Counseling in a Time of Feeling

JOHN PATRICK

Psychologists today have recognized that their understanding of the human person has not become more scientific but belongs to other disciplines. They no longer believe that to label their discipline a science is either possible in practice or desirable in theory. Instead, psychologists have grasped that psychotherapy best understands itself and best serves its clients by locating itself in the humanities and making use of concepts and approaches traditionally found there. For example, recent theorists such as Roy Shafer, Donald Spence, Jerome Bruner, and Dan McAdams have emphasized a narrative understanding of personality, as well as storytelling aspects of knowledge in general, and of the therapeutic session in particular. Others have placed psychology in the broad field of hermeneutics, in which it becomes part of interpretive frameworks more closely related to theology, philosophy, and ethics than to traditional science. The result is that psychotherapy has begun to return to its roots in the pre-modern era, when psychology was understood to be a sub-discipline of philosophy.[1]

The paragraph above from ten years ago is very relevant to medicine today. It was prescient. In medical practice today many patients are lost souls wandering in a world that has neither apparent meaning nor offers a map to follow. Add to this the bureaucratic obsession with measureable outcomes that increasingly rewards doctors for finding something quantifiable, labeling the patient and the measureable variable, and allowing a faceless bureaucrat to claim success for their procedures. We all know this facile reductionism carried to absurdity. For example, the over-weight patient with Type 2 Diabetes and mild hypertension can be dealt with in less than 10 minutes with pills for both, but leaving their fundamental problems untouched and often aggravated by the therapy. Any attempt to deal properly with the patient would take too much time and lead to bureaucratic scolding or worse.

To address the real problem is possible but, as Vitz points out, requires that the patient's life story and their interpretive framework be explored – not a 10 minute option! Most patients and some doctors are turned off by jargon, terms like informative frameworks. Most patients have a limited framework, often not rooted in serious thought but merely in the vestiges of Judeo-Christian ethics which are steadily eroding under the influence of our liberal elites in education, media and public policy. What is our role in this context?

I believe we must find sensitive ways of recognizing our brothers and sisters in Christ among our patients, as well as others with a strong but different faith system. When that is done, then a door is opened upon a range of resources that can help patients re-connect with, strengthen and grow their faith. (I am well aware that church suppers provide no evidence that church is good for the problem of obesity!)

In United States I have seen the effective use of interviews that involve ancillary staff, including chaplains, to help patients identify their problematic behaviour and begin to take responsibility for it. Many surveys show that most patients would like prayer to be part of the system of care.[2] Thus it seems that, having a notice saying if you would like prayer to be part of your care, just ask us, is a completely defensible approach.

I also believe we need to be very actively involved in our churches, especially in these days when our rights of conscience are under attack. We need to educate people on all the contentious issues of life, death and sexuality; for example, by putting some thoughtful quotations in your church bulletin and say you are open to talk. Our churches must educate the young into the art of questioning the culture – most haven't a clue as to how. The homosexual issue was brilliantly carried by the activists simply by framing the question as an equality question with both groups having the same sort of feelings. Accept those premises and you have lost the argument.

Physicians have often been taught that medicine is a profession that is scientific and must use naturalistic categories. I did not understand or ask why for years! A moment's thought would have been enough to see the error. Physical facts cannot provide moral categories but we cannot live without them. Yes, more education and counseling is needed but we also need to help our patients discover and uncover their interpretive frameworks, and recover ethics and morality in medicine. As Christians we can offer a meaningful map for people to follow.

1 Vitz, Paul C. Psychology in Recovery, *First Things*, March, 2005.

2 E.g., King DE, Bushwick B. Beliefs and attitudes of hospital patients about faith healing and prayer. *J Fam Pract*. 1994, 39:349-352.

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Vocational Excellence in a Pluralistic Society

DAN REILLY

When a patient brings up my faith during a clinical encounter, it always makes me nervous. Most often the patient is suggesting that either my faith makes me a more competent physician or that I will give that patient special treatment because we share Christian faith. The first expectation endangers the patient, and the second offends my Christian faith by asking me to violate professional ethics.

My faith does motivate me to vocational excellence. As a Christian I understand being the best doctor I can be is both an effective witness for Christ and an important aspect of my worship of Christ. My problem with the patient's assumption that Christian physician equals excellent physician is three fold:

1. Vocational excellence can be pursued and achieved with a variety of motivations that having nothing to do with faith.
2. Motivation does not necessarily lead to success. My faith may motivate me to an excellence that other factors prevent me from achieving.
3. Many Christians do not see vocational excellence as related to either worship or witness.

The patient who asserts that my being a Christian means I must be an excellent physician misunderstands reality. Her error causes her to trust me too much and puts her in danger of not recognizing incompetence or being taken advantage of. And when her error about someone who claims Christianity does her harm she may blame Christianity.

The expectation that I will give a patient special treatment because we share Christian faith can only be met if I violate professional ethics. Vocational excellence as a physician or dentist demands that all patients receive the best care I can provide within the limits of my skills and access to resources. The patient who suggests that she should get special treatment because of our shared faith understands neither my ethical obligations as a physician nor our moral obligations as Christians.

Dr. Patrick's suggestion that we must "find sensitive ways of recognizing [Christians] among our patients" and then provide them with resources not available to other patients is in error about both vocational excellence in medicine and our professional obligations to all patients. It is now the standard of care in medicine that all physicians understand the belief system of the patient if the care the physician is providing makes those beliefs relevant. In primary care the patient's worldview is almost always relevant. The professional standard is to find sensitive ways to elicit the spiritual/religious views of every patient. Once physicians know the patient's belief system, they can connect her to whatever resources are potentially useful to her given her medical issue. That professional obligation applies equally to patients who are brothers and sisters in Christ and to those who are not.

If Dr. Patrick's suggestion that physicians take spiritual histories was a new thought for you then you have failed to achieve vocational excellence. You, your patients, your Christian witness, and your worship of Christ will all pay the price. If patients of faith receive a different standard of care from you than unbelieving patients then your professional ethics endangers your career and Christian witness.

Our role as Christians is to, in every context, glorify God and witness effectively for Christ. Being the best physician or dentist we can be is one way that we do both.

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