Spiritual Care Services in Emergency Medicine

Mildred Best MDiv., MSS, BCC, Andrew French MD,
Marcus L. Martin MD, S. Sarvaananda PhD, BCC

Abstract

Providing spiritual care services in Emergency Departments is essential to recognizing the importance of treating the patient in a holistic manner. After all, a patient is not an illness or a statistic but a complex human being; a mass of emotions and fears facing an unknown. As simple as this concept is, it can easily appear to be forgotten in a fast-paced Emergency Department. Sensitivity to the spiritual needs and differences that patients bring to the ED helps to foster humanity for each patient regardless of cultural, socio-economic, ethnic, or religious differences. Understanding the patient as a spiritual being necessitates the care of not only the body (physical) and the mind (mental), but also the spirit (spiritual health and wellness). Spiritual/pastoral care services provided in Emergency Departments are a significant aspect of treating the whole patient during a health crisis or trauma. Above all, the effort to recognize and address the spiritual needs and differences of patients through spiritual/pastoral care because of injury or disease demonstrates cultural competency.

Introduction

Spiritual Differences Defined

A broad definition of spirituality is that which gives a person's life ultimate meaning. For many, it might be a belief in God as expressed and lived out in a community of faith (i.e. church, synagogue, etc.) with others of like mind. For some, it might be the belief in many gods as an expression of the divine. Still for others, it might be a personal relationship with God, or a connection with the universe and nature, or an understanding of a connection with a higher power or supernatural being. Spirituality can also be defined as that which an individual holds sacred. These beliefs and understandings are informed and influenced by race, ethnicity, religious status, culture, nationality, gender and worldview, etc. Spirituality is often what gives an individual hope to strive for wellness and wholeness during adversity and illness. Spiritual differences encompass the awareness that no two persons, regardless of similarities in faith or ethnicity, are the same as innately spiritual beings. Their life stories are unique, so their spiritual background and their understanding of life's situations will be different

Spiritual differences are also informed by faith tradition and/or a system of beliefs, be it Christianity, Judaism, Islam, Hinduism, Buddhism, Paganism, or even Atheism. To understand spiritual differences in Emergency Medicine, one must first understand that world religions "flourish" in communities served by Emergency Departments throughout this country.[1]

Health-Related beliefs and Cultural Values and Traditions

Health-related beliefs and assumptions are prevalent in many faith traditions. These beliefs become the lenses through which the patients' worldviews and understanding of their illness is seen. Some of these beliefs and practices are clearly articulated by the spiritual community and are well-known in the medical community. One example of this is "the religious prohibition for Jehovah's Witnesses against the use of blood and blood products".[2] For others, beliefs may be unique to an individual's own understanding of his or her spiritual practices. Such beliefs and understandings may be articulated freely, but at other times may be unknown and not easily explained by the patient. These beliefs will affect whether a patient or family makes a decision about a DNI or a DNR, or accepts or refuses a particular medical treatment or procedure. Some may view modern medical technology as a gift from God for healing. Just a basic awareness will help emergency physicians and healthcare teams understand the connections between spirituality and informed healthcare decision-making. This is an important element in providing cultural competency for the ED.

Healthcare Provider Knowledge

Healthcare providers, such as physicians, should have a basic understanding of the health-related belief systems of patients from varying faith traditions and an awareness of how these belief systems may inform the patient's healthcare decision-making process. There should also be an understanding of the ways in which religious beliefs and spiritual differences may enhance or detract from the doctor-patient relationship. For example, a patient who believes that all healing comes from God might decide that they want to "hold out" for a direct healing from God and might delay or outright reject medical intervention as illustrated by the following example:

> An African American family…was resistant when the physician attempted to explain why a do not resuscitate (DNR) order was needed. A family member said that they would wait on God and that God would have the last word. At the time, the family felt that to agree on a DNR would be the same as giving their loved one a death sentence. The struggle for this family was whether to trust *man,* meaning the medical establishment as represented by the physician, or to trust in God.[3]

Awareness of Practitioners in the Emergency Department

In Emergency Departments, it is especially important to recognize that, in the face of trauma and the unexpected onset of illness and disease, patients can be at significant "spiritual risk." These individuals are considered "at risk for poor health outcomes as a result of under-developed, conflicted, overwhelmed, or negative spiritually resulting in "high spiritual needs and low spiritual resources" to meet these needs.[4]

It then becomes extremely important that practitioners in the Emergency Department recognize their limitations and determine when it is appropriate to refer to a chaplain or other spiritual care provider. This is not to say that the physician and healthcare providers need not be sensitive to various religious belief systems and their impact on illness. Instead, it is a recognition that there are those who have dedicated their life and education to become credentialed in the area of pastoral/spiritual care/chaplaincy, just as the physician is educated and credentialed in providing medical care. An awareness of religious tradition and a basic understanding that some patients might be in a spiritual crisis are reasons for immediate referral to a chaplain or spiritual care provider/clergy.

Chaplain/Spiritual Care Provider Knowledge and Education

As pastoral and spiritual care providers, chaplains are educated to meet the spiritual, religious, and pastoral care needs of patients. "To become a qualified chaplain

and certified member of the Association of Professional Chaplains requires clinical supervision and training at least equal to qualifications to become a licensed clinical social worker. A certified chaplain requires a minimum of 4 years of undergraduate and 3 years of graduate [theological training leading to a Master of Divinity degree] education along with 1,635 hours of clinical supervision. The profession seeks to integrate mental health skills with religious training [inclusive of theological reflection] to prepare a chaplain to intervene effectively in a troubled person's life."[5]

The 1,635 hours of clinical supervision are provided through Chaplaincy and Pastoral /Spiritual Care Departments in hospitals and other healthcare centers. These centers are accredited by the Association of Clinical Pastoral Education to provide clinical supervision for chaplain residents (who meet the education requirements listed above) to earn the clinical hours needed for Board Certification eligibility in various competency/outcome areas. These individuals are supervised and trained by Clinical Pastoral Supervisors/Educators who are certified by ACPE. The ACPE competencies include self-awareness, interpersonal awareness, conceptual ability, pastoral functioning, ministry management, and development. There are competencies and outcomes in each category. For example, interpersonal awareness requires that chaplain residents demonstrate competence in providing pastoral care to patients from various religious, racial, ethnic, and socioeconomic groups.

Spiritual Care Available

Pastoral/spiritual care has been traditionally rooted in enabling, encouraging and facilitating the patient to access and make use of her/his own religion, belief system, and/or spirituality as a resource for sustaining her/him through crisis and illness. The chaplain's role has been to employ intervention tools like *healing, sustaining, guiding, reconciling and liberating,* all in an empathetic spiritual relationship that is called the pastoral conversation.[6] Some aspects of the pastoral conversation consist of "following the patient's direction, responding with empathetic understanding, and retrieving and connecting lost conversational fragments to the central theme the patient raised."[7] The pastoral conversation is but one aspect of pastoral/spiritual care, which is used to address

the spiritual care needs of patients. Harold G. Koenig of Duke University Medical Center describes the spiritual needs of patients as follows:

- **A need to make sense of the illness.** Patients need to understand why they have been singled out for illness, what it means for them, their future, and their families' future. They need to know how they are going to cope with, and bear the burden of, a changed life that may involve long-term physical discomfort.
- **A need for purpose and meaning in the midst of illness.** Patients need renewed purpose and meaning in order to continue to fight illness. They need to know that they can still contribute, despite their illness. Religious and spiritual beliefs often lie at the core of what gives life purpose and meaning in these circumstances.
- **A need for spiritual beliefs to be acknowledged, respected, and supported.** When patients are sick and in the hospital, religious or spiritual beliefs become increasingly important. Patients need their health professionals to acknowledge, respect, and support those beliefs.
- **A need to transcend the illness and the self.** Patients need to get their minds off of themselves to counteract the obsessive preoccupation with self that almost always accompanies serious illness. Focusing on spiritual matters often helps patients put their own concerns into perspective.
- **A need to feel in control and give up control.** Hospitalization and illness makes patients feel isolated from others. Spiritual beliefs, visits from their pastor or a member of their congregation, [a hospital chaplain], or knowing that members of the faith community are praying for them, all help to re-establish connection with others. Feeling connected to, cared for, and loved by God also helps to relieve loneliness.
- **A need to acknowledge and cope with the notion of dying and death.** Having illness serious enough to warrant hospitalization sends a terrifying message to many patients – that they cannot live forever. Many fear death less than they fear the process of dying, and the discomfort, isolation and loss of control associated with it. Spiritual beliefs provide a world-view that makes sense of life, death, and suffering – and gives answers that medicine and science cannot provide. On the

other hand, patients may not feel spiritually ready to die. They may fear punishment after they die, or worry about their relationship with God.

- **A need to forgive and be forgiven.** Because illness can sometimes be perceived as punishment and because it forces us to confront our ultimate mortality, the need to give and receive forgiveness is greatly enhanced. Religious and spiritual rituals exist that help patients to forgive others and accept forgiveness themselves, releasing them from the emotional turmoil that guilt and bitterness produce.
- **A need to be thankful in the midst of illness.** Being thankful and grateful for the health and relationships they still have helps patients to adapt more quickly to illness and maintain a positive outlook. Religious beliefs and stories both encourage an attitude-of-gratitude, and provide role models to help accomplish them.
- **A need for hope.** Hope is the engine of motivation. Without hope, patients give up, neglect themselves, and strike out at others trying to help them. Spiritual beliefs are a powerful source of hope for many patients.[8]

Even though the pastoral/spiritual conversation is an important tool in the clinical setting when providing spiritual care to patients, it is also important that chaplains are educated in Clinical Pastoral Education (CPE) programs on the religions practiced in the United States and their implications for pastoral/spiritual care. This also includes the importance of religious rituals, religious observances, and the implications for medical care. For example, at the University of Virginia Department of Chaplaincy Services and Pastoral Education, which is accredited by the Association of Clinical Pastoral Education, an understanding of various religious traditions is incorporated into the curriculum in the form of didactic seminars on pastoral or spiritual care to patients who are from Hindu, Muslim, Jewish, Catholic, Pentecostal, and main line Protestant traditions (i.e. Methodist, Baptist, Episcopal). Chaplain residents and interns in the educational program are encouraged to develop learning goals that enhance their knowledge in traditions other than their own in order to develop competencies in this area and meet ACPE standards.

Discussion

In the year 2000, the majority of Americans (92.5%) in the United States believed in God. Of this number, 88% practiced some form of Christianity (60% Protestant, 28% Roman Catholic). Despite these statistics, the United States has representation in its population from all the major world religions. It is a given that the healthcare system and Emergency Departments will encounter patients from various religions/faith traditions at one time or another. In healthcare, people from various traditions will walk through the doors of Emergency Departments daily. The population of people in the United States who practice religions other than Christianity is a testimony to this fact. **For example, in the United States, 2.5% are Jewish, 0.5% "practice" Islam, and Hinduism and Buddhism are practiced in this country (less than 1%).[9] The population representing other faith traditions in the United States is shown in Table 1:[10]**

Selected Religious History

Religion	Facilitating Practices and Lifestyle	Food and Diet	Illness	Healing	End of Life
Buddhism	Peaceful and quiet meditation are a mainstay	May be vegetarian	Results from karma and is divided into six categories each with own traditional therapy	No faith healing but great emphasis on attainment of a clear and enlightened mind	Death is a transition into the next life - meditation and rituals are designed to promote a higher level of reincarnation
Baptist	Strong prohibition against homosexuality and alcohol	No outlined restrictions other than alcohol intake	Variable with individual	May request prayer support from congregation	Belief in life after death makes prayer for the terminally ill important
Pentecostal	Prayer and scripture readings daily	No outlined restrictions	Variable with individual	Strong emphasis on faith healing	Belief in life after death and emphasis on faith healing makes prayer for the terminally ill important
Roman Catholic	Restriction on all birth control other than the Rhythm method	May avoid meat other than fish on Fridays and during the season of Lent	May result from predestined fate or be the result of punishment for wrongdoings	No restrictions on most modern medical practice as long as it does not violate Natural Law	Believe in life after death therefore Sacrament of the Sick is important
Islam	Increased importance of modesty and potential gender segregation	No pork or alcohol with other variable restrictions including shellfish	May serve religious roles and therefore treatment may be refused	Medications containing forbidden dietary products are strictly forbidden	Multiple rituals and needs must be met, including confession of sins, proper body placement, and a reciting of the Islamic Creed
Judaism	Increased emphasis on sexual relations beyond the duty to procreate	Determined by Kosher law	Variety of theodicies	Unless absolutely necessary, surgical procedures to be avoided on Sabbath	Increased value on prolonging life, which raises a multitude of ethical issues

Table 1: Summary of major religious/medical points previously presented. Those issues not addressed within the text have been adapted from The St. Joseph's Hospital "Quick Guide to Cultures and Spiritual Traditions" cited above

Grasping the issues raised by a patient's religion is only part of what it takes to use that knowledge to treat the individual. As most people know, a religious affiliation can mean one is a strict adherent or that one is simply following the religion of his or her family without being a true worshipper. Of course, it could also mean that the patient has a level of religious commitment anywhere in between those two extremes. It therefore becomes the doctor's responsibility to assess the level of religious commitment by taking a proper and sometimes detailed spiritual history. Table 2 provides four models adopted from the University of Texas Medical Branch Spirituality and Clinical Care syllabus.[11] Any of the models can be used to determine spiritual commitment, although some models will elicit more detailed information (Model IV) than others (Model I). Use of the models can be adjusted to the patient and to the needs of the physician. Equally important is understanding when to ask the spiritual history. A spiritual history can flow easily from questions about church involvement or support during difficult times. As physicians gain experience, they may find their own style and specific area of use for the spiritual history. Assessment of the spiritual history requires understanding basic knowledge of major religious traditions.

Model I: Three Questions	Model II: FICA	Model III: HOPE	Model IV: SPIRITual History
What helps you through the tough times?	**F**: Is spirituality or faith an important part of your life?	**H**: Sources of hope, meaning, comfort, strength, peace, and connectedness?	**S**: Spiritual belief system
Who do you turn to when you need support?	**I**: What impact do your spiritual beliefs have on your health choices? How do your beliefs affect your illness?	**O**: Organized religion?	**P**: Personal spirituality
What meaning does this experience have for you?	**C**: Do you have a spiritual, religious, or other community of people who support you in a time of crisis?	**P**: Personal spirituality or practice?	**I**: Integration with spiritual community
	At: Is there something you would like me to do to assist you in this area?	**E**: Effects on medical care and end-of-life issues	**R**: Ritualized practices and restrictions
			I: Implications for medical care
			T: Terminal events planning

Table 2: Various question formats used when eliciting a spiritual history

Buddhism

The basic foundations of spiritual enlightenment, karma, and reincarnation are central to both the religion and the healthcare of the Buddhist patient. Outlooks on health, lifestyle, illness, and death are shaped by these principles.

For the Buddhist, "the central focus is attainment of a clear, calm state of mind, undisturbed by worldly actions or suffering and full of compassion and enlightenment."[12] This personal enlightenment is obtained via an eightfold path based on the right understanding, thought, speech, action, livelihood, effort, mindfulness, and meditation. It then progresses to the complete and total study of the laws of cause and effect, or karma, which replaces a belief in God.[13,14] Illness to the Buddhist is a result of karma from either this or a previous life and is therefore not considered to be a punishment by a divine being. Because of the denial of a supreme deity being responsible for illness and

suffering, the laws of karma circumvent the problem of theodicy for the traditional Buddhist. These beliefs have a direct effect on healing the Buddhist patient, which can be somewhat unique compared to other religions.

The first noteworthy concern when dealing with some Buddhist patients is to understand that some traditional beliefs place the illnesses brought about by karma into six categories ranging from improper diet to poor meditative practices.[14] The challenge to the physician is that each of the six categories also has a traditional Buddhist treatment. A physician must be aware that such a patient may have used or be using a traditional method of healing such as herbal remedies that may be contraindicated in the patient's new therapy. Furthermore, if any traditional treatment is being utilized, it must be determined whether or not this treatment is harmful, helpful, or benign in and of itself.

For Buddhists, healing comes from belief in enlightenment. For the patient following Buddhism, "healing and recovery are promoted by awakening to the wisdom of Buddha, which is spiritual peace and freedom from anxiety"[12] This may cause Buddhists to employ a variety of meditative techniques which are key to both their physical and spiritual health. Similarly, because of this same belief in enlightenment and karma, Buddhists do not believe in any type of faith healing. Therefore, instead of prayer, the patient may wish for undisturbed silence in which to meditate.

Medications must be chosen carefully for the true Buddhist. Because of the emphasis on mental clarity within this religion, it is of great importance that medications do not affect the patient's state of mind. This has even more implications when dealing with palliative care for the dying, as will be seen. Also, for some Buddhists, medications must not contain elements of slain animals because Buddhists are against suffering of any life form and because some animals are believed to contain reincarnated human spirits.[3]

For the Buddhist, death is the transition into the next life via reincarnation. Furthermore, the level of clarity and calmness reached in that lifetime and the state of mind at the moment of death are the most important influences that promote a higher

human rebirth. Therefore, increased meditation and any traditional rituals performed at the end of life are aimed at promoting the level of reincarnation. When nearing the time of death, the Buddhist patient may wish to frequent a shrine, or simply display a picture of Buddha as his or her shrine.[15] It is important for hospital staff to note that the patient is in meditation when a picture of Buddha is in view of the patient. Also, it may also be imperative to the patient that a Buddhist representative be notified to find an appropriate person to provide some spiritual care for the dying patient. In addition, it becomes even more important at this time that any medications or therapies not affect the patient's mental state. To disrupt the patient's mind would be to hinder his personal quest for enlightenment and progression into a higher spiritual plane. Understanding the Buddhist will help promote health and spiritual enlightenment.

Christianity

Baptist views affecting lifestyle choices are most often recognized and newsworthy. The most conservative and noteworthy of these denominations is the Southern Baptist denomination. The first issue to address is the prohibition of alcohol and tobacco. Although there is some division within the church about the abstinence from tobacco, at least from a religious perspective, it still deserves to be addressed. Prohibition from alcohol has been attacked by Baptists on three fronts--religious, medical, and social. To many Baptists, "alcohol was bad for health, injurious to society, disastrous to family life, and psychologically detrimental to an individual."[1] "The Bible taught that wine was a mocker and deceiver (Prv. 20:1) and that it led to spiritual ruin."[16] Furthermore, the ultimate solution to the problem has always been spiritual. Only the grace of Jesus Christ can save people from drink. It must be noted that many Southern Baptists do not take this outlook, but for those who do, the consequences could be emotionally and mentally troubling if alcoholic drinks are consumed. A Baptist alcoholic, who belongs to a church holding this belief, would be expected to recover through prayer and the spiritual guidance support of other Baptists. Likewise, because a spiritual recovery seems best to a Baptist, he may or may not have to face feelings of guilt in front of his congregation for an ailment which he may not be able to cure through

his faith. In this light, such a strong and steadfast abstinence from something unhealthy may have detrimental consequences for those who suffer from the illness of alcoholism.

It has been no secret that this Christian group has taken a firm stance against homosexuality. References from www.religioustolerance.org and an online Southern Baptists of Texas Convention Newsletter show what Southern Baptists generally believe: that the Biblical passages condemning homosexuality are still valid today (Gen 19 [cf. Jude 7; 2 Pet 2:6-10]; Lev 18:22; 20:13; Rom 1:24-27; 1 Cor 6:9-11; 1 Tim 1:8-11), that people can change their sexual preference and thus that homosexuality is not genetic or hormonally caused, and that discrimination against homosexuals is acceptable in certain circumstances such as employment or social institutions.[17,18] It must also be noted, however, that although homosexuality is regarded as a sin, it is not unpardonable, and therefore Southern Baptists "lovingly and compassionately seek to bring people to faith and forgiveness in Jesus Christ."[18] The medical concern is not truly the stance on homosexuality, but rather how that stance may affect an adolescent boy or girl as they mature and discover their sexuality, especially if it is homosexual. Mental, emotional, and spiritual damage could be lasting and severe with expected repression of their desires and who they are. It is once again this indirect effect of a religious belief that physicians must be aware of with their Baptist patients.

Pentecostal

The following quote, taken from the United Pentecostal Church International, gives a concise summary of the healing beliefs of this Christian denomination. "God is the Great Physician. His knowledge of the human mind and body is complete. He can do more for the sick and the diseased than can all earthly doctors and surgeons combined. He created us; is it not reasonable, then, to believe that He can heal us when we are sick?"[19] The deep belief in "faith" or "divine" healing is the central focus of a number of Pentecostal traditions concerning health and illness. Pentecostal interpretation of the Bible is literal, and the complete truth of the gospel is held as a vital element. Although Pentecostals still believe that modern medicine has benefits (although only because it was God who created doctors and medicine), it is through prayer, faith, and the church that

one is truly healed. Much of the New Testament scripture is used to back their beliefs. For example:

> "These signs shall follow them that believe; In my name shall they cast out devils . . . they shall lay hands on the sick, and they shall recover" (Mark 16:17-18). Listed among the gifts of the Spirit for the present-day church are "the gifts of healing" (I Corinthians 12:9).
>
> James 5:14-15 presents God's plan for divine healing: "Is any sick among you? Let him call for the elders of the church; and let them pray over him, anointing him with oil in the name of the Lord: and the prayer of faith shall save the sick, and the Lord shall raise him up." Laying of hands and anointing with oil usually accompanies prayer for healing, in accordance with God's Word and to focus faith.
>
> Faith in the Lord is the key to receiving healing. The Gospels record that Jesus healed people according to their faith (see Matthew 9:29;13:58; Mark 2:5; 5:34, 36; 9:23-24;10:52.) By the power of God, the Apostle Paul was able to raise up a lame man at Lystra because he perceived that the man had faith to be healed (Acts 14:8-10).

The modernization of many Pentecostal traditions has brought about a greater willingness to accept modern medicine and its treatments.[20] However, as a physician, it is very important to be aware of the patient's level of commitment to his or her religion. This may give clues as to delayed medical treatment or even resistance to treatment. By showing an understanding of the patient's beliefs and encouraging the use of faith healing *with* modern care, the physician can maximize the patient encounters and eliminate total dependency on the church.

Roman Catholic

Although Roman Catholics are generally very accepting of most aspects of modern medical practice, areas where they differ have been subject to much debate and have been put at the forefront of one of the most controversial medical topics in the

United States. The outlooks on conception, pregnancy, and beginning-of-life issues have linked Catholicism to legal and political topics - a popular realm for religion in today's society.

Catholics have historically been well-known for prohibiting nearly all forms of contraception. Instead, they suggest natural family planning or the rhythm method which consists of only engaging in sexual intercourse when the woman is not fertile (just before, during, and just after ovulation). The basis for this belief lies in the Catholic concept of natural law. In its most basic form, natural law reasoning assumes that every human act has a natural goal attributed to it by God. Any attempt to frustrate that goal is unnatural and therefore wrong. In this instance, sexual intercourse is clearly designed to produce offspring. Any method of contraception other than taking advantage of a woman's "natural rhythms" interrupts the natural goal and is thus considered unacceptable.[21] Likewise, Catholics may refute some birth control methods with additional moral arguments. As will be discussed, most Catholics view life as beginning with fertilization.[22] Therefore, any device that allows fertilization, but not implantations (RU-486, copper IUD etc.) is viewed as essentially causing the murder of a developing life, which would clearly be morally wrong.

Beyond the concept of denying implantation to a fertilized egg is the idea of abortion. Again, because the Catholic religion gives the fertilized egg the dignity of human life, ending a pregnancy at any stage is considered murder. Initially the prohibition against abortion stood for any circumstance, even if it meant death for the mother and the baby. Today, however, the belief has evolved for most Catholics. "The moral principle which ought to govern the intervention can be formulated as follows: since two lives are at stake, one will, while doing everything possible to save both, attempt to save one rather than to allow two to perish."[22] In basically all other circumstances where the mother's life is not in danger, abortions are still considered murder. However, the medical profession should watch for further directional alterations of this concept in Catholicism. For example, Father Richard McCormick cites a study by Susan Teft Nicholson who suggested that abortion may be reconceptualized from a

killing intervention to the withdrawal of maternal assistance. This raises a new question whether a woman would be "bound to provide assistance when the pregnancy is the result of rape."[22] Physicians must be aware that although a religion may be thousands of years old, its beliefs are not.

The final point to examine about the Roman Catholic faith is their outlook on illness and suffering. With the monotheistic background and the emphasis in the afterlife of heaven and hell, the "Sacrament of the Sick" becomes very important.[23] An ill or dying person often desires to see a Catholic priest in the hospital, including at the time of death. The Catholic patient may wish to pray or confess his or her sins before departing to the afterlife, and their ability to do so may be seen as promoting their entry into heaven. It is therefore imperative to many Catholic patients that the appropriate clergy be notified in advance of death.

Also linked to the monotheistic idea of an omnipotent, all-powerful God is the belief by some that illness and suffering may either be predestined fate or punishment for wrongdoings.[23] The latter is an example of free will theodicy. From a Bible that speaks of God striking down rebellious people with illnesses such as scurvy, blindness, and boils, it is an easy transition to think that one's illness may be a punishment from God. For some, this may bring feelings of guilt or misunderstanding. For others, it may bring a type of resigned penance to their illness, or a feeling that they must endure God's punishment. Some may see it as a test of faith or a type of educative theodicy, but others may have none of these thoughts. Evaluation of the patient's religious commitment and involvement is the key to understanding in this situation. Without this understanding, the doctor may not comprehend or even be aware that such hardships exist for these patients.

Islam

Of great importance to people in the Islamic religion is the concept of modesty, which stems from a deeper belief in sex segregation. This belief is central to the medical care of Islamic patients in many ways. For instance, women may insist on wearing the traditional garments that completely cover their body when in the hospital rather than the

traditional and sometimes revealing hospital gowns.[24] They may also wish to have an all-female staff to provide their care. Furthermore, a Muslim woman shall not be left alone with a man who is not her husband.[25] Men may wish to remain clothed from the waist down even in front of other men.[26] Some customs may even prevent handshakes or contact between genders. Interestingly, these traditions of sex segregation do not find their origins in the Qur'an. The Islamic holy book simply advises that "in mixed gatherings, men and women should exercise 'sex-modesty.'"[27] It was not until later in the Islamic tradition that specific forms and rules of sex segregation were imposed. In fact, the Prophet himself as well as other orthodox founders of Islamic law encouraged the practice of cross-gender healthcare in times of injury or illness.[27]

The Muslim diet is another very important aspect of the Islamic lifestyle that affects health care.

> Food has a central role in the lives of Muslim families, and dietary restrictions may vary between countries depending on how the members follow tradition. The diet of the Muslim patient should not contain pork, pork products, or alcohol. Most Muslims will not eat shellfish, and some believe meat must be "halal," that is, from animals slaughtered in the prescribed manner. Some patients desire a Kosher or vegetarian diet. During Ramadan, the ninth month of the Muslim year, faithful Muslims fast from dawn to sunset for 28 days. This fast includes abstinence from food, drink, smoking, and sexual intercourse. It is believed that fasting teaches obedience to God and is required only by adults who are physically capable and mentally competent. Elderly people, ill people, travelers, pregnant women, lactating mothers, menstruating women, women with postpartum discharge, and women who have experienced a miscarriage are exempt from fasting. Children are exempt, but at the age of 12 or 13, adolescents are urged to attempt to fast in preparation for adulthood.[25]

Some Muslims, especially the older and more conservative ones, may refuse to eat hospital food altogether and insist on having their food brought to them by friends or relatives of the Islamic faith.[26]

A related aspect of dietary restrictions arises when faced with the controversy between restrictions of the diet and medical necessity. Can a Muslim consume, as medicine, what has been prohibited by religious law? "On the eating of the pig, wherever the Qur'an mentions a prohibition, it always makes an exception for 'cases where it may be necessary, without willful transgression of the Law.'"[27] However, in the case of alcohol, the Qur'an severely denounces its use without giving an outright and explicit prohibition. Lastly, some Muslims may not accept medicines prepared by non-Muslims for fear they may have used ingredients whose consumption is not allowed by Islamic law. Because of these restrictions and other variations within Islamic groups, it is imperative that the Muslim patient be questioned about dietary preferences while in the hospital.

The attitudes of Muslim patients may pose serious problems in the treatment plan. Many Muslims may refuse treatment of any kind, especially if brought into the hospital against their will. The reason for this lies in the etiology of illness according to Islamic teachings. As health is the greatest blessing of God, illness serves three important functions: (1) it is regarded as a purgative role; (2) it may be a punishment for sins; and (3) it may entail positive reward. In all three situations, illness is regarded as a blessing. Furthermore, some traditions emphasize not seeking medical treatment for an illness until it becomes unbearable.[28] Obviously, this could pose great challenges to the physician attempting to treat certain members of the Muslim faith. However, as a useful tool for the health care provider, the Qur'an states that saving and preserving life are among the most highly-regarded tasks within the religion.[29]

Death itself is a taboo subject for many Muslims. Although members must face death as part of Allah's will and acknowledge submission to Allah's plan for their life, it is also believed that one should never give up hope, because to do so would be to deny

the will of Allah.[2] When caring for the dying Muslim patient, the physician must be aware that the patient may be quite passive for one of three reasons: (1) a resigned acceptance of their fate; (2) a disguising of fear, since fear would indicate a lack of trust in Allah's judgment and mercy; or (3) guilt over inadequate submission prior to illness.[26] These reflect both the free-will and eschatological theodicies associated with the Islamic religion. Also, because life is viewed as preparation for eternal life after death, a dying Muslim may have specific needs to prepare for passage. First, a Muslim may desire to sit or lie facing Mecca. Secondly, a Muslim may wish to confess sins and beg forgiveness in the presence of family before death. Lastly, a believer may want the Islamic Creed recited as the moment of death approaches. Because of these needs, the physician might need to make patient visitation more flexible and take great care in attempting to estimate the final remaining days or hours of life.

Judaism

Judaism in its most traditional form, Orthodox Judaism, conducts life by the laws contained within the Torah (the Five books of Moses). Members of the religion use these laws as justification for everything in life, from diet to sexuality and death. As one moves from Orthodox to Conservative to the Reform Jewish communities, some of the laws are adjusted to a more modern era. There are, however, very important threads that bind them all and in some way affect the medical care they may receive.

The first of these common threads lies in dietary laws, or the provision of Kosher foods. Kosher laws refer not only to the preparation of foods, but also to which items may be consumed. For example, meat must undergo special slaughtering, milk and meat must be separated, and some items are forbidden from the Jewish diet (e.g. pork).[30] These laws can be complicated depending on the personal adherence of the patient in question, which makes questioning dietary preferences all the more important. A Jewish minister or Rabbi can often assist in food issues for Jewish patients. For a more complete list of general Jewish dietary needs, see the Jewish Outreach Institute at http://www.joi.org/qa/kosher.shtml.[31] Healthcare staff should also be prepared for the request to bring food from home into the hospital. The origination of these laws was

considered by many Jews and non-Jews to be for health maintenance reasons. In fact, "some modern Jews use this explanation in order to justify their abandonment of those rules, reasoning that the work of the United States Food and Drug Administration makes the health measures involved in Jewish dietary laws unnecessary."[32] This confusion may have resulted from the Biblical terms of "clean" and "unclean" that have nothing to do with sanitation, but rather purity. The issue is still debated, although the original importance of Kosher laws does not seem to be true. In fact, "the Bible specifically indicated several times that the rationale for restricting the number of animals that could be eaten was to make the people of Israel holy (Lv. 11:43-45; Dt. 14:1-3, 21)."[32]

Interestingly, Jewish views on sexuality are more direct and explicit than many other religious traditions. This may prove useful for the family practitioner or counselor of Jewish couples. Two separate commandments, one to multiply and the other not to withhold conjugal rights from one's wife, exist in the scripture.[32] This means that a man has a sexual duty to fulfill his wife's sexual needs even after they have had children. In fact, the book of Exodus speaks of how often a man should have "sexual relations with his wife in order to fulfill the commandment," which depended upon the husband's occupation.[32] A physician will be more capable of assisting a patient with sexual issues if he understands the religious implications.

The Jewish views on end-of-life issues are unique and significant from an ethical standpoint. Stemming from the Jewish code stating "'One should aim to maintain physical health and vigor in order that his soul may be upright, in order to know God….Whoever follows this course will be continually serving God….'".[33] From this stems the basic tenet of Judaism: that nothing must stand in the way of preserving or prolonging life. Furthermore, the role of the physician in the Jewish religion is held in the highest regard, because as a physician one is the healing agent of God. Thus, a doctor's duty is to prolong life and undertake no actions which may in any way hasten the time of death. In fact, the Jewish faith asserts that all life support and active treatment be maintained until death insofar that the life can be saved and meaningfully prolonged. Questions then arise: What defines death? If life support may maintain a person's life

indefinitely, is it ethically just to do so? For a patient in extreme pain at the end of life, is it ethical to maintain their life at all costs? It has been written that no active or passive hastening of death is permitted, but removing a natural hindrance of death is permitted.[33] Obvious difficulties arise when trying to decide what would constitute removing a natural hindrance versus hastening death. It would benefit the physician to understand the patient's and patient's family's belief system as soon as possible before one of the above situations arises. Careful understanding and preparation for a Jewish patient's death could help to circumvent such dilemmas before they became problematic.

The great respect for the patient's body continues after death and is reflected in the Jewish views on handling the deceased body, as well as outlooks on autopsy. In most instances, death is presumed when breathing has stopped. When this has been established, the eyes and mouth are closed (preferably by a relative), arms and hands are extended at the side of the body, lower jaw is bound up, and the body is placed on the floor with the feet toward the door and is covered with a sheet. A lit candle is also placed close to the head. In addition, if death occurs on the Sabbath (Friday evening sunset to Saturday evening sunset), the body is not to be moved until after Saturday evening sunset plus 30 minutes.[30] Furthermore, if no fellow Jews are available, it is often asked that the hospital staff carry out these requests. Lastly, the Jewish association Chevra Kadisha should be notified immediately, because it functions as the Jewish burial society and will take charge of all arrangements after the time of death.

The issue of autopsy must also be discussed since Jewish law forbids autopsies unless ordered by law, when three separate doctors cannot ascertain the cause of death, or if it will help save the lives of others or prevent their suffering.[32,33] The latter also serves as justification for dissection of the deceased in organ transplants. The reasoning for autopsy denial lies in the belief that dissection of the body after death shows great dishonor of the human body.

The Jewish tradition poses issues, both practical and ethical, to the medical community. Understanding these key issues can benefit the physician, medical student, and healthcare team.

Table 2 presents a summary of the information presented along with some additional points. It may be used for a quick patient reference, a comparison between religions, or even as a concise synthesis of some of the major points presented above.

Recommendations

- A chaplain or chaplain resident should be responsible for providing pastoral and spiritual care coverage in the ED;
- The department for spiritual/pastoral care should provide education and resources to physicians and residents on religious beliefs from various religious groups and their impact on healthcare decision-making;
- Physicians should be familiar with research and literature on the connection between religious faith and practice (i.e. prayer) and health and healing;
- ED physicians and staff should have a basic understanding of spiritual risk assessment in terms of simple, non-intrusive ways to determine if a patient is experiencing spiritual injury and is at spiritual risk in order to make an appropriate referral to a chaplain.

Conclusion

Medicine is based on eliciting information, understanding that information, and then knowing how to apply it to the treatment of one's patient. Use of the presented information is no different. Eliciting spiritual history, understanding the implications of the patient's religion, and then being able to apply that to a tailored treatment plan designed to heal and comfort the patient spiritually and medically is important. Provision of culturally competent spiritual care depends upon the collaborative efforts of physicians, chaplains, social workers, nurses, and others. The practice of medicine is more than mere scientific diagnostics and problem-solving; rather, medicine is about science *and* emotion, religion, and spirituality.

References

1 Neusner, Jacob., ed., World Religions in America: An Introduction. Louisville: Westminster John Knox Press, 2000, p. 1.

2 Zie, Paul et al. Nonoperative Management of a Splenic Tear in a Jehovah's Witness with Hemophilia. The Journal Trauma, Infection, and Critical care. 1966 February: 40(2): 299-301

3 Best, Mildred. A Spiritual Perspective: Why Do African Americans Resist End-of-Life Decisions? Chaplaincy Today 2003 Autumn/Winter (19)2: 7-9.

4 Fitchett, George. Screening for Spiritual Risk. Chaplaincy Today. 199: (15(1): 2-12.

5 Weaver, Andrew et al. A 10-year Review of Research on chaplains and Community-based Clergy in 3 Primary Oncology Nursing Journals: 190-1999. Cancer nursing 2001 October 24 (5): 355-340.

6 Lester, Andrew. Hope and Pastoral Counseling (MILDRED TO EXPAND REFERENCE)

7 Gibbons, Grame, Retsas, Andrew and Jaya Pinikahana. Describing What Chaplains Do in Hospitals. The Journal of Pastoral Care, Summer 1999: 53(2): 201-08

8 Koenig, Harold G. Meeting the Spiriutal Needs of Patients. The Satisfaction Monitor. (Jul/Aug 2003): 1-4.

9 Neusner, Jacob, ed., p. 1.

10 Matlins, Stuart M. & Magida, Arthur J. How to Be a Perfect Stranger: The Essential Religious Etiquette Handbook. , 3rd ed., Woodstock: Skylights Path Publishing, 2003.

11Vanderpool H., Sierpina V., Sandor K., Gerick S. Spirituality and Clinical Care 2003 Course Syllabus. Galveston: University of Texas Medical Branch; p. 29.

12Wintz S, and Cooper E. A Quick Guide to Cultures and Spiritual Traditions: Unit Resource Packet. St. Joseph's Hospital and Medical Center. 2001.

13Birnbaum, R. Chinese Buddhist Traditions of Healing and the Life Cycle. In: Sullivan L.E., editor. Healing and Restoring. New York: Macmillan; 1989.

14Kitagawa, J.M. Buddhist Medical History. In: Sullivan L.E., editor. Healing and Restoring. New York: Macmillan; 1989.

15Kirkwood N. A Hospital Handbook on Multiculturalism and Religion: Practical Guidelines for Health Care Workers. Harrisburg: Morehouse; 1993. p.87.

16Weber T. The Baptist Tradition. In: Numbers R., Amundsen D., editors. Caring and Curing: Health and Medicine in the Western Religious Traditions. New York: Macmillan Publishing Company; 1986.

17Religous Tolerance web page. http://www.religioustolerance.org/hom_sbc.htm. Accessed 2004 Jan. 15.

18The Southern Baptists of Texas Convention Newsletter. http://www.sbtexas.com/texan/issues/news.asp?94. Accessed 2004 Jan 15.

19The United Pentecostal Church International official web page on Divine Healing. http://www.upci.org/doctrine/divine_healing.asp. Accessed 2004 Jan. 10

20Wacker G. The Pentecostal Tradition. In: Numbers R., Amundsen D., editors. Caring and Curing: Health and Medicine in the Western Religious Traditions. New York: Macmillan Publishing Company; 1986.

21O'Connell, M. The Roman Catholic Tradition Since 1545. In: Numbers R., Amundsen D., editors. Caring and Curing: Health and Medicine in the Western Religious Traditions. New York: Macmillan Publishing Company; 1986.

22McCormick R. Health and Medicine in the Catholic Tradition: Tradition in Transition. New York: Crossroad; 1987.

23Wintz S, and Cooper E. A Quick Guide to Cultures and Spiritual Traditions: Unit Resource Packet. St. Joseph's Hospital and Medical Center. 2001.

24Wintz S, and Cooper E. A Quick Guide to Cultures and Spiritual Traditions: Unit Resource Packet. St. Joseph's Hospital and Medical Center. 2001.

25McKennnis A. Caring for the Islamic Patient. AORN Online 1999 June; 69(6). http://gateway1.ovid.com/ovidweb.cgi. Accessed 2003 May 13.

26Kirkwood N. A Hospital Handbook on Multiculturalism and Religion: Practical Guidelines for Health Care Workers. Harrisburg: Morehouse; 1993. p.35-48.

27Rahman, F. Health and Medicine in the Islamic Tradition: Change and Identity. New York: Crossroads; 1989.

28Raham, F. “Islam and Health/Medicine: A Historical Perspective.” Healing and Restoring. Sullivan L.E. ed. New York: Macmillan; 1989.

29Antes, P. Medicine and the Living Tradition of Islam. Healing and Restoring. Sullivan L.E. ed. New York: Macmillan; 1989

30Kirkwood N. A Hospital Handbook on Multiculturalism and Religion: Practical Guidelines for Health Care Workers. Harrisburg: Morehouse; 1993.

31The Jewish Outreach Institute. JOI homepage http://www.joi.org/qa/kosher.shtml. Accessed 2003 Nov. 5

32E.N. The Jewish Tradition. In: Numbers R., Amundsen D., editors. Caring and Curing: Health and Medicine in the Western Religious Traditions. New York: Macmillan Publishing Company; 1986.

33Feldman D. Health and Medicine in the Jewish Tradition: L’Hayyim to Life. New York: Crossroads; 1986.