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

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Invited contribution:

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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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Abstract

It is ethically inappropriate for physicians to offer to pray with patients in the ICU. Patients in ICU are seriously ill, helpless and vulnerable. Appropriate spiritual or religious support should be provided to them by properly trained chaplains. Religious and spiritual belief is diverse, and an unsolicited invitation to joint prayer from a stranger will predictably provoke negative feelings in a proportion of patients. ICU patients are very likely to be delirious and to suffer adverse psychological sequelae, which means that well-meant but ambiguous behaviour by a physician is easily misinterpreted.

From an ethical point of view, the main objection to an ICU physician offering to pray with a patient is that the action, although well-intended, is not intrinsically benign. There is a tangible risk of harm, and there is no simple guidance that can reliably protect patients from that harm.

Treatment in an ICU is frightening for patients and their families. The rate of Post-Traumatic Stress Disorder and other psychological sequelae after discharge varies between studies[1] but they appear to be common[2]. On admission to ICU, patients are, by definition, at immediate risk of death. Patients are ill and, if they are conscious, fearful. They are helpless and have little or no control over anything that happens to them. They may witness the death of other patients. The environment is daunting and dominated by clinical machinery. Human warmth and comfort are precious under these conditions, and for many people *in extremis*, spiritual or religious support is important to them. However, the treating physician is not the right person to take this role.

There are conflicting bodies of opinion as to whether it is *ever* ethically permissible for physicians to pray with patients in clinical settings[3,4]. Even those authorities that favour a permissive position recognise the risk of harm and a need for caution. They emphasise that prayer should be initiated by the patient. The ethical problems associated with a physician making an unsolicited offer of prayer are heightened when the patient is seriously unwell.

We are based in the UK, but we do not believe that the issues are significantly different in the USA. A little over half of the UK population describe themselves as having no religion[5]. Although rates of religious observance are higher in America, it too is secularising rapidly. In a 2019 survey, 25% of the population designate themselves as having "no religion"[6]. Some people with no religion consider themselves to be spiritual, some do not. Patients in both countries belong to a range of Christian denominations, not all of whom accept the legitimacy of other denominations. There is significant representation of non-Christian faiths, particularly Judaism, Islam and Hindu. In the modern world, religion and spirituality are marked by wide diversity.

The broad range of prevalent belief systems means that a suggestion of joint prayer from a stranger is likely to provoke a range of responses, not all of which will be positive. Some reactions will be very negative. ICU physicians do not have a prior relationship with their patients. A physician who offers to pray with a patient has no way of knowing how this will be received. Patients are sometimes seen by ICU physicians preoperatively, but this is a particularly bad time to make a non-clinical suggestion that may be badly received.

Physicians have an ethical obligation to respect diversity and to show tolerance of their patients' beliefs where they do not share them. From Hippocrates onwards the profession has recognised an overriding imperative to do no harm. Religion always has a close relationship to power, and most religions have a history of suffering discrimination at the hands of people from other faith traditions, or none. This creates pitfalls for physicians of faith who lack self-awareness. Good intentions do not reduce the risk that the outcome of an unsolicited offer of prayer will be a loss of confidence in the physician. Barbers are taught to avoid needless discussion of religion with their customers, and that wisdom has equal relevance to physicians.

Physicians are experts in applying medical science to health care. They have an ethical and legal obligation to remain within the professional boundaries that delineate their special expertise, based upon their specific training and experience. They are not experts in *everything* that is helpful to people who are ill. There is a professional group that has specific training to offer appropriate inter-denominational spiritual care, and that is trained hospital chaplains. People cared for in ICUs should have access to chaplaincy services[7]. It is an important role, which should not be usurped by untrained physicians.

As experts in spirituality, hospital chaplains acknowledge that there are pitfalls associated with their work and that there is a significant risk of causing distress or harm[8]. They are trained to proceed with care. The majority of patients in ICU are not conscious. When they can communicate, their cognitive functions are affected by powerful medications and by illness. Chaplains are aware that this can make patients suggestible, and can distort their perception of ordinary religious ritual.

Chaplains' work in ICU frequently involves the families of unconscious or delirious patients. It is not uncommon for families to want chaplains to pray with the patient, but under these circumstances, it is necessary to assess what the patient's wishes might be. Sometimes families want to bring loved ones who have lost their faith back into the fold of their religion when they are at risk of death. This is entirely understandable, but for the chaplain to collude would exploit the patient's vulnerability and powerlessness. When the patient recovers and remembers (or learns of) unwelcome prayer, family relationships can be seriously damaged.

Medicine is always practiced across a steep power gradient. It can be hard for physicians to be aware of this all of the time. It can be especially difficult to think about therapeutic relationships when treating people who are critically ill, but problems still arise and can affect patients. At least a third of ICU patients are delirious and suffer from unpleasant experiences such as hallucinations[9]. This creates a rich substrate for misinterpretation of ambiguous behaviour in clinicians. Patients may not ostensibly react whilst they are gravely ill, but as ICU care is known to routinely have adverse psychological sequelae, there are good practical and ethical reasons to avoid needlessly compounding the risks. A suggestion of prayer may cause the patient to become alarmed because they assume it signifies that hope of recovery by medical means is fading. Where they do not share the physician's faith, they may lose confidence in the doctor, increasing their distress. They may receive the offer as proselytisation, which, under the circumstances, is an abuse of power. Each of these could adversely affect the patient and their future relationships with other physicians. If prayer for a specific outcome appears to go unanswered, it may result in the patient suffering a loss of faith, which is one reason why hospital chaplains generally avoid such prayers.

We contend that the pitfalls of offering to pray with an ICU patient outweigh any potential benefits, given the availability of a profession with specific expertise on offering spiritual care, namely the hospital chaplaincy . Ethical medical practice depends on clear professional boundaries. In order to be useful to clinicians, boundaries should be tightly drawn. It is possible to think of circumstances where breaching such boundaries might appear to be the

right thing to do. If a physician chooses to do so, it should be clear that the onus is on the clinician to justify their actions.

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