

# Sharing Faith In Practice

As Christians we should share the good news of Jesus Christ. Christ has explicitly called us to make disciples.

As Christian physicians and dentists we seek the well-being of our patients in our covenantal relationship with them. Clinical studies have demonstrated the importance of spiritual health in physical well-being. It is concern for the well-being of our patients that leads us to take a spiritual history from and share our faith with our patients.

As Christians we acknowledge the central role of the Holy Spirit in the process of evangelism. We rely on the discernment provided by the Holy Spirit to know when and how it is appropriate to share our faith. We recognize conversion is the Spirit's work, not ours.

Our faith should be implicit in our actions. We should be prepared to share our faith with patients and colleagues when our actions and the Holy Spirit prompt them to ask us questions. We should readily accept invitations from our patients to pray with them. We should offer to pray with our patients when they have indicated a belief in God and a practice of prayer. Some physicians and dentists choose to make their faith manifest through their statements, attire, or their office environment. Such indicators are not inherently disrespectful of patients and have the beneficial effect of making them aware of their doctor's faith perspective.

At times we may be prompted to initiate sharing our faith with our patients. In these situations, recognizing their vulnerability, it is appropriate to receive their permission for such an interaction. We should remain sensitive to patients' wishes in such interactions, especially when communicating with those who are of another culture or when caring for patients with diminished decision-making capacity.

Just as we respect our patients and their beliefs, our faith should be respected by the institutions in which we work. Policies that prohibit physicians and dentists from sharing their faith with others as described above restrict the freedoms of speech and religion of all involved and should be opposed.

*Approved by the Board of Trustees  
January, 1997. San Antonio, Texas*

*Approved unanimously as amended by the House of Delegates  
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## Explanation

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### Background

The United States was founded by people fleeing religious persecution. The freedom to practice one's own religion has been one of the basic and cherished freedoms of this country. Because everyone enjoys that same freedom, there has been both considerable freedom to talk about one's own beliefs and considerable caution about where and when that activity is allowed to take place. Witness the frequent

and emphatic discussion of the "separation of church and state" which is often invoked inappropriately. That original concept was articulated to ensure that the state did not endorse any one form of religion. But the precept is often brought up in discussion as if it meant that the state must pretend that religious belief does not exist and enforce that agnosticism.

### **Secular Perspective**

The relationship between healthcare professionals and their patients may be construed in many ways: as profession, as mission, as covenant, as contract, as duty, etc. But one of the most commonly invoked constructions is that it is a "fiduciary" relationship, i.e. an unequal relationship in which one party (physician, dentist, nurse, etc.) has more knowledge and skill than the other (patient), and therefore the former has an obligation to always act in the best interests of the latter. This same fiduciary relationship exists between an attorney and client, banker and customer, etc.

Prior to the current generation, physicians and dentists often acted in a paternalistic manner toward their patients. Assuming they knew what was best for each patients, they often made decisions and gave orders without discussing other options with the patient. Even though this was almost always done in a beneficent way, clinicians came under justifiable criticism for this seemingly arrogant attitude.

In the social upheaval of the 1960's, individual rights became first a focus of activism, and later became the preeminent social value. This was manifest as activism for minority rights, women's rights, consumer rights, and also patients' rights. In this generation, the individual patient's right to self-determination has become the dominant force in medical ethics. Patients now have the right to refuse unwanted treatment, and sometimes even assume that they have the right of entitlement to demand any treatment they want.

In this atmosphere, healthcare professionals who "share their faith" with patients have become suspect of taking advantage of the fiduciary relationship by forcing on the vulnerable patient a belief which they may not share or want to hear about. Physicians or dentists who actively witness to their patients have often been criticized. But there have been few if any sanctions against the self-employed individual practitioner; it is assumed that patients may leave and go to another professional if they are offended. However, clinicians who work for someone else, whether another individual practitioner, a clinic, or a large secular institution, have occasionally been forced to curtail their witnessing or risk losing their position.

### **Christian Perspective**

Unfortunately, this negative perception of witnessing sometimes conjures up the image of a high-pressure used car salesman. However, the task of evangelism is not to force a conversion, but simply to proclaim the good news of Jesus Christ and allow the Holy Spirit to work in that individual's life. Thoughtful Christians realize that high-pressure tactics represent an invasion of privacy and can be counterproductive.

Christian physicians and dentists have a broader obligation than merely caring for the physical needs of their patients. Jesus demonstrated through his healing ministry a concern for both the physical and spiritual aspects of human illness. Jesus also gave us a mandate to "go and make disciples of all nations" (Matthew 28:19). To assist with the carrying out of this mandate, we have been promised the power of the Holy Spirit to make this possible (Acts 1:8).

The Christian Medical and Dental Society has been aware of the tension between this gospel mandate and the above-mentioned societal mandate to respect others by not forcing religious beliefs on them. CMDS has given support to some individual practitioners who have been sanctioned for their witnessing. Many individual CMDS members have developed their own styles and methods of witnessing. And CMDS members have developed methods which can be adopted and adapted, e.g. the METS (Medical Evangelism Training & Strategies) Program and the Saline Solution.

In preparing this statement on Sharing Faith in Practice, the CMDS Ethics Commission and House of Delegates have been conscious of both the importance of individual witness and the potential vulnerability of the individual patient.

## **Abstracts**

### **McBride JL, Arthur G, Brooks R, Pilkington L. The relationship between a patient's spirituality and health experiences. *Fam Med.* 1998;30(2):122-6**

The authors believe that the relationship between spirituality and health is a new frontier in medicine. The study is a preliminary investigation into the relationship between a patient's experience of overall health, physical pain, and intrinsic spirituality. The study found significant correlation between patient health and spirituality. Significant differences were also found in both overall health and physical pain, based on the study's three levels of spirituality. The study suggest an association between intrinsic spirituality and a patient's experience of health and pain. Assessment of spirituality may be important for family physicians to consider as a supplement to patient interviews.

### **Magaletta PR, Duckro PN, Staten SF. Prayer in office practice: On the threshold of integration. *J Fam Pract.* 1997;44(3):254-6**

The article reminds physicians of the importance that prayer plays in the lives of a majority of Americans. With this in mind, the authors suggest that once the religious preferences of the patient and physician are accounted for, it is appropriate for the physician to privately pray for the patient, and pray with the patient. The authors believe that physicians can play a crucial role in validating the faith of their patients in a time of crisis, and can harness the positive effect that faith and prayer have on physical and mental health.

### **Olive KE. Physician religious beliefs and the physician-patient relationship: A study of devout physicians. *South Med J.* 1995;88(12):1249-55**

The authors attempted to determine the type and frequency of religious interactions that occur between devout physicians and their patients. Physicians identified by their peers as having religious or spiritual beliefs that were an important part of their lives were surveyed. Forty physicians responded (response rate 77%). In general, these physicians agreed that their religious beliefs have an important influence on their practice of medicine. Thirty-two percent reported having shared their beliefs with patients. Praying aloud with patients occurred with only 13% of patients, but 67% of respondents reported having done this on at least one occasion. Multivariate analysis showed the physician's religious group to be the most important determinant of sharing beliefs with patients, occurring most commonly with Protestant physicians. In this small sample of devout physicians, physician religious beliefs appear to influence the interactions between physicians and their patients.

### **King DE, Bushwick B. Beliefs and attitudes of hospital inpatients about faith healing and prayer. *J Fam Pract.* 1994;39(4):349-52**

Physicians rarely question patients about their religious beliefs. This lack of inquiry may be contrary to patients' wishes and detrimental to patient care. This study examined whether patients want physicians to discuss religious beliefs with them. Two hundred three family practice adult inpatients at two hospitals were interviewed regarding their views on the relationship between religion and health. Many patients expressed positive attitudes toward physician involvement in spiritual issues. Seventy-seven percent said physicians should consider patients' spiritual needs, 37% wanted their physicians to discuss religious beliefs with them more frequently, and 48% wanted their physicians to pray with them. However, 68% said their physician had never discussed religious beliefs with them. This study supports the hypothesis that although many patients desire more frequent and more in-depth discussions about religious issues with their physicians, physicians generally do not discuss these issues with their patients.

### **Daaleman TP, Nease DE. Patient attitudes regarding physician inquiries into spiritual and religious issues. *J Fam Pract.* 1994;39(6):564-8**

Most physicians do not address spiritual and religious issues with patients, although there are data documenting the relationship between religious variables and disease, health, and well-being. The purpose of this study was to examine patient attitudes regarding physician-directed inquiry about issues related to spiritual matters and faith; and to identify screening variables that would identify patients who would be receptive to such a discussion. This study supports the use of frequency of religious service attendance as a screening variable for patients receptive to physician-directed inquiry into religious and spiritual issues. It also confirms that patients are accepting of physicians' referring patients to pastoral professionals (ie, clergy) for spiritual problems.

**McKee DD, Chappel JN. Spirituality and medical practice. J Fam Pract. 1992;35(2):201, 205-8**

Spirituality is an important aspect of health care that is not often addressed in modern day primary medical practice. Controversy surrounds the role of spiritual issues in medical practice. Some of this stems from confusing spirituality with religion. This paper distinguishes between spiritual and religious issues and reviews the history of these issues in medicine, the growing medical literature in this area, and some practical guidelines for the practicing physician. The authors conclude that, when appropriate, spiritual issues should be addressed in patient care since they may have a positive impact on patient health and behavior, and recommend that the medical model be expanded to a biopsychosocial-spiritual one. The guidelines developed by the American Psychiatric Association provide a useful model for the practicing physician to follow. More research is needed in this area, but the authors conclude that enough is already known to support the inclusion of spiritual issues in medical education.

**Schreiber K. Religion in the physician-patient relationship. JAMA. 1991;266(21):3062, 3066**

The author calls physicians to recognize the importance that religion plays in the lives of patients. Only then, she argues, can positive effect of spirituality on mental and physical health be effectively harnessed.

**Koenig HG, Bearon LB, Dayringer R. Physician perspectives on the role of religion in the physician-older patient relationship. J Fam Pract. 1989;28(4):441-8**

The study of 160 family physicians and general practitioners found that the majority of physicians believed that religion has a positive effect on the mental health of older patients, and many believed that religion has a positive effect on physical health. While more than one half reported that patients only rarely, if ever, mentioned religious issues during a medical visit, a significant proportion of the physicians felt they should address religious issues when an older person indicates religion's importance and that religious issues should not be reserved completely for the clergy. Nearly two thirds of the physicians felt that prayer with patients was appropriate under certain circumstances, and over one third reported having prayed with older patients during extreme physical or emotional distress. The strongest predictors of physicians' belief in the appropriateness of addressing religious concerns were an understanding of the importance of religion in the lives of older adults and an awareness that patients might desire to engage in prayer with them. The authors found that the beliefs and attitudes of the physician appear to be important factors in determining their receptivity to discussion of religious issues, which in turn may influence whether patients mention such issues in the context of the medical visit.

**Sulmasy DP. The wine of fervent zeal and the oil of compassion. Chapter 3 in The Healer's Calling. New York, NY: Paulist Press, 1997**

Recognizing the importance of spirituality in the relationship of patient and physician, the author remarks "Christian health care professionals are also people of genuine hospitality, who welcome patients into the space of Christian healing and invite them to share their stories of faith, hope, and love."

**Chen Y. Doctor on the front lines. Physician; March/April 1990:8-10; and Wright R. Faith and practice. Physician; September/October 1998:20-22**

The first article is an interview with the president of, and the second a description of, the Medical Strategic Network. This organization (1) holds seminars (METS Conferences; Medical Evangelism Training & Strategies) to train physicians in how to share their faith; (2) develops mentoring relationships between younger and more experienced Christian physicians; and (3) cultivates a biblical and culturally relevant medical mission mind-set.

## **Bibliography**

**Peel WC. The Saline Solution. Today's Christian Doctor. Fall, 1996;27(4):8-11**

In an effort to find an appropriate method for physicians to discuss faith with patients, the author describes the inception and basic methods of a program designed to facilitate spiritual discussion in the clinic. The program calls physicians to use simple remarks in discussion to help patients identify them as persons of faith.

**Neely WF. Finding the open doors. CMDS Journal. Sept-Oct, 1994;25(5):30-1**

Recognizing the difficult challenges that many patients face, both in illness and life, and the important role that faith plays in the lives of many, the author asks physicians to allow the holy spirit to guide them in the arena of prayer, spirituality, and physician-patient relations.

**Short D. Total patient care. British Journal of Hospital Medicine. 1994;51(4):189-91**

The author argues that the true role of a physician goes beyond the physical and psychological needs, and includes both the social and spiritual. He finds that ignoring the spiritual element is to practice merely as a technician.

**Shuler J.E. Earning the right to intrude. CMDS Journal. Spring 1993;24(1):30-1**

The author argues that through a long term commitment to the patient's general welfare, we can develop a relationship to discuss issues of faith.