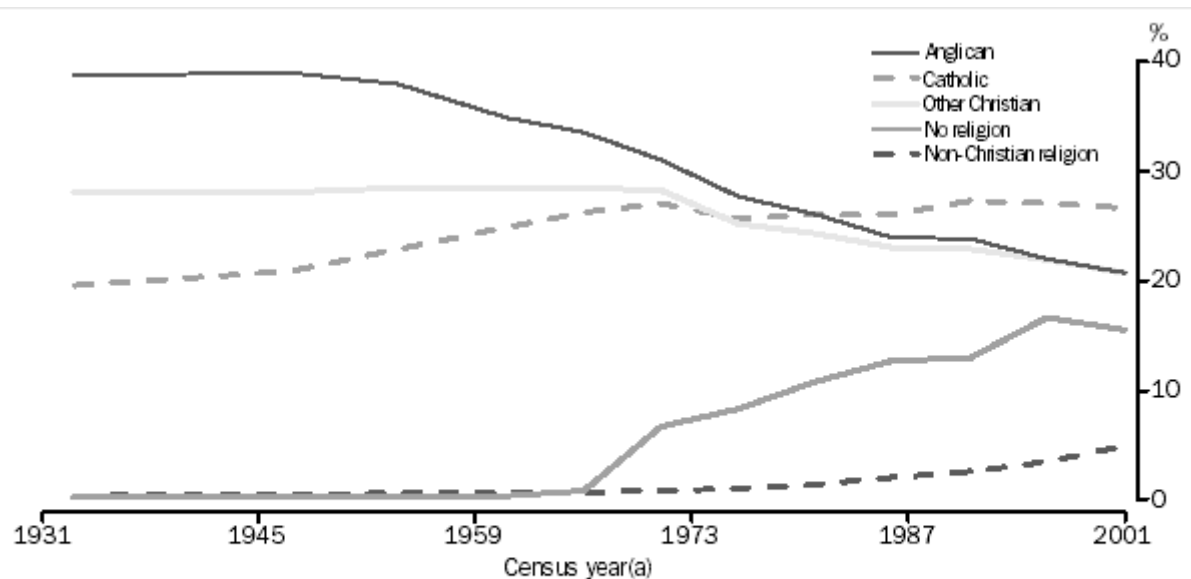


FUNDAMENTALISM AND THE DOCTOR PATIENT RELATIONSHIP

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This paper should be seen as a personal reflection on an issue that is relatively new in Australian Medical Schools. Over the past few decades, despite an overall tendency towards secularism in Australia (1) there has been an increase in activity and probably an increase in devotees to Fundamentalist Christianity, or Evangelicalism (2). It is particularly a protestant phenomenon, although some of the issues I discuss may involve strict Roman Catholics and certainly are institutionalised in the Roman Catholic Medical schools of Notre Dame University in Australia (3).

RELIGIOUS AFFILIATION OF AUSTRALIANS OF ALL AGES



(a) Censuses were conducted in 1933, 1947, 1954, 1961, and subsequently at five-yearly intervals to 2001.

Source: Year Book Australia 2003 (ABS cat. no. 1301.0).

I do note as an aside for our Greek hosts and participants that as far as I can ascertain from published literature that this is not yet a subject of concern in Greece where such proselytising fundamentalist organisations are vigorously opposed by the Greek Orthodox church and the state (4).

The trigger for my concern arose when I was conducting a tutorial in year 1 in our Professionalism and Leadership (PAL) theme, using a scenario based tutorial. The scenario was that of a 15 year old with an unplanned pregnancy and the student was asked to respond to this. Her response was short and to the point.

"I would tell her to burn in hell"

When told that it was her ethical duty, indeed legal obligation to at least provide an appropriate referral:

"We will change the law"

I have taught in Medical Schools for 37 years and I had never seen such overt bigotry before. I had on-going dealings with this student and happily she gave up medicine, unable to reconcile her beliefs with her professional expectations.

I became interested in this group of students as it became apparent that we were enrolling one or two in each year. It became apparent that they were systematically attacking the PAL teaching using our anonymous intranet based feedback and would take a serve at anyone who discussed evolution or climate change.

There has been a significant growth in Australian Universities of Fundamentalist Christians (2) and as one who has a particular interest in the Doctor Patient relationship I decided to examine their beliefs more carefully.

TOPICS TO BE COVERED

- The current canonical view of the doctor patient relationship
- The evangelical view of illness and suffering
- The problems with conscientious objection
- Are these compatible with good professional behaviour?

THE DOCTOR PATIENT RELATIONSHIP

- The current basis of our views about professionalism in medicine
- Professionalism also includes interactions with colleagues, other professionals, management
- Professionalism in medicine has been the subject both of outside criticism and internal soul searching
- The elements of professionalism have been redefined

What do I mean by Professionalism?

I have found a publication from the Royal College of Physicians in the United Kingdom to be most useful in developing my own views on this matter. While very similar views are found in Australian documents, I believe these from the United Kingdom reconcile better

the potential conflicts of public service and individual practice. Also in Australia we are still cursed by the “railway gauge phenomenon”.

Medical professionalism signifies a set of values, behaviours, and relationships that underpins the trust the public has in doctors

Medicine is a vocation in which a doctor’s knowledge, clinical skills and judgement are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability

In their day to day practice doctors are committed to :

- *Integrity*
- *Compassion*
- *Altruism*
- *Continuous improvement*
- *Excellence*
- *Working in partnership with members of a wider health team*

These values which underpin the science and practice of medicine, form the basis for a moral contract between the medical profession and society. Each party has a duty of care to strengthen the system of health care on which our collective human dignity depends.

There have been changes in the way in which we think about professionalism in medicine. Mastery, autonomy (for the doctor), privilege and total self-regulation have been dropped. Competence has been replaced by excellence and appropriate accountability has been added. In an attempt to restore the high moral ground, lost because of real and perceived commercialisation the relationship is seen as: “Patient centred” - achieved with ideas of partnership, well-being, mutual respect and human dignity (5).

Similar redefining has occurred in other countries, notably Canada and more recently Australia. The sentiments are broadly similar, the Australian effort runs the risk of being smothered in qualifying language and parochial arguments. ANUMS has embraced human rights as an important part of this relationship, this is no longer unique and broadens the relationship to one beyond the specific patient with which one has a relationship.

These ideas are not new, but have evolved over millenia, first enunciated in Ancient Greece. They have evolved as our understanding of disease has changed, allowing us to

move from mere relievers of suffering to cure and prevention. They have evolved with the views of the enlightenment, humanity, equality and ultimately human rights.

They are underpinned by an ethical framework, not universally agreed to although the commonest in the western world are described as Principism and some times called the big four (6).

FOUR BASIC PRINCIPALS OF BIOMEDICAL ETHICS

These are the four essential points:

- Respect for autonomy – autonomy of the patient and their carers
- Beneficence – who benefits and how?
- Non-Maleficence – who may be harmed? Can it be avoided?
- Justice – is the action equitable?

I state these because I will later argue that Fundamentalism essentially breaks all four.

THE FUNDAMENTALIST VIEW

My presentation is largely concerned with evangelical Christians because their beliefs are the issue in the ANU Medical School. I will make some comments on positions taken by the Catholic Church. The discussion is based upon the published literature and in particular on a local survey of evangelical practitioners carried out by an evangelical student.

THE 5 PILLARS OF EVANGELICAL CHRISTIANITY

It is necessary to identify the main concepts, namely:

1. Conversionism – faith comes from repentance
2. Biblicism – universal and eternal truth
3. Crucicentrism – atonement of Christ for all
4. Activism – demonstration of gospel truth in evangelicism and service
5. Christocentrism – God's word became human through Jesus (7)

These beliefs held rigidly, which they usually are lead to particular views that impact upon what the majority of the faculty and I hope the majority of graduates believe

- The earth was created in 6 days about 6,000 years ago
- As God controls everything there appears a complex view about environmental events. By way of example I have not found a student who rejects the "Germ Theory", but global warming is strictly in the hands of God.

- Disease and suffering are held to be due to “the fall” or sin.
- The evangelical doctor is a Christ surrogate aiding patients by helping them atone for their sins
- As Jesus loves all no patient should be rejected however grievous their sin. Frankly I find the last the only one compatible with modern medical practice.

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The results of these beliefs are:

- The scientific basis of medicine is rejected
- The humanistic basis of the interaction between a doctor and a patient is replaced by extreme patriarchy
- Beginning and end of life sins appear to get the most attention
- However, all sinners are welcome

In my experience and that of faculty who have attempted to engage with these students these views are rigidly defended, although practitioners interviewed appear to avoid deliberate confrontation with their patients.

“Of all the tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. It would be better to live under robber barons than under omnipotent moral busy-bodies. The robber baron’s cruelty may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience” - CS Lewis - cited in the New England Journal of Medicine in 2009 (8)

CONSCIENTIOUS OBJECTION

- This has risen with the rise in fundamentalism
- Most jurisdictions in advanced countries allow for conscientious objection provided appropriate expeditious referral can be made; eg. in Australia
- The need to refer is being widely eroded by changes in law, especially in the USA, although some states have passed contrary laws.
- Claiming conscientious objection occurs more out of fear or convenience than rigorously held belief
- Manifestations are seen particularly at the beginning and end of life

There has been much literature about who can claim conscientious objection. For example:

- Can a group who have an effective monopoly?
- Can an organisation?
- Can those who are employed rather than private providers?
- Can nurses employed by an organisation who have not initiated treatment?
- Can pharmacists who have not initiated treatment?

It is possible to argue for changes in the current trends:

- An organisation cannot claim conscientious objection status
- Claiming conscientious objection status should be much more stringent
- The obligations of a professional could be argued to override conscientious objection
- Beliefs like skills that potentially affect care should be openly disclosed
- The Roman Catholic church does give an out with the principle of Double Effect, they could potentially liberalize the interpretation

Conscientious objection clearly may clash with patient expectations, legislation and professional obligations (9, 10, 11). This was appreciated by an unexpected commentator:

Freedom of Conscience does not confer a right to indiscriminate recourse to conscientious objection. When an asserted freedom turns into a license or becomes an excuse for limiting the rights of others, the state is obliged to protect, also by legal means, the inalienable rights of its citizens against such abuses - Pope John Paul II - 1991

He was in truth describing totalitarian political regimes not totalitarian religious sects (11).

Having described medical professionalism, the basics of current medical ethics and the views of Fundamentalist Christians my view is that many of the beliefs of the latter are in deep conflict with the principle tenets of the former.

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Bibliography

- 1 Australian Bureau of Statistics. Australian Social Trends; Cat No. 4102.0, 2004
- 2 ABC News www.abc.net.au/news/2008/09/19/2369179.htm (accessed 24/8/09)
- 3 Kerridge I, Ankeny R, Jordens C, Lipworth W. Increasing diversity at the cost of decreased equity? Issues raised by the establishment of Australia's first religiously affiliated medical school. *Med J Aust.* 2005; 183:28-30.
- 4 [Http://www.religioustolerance.org/rt_greec.htm](http://www.religioustolerance.org/rt_greec.htm) (accessed 19/8/09)
- 5 Royal College of Physicians. *Doctors in society: medical professionalism in a changing world.* Report of a working party of the Royal College of Physicians of London. London. RCP, 2005.
- 6 Office of Public Policy and Ethics. UQ. <http://www.uq.edu.au/oppe> October 2002 (accessed 19/8/09).
- 7 Hillborn D Rev Dr., Evangelicism: a brief definition. http://www.eauk.org/about/what_is.cfm (accessed 17/08/09).
8. Charo RA. The celestial fire of conscience – refusing to deliver medical care. *N Engl J Med.* 2005; 352:2471-2473.
9. Meyers C and Woods RD. An obligation to provide abortion services: what happens when physicians refuse? *J Med Ethics*, 1996; 22:115-120.
10. Davis JK. Conscientious refusal and the doctors right to quit. *J Med Phil.* 2004; 29:75-91.
11. Cook RJ and Dickens BM. On the growing abuse of conscientious objection. *Virtual Mentor* May 2006 www.virtual.org (accessed 18/08/09).