

Secularism as a Professional Boundary in Psychiatry



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I should start by declaring a potential conflict of interest. I am an atheist. I do not believe that this is relevant to what I have to say, but I do recognise that you might think differently. I have no desire to press my personal beliefs on you, and I disapprove of Richard Dawkins' attempts to proselytise atheism. However, I do expect that my beliefs should be shown as much respect as anybody else's. I also hold strong political beliefs and everything that follows with respect to spirituality within clinical practice applies equally to politics.

It is not the objective of this presentation to persuade members of the Spirituality and Psychiatry Special Interest Group (SPSIG) to my point of view. Over the past two years I have been engaged in an extended exchange of views with prominent members of SPSIG, some of it in the correspondence columns of 'The Psychiatrist', some of it in private. It is quite clear that we disagree on a number of points. Instead, my objectives today are:

- to explain the position of the multidisciplinary, multifaith group which I will call 'the Wrexham Group', which includes the Poole-Higgo co-authorship. We feel that our position has been misunderstood and sometimes (no doubt inadvertently) misrepresented.
- to acknowledge that conscientiously held positions on these matters are in conflict with each other.
- it is now evident to me that I have unwittingly caused offence in suggesting that the SPSIG is conducting a determined campaign to integrate spirituality into psychiatric practice, and I shall briefly consider the evidence that there is such a campaign
- picking up on a point that Chris Cook has made elsewhere, to determine where the burden of proof lies with regard to any potential harms that might arise from an integration of spirituality into psychiatric treatment.

To me, the term 'intolerant secularisation' is an oxymoron, but clearly this is not a universally held view. The trouble with secularism is that it is hard to define. For me, secularism is all about tolerance of the existence of a diversity of belief. However, tolerance creates ambiguities. A classic example is the 'no platform for fascists' arguments, which were recently resuscitated around the appearance of the leader of the British National Party on 'Question Time'. Is tolerance better served by allowing people to expound intolerant views, or does tolerance embrace intolerance of intolerance? I offer no solution to the dilemma, but I note that tolerance always creates major ambiguities. It is not a simple idea. Certainly there is some evidence that secularism is not the enemy of religion. The USA is the most religious country in the developed world, which has been built within a strictly secular state. As an atheist, it is hard for me to miss the irony that the Pope, during his recent visit to the UK,

expressed the view that secularism was at the root of many of the evils in the world, given that 200 years ago, before the spread of secularism, he would not have been welcomed and given a platform to express his views in the United Kingdom.

Turning to the legitimate role of medicine, it is clear that the fundamental concept of medical treatment rests upon applied science (which is not to deny that there are gaps in the evidence base and that there are imperfections in medical science). In the modern world it is equally important that medicine is practiced with reference to explicit values; in the UK these are set out by the General Medical Council and other bodies so that they can be understood by the profession and patients alike. One of these values is that medicine should prioritise the need of the individual patient. Another is that we should not make unsubstantiated claims for our treatment and that we should confine ourselves to our areas of specific and special expertise.

In order to achieve this, the observation of boundaries in clinical practice is critical. These boundaries are very different to those that are observed in ordinary social interaction. Doctors have to set aside their own needs in clinical settings. We must be aware that our personality and idiosyncratic values affect what we do and how we act. We have to try to contain the effect of this as best we can. Guarding boundaries is complicated and difficult. Sometimes boundaries have to be knowingly crossed. For example, affectionate touch or social kissing is a boundary breach in ordinary clinical practice. Many patients, however, grateful for the treatment they have received, want to hug the doctor at the end of treatment. To refuse this is likely to cause offence. The boundary exists in order to protect the special nature of a clinical relationship and to protect the patient from inappropriate intimacy that might go on to abuse. In breaching the boundary at the end of treatment, the onus is on the practitioner to justify his/her action should any complaint be made or any adverse consequence follow. In order to protect the nature of the relationship, and particularly the trust that patients invest in doctors, boundaries have to be drawn close and clear rather than loose and fuzzy.

Psychiatry has no answers to questions of human happiness. One of the historical flaws of psychoanalysis was that it claimed to have such answers when in fact it didn't. Recognising that we do not have answers to human happiness marks an important boundary with regard to our expertise. Recovery from mental disorder, not happiness, is the achievable outcome that we can work towards alongside patients.

None of this is to deny understanding the patient's personal context is very important in all medicine, including their cultural, social and psychological context. For some people, religion and spirituality are important contextual issues, and this has to be sympathetically understood, even by atheists like me.

In June 2008, the Psychiatric Bulletin (as The Psychiatrist was then called) published an editorial by Harold Koenig¹, together with a broadly favourable

commentary by the then President of the Royal College². Robert Higgo and I, together with other members of the Wrexham Group, felt that we had no alternative but to contradict some elements of what Koenig had said³. We felt that they represented a real threat to appropriate clinical practice in this country if they went unchallenged. The points of contention were:

- that all psychiatric patients should have a spiritual history taken, even where this is resisted or the patient is an atheist
- that it is appropriate for psychiatrists to pray with patients under particular but unspecified circumstances (though Koenig did urge caution)
- that psychiatrists should challenge unhealthy religious beliefs and support healthy ones.

The support of the President considerably exacerbated our concern. The proposals seemed to us to be self-evidently in conflict with GMC guidance. The Good Medical Practice guidance⁴ states: *'You must not express to your patients your personal beliefs, including political, religious or moral beliefs, in ways that exploit their vulnerability or are likely to cause distress.'* The GMC supplementary guidance on Personal Beliefs and Medical Practice⁵ goes further: *'You should not normally discuss your personal beliefs with patients unless those beliefs are directly relevant to the patient's care. You must not impose your beliefs on patients or cause distress by the inappropriate or insensitive expression of religious, political or other beliefs or views. Equally, you must not put pressure on patients to discuss or justify their beliefs (or the absence of them).'*

At this point it seems relevant to quote Andrea Williams' abstract of her presentation, published in today's programme: *'Intolerant secularism says that faith should not enter the workplace and it should effectively be left at the door. This was demonstrated well by North Somerset Primary Care Trust, who last year suspended community nurse, Caroline Petrie for offering to pray for a patient. The nurse was previously told that 'You must not use your professional status to promote causes that are not related to health.'*

I have no personal knowledge of Caroline Petrie, and my understanding of the case entirely arises from press reports, which may be inaccurate. However, some of those press reports say that the patient *complained* about the offer to pray *with* her. If this is true, we appear to have a situation where both nurse and patient might be regarded as intolerant. Under these circumstances it seems perfectly clear to me that the patient's needs should prevail. In considering the case as hypothetically set out here, does it make a difference if the nurse was expounding beliefs related to being a homeopath or a Marxist, a Scientologist or a Reichian psychotherapist? I would suggest not.

In a multicultural, pluralistic society, concepts of spirituality are not universal, even if some people think they are. Indeed, universalistic models of spirituality have a particular resonance with Anglican ecumenicalism. In other faiths, doctrinal correctness is much more important than it is in our national established religion. In some other faiths, concepts of heresy or apostasy are highly salient. It seems to me that this gives rise an altogether different model

of spirituality. Insistence on a universal model of spirituality can have an evangelical implication for some people, which is given a particular relevance by the role that Anglicanism is perceived to have had in programmes of imperial colonisation.

Of course, psychiatrists must sometimes explore spiritual and religious issues, and not only because they are contextually important. Sometimes the spiritual and religious are caught up with psychopathology. Psychiatrists should work with clergy and religious leaders when necessary, because they have real expertise in understanding spiritual and religious experience. I have often done so over thirty years as a clinician. However, there is absolutely no reason for mental health professionals to do the religion themselves and there are many reasons why not. There are others much better placed to offer spiritual support and guidance than psychiatrists. This illustrates one of the problems with the concept of 'holistic care'. Although it sounds like a good idea, with a little critical examination it is evident that it is fraught with difficulties, not least in compromising of the core responsibilities within specific roles in helping people.

As applied scientists, it is natural that we might look to the evidence base. Koenig's 'Handbook of Religion and Mental Health'⁶, and Cook, Powell and Sims' book 'Spirituality and Psychiatry'⁷ (published by the College) both suggest that there is strong evidence that either religion or spirituality or both are on balance good for people's mental health. On the other hand Sloan's book 'Blind Faith, the Unholy Alliance of Religion and Medicine'⁸ looks very closely at the methodology and findings of the evidence base on religion and health, and comes to quite different conclusions. A respectable meta-analysis⁹ concludes the evidence is at best equivocal. I have to say that personally I have always assumed that having a religious faith was probably, on balance, good for people's mental health. Having recently examined the literature, I am not so sure anymore.

It might be supposed that my opposition to integrating spirituality in psychiatric practice is essentially ideological or theoretical, and that problems related to this are hypothetically possible but infrequent in reality. My personal and professional experience suggests otherwise. As a carer of various family members with a variety of medical problems, I have encountered medical practitioners who have broken the secularity boundary on a number of occasions. My family share my beliefs, and the introduction of religion into a medical consultation has not just caused offence. It has sometimes caused a degree of alienation, an uncomfortable feeling of being unable to talk freely with these professionals. This has bothered me when my kith and kin have been unwell and vulnerable. The irrelevant introduction of religion has felt intrusive, unhelpful and, frankly, self-indulgent.

One of the roles that I have fallen into professionally over the last ten or fifteen years has been to investigate problems with individual practitioners or whole services, a role that I have to say has not made me particularly popular. I cannot claim that difficulties regarding religion and other personal beliefs have been the commonest cause of difficulties, but they have not been uncommon

either. These have included incidents of habitual proselytisation, the expression of religious ideas interfering with therapeutic relationships, the establishment of damagingly close relationships through religion creating a sense of special empathy, incidents where offence has been caused, abuses of power and a wide range of problems associated with boundary breaches.

So, to articulate the Wrexham Group's position:

- secular practice does not necessarily ignore the place of religion or spirituality in people's lives,
- there can be no objection to working with clergy, imams and other religious leaders,
- spirituality and religion do not belong in the consulting room or the operating theatre unless the patient brings it there.

Sloan suggests that some American surgeons routinely offer to pray with patients in the pre-op room prior to the administration of anaesthetic. I do not think that it is only atheists that might find this alarming.

To return to my original objectives, is there a determined campaign by SPSIG to integrate spirituality and clinical practice? Just from the conversations that I have had today, I can now see why I have caused offence in suggesting this. SPSIG clearly embraces a greater diversity of beliefs and ideas than I had realised. However, *somebody* is conducting a determined campaign, and prominent members of SPSIG are undoubtedly involved. Larry Culliford and I were interviewed on BBC Radio 4's Sunday Programme in 2008. I expressed very similar views to those that I have expressed today. Larry eventually said 'You are like King Canute, Rob', which did suggest to me that he felt that I was resisting something very powerful. Whilst I may have erred in suggesting SPSIG is organising a determined campaign, there is obviously a *de facto* campaign. I think it is evident from what I have already said, particularly from the GMC Guidance, that the integration of spirituality into clinical practice in the UK involves a significant change in professional boundaries as they apply in the UK. Under almost all circumstances, the burden of proof with regards to the potential for harm lies with the advocates of change, not those who urge caution. This is, after all, the reason why drugs have clinical trials these days.

The debate is far from over. In January the journal 'Mental Health, Religion and Culture' are publishing a special edition on this subject with contributions from a number of us. The British Journal of Psychiatry has recently invited Chris Cook and me to engage in an 'In Debate' article for publication.

Finally, I believe that we are having this debate because of a rapid change in the structure of global society and communications, which is having the effect within psychiatry of a massive identity crisis, as illustrated by the emergence of Bracken and Thomas' 'Post-Psychiatry' project, (which I fear Robert Higgs and I have been rather rude about in print)¹⁰ and the Craddock letter¹¹ pleading for a more biological role for psychiatry. I have been unable to find an appropriate quotation from Gramsci on this matter, but had he written about it, he might have said something like this:

'We are in a transitional epoch where an old world of separate nations, classes, ideas, religions and cultures and relatively stable power structures, is rapidly moving towards a complex global network of free movement, free communication and intermingling.

The result during the transition is chaos in all aspects of human affairs, characterised by instability, war and fear for the future. Although based on very different assumptions, theology and science both aspire to be rationalist systems of thought. Both have tried to retain a role in a world where the central concept of rationalism is under threat. New intellectual alliances have been formed in the struggle and new schisms are appearing.

Throughout the recorded history progressive thinkers have adhered to an overarching value: that human beings share much more than divides them. The future of humanity will only be secure if we can agree on what we share and accommodate to our differences. This is a huge task that has to be managed at the individual and personal level, and it touches on the true nature of tolerance'.

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