoint: Is it ethically appropriate for physicians to offer to pray with patients in the ICU (Intensive Care Unit)? No: Rebuttal"

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Declaration of competing interests

Rob Poole and Ben Richardson are atheists. No other competing interests to declare.

Key Words

Ethics, prayer, religion, spirituality, ICU

Abbreviations list

ICU: Intensive Care Unit

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In their POINT defence of physician-initiated prayer[1], Frush and Curlin state that our fundamental disagreement concerns the nature of medicine. They offer a false dichotomy between their model of "moral friendship" and an industrialised, technical model of medicine that operates outside of the framework of a therapeutic relationship. These are not the only two options, and we advocate neither of them. One of us has written extensively about therapeutic relationships in a way that does not depend upon religious engagement between doctor and patient[2,3].

Their arguments are predicated upon two implicit and flawed assumptions. The first is that doctors and patients alike understand their relationship to be a "moral friendship", or at least that patients should accept this if the doctor sees their relationship in these terms. The model of "moral friendship" as described appears to be highly paternalistic. The physician alone determines the nature of the therapeutic relationship. Frush and Curlin are explicit that the physician is the arbiter of "health", which is "an objective human good", determined by the physician's "long study and experience". This may be a traditional view, as they say, but it is archaic. The model offers the patient little or no agency in their own health. A proportion of patients will arrive with an incompatible understanding of their relationship with the doctor: for example, that they are purchasers of technical expertise. It is not clear how the physician can guide the relationship on to a different footing, or what happens if the patient rejects the proposition of a "moral friend". How can a moral friendship survive if, for example, the physician believes that the patient's sexual orientation is sinful? Presumably it would be permissible for the physician to judge the patient's lifestyle to be unhealthy and discourage it, given the assertion that the doctor's understanding of health is "objective" and is to be preferred to the patient's. Of course, disapproval may arise in any interaction between doctor and patient, but we suggest that it is a bigger problem when religion is placed at the core of the relationship.

The second flawed assumption is that doctors and patients share religious and personal beliefs. We have explored the issue of diversity in our COUNTERPOINT[4]. We do not understand how the "moral friendship" model can accommodate diversity. Frush and Curlin make no mention of power imbalances. They make little reference to the specific difficulties of the ICU care of critically ill patients. They reify the doctor-patient relationship, with no mention of other health professions. We suggest that an emphasis on the transcendent that is intrinsic to religious interaction makes it difficult for doctors who adhere to this "moral friendship" model to maintain awareness of important profane factors.

In summary, we recognise the humane intentions behind Frush and Curlin's arguments, but, in our opinion, they invoke an imagined golden age of medical values that is inappropriate to modern clinical practice and prevalent social attitudes.

References

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