COMMENTARY

Interfaith Dialogue and Sir William Osler

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ABSTRACT

In recent years, the US has become extensively polarized across social, political, and religious divides. As the cultural, political, and social divides continue to grow, the medical establishment has shown similar divisions between clinicians and patients. However, an inclusive dialogue that recognizes the intellectual and interpersonal boundaries of opposing groups and traditions would provide an avenue toward mutual understanding and further collaboration toward a common goal and solution. One such method for building bridges between opposing groups can be found in interfaith dialogue. The goal of interfaith dialogue is not merely to exchange pleasantries but also to develop a mutual collaboration addressing moral and ethical issues with a unified voice. This is achieved through moving beyond separation and suspicion, inquiring more deeply, sharing both the easy and the difficult parts, moving beyond safe territory, and exploring spiritual practices from other traditions. A physician who exemplified many aspects interfaith dialogue in his clinical practice was the late Sir William Osler. Through examining Osler's application of interfaith dialogue, we may develop a framework by which clinicians can actively build new bridges and dialogue between their patients and society.

INTRODUCTION

In recent years, the US has become extensively polarized across social, political, and religious divides. With social media, mass communication, and computers, polarization between opposing groups and traditions has only sharpened the divides and prevented open dialogue between opposing viewpoints. Such divisions may reflect the increasing globalization of American culture as immigration and incorporation of various cultural practices become commonplace. In some respects, these developments are not surprising. Historically, humans have formed groups with those who share similar beliefs, hobbies, and goals as a means for protection, security, and socialization. However, an inclusive dialogue that recognizes the intellectual and interpersonal boundaries of opposing groups and traditions would provide an avenue toward mutual understanding and further collaboration toward a common goal and solution.[1] This is particularly true between physicians and patients where 2 individuals must come together to overcome personal biases, interpersonal boundaries, and fears toward a common decision for a patient's medical care. One such method for building bridges between physicians and patients can be found in interfaith dialogue.[2]

Interfaith Dialogue

Although interfaith dialogue has occurred throughout human history, the first examples of interfaith dialogue dates to the 16th century when the Emperor Akbar encouraged tolerance in Mughal India between Islam, Hinduism, Sikhism, and Christianity.[3] Other examples can be found in the religious dialogues between Christians and Jews written in the *Disputation of Barcelona* during the 12th century.[4] Interfaith dialogue has therefore been an essential component of religious tradition and interactions since the dawn of civilization. In interfaith dialogue, the goal is to establish mutual collaboration and discussion between different religious traditions toward creating a unified voice. This is achieved through the 5 stages of the interfaith journey: moving beyond separation and suspicion, inquiring more deeply, sharing both the easy and the difficult parts, moving beyond safe territory, and exploring spiritual practices from other traditions.[2] Through listening and sharing stories, we open dialogue on important issues while simultaneously moving beyond suspicion and separation.[5] In such dialogue, we begin developing a sense of oneness, love, compassion, and forgiveness within and beyond our religious traditions and political affiliations. Therefore, the goal of interfaith dialogue is the inclusion of all religious and nonreligious beliefs to build bridges of dialogue, understanding, and progression toward addressing the challenges faced around the world without objectifying another mindset but instead placing themselves in proper subjectivity to it.[5] Such dialogue can be applied to improving the medical field and the physician-patient relationship to incorporate the religious and spiritual traditions of the patient into clinical decision-making.[5]

The physician-patient relationship is an intimate relationship fostering open communication while respecting patient autonomy.[6] Traditionally, the leadership role in the physician-patient relationship rested primarily on the physician.[7] This model, known as medical paternalism, placed responsibility on the physician to determine what treatments or choices a patient should take with respect to

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their illness.[7] In this model, the physician-patient relationship is the ship, and the physician is its captain. Although this may be helpful in complex medical situations, patients prefer having a shared decision-making in understanding their diagnosis and treatment options. As a result, medical paternalism can cause ineffective communication leading to poor management and coordination in a patient's treatment.[7]

In an interfaith dialogue framework, a physician seeks to cultivate improved relationship with patients and healthcare workers toward achieving a common vision and connection.[5] A physician trained using the principles of interfaith dialogue seeks to understand people's motivations, how they acquire and utilize information, and how they influence the physician-patient relationship.[5] A physician who applies interfaith dialogue seeks to foster teamwork, to coach and develop, to improve self-management, and to accelerate change in an organization.[5] Furthermore, this interfaith dialogue framework fosters a physician's ability to sympathize with their patients joys and sorrows.

A physician who exemplified interfaith dialogue in his clinical practice and personal life was the late Sir William Osler. Dr Osler was a Canadian physician who practiced during the 19th and 20th centuries and has become immortalized as the ideal model for clinicians in perfecting proper physical examination, diagnostic reasoning, and the physician-patient relationship.[8] Despite his busy schedule, Osler was able to maintain a sense of intimacy and cooperation with his patients despite his periodic feelings of tiredness, lack of enthusiasm, cynicism, and diminished sense of personal achievement and satisfaction.[9] Beyond his impressive skills as a clinician, Osler's essays on the medical practice and leadership and his personal charisma continue to serve as a model for physician behavior at the bedside.[10] Furthermore, Osler's ideas on faith, medicine, and the physician-patient relationship show similarities to interfaith dialogue and provide a prime example of how such dialogue can occur in modern medical settings. Therefore, examining Osler's bedside manner and relationships with patients may provide an example of how interfaith dialogue may provide a framework and example by which clinicians can build new bridges between their patients and society.

Osler and Interfaith Dialogue

Throughout his career, Osler had great respect for religious traditions. Osler's own father and many of his mentors were ministers of the Church of England.[11] In his early days, Osler was a knowledgeable student of scripture and planned to become a minister himself until eventually pursuing medicine.[11] In Osler's later years, his views on religion changed with the developments of science, particularly with respect to Darwin's theory of evolution.[11] Many of his friends and colleagues described Osler as an agnostic. However, Osler had a deep appreciation and tolerance for religious faith with his friends, family, and patients.[11]

For Osler, faith and medicine were the bridges by which the physician-patient relationship could harbor honest and open dialogue. Osler was often reported to have quoted the views of the philosopher Prodicus, who believed "That which benefits human life is God."[11] In this context, Osler saw faith, religion, and spirituality as important components for benefitting society and human beings. With regard to the physician-patient relationship, Osler often encouraged his medical students and residents to address the emotional and spiritual needs of their patients.[10] In one story, Osler is reported to have asked his students what was the most important responsibility a surgeon had to his patient before surgery.[11] When none of his students could respond, Osler replied that the surgeon should whisper words of comfort into the patient's ear.[11] Stories such as these demonstrate the humanistic ethic, generosity, and warmth Osler applied to his bedside manner with patients.

With respect to the first step of interfaith dialogue, Osler moved beyond his suspicion and desire to distance himself from his patient's suffering. This aspect of Osler's clinical practice remained an prominent memory for patients and colleagues who interacted with him.[10] In most cases, Osler's patient encounters required him to face his own imperfections and limited knowledge to foster compassion and empathy for his patients. Proceeding to the second step of interfaith dialogue, Osler encouraged physicians to inquire more deeply about their patient's story and chief complaint. Specifically, Osler taught his students to remain calm and listen intently to their patients while being aware of their own weakness and frailties. This form of bedside manner, known as clinician-patient communication, has become the cornerstone of modern medical practice. Clinician-patient communication invites a patient to share their concerns, fears, and anxieties about their medical condition while the physician listens and then summarizes the relevant information provided by the patient.[12] This form of communication fosters mutual respect and a supportive environment to make better decisions within the physician-patient relationship.[13] With respect to interfaith dialogue, Osler's application of clinician-patient communication is part of inquiring more deeply about a patient's own story to foster shared decision- making between the physician and patient while preventing breakdowns of communication or disregarding a patient's understanding of their illness.[13]

With respect to the third and fourth steps of interfaith dialogue, Osler used humor to encourage patients to share both the easy and the difficult parts about their personal lives and medical conditions. This allowed Osler to move beyond safety of his patient's insecurities or potentially embarrassing

details that would impede his ability to diagnosis and treat his patients. More often than not, Osler's conversations with his patients often revealed humorous, odd, or embarrassing habits of his patients. As one colleague remarked, "Never has a man masked so successfully earnestness of purpose and a real love of his fellow men with a glimmering veil of humor. He was most in earnest when he was most in fun."[14] Although the humor was most like a coping mechanism for this stress, Osler's humor allowed him to form a rapport with his patients that encouraged them to reveal intimate aspects of their fears, worries, regrets, and despair surrounding their illness and death. Although some patients were difficult to form relationships with, Osler's humor disarmed his own biases and frustrations that were preventing him from empathizing with his patients. In interfaith dialogue, the courage to discuss the easy and difficult parts establishes trust and mutual respect between opposing groups. Without this trust, any form of a physician-patient relationship would be impossible to form, let alone maintain.

With each encounter, Osler would expand his medical knowledge and bedside manner, moving beyond current medical practice. Osler was charitable to religious faiths, arguing that the continued evolution of spiritual thought was the bedrock for improving the moral heart of humanity.[15] Part of his motivation was to free dying patients from their physical and mental pain and ensure their peace of mind in the face of their own mortality.[16] As in interfaith dialogue, we deepen our understanding and relationships with opposite faith groups by exploring new areas where our faiths may overlap or conflict. For Osler, his encounters with faith in the clinic challenged his own beliefs concerning the importance of science while remaining open to aspects of faith and religion.[15] However, it is only through exploring our beliefs that we discover the truth. As Osler reflected in his own search for truth, "The truth is the best you can get with your best endeavor, the best that the best men accept-with this you must learn to be satisfied, retaining at the same time with due humility an earnest desire for an ever larger portion."[17]

CONCLUSION

Although Osler's view of God is complex, he saw faith as an essential aspect of the human experience capable of bringing people together toward a common good. In interfaith dialogue, the continual exploration is similar to a life-long pilgrimage in search of refining one's beliefs while continuing their own search for truth. Interfaith dialogue has the potential to pull us out of our individualism and create a new sensibility about being human and empathizing with our struggles and journey in life. As physicians and healthcare workers, we have the unique opportunity to help improve the physician-patient relationship in spite of the widening polarizations of society. Toward this end, physicians can foster the physician-patient relationship by first identifying and exploring ways their own religious or philosophical beliefs shape their clinical encounters and ability to act as facilitators for improving patient care.[5] Beyond personal investigation, medical institutions can provide seminars and grand rounds to facilitate religious dialogue between caregivers and patients. Furthermore, medical schools can incorporate curricula to help medical students address the spiritual, psychosocial, and ethical principles underlying patient care. For example, Texas Tech University Health Sciences Center offers medical school students the opportunity to participate in a humanities and spirituality course, which addresses a wide range of topics ranging from literature to ethical cases reported in the literature. Physicians can practice this by observing the practice and interactions of interfaith chaplains with patients. Overall, institutions can provide educational opportunities allowing for open discussion on religious or spiritual topics to encourage physicians to take a spiritual history of all new patients, including their religious background and the role their beliefs play in their decision-making. However, it remains an active area of discussion of when these sorts of interactions can occur logistically within patient care as well as in what manner they should be discussed. Despite the significant challenges faced with bridging the polarizations of modern society, physicians throughout history have forged ahead a new path for reconciliation and healing. It is when we work together that we reach our highest potential as human beings. ❖

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Authors' Contributions

All authors (JK, MW, and CG) contributed equally to the creation of this manuscript in both writing and editing.

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