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Short Communication

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Unsolicited Prayer to patients by Migrant Healthcare Practitioners: A Medico-Legal and Ethical Perspective

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1. Introduction

In recent years, several migrant healthcare practitioners in the United Kingdom have reportedly faced disciplinary action, dismissal from employment or deportation from the country for unsolicited prayers for patients. These incidents occur despite the fact that many patients and healthcare workers have reported finding comfort in prayer, which may also support individuals and families in coping with illness or significant life events. The question of whether healthcare workers should pray with or for patients remains the subject of ongoing debate within the broader landscape of spiritual care in clinical settings. This is against the backdrop of research finding which indicates that nurses are frequently asked by patients to offer them prayer or provide them with spiritual support as part of holistic care [1,2].

Although care settings within the larger NHS make specialised spiritual support available for patients; availing of such support should be voluntary and must never be imposed. Giving unsolicited prayer by migrant healthcare practitioners therefore raises a complex medico-legal dilemma which situate at the intersection of spiritual care and clinical practice. This dilemma encompasses issues bordering around professional regulation of healthcare practice, ethics, patients bill of rights, equality and human rights law. Pertinent to point out that prayer & spiritual interventions may be motivated by a practitioner's faith identity, cultural norms prevalent in their country of origin, or a genuine compassionate desire to provide comfort; however, these actions must align with legal and ethical obligations relating to patient autonomy, patient dignity and respect for patient's religious bias.

Hospital policies in the NHS settings generally recognise the diversity of spiritual needs and provides guidance on culturally sensitive care while maintaining appropriate boundaries between religious expectations and clinical practice. Spiritual support must therefore be delivered with the consent of the patient and within the ambit of professional regulatory frameworks.

2. Professional Regulatory Framework and Professional Ethics

Professional regulatory authorities prescribe the standards for spiritual care for patients in clinical practice for their members. NHS guidance on chaplaincy care emphasises that spiritual support must be delivered ethically, fairly and with respect for patient's choice & preference. The guidance also defines the role of trained chaplains and requires that spiritual support be offered only in ways consistent with governance standards to protect patient's autonomy and privacy.

Similarly, the Nursing and Midwifery Council (NMC) Code instructs nursing practitioners to preserve patient trust, maintain appropriate boundaries and refrain from imposing personal beliefs on patients [3]. The NMC's fitness-to-practise guidance also states that although freedom of religious expression is protected, such expression may be curtailed where it is necessary to protect patient safety, uphold public confidence or maintain professional standards.

3. Equality and Human Rights

Two statutory frameworks regulate religious expression in healthcare. The Equality Act (2010) designates religion or religious belief as a protected characteristic. This therefore prohibits discrimination, harassment and victimisation based on religion in employment and service delivery. Whereas an unsolicited or repeated offer of prayer to a patient may constitute harassment, particularly where patient is either vulnerable, hold differing religious belief or has none. The Human Rights Act (1998) incorporating Article 9 of the European Convention on Human Rights (ECHR), provides right to freedom of thought, conscience and religion. This right, however, is qualified and restrictions may

be imposed where necessary to protect the rights and freedom of others. In the clinical context, this means a practitioner's right to manifest religious belief does not override patient's autonomy, right to religious preference, or the right to be free from unwanted religious influence.

3.1. Medico-Legal Issues in Unsolicited Prayer Consent and Autonomy

Unsolicited prayer may contravene the principle of informed consent and patient's autonomy if patient feel pressured to accept religious expression or comply with the practitioner's belief system. Even well-intentioned spiritual actions may be experienced as being coercive within the practitioner–patient relationship.

3.2. Professional Boundaries and Scope of Practice

Healthcare professionals must adhere to professional boundaries and practise within their competence and scope of practice. Providing spiritual interventions without consent, or effectively undertaking chaplaincy functions without training or proper referral, may breach professional codes.

3.3. Discrimination and Harassment

Intrusive or repeated prayer may constitute harassment under the Equality Act (2010), particularly when directed at patients of different religious beliefs. Vulnerable, gravely ill or marginalised patients may feel less able to decline such interventions.

3.4. Fitness to Practice

Professional regulatory bodies may assess the manner in which a practitioner express religious belief when conducting fitness to practise. Conduct that compromises patient safety or erode public confidence may justify regulatory sanction, regardless of the protected nature of the belief. This includes conducting prayer in inappropriate clinical areas, or documentation of religious interactions in a manner inconsistent with information governance standards, may jeopardise patient dignity and breach NHS expectations.

3.5. Particular Considerations for Migrant Practitioners

Migrant practitioners from culturally religious societies may feel particular pressure to offer prayer to patients, drawing on cultural norms of compassionate care or their own religious orientation.

While diversity should be respected, migrant practitioners must also comply with the regulatory and legal expectations of the host country.Employers should recognise that cultural competence includes balancing personal faith with legal duties concerning consent, equality, autonomy and boundaries. Failure to meet these obligations may expose migrant practitioners to misconduct allegations, sometimes more readily than non- migrant colleagues.

3.6. Good Practice for Migrant Practitioners

3.6.1. Informed Consent

Practitioners should obtain explicit consent before offering prayer or spiritual support. Offers should be optional and refusal respected. Alternatives such as chaplaincy referral should be clearly presented.

3.6.2. Engagement with Appropriate Professionals

Where prayer is requested, it should ideally be provided by trained chaplains or pastoral care staff. Practitioners should facilitate referrals and ensure appropriate documentation.

3.6.3. Training and Supervision

Employers should provide training on cultural orientation and professional boundaries especially as it concerns spiritual care. Supervision should facilitate reflection on the appropriate expression of personal faith in clinical contexts.

3.6.4. Clear Local Policy

NHS Trusts and private health institutions should maintain clear policies & guidelines on religious expression and spiritual care. Such policies should incorporate equality duties and professional codes, clarifying that protected belief does not permit conduct that could harm patients or undermine professional standards.

3.6.5. Documentation

Where clinically relevant, offers of spiritual support and patient responses should be recorded factually in line with information governance requirements. Documentation may also aid escalation where concerning patterns of behaviour emerge.

4. Conclusion

Unsolicited prayer by healthcare practitioners is a sensitive issue requiring a balance between the practitioner's right to manifest religion and the patient's rights to autonomy, dignity and non-discriminatory care. Professional codes and NHS guidance emphasise that spiritual care must be voluntary and patient-centred, preferably delivered by trained chaplains. Regulatory intervention is justified where religious expression jeopardises patient safety or breaches professional boundaries [4,5]. Effective policy, cultural-competence training and robust consent practices are essential to safeguarding both patients and practitioners in a pluralistic healthcare environment.

References

1. DiJoseph, J., & Cavendish, R. (2005). Expanding the dialogue on prayer relevant to holistic care. *Holistic Nursing Practice, 19*(4), 147-154.
2. Nursing and Midwifery Council (Great Britain). (2018). *The code: professional standards of practice and behaviour for nurses, midwives and nursing associates*. NMC.
3. Taylor EJ, Spiritual Care: Nursing Theory, Research, and Practice (Prentice Hall 2003). Equality Act 2010
4. Human Rights Act 1998
5. European Convention on Human Rights, art 9