

Chapter 21

RELIGIOUS AND CULTURAL CONSIDERATIONS IN MILITARY HEALTHCARE

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Aaron Bohrod, 1944

Military Necessity

Pont L'Abbe, Normandy, World War II

First elements of the 90th Infantry Division saw action on D-Day, 6 June 1944, on Utah Beach, Normandy. The remainder entered combat 10 June, cutting across the Merderet River to take Pont l'Abbe in heavy fighting. Once it was secured, it was used as a staging area. This painting depicts the use of a religious structure as a communications pole to coordinate the ongoing action in the area, thus the title "Military Necessity."

Art: Courtesy of Army Art Collection, US Army Center of Military History, Washington, DC.

INTRODUCTION

Over the past several decades, medicine has moved away from viewing the patient simply as a biological mechanism in need of “repair” and toward a more complete view of the patient as a person with a health need who is also part of a complex social system. A significant portion of who that patient “is” comes from the patient’s religious and cultural background. Most of the time, religious and cultural considerations in patient care decisions seem invisible, indeed almost “hidden,” in cases where the healthcare professionals, the patient, and his or her loved ones substantially agree about the appropriate therapy, treatment, or outcome to be sought. However, their presence may be more readily observed when the parties disagree because of differences in their religious beliefs and cultural values. It is easier to see these differences when they are succinctly stated by the participants. Therefore, this chapter will begin with a case in which there is a clear statement of these differences and what the patient’s family believes must occur as a result. By understanding the more obvious cases, the physician will, it is hoped, become more attuned to the less obvious, but nonetheless significant, situations that involve differing views regarding what is “best” for a patient.

The following case illustrates the dilemma that can occur when differing religious beliefs and cultural values clash in the patient–physician relationship.

Case Study 21-1: What Should Leah Be Told? Leah, an 18-year-old Israeli girl (similar to the girl shown in Figure 21-1), is diagnosed with clear cell adenocarcinoma of the vagina. Her family is ultraorthodox. She is being seen in a prominent American hospital because of its reputation as the best in the world at treating clear cell cancer. The prescribed treatment for her would be a course of radiation therapy to shrink her tumor and then a hysterectomy. Her father does not want her to be told that she will be sterile because she was recently engaged and the wedding will be very soon.

Jewish religious law will not permit a woman known to be infertile to marry, except to a man who is infertile or to a widower with children. Leah’s father says that “if she needs treatment, give it to her. We will explain the infertility later.” When told that she would need to give informed consent to the radiation treatment and surgery, her father replies, “but she doesn’t understand any of this. Look, tell her you’re taking her uterus out. Just don’t explain what it means. She won’t understand, she’s very naive.”^{1(pp81–82)}

Comment: Traditional Jewish belief does not recognize patient autonomy. According to Judaic teachings, life comes from and belongs to God. Treatment that can preserve life, as in this case, is obligatory and one cannot refuse the treat-

ment. Although she is being treated in a country where autonomy is respected and informed consent is required as a condition for treatment, for Leah, exercising her autonomy by giving an informed consent might require her to reject the teachings of her religion.^{1(pp83–84)}

Two very different concepts of what ought to take precedence in deciding to proceed with the needed lifesaving radiation and surgery are at work in this situation. One concept is that of honoring and following the patient’s religious-cultural beliefs (ie, putting the beliefs of the patient before the profes-



Fig. 21-1. “Mina.” Oil on canvas by Raphael Soyer, 1932. This portrait of a young Jewish woman, painted almost 70 years ago, captures the vulnerability of “Mina.” A father’s desire to protect a daughter is common to all societies, but is particularly strong in a patriarchal culture such as Judaism. Reproduced with permission from Forum Gallery, New York.

sional requirements of the physician). The other concept is that of following accepted American medical-legal-ethical practice concerning the patient's right to make an informed consent, even if that right of informed consent is alien and distressing to the patient. Although this particular dilemma is perhaps more clearly enunciated than many, it nonetheless is indicative of the ethical dilemmas in the provision of medical care in an increasingly multicultural patient base.

Medical, nursing, social work, and clinical pastoral journals have all reported and discussed an-

ecdotal accounts of ethical dilemmas faced by healthcare professionals, their patients, and family members as they all seek what they believe to be the best solution to a medical problem. Within the last few years the literature has also included discussion focused specifically on the patient's religious beliefs and cultural values in particular cases, while there has been only limited discussion of the healthcare professional's personal religious beliefs and cultural values. There has been, however, no discussion of religious and cultural considerations as they affect military healthcare specifically.

THE IMPORTANCE OF UNDERSTANDING DIVERSITY

Knowledge of religious and cultural considerations can help all healthcare professionals to:

- realize that religiously and culturally grounded concepts, values, and interpretations differ about what are appropriate conduct and good outcomes within the therapeutic relationship;
- become aware of their own personal and professional religious beliefs and cultural values as healthcare professionals and how these values influence their perceptions of (and actions and interactions with) patients; and
- become sensitized to the specific cultural and religious values, beliefs, and actions that affect patient care decisions.

Having an awareness of the influence of religious and cultural factors in healthcare is essential to American healthcare and especially to military healthcare, given the military's worldwide deployment. A military healthcare professional will find such knowledge helpful in providing medical care to persons of a non-American or non-Western religion or culture, whether at home or in a distant part of the world. This is particularly true where religious and cultural considerations pose significant value conflicts between military healthcare professionals and patients and their families.

This chapter's discussion of religious and cultural considerations in military healthcare will explore religious considerations and cultural considerations in general, as well as examining how these

EXHIBIT 21-1

DOES HEALTHCARE POSSESS RELIGIOUS VALUES THAT AFFECT PATIENT-CARE DECISIONS?

Thinkers disagree about the impact of religious values on patient-care decisions. Callahan would answer that religious values do not impact patient care, arguing that, "for all the steady interest of some physicians in religion and medicine, the discipline of medicine itself is now as resolutely secular as any that can be found in our society. It is a true child of the Enlightenment."^{1(p3)} Geisler, however, argues that if the discipline of medicine substantially embraces secular humanism, then secular humanism's significant value orientations qualify under some definitions as a personal or corporate religious belief or creed.^{2(p174)} Geisler argues that secular humanism, as a world view, contains distinctive value orientations that are both cultural and religious in nature. In demonstrating his position, he contrasts a traditional Judeo-Christian world view with a secular humanistic world view. In the former, there is a creator, man is specially created, God is sovereign over life, sanctity-of-life is more important than quality of life, and ends do not justify means. In a secular humanistic world view, there is no creator, man evolved from animals, man is sovereign over life, quality of life is more important than sanctity-of-life, and ends do justify means.

Sources: (1) Callahan D. Religion and the secularization of bioethics. *Hastings Cent Rep.* 1990;20(4):Suppl.2-4. (2) Geisler N. *Christian Ethics: Options and Issues*. Grand Rapids, Mich: Baker; 1989.

considerations influence the healthcare environment, especially within the context of a military deployment. As already alluded to, the difficult issue is first being aware of these differences, then responding appropriately. As Kluckhohn points out, cultural value orientations answer important human questions about the nature and purpose of man, man's relationship to nature and his fellow man, and man's time dimensions.^{2(p64)} Religious value orientations address the same questions with an additional emphasis on a person's relationship to God.

This chapter, although at times emphasizing medicine's role in value conflicts, seeks overall to encompass all military healthcare professionals. It is neither intended to be an outlined primer of specific religious or cultural beliefs, nor an overview

of healthcare cultural anthropology, but rather describes only some of the potential conflicts posed by religious and cultural considerations. In keeping with that philosophy, this chapter discusses only briefly the dynamics of the individual healthcare professional's personal religious beliefs as they relate to patient-care decisions. Likewise, this chapter addresses indirectly the question of whether healthcare possesses religious values or beliefs that play a part in patient-care decisions. (Exhibit 21-1 explores in detail the disagreement between philosophers regarding this question.) Regarding healthcare values that are arguably "religious," this chapter discusses them and their influence on patient-care decisions as a part of the "culture" of healthcare.

RELIGIOUS CONSIDERATIONS IN HEALTHCARE PROVISION

For a physician to appreciate others' religious and cultural values, an understanding of one's own religious and cultural roots and their influence on one's thinking is essential. Though this country, especially its military, has increasingly become multicultural in composition and pluralistic in religious belief, there is a religious and cultural tradition that has had an effect on American medicine and the ethics that define it. That tradition has been defined as American moralism, which was shaped by the Calvinist tradition brought from England by the Puritans in the 1600s and the Jansenist tradition brought from Ireland by Irish-Catholic immigrants in the 1830s.^{3(pp114-115)}

Religious Culture's Shaping of America and American Healthcare

The early immigrants to this country did a great deal to shape America as it is today. In order to understand these influences, it is necessary to look at religious traditions in America and how they gave rise to American moralism.

America's Religious Traditions

Calvinism, as practiced by the Puritans, professed that believers are to plunge into secular world activities with a pure heart. Calvinists believed that a clear, unambiguous perception of God's commandments and an unquestioning, voluntary dedication to their observation would protect them from contamination as they moved to subdue nature and society to Divine Governance.^{4(p23)} Through the revival movements (Figure 21-2) fol-

lowing the American Revolution and in the post-Civil-War period, this moralism took on the task of ascertaining the sins of the community that needed reforming and saving the Western migration from barbarism. A profoundly emotional fundamentalism emerged, with overwhelming emphasis on soul-saving, personal experience, and individual prayer.^{5(p13),6(p120)}

Jansenism, spiritually inspired by the theology of Saint Augustine in that humanity had to be kept in check by penitential vigor, is a Catholic cousin of Calvinism. Jansenists opposed "probabilism"—a rule that allowed a person whose conscience is troubled about the right course of action to choose and act on any well-founded opinion that is "certain" or, at least, "more probably" correct. Like its Protestant counterpart, Jansenist revivalism spread throughout American Catholicism in the latter 1800s.

Both traditions, though different, had in their common, recurring themes^{3(pp118,120)}:

- insistence on clear, unambiguous moral principles, known to all persons of good faith;
- denial of the possibility of moral paradox or irreconcilable conflict of principles;
- avoidance, as much as possible, of detailed examination of exceptions to principles and rules;
- reduction of complex moral problems into simple, overarching ideals that linked together issues that, viewed from a more discerning viewpoint, appear distinct (eg, for Protestants, sex education and pornography);



Fig. 21-2. Converts weep and pray in this drawing of an 1836 revival meeting in the state of New York. Revival meetings encouraged individuals to repent of their sins and to work toward reforming their communities. Reproduced with permission from *LIFE, Bicentennial Issue: The 100 Events That Shaped America*. 1975; 63.

- for Catholics, contraception and abortion);
- affirmation of absolute moral principles, from which any departure must be counted as sinful, making little or no room for justifiable exceptions (although the contents of those principles varied between the two traditions);
- assertion of the Ten Commandments as dominant; and
- adherence to cherished and strictly ordered plans of life.

American Moralism

What emerged from these common, recurring themes of the Calvinist and Jansenist traditions was a pervasive American moralism that:^{3(p121)}

- emphasized continual reliance on fundamental moral principles;
- furthered the tendency to remove a moral

problem from the actual circumstances of moral action;

- declared that moral principles in themselves must be affirmed—exceptions and excuses must not be considered because such considerations would distract from the principle itself;
- maintained that antithetical categories that sought boundary systems and patterns of control would affirm order against disorder; and
- insisted on a stream of thinking that deeply believed in clear, unambiguous moral principles, the ability of common sense to grasp these principles, and the importance of the observance of these principles for the common good of the community.

Although modern America has forgotten about its moralistic sources, and “the rigidity of the Calvinist and Jansenist heritage seems to have evolved

into a vague tolerance for all but the most outrageous violations,"^{3(p122)} Jonsen maintains, "the moralism generated by [these] deep traditions, survives in the form, if not the content of the American mentality."^{3(p122)} The remnants of American moralism not only affect the ways Americans think today; they have greatly influenced American medical ethics as well. Jonsen believes that the original impetus for American medical ethics came from American moralism—which helped to bring the chaos of the new scientific medicine into the order of moral principle.^{3(p126)}

Jonsen cites several examples of science's pursuit of principle. Paul Ramsey's book, *Patient as Person*,⁷ written by a man steeped in Calvinism, is, according to Jonsen, one moralist's attempt to subjugate the new chaotic features of contemporary medical science to moral principles. Other attempts to ensure morality in science have been made by groups of individuals selected for their moral authority. For example, the Totally Artificial Heart Assessment Panel⁸ assessed ethical and moral implications and guidelines in using implantable artificial hearts. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research studied the principles governing biomedical research. Their work resulted in the *Belmont Report*,⁹ which applied bioethical principles to research activities. The President's Commission on the Study of Ethical Problems in Medicine¹⁰ studied principles governing the care of the terminally ill and patients in the persistent vegetative state.

Probably the most enduring contribution that the American moralism movement has produced is "principlism"—the four principles of American biomedical ethics: autonomy, beneficence, nonmaleficence, and justice.¹¹ Only in the last two decades have other medical ethical models arisen to challenge the principle-based model. Clinical models, based on practical medical considerations, are espoused by Jonsen and colleagues¹² and Fletcher and colleagues.¹³ Jonsen and Toulmin, in *The Abuse of Casuistry*, propose classical casuistry as principlism's chief opponent.¹⁴ Pellegrino and Thomasma¹⁵ advocate a virtue ethic that focuses on right behavior by physicians. Fry¹⁶ proposes an ethic of care that requires a moral point of view of persons and establishes moral commitments that naturally emerge from context of the professional-patient relationship. (Chapter 2, *Theories of Medical Ethics*, discusses these and other models in detail.) Medicine in the United States today is based on ethics that reflects a secular fundamentalism that: (a) describes the same absolutism, same dichotomous world of

good and bad, right and wrong as seen by the moralists, but shorn of religious rationale and religious sanctions; and (b) has the same obedience to the law but without the sanctions of eternal reward and punishment.^{17(pp27-28)}

The work of ethicists can no longer be expected to uphold the clear and unambiguous principles of American moralism. Nevertheless, there is still a tension between those who find comfort in holding to the certitude of moralism and those who realize the ambiguity that pervades many ethical dilemmas that exist at the bedside.^{17(p31)}

Religious Culture's Influence on Western Medicine

American moralism has not only affected the evolution of basic principles and institutions in America; it has also greatly influenced the Western world, its practice of medicine, and the development and application of medical technology. Pellegrino asserts that

the transcultural challenge of accepting what medical knowledge has to offer in light of a particular culture's values and beliefs, is vastly complicated because medical science and technology, as well as the ethics designed to deal with its impact, are Western in origin.^{18(p191)}

Western cultures differ from other cultures in how empirical science is conducted, in what constitutes ethical behavior, and in the political systems that guide and adjudicate the practice of medicine. Military healthcare professionals, because of their role in worldwide medical deployments, especially need to be aware of these differences.

In the Western world science is both empirical and experimental. It pursues objectivity and seeks the quantification of experience. It is driven by a common desire to gather information, share that knowledge, and build on it for future study or practical use. Science is both basic and applied; basic when it seeks to understand how or why something is, applied when it seeks a solution to a specific problem. Other cultures may be less inclined to aggressively uncover nature's mysteries, less obsessed with the need for experimental verification, and more strongly drawn by the spiritual and qualitative dimensions of life.

Western ethics, especially medical ethics, is principle-based, analytical, rationalistic, dialectical, and often secular in spirit. As previously noted, the United States as a country is multicultural and plu-

ralistic. These American characteristics have increasingly influenced other Western nations. Other cultures, however, are not as multicultural and pluralistic. The ethical systems of those cultures may be less dialectical, analytical, logical, or linguistic in character, and be more sensitive to family and community consensus than to autonomy, and more virtue based than principle based.

These distinctly American characteristics, the result of both past history and current demographics, result in Western political systems that tend to be liberal, democratic, individualistic, and governed by law. The political systems in other cultures may be more attuned to authority, tradition, ritual, and religion. Some of these are more comfortable with, and more responsive to, the decentralization of decision making and more tolerant of social stratification and inequality.^{18(pp191-192)}

Pellegrino's observation, focused at the macro-cultural level, suggests serious conflicts at the individual microcultural level. There, healthcare professionals steeped in Western healthcare cultural values interact with patients whose cultural orientations may or may not be the same. As the power and influence of Western medical science and technology expand throughout the world, the conflicts with different belief systems will only increase. With American military physicians routinely being deployed globally in military and humanitarian missions, the necessity for meaningful interaction and a developed sensitivity to different cultural beliefs is greatly increased—a need generally overlooked or at least underappreciated.

Religious Beliefs and Values of the American Patient

Regardless of the culture, the degree of modernization, or the policies or laws of a government, religious beliefs and values strongly influence many persons' lives, both in America and abroad. One can gain a clearer understanding of a person's present behavior or viewpoint by examining his religious beliefs, both past and present. Sometimes a person's actions or beliefs are readily articulated in terms of a current religious belief. However, sometimes individuals may not be aware that the basis for their present behavior or viewpoint is a religious belief that they previously held or that influenced them earlier in life. In either situation, one may gain a clearer understanding of others by examining the religious beliefs and values that influence their behaviors, as well as the historical relationship be-

tween medicine and religion, and the little understood relationship between religious belief and health.

Religious Beliefs and Values

Religious beliefs and values provide a framework for understanding life and defining its limits. This framework is passed from one generation to the next through religious training and ceremony (Figure 21-3). Religion helps people understand their mortality. It develops an awareness of external conditions about which they can do nothing—conditions that circumscribe their existence and must be attended to if they are to continue to exist. These are the empirical conditions needed for the development and maintenance of all humans. Religion also shapes and helps people interpret the historical and cultural circumstances in which they are born and live, as well as many things about all people as individuals. These are the character and personality traits, proclivities, and cognitive tendencies that distinguish humans from all other species.^{19(p127)} Thus, religion describes and explains the human condition at its most fundamental level.

Religion also provides a person with a unique concept of personal identity in the fullest sense. It helps people to understand themselves and the world around them in a more complete and satis-



Fig. 21-3. An Orthodox Christian baptism. Father Georgii Studyonov baptizes a child in his church in southwest Moscow. Although officially banned by the former Soviet government for almost 75 years, religion remained an important part of the lives of many Russians. Ceremonies such as this one, performed here as it has been performed for centuries, help ensure the continuity of religious tradition through the most difficult of times. Reproduced with permission from *National Geographic*. Feb 1991;36-37.

fying way. Through religion they realize that their actions may have effects beyond their control in relation to others, the actions of those others, and subsequent events. People can, indeed must, live with others in a world that is not always friendly, is sometimes indifferent, and may be even hostile. The pervasive, supremely important integrating and reconciling function that religious beliefs and values accomplish in a person's life often gives sense to the meaning of that life—a sense that might otherwise never be found. To better understand how this “sense to the meaning of life” can influence patients in other countries, it is helpful to first explore its impact on patients in America. By becoming aware of the prevalence of religious beliefs and values in patients seen stateside, military healthcare professionals can become more attuned to variations on these common themes in other cultures.

A casual observer of contemporary American culture, with its emphasis on speed, immediate gratification, and acquisition of material goods, might be surprised to learn that Americans are a highly religious people. In studies of Gallup surveys, 95% of Americans said that they believe in God,²⁰ 72% agree or strongly agree with the statement, “My religious faith is the most important influence in my life,”²⁰ 66% consider religion to be most important or very important in their lives,²⁰ 57% pray (Figure 21-4) at least once a day,²⁰ and 40% have attended church or synagogue within the past week²⁰ (a figure that has remained remarkably constant in more than 20 Gallup surveys conducted between 1939 and 1993).

Americans also frequently participate in religious healing activities. Although the data vary somewhat from region to region, the overall picture that emerges is one of religion playing an active role in healthcare issues for a considerable portion of the American population. In a survey of 586 adults in Richmond, Virginia, in the mid-1980s, 14% of the sample attributed physical healings (most commonly viral infections, cancers, back problems, and fractures), as well as help with emotional problems, to prayer or divine intervention.²¹ In another recent survey of 325 adults, 30% reported praying regularly for healing and for health maintenance; consulting a physician was inversely correlated with the patient's frequency of prayer and belief in the efficacy of prayer.²² In a study of 207 patients in a family practice clinic, 56% reported that they had watched faith healers on television, 21% had attended a faith-healing service, 15% knew someone who had been so healed, and 6% reported that they

had themselves been healed by faith healers.²³ In a survey of 203 hospitalized patients in North Carolina and Pennsylvania, 94% believed that spiritual health is as important as physical health, 73% prayed daily, 58% reported having strong religious beliefs, and 42% had attended faith-healing services.²⁴

In summary, Americans are indeed a highly religious people. Whether or not they attend church, Americans' religious beliefs and values are an integral part of who they are and what they are likely to do, or to not do. This is important for the healthcare professional to remember as he treats the patient not as a biological entity with a specific dysfunction, but rather as a whole person who is part of a complex social network. This relationship between religious beliefs and values, on the one hand, and health and healing, on the other, has not been exclusive to individuals. The relationship has existed between the professions of medicine and religion as well.

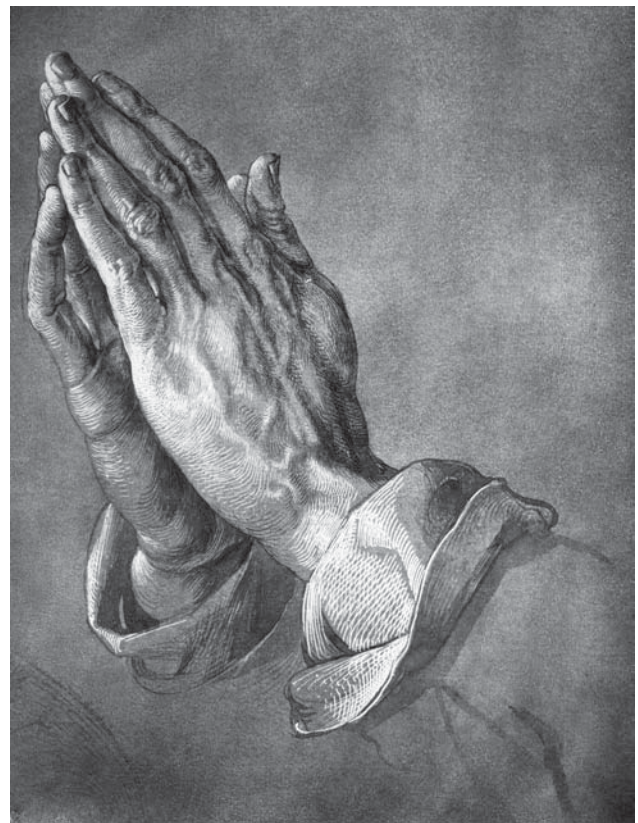


Fig. 21-4. A. Durer: “Praying Hands.” *Great Ages of Man: Age of Christianity*. Prayer, a central tenet of many religions, is increasingly being recognized as an important aspect of health and healing. Reproduced with permission from Corbis, Inc.

The Historical Relationship Between Medicine and Religion

Medicine and religion have worked hand-in-hand in the process of healing for thousands of years because suffering is universal and mysterious. Suffering necessitates healers to witness, understand, explain, and relieve that suffering.²⁵ These medical and religious practitioners have generally enjoyed an important and respected role in society. In ancient societies (as well as in some contemporary primitive societies), illness was perceived as primarily a spiritual problem. Religious and medical authority was often vested in the same person (eg, an Aaronic priest) who might himself become an object of worship (eg, Imhotep, Asclepius, Jesus Christ). From the early Christian era through the Reformation, the linkage between medicine and religion remained close. The first hospitals were founded in monasteries, and the missionary movement linked physical healing with spiritual conversion.

By the 17th century, challenges to church authority and the rise of empirical science created rifts between medicine and religion. Science claimed the body (and later, the “mind,” or cognitive processes) as its domain, while religion held onto the soul. As science advanced the knowledge of the heretofore unknown, condemnatory critiques of religion arose: “the opium of the people”²⁶ (Marx), “a universal obsessional neurosis”²⁷ (Freud), and “equivalent to irrational thinking and emotional disturbance”²⁸ (Ellis). Early Western modern science, in its belief that it could ultimately solve all health problems, appeared to have supplanted religion. However, by the late 20th century, a growing disillusionment with modern science’s limitations coupled with more holistic concepts of health and suffering opened up the possibility of a rapprochement between medicine and religion. Nowhere is this rapprochement seen more clearly than in the willingness of scientists to investigate those religious beliefs that previously had been dismissed as irrational, self-fulfilling prophecies.

Documented Medical and Psychological Benefits of Religious Beliefs

A body of research correlates religious belief with improved physical, emotional, and behavioral well-being, making a strong case for the incorporation of religious and spiritual values into medical treatment regimens. Research has examined areas as diverse as substance abuse, grief reactions, general health, general well-being, and survival rates for

various illnesses. In each area, religion has been found to have a profound and positive effect for those who believe. These research studies have been carefully constructed and have withstood the rigor of the scientific research model, including statistical analysis.

The question of how religious commitment might affect substance abuse has been the subject of several studies. For example, of 1,014 males matriculating between 1948 and 1964 at Johns Hopkins Medical School, 13% met criteria for alcohol abuse. The strongest predictor of subsequent alcoholism during medical school was a lack of religious affiliation, followed by regular use of alcohol, past history of alcohol-related difficulty, non-Jewish ancestry, and a number of other criteria.^{29(p332)}

Of 248 men (87% Mexican-American) with opiate addiction treated at a Public Health Service hospital from 1964 to 1967, 11% subsequently enrolled in a long-term religiously based program. These patients were significantly more likely (45% vs. 5%) to abstain from opioids for 1 year after the program.^{30(pp74-75)} The researchers note that “[f]rom the standpoint of attractiveness or acceptability to opioid users, however, religious programs do not appear especially effective. Admissions to these programs equal only 3% of all admissions to treatment and only 11% of all subjects in the study.”^{30(p75)} They did add that “[a]lthough religious programs seem to attract only a small minority of opioid users, they are an effective alternative to conventional therapies for some.”^{30(p80)}

There were 2,969 participants in the National Institute of Mental Health Epidemiologic Catchment Area survey (1983–1984) in North Carolina, which lasted 6 months. The researchers found that “those who attended church at least weekly ... [had a] likelihood of abusing or being dependent on alcohol [that] was less than one-third (29 percent) the rate among those who attended less frequently.”^{31(p229)} “[T]hose who prayed and read the Bible at least several times a week ... [had a] likelihood of having had an alcohol disorder in the past six months [that] was less than half (42 percent) the rate for the rest of the sample.”^{31(p229)} The researchers concluded “[t]he data presented here do not lend themselves to interpretations about the cause of the relationships between religious variables and alcohol use, for two reasons. One, the data are cross-sectional in nature, and two, although our analyses were controlled for a number of basic demographic and health variables, it was not possible to account for the full range of variables in which religious behaviors and alcohol use may be enmeshed.”^{31(p231)} Nonetheless, the data raise interesting questions for fur-

ther research.

Another area of interest to researchers was that of adjusting and coping during and after long-term terminal illness of a loved one. In a study of 145 parents of children who had died of cancer, 80% reported receiving comfort from religion during the year after the child's death and 40% reported a strengthening of their religious commitment during that year,^{32(p226)} which was positively associated with better physiological adjustment, emotive adjustment, and perceived helpfulness of religion.^{32(p233)} The study authors concluded: "Basically, it appears that religious commitment is both a cause and a consequence of the process of adjustment to bereavement. Both segments of the analysis revealed a stronger religious commitment arising out of an individual's attempts to cope with the death. ... With regard to religious commitment as a determinant of adjustment, the qualitative segment of the analysis found that the likelihood that parents would derive comfort from the theodicy of purposive death was increased if they also displayed an especially strong religious faith."^{32(p237)}

In a 1985 study of 65 low-income elderly women who had one or more stressful medical problems within the previous year, the most frequent coping responses for handling medical illness were prayer, selected by 59 of the respondents (91%) and "thinking of God or religious beliefs," selected by 56 of the respondents (86%).^{33(p44)} In addition, in a 1988 survey of 62 caregivers of Alzheimer's disease and cancer patients, religious faith was positively associated with a positive emotional state and negatively associated with emotional distress.^{34(p334)}

Many religions worldwide believe that the prayer of others, as well as one's own beliefs, can aid in overcoming many difficulties, including health problems. Research supports these beliefs. Religious and spiritual commitment and belief is indeed correlated to physical symptoms and general health outcomes. In a 1992 study of 172 students enrolled in Christian faith groups and 127 unaffiliated student controls, the faith group had statistically significant better perceived health; more positive affect; higher satisfaction; fewer emergency room, physician, walk-in clinic, and dentist visits; and fewer hospital days than the unaffiliated group.^{35(p68)} Among 1,344 outpatients in Glasgow, Scotland, those who participated in a religious activity at least monthly were less likely to report physical, mental, and social stressors associated with daily living after controlling for age and gender.^{36(p684)} In addition, in a prospective study of 2,812 elderly persons in New Haven, Connecticut, religiosity was

inversely related to subsequent disability and directly related to improved functional ability.³⁷

Religious and spiritual commitment and belief also have positive correlation to one's perceived general well-being and quality of life. Among 560 telephone survey respondents in Akron, Ohio, general life satisfaction was strongly correlated with religious satisfaction, closeness with God, prayer experience, frequency of church attendance, and church activities.^{38(p267)} Among 2,164 persons in the National Quality of Life Survey, feelings of being worthwhile were significantly related to the importance of faith,^{39(p300)} church membership,^{39(p302)} and church attendance.^{39(p302)} Using the same data from the National Quality of Life Survey, satisfaction from religion was found to be highly correlated with marital satisfaction, and satisfaction with family life, as well as general affect.⁴⁰ And, among 997 respondents to the 1988 General Social Survey, church attendance was positively correlated with life satisfaction.^{41(p86)}

Finally, a series of studies examined the effects of religious and spiritual commitment and belief on survival. The largest of these studies surveyed 91,909 individuals who lived in Washington County, Maryland. The researchers compared persons with various diseases who had died of those diseases and then examined the frequency of church attendance (once or more a week vs. less than once a week) among the total group, over a 3-year period. The study results found that those who attended church once or more per week had 74% fewer deaths due to cirrhosis, 56% fewer deaths due to emphysema, 53% fewer suicides, and 50% fewer deaths due to coronary artery disease than those who attended less than once per week.^{42(p669)} In a prospective cohort study of 4,725 individuals in Alameda County, California, those who were church members had lower mortality rates than others independent of socioeconomic status and health behaviors (eg, smoking, drinking, physical inactivity, obesity).^{43(p189)} In a retrospective cohort study of 522 Seventh Day Adventist deaths in the Netherlands from 1968 to 1977, Adventists were found to have an additional life expectancy of 9 years for men and 4 years for women when compared with the general population. Adventists had lower rates of overall mortality (45% of expected), neoplasms (50% of expected), and cardiovascular diseases (41% of expected).^{44(pp456-457)} Mormons also enjoy unusually good health, with cancer and heart disease rates less than one half those of the general population. Furthermore, the rate of cancer varies inversely with the degree to which the individual adheres to church teaching

(including dietary restrictions) and participates in church activities, with highly religious Mormons experiencing one half the rate of cancers of less adherent members of the faith.^{45(pp252,256)}

There are other studies that show equally impressive relationships between persons' religious and spiritual beliefs and their physical, mental, and emotional well-being. These studies show that, regardless of a particular patient's diagnosis or prognosis, to ignore or discount a patient's religious or spiritual belief could omit a key element in a treatment regimen that could enhance returning that patient to a healthy state.

Some General and Specific Religious Considerations

As American healthcare professionals provide care for an ever-widening spectrum of patients, it has been shown that one can expect to encounter patients with varying degrees of religious belief that influence their healthcare values. This religious worldview may often be the framework for persons' self-worth, their view of the outside world, and their interaction with key people and situations in their lives. Developing an appreciation for the religious component of this framework may be a valuable key to understanding a patient's approach to health, illness, and how the patient will cope with medical treatment with all of its complexities.

Major Dimensions of Religion

Faulkner and DeJong^{46(p354)} propose five major dimensions of religion, each of which can be of unique significance to one's health and illness. These are:

- (1) **Experiential:** The religious person will at some point in life achieve some direct knowledge of ultimate reality or will experience religious emotion (be "born again," "come into full knowledge," and be "slain in the spirit" are terms basic to fundamentalist Christian denominations).
- (2) **Ritualistic:** Religious practices that are expected of followers include worship, prayer, sacraments, and fasting (Roman Catholics, Lutherans, Episcopalians).
- (3) **Ideological:** These are the set of beliefs to which a religion's followers must adhere in order to call themselves members.
- (4) **Intellectual:** The specific acts, beliefs, or explanations that members are to be in-

formed about are called many things, to include: the basic tenets, the sacred writings, and the scriptures. These are written down, and available for study and discussion (eg, Christians—Bible, Jews—Torah, Muslims—Koran).

- (5) **Consequential:** Religiously defined standards of conduct are religious tenets that specify what followers' attitudes and behaviors should be as a consequence of their actions (eg, the Biblical Ten Commandments, Five Islamic fundamentals, Jewish social and religious laws).

Expression of Religious Beliefs

There are many ways in which religious beliefs are expressed or demonstrated. Among these are prayer, holy days, religious symbols, garments, and dietary practices.⁴⁷ Although the specific guidelines for these expressions may vary from religion to religion, they all are important aspects of religious beliefs. And, as the preceding discussion of the documented medical and psychological benefits of religion has so aptly demonstrated, these expressions are a valuable adjunct to the overall healing process. By understanding and accepting the expression of these beliefs, the healthcare staff can also be aware of those expressions that may be detrimental to the health of the patient, especially certain dietary practices. Again, the emphasis is on the patient in a social context, to include religious beliefs and their expression.

Prayer. Prayer can be a great source of emotional strength and comfort for those who are ill and also for their family and friends. Prayer can be formal, following a specified liturgy (eg, Roman Catholic, Episcopalian) or as a tenet of faith according to set rules. Devout Muslims must pray to Mecca, a holy city in Saudi Arabia, five times a day. Traditionally, they pray on a special prayer rug placed on the floor and facing in the direction of Mecca. Many Muslims in this country do this in the privacy of their homes or away from the public. In the case of a devout Muslim who is hospitalized, it is not unusual to have his prayer rug in the room so that he can engage in this ritual at the prescribed times. Prayer can also be informal or spontaneous, such as those that are offered at the patient's bedside by members of visiting clergy. Many devout Christians (eg, African-Americans, fundamentalist-believers) view religion as an essential and integral part of life. They believe that God, the source of good health and healing, can cure disease and heal injury. To receive

this healing they must pray and have the faith that these prayers will be answered. This may also involve the presence of family members and friends in a prayer circle in the patient's hospital room or in the hospital chapel. It is not unusual for them to ask their healthcare professionals to join them in prayer, because they view their healthcare professionals' talents and skills as being under God's guidance and use. Health care professionals should be sensitive to these expressions of faith.

Holy Days. Holy days, which vary from religion to religion, are days devoted to participating in religious activities while often limiting nonreligious activities. Thus, depending on the religion, holy days may be days that are not well-suited to routine medical procedures, or may be problematic in the treatment of certain diseases. For Muslims, Ramadan (a period of 30 days around February or March) requires periods of fasting from sunup to sundown. For many Orthodox Jews, the Sabbath (from sundown Friday to sundown Saturday) is a time to spend with family and to worship God. On the Sabbath, work of any kind is prohibited, including driving, using the telephone, handling money, and even pressing an elevator button. The only law that is higher than observing the Sabbath is the law that requires everything possible be done to save a life. As these two examples demonstrate, there is a great deal of diversity between various religions in their holy days. It is obviously not possible for healthcare professionals to know every separate religion and its specific holy days. However, by being aware that there are various holy days for different religions, with specific restrictions, healthcare professionals can better plan with their patients the best course of action for treatment. This process need not consume a great deal of time, but it can do a great deal of good for the patient.

Religious Symbols. In hospitals, one of the admission procedures is often the removal of all personal items of value from patients, including jewelry, watches, and so forth, for safekeeping. Many diagnostic tests require the removal of any items that might interfere with the procedure. In the event of a surgical procedure, all items are removed from the patient's body before the operation to ensure a sterile environment for the patient (ie, jewelry) or to prevent a medical problem (ie, removal of false teeth). However, a number of religious faiths have symbols that have special meaning to those who wear them. Roman Catholics may carry or wear a rosary or wear a medallion. Jews may wear a Star of David on a necklace around their necks. Christians may wear a cross. Hindus may wear sacred threads

around their necks or arms. Native-American Indians may carry medicine bundles. Mexican children may wear a bit of red ribbon. Mediterranean peoples may wear a special charm (eg, mustard seed in a circle or a ram's horn) or a chain. Healthcare professionals unfamiliar with these religious symbols should learn about their significance to the patient. If, because of medical procedures, the symbol must be removed, a full explanation of the reason may need to be given to the patient. Sometimes an accommodation can be made to keep the symbol in the patient's possession or close by so that the patient can derive the symbol's benefit.

Garments. At the same time that items of value are placed in safekeeping for the patient, the patient is also told to change into a hospital issued gown after completely removing all street clothing. However, some religions have prescribed particular garments for wear by their believers. Men of certain Jewish sects wear a prayer shawl (tallit) underneath their outer garments, though more than likely this garment is worn as an outer garment only when prayer is offered. A Mormon adult wears a special type of "garment," which resembles short-sleeved long underwear that ends just above the knee. Usually the garment may be removed to facilitate care in a hospital, but some Mormons, particularly the elderly, may not wish to part with the garment, which symbolizes covenants or promises the person has made with God and signifies God's protection. Where complete removal is not agreed to, it may be possible to adjust the positioning of the garment to allow medical care while still addressing the patient's religious beliefs.

Dietary Practices. Of all of the religious expressions, dietary practices are of the greatest concern to the medical professional. Whereas the other religious expressions generally only affect the delivery of patient care, some dietary practices affect patient health and outcome. Having noted that, it is important that the healthcare professional distinguish between those practices that require modification of hospital routine and those that are hazardous to patient health. For instance, both Muslims and Jews are forbidden by their religions to eat pork. This prohibition also extends to many foods that contain pork products such as ham or bacon fat. These prohibitions can be readily accommodated by the dietetic staff. Other foods can be dangerous. Dates, a favorite food of many Arabs, are very high in potassium, which must be strictly limited for patients suffering from renal problems. In some Arab countries, however, food deprivation is considered a precursor to illness, and to deprive an Arab of dates

would be viewed as helping to bring on an illness. Orthodox Jews, following kosher dietary practices, will not eat pork, shellfish and non-kosher red meat and poultry. Mixing meat and dairy products, either in the same meal or by using the same plates, pots, or utensils for both, is prohibited. Nonreligious food restrictions can also create problems. Some ethnic groups will eat only hot or cold foods, depending on the seasons. The hot and cold are qualities, not temperatures. These foods, which make them “cold” inside their bodies in the winter or “hot” inside their bodies in the summer, are to be avoided if these patients are to develop appetites. It is best to ask about food preference at admission so that arrangements can be made either for the dietary staff to meet these dietary practices or for family members to bring in the appropriate foods. Also, each ethnic group has their own food preferences while other ethnic groups cannot tolerate certain foods. Many Asians like rice with every meal but are lactose intolerant, as are many African-Americans and Native Americans. Asian diets are gener-

ally very high in sodium but low in fats. Mexican-Americans tend to use a lot of salt and fats in their cooking. Either of these ethnic cooking styles could be problematic for hypertensive patients. Thus it is important to explore the dietary practices of all patients, accommodating those that can be, and explaining the medical reasons for those that cannot be accommodated during the hospital stay. If the healthcare professional has been open and accepting of these various religious expressions, the patient is more likely to respond when queried about specific dietary needs and more likely to cooperate with hospital dietary staff. However, if members of the medical staff, including the attending physicians, have indicated that the patient simply has to eat whatever the hospital provides, and brush off any protests to the contrary, there is the distinct possibility that family members will sneak in foods that may indeed be harmful to the patient. By understanding that the patient has religious beliefs, and religious expressions, the benefit of these beliefs can be incorporated into the healing process for the patient.

CULTURAL CONSIDERATIONS IN HEALTHCARE PROVISION

A General Overview

Culture can be viewed as all of those parts of life that surround and influence people from the time they are born. It is a vital part of why and how persons make decisions. A culture has four basic characteristics^{48(p10)}: (1) it is learned from birth through the processes of language acquisition and socialization; (2) it is shared by all members of the same group; it is this sharing of cultural beliefs and patterns that binds people together; (3) it is an adaptation to specific conditions related to environmental and technical factors and to the availability of natural resources; and (4) it is a dynamic, ever-changing process, passed from generation to generation.

Significance of Cultural World Views

Every society has a basic value orientation that is shared by the bulk of its members because of early common experiences. In general, the dominant value orientation, or world view, of each culture guides its members to find solutions to the following five basic human problems.^{2(pp67-69)}

- (1) *What is man's basic innate human nature?* Is it good, in that it is unalterable or incorruptible? Is it mixed with combinations of good and evil where lapses are unavoid-

able but self-control possible? Or is it evil, in that it is unalterable, or perfectible with discipline?

- (2) *What is man's relationship to nature?* Is there a sense of destiny, in that persons are subjugated to nature, where fatalism and inevitability guide their endeavors? Is it viewed as mastery, in that the natural forces are to be overcome and be put to humankind's use (American)? Or do people and nature exist together in harmony as a single entity (eg, Native Americans and Asians, who are more likely to ignore preventative medical measures)?
- (3) *What is man's significant time dimension?* Is it centered on the past, where focus is on ancestors (Chinese) and traditions (British)? Is it oriented to the present, in that little attention is paid to the past and the future is considered vague and unpredictable (Hispanic and African-Americans)? Or is it future-oriented toward progress and change, lacking content with the present and viewing the past as “old-fashioned” (Americans and some Western cultures, who are more likely to stress preventative medicine)?
- (4) *What is the purpose of man's being?* Is it focused on being—a spontaneous expression

- of impulses and desires—or on doing—an active striving and achieving, a competition against externally applied standards?
- (5) *What is man's relationship to his fellow man?* Is it lineal, stressing continuity through time, heredity and kinship ties, and an ordered succession (British)? Is it collateral, where group goals and family orientation are the primary focus (Haitians)? Or is it focused on the individual, with personal autonomy and independence as primary, authority limited, and individual, not group, goals dominant (Americans)?

It is important to recognize that all societies are made up of collections of individuals who reflect to one degree or another the shared cultural heritage, or world view, of the group. Of course, individual variation within any cultural group is normal. One must be careful not to stereotype an individual simply because he comes from or belongs to a particular society or culture. Individuals share some part of the cultural heritage of their group, but never all of it, and they can interpret and apply social, cultural norms in a variety of ways, especially when norms are in conflict with each other. Individuals may evade norms, particularly norms that are weakly enforced. In addition, some norms are not learned by all members of a society.

Cultural Concepts of Health

The definitions of health and disease in any society are culturally influenced. When individuals become aware of a sign or symptom that indicates illness, they must make some choice about care, including the decision to perhaps not seek care. The choice is often based on the cultural characteristics and definitions of health, illness, and disease that these individuals accept as their own. As noted in the introductory comments to this chapter, when these concepts of health are similar to those of the healthcare professional, they receive little outward notice. The more these concepts differ from those of the healthcare professional, however, the more they are likely to be perceived as strange or not of relevance to the medical situation at hand and its successful resolution. For that very reason, this discussion of cultural concepts of health will begin with voodoo—a belief system that many medical personnel might find to be beyond their own cultural concepts of health.

In Haiti, voodoo priests and priestesses treat a wide variety of problems. Clients come to them for

help with love, work, and family problems as well as sickness. The voodoo practitioner's first determination is whether the problem "comes from God." If so, it is seen as "natural"—is meant to be, is unavoidable, and is for the greater good of the person. No priest or priestess will interfere in such a case. Only "supernatural" problems—those not part of the natural order or likely to have been caused by the spirits—will be appropriate for voodoo treatment.^{49(pp50–51)} Many Haitian patients receiving Western medical care will share the cultural concepts of voodooism. Therefore, those providing their medical care need to understand how these concepts will influence the patient in terms of the type of care the patient is willing to receive and how that patient may view that care. To ignore these issues may result in the patient being offered or given a treatment that is not allowed within this culture.

Another example of a cultural concept of health and healing that differs from Western medicine involves the Chinese concepts of *yin* and *yang*. The *yin* force in the universe represents the female aspect of nature and is characterized as the negative pole, encompassing darkness, cold, emptiness. The *yang*, or male force, is seen as the positive pole and represents fullness, light, warmth. An imbalance of *yin* and *yang* forces creates illness, which is interpreted as an outward expression of disharmony. Going in and out of balance is seen as a lifelong natural process; accordingly, no sharp line is drawn between health and illness. Both are seen as natural and as part of a continuum.^{50(pp109–110)} *Yin* and *yang* conditions are assigned to body organs and health conditions. *Yin* is associated with cancer, pregnancy, menstruation, kidney, liver, lungs, and spleen; *yang* with constipation, hangover, hypertension, toothache, bladder, gallbladder, intestines, and stomach.⁵¹ Thus, in these situations, it is important that the medical professional and the patient discuss these cultural differences to arrive at the best course of treatment for the patient.

What a person recognizes as illness or disease is also culturally influenced. Most Americans believe that "germs" (biological processes) cause disease. Not all cultures share that belief. Other causes of disease include: (a) upset in body balance (Asia, India, Spain, Latin America), (b) soul loss (some African cultures), (c) spirit possession (Haiti, Ethiopia), (d) breach of taboo (Haiti, Caribbean cultures), or (e) object intrusion (some African and Pacific cultures). Again, the healthcare professional must be aware of these cultural differences in general, and determine whether or not the patient holds these non-Western beliefs.

Healing Systems

People throughout the world use several types of healing “systems,”⁵² to include those found in the popular sector, the professional sector, and the folk sector. The popular sector consists of lay people who typically activate their own healthcare by deciding when and whom to consult, whether or not to comply, when to switch treatments, whether care is effective, and whether they are satisfied with the quality of care they have received. Individual, family, social, and community networks often provide healing support in this type of healing system. The professional sector consists of any professional healing group (physicians, osteopaths, chiropractors, homeopaths, nurses, pharmacists), or other healers (such as traditional Chinese medical healers, or the practitioners of Ayurvedic medicine found in India). It is the folk sector that is of greatest import to the subject of this chapter, for it is this sector to which many patients turn for help. A mixture of many components, including all nonprofessional, nonbureaucratic specialties, comprise the folk sector. These components are subdivided into secular (eg, fortune tellers, astrologers) and sacred (eg, priests, shamans) categories.

Western medicine’s adherence to a rational scientific-based healing tradition is in fact a minority view in comparison with other cultures around the world. There is, within Western medicine, an “etiology of disease,” which adheres to a scientific or biomedical health paradigm by holding that physical and biomedical processes can be studied and manipulated by humans and the use of a wide range of medical technology. The majority of world cultures advocate more non-traditional modes of healing.⁵³

Holistic health paradigms hold that the forces of nature must be kept in natural balance or harmony. Practitioners of organic healing and medicine use drugs, surgery, and diet to treat traumatic injuries and certain pathological conditions. Nonorganic means use semimystical or religious practices to influence the patient’s mind and thereby cure certain specified physical or mental states. Religious and spiritual healing can range from scriptural-based faith healing that is found in a number of American fundamentalist religious denominations to the magico-religious health paradigms found in Haiti and many African cultures where supernatural forces dominate. These paradigms differ greatly from the scientific or biomedical health paradigm of Western medicine with its focus on the “etiology of disease.”

The Culture of Military Healthcare

American civilian and military healthcare are intimately intertwined. Indeed, military healthcare derives much of its culture from civilian healthcare. American civilian medical and nursing schools train most military doctors and nurses. The same professional standards usually govern both civilian and military healthcare practice. American military hospitals voluntarily comply with accrediting standards of the Joint Commission on the Accreditation of Healthcare Organizations. And, although military healthcare has long been “managed care,” it isn’t unique—civilian managed care organizations are increasingly providing America’s healthcare.

Mixed Agency in Military Healthcare

The military healthcare professional wears two hats as a member of two cultures—civilian healthcare and the military. In both professional arenas, the cultures are highly structured, routinely demand more than minimal personal sacrifice of their members, and require their members to maintain high standards of personal and professional conduct. Ironically, one culture (medical) aims to preserve life, while the other (military) stands ready to take lives (arguably, to protect and preserve other lives).

Military healthcare differs from its civilian counterpart because of unique differences in the military’s culture. For example, military rank structure creates unique power issues among military professionals and patients. Unlike civilian patients who can pursue legal causes of action against their care givers, military service members are prohibited by federal law from suing the government in response to failed care. Indeed, sometimes a military service member’s medical decision-making ability is severely restricted, such that failure to consent to a medical procedure may mean immediate employment termination.

Military healthcare providers have both a peacetime and a wartime mission. Peacetime missions include providing healthcare to service members and their authorized dependents as well as operations other than war, such as humanitarian missions (eg, Hurricane Andrew, Somalia) or a multinational peacekeeping mission (eg, Bosnia). Wartime missions include providing healthcare for US and allied service members, enemy prisoners of war (EPWs), and often civilian populations indigenous to the war’s location (Figure 21-5). The provision of wartime healthcare is governed by the Geneva

Conventions. Given the requirements of international law and the military's readiness and war-fighting goals, military healthcare's obligations and responses to patients can vary greatly, differing perhaps from civilian triage. Thus, for example, prioritization based on the Geneva Conventions or the principles of battlefield triage, which emphasize military mission, suggests potential differences from civilian mass casualty triage principles.

Values like courage or integrity that are deeply imbedded within military culture suggest potential differences from civilian healthcare when those military values encounter healthcare values like relieving suffering or therapeutic privilege. Although these norms and character attributes are observable in civilian healthcare, it is doubtful that they are, on the whole, as pervasive there as in the military context.

Major Subcultures in Healthcare

Although the medical healthcare team functions as a team, there are several subcultures within healthcare. Understanding these subcultures helps to facilitate effective communication and lessen misunderstandings and tensions between the various healthcare professionals.

Medicine and Nursing. Medicine and nursing (Figure 21-6) are healthcare's most easily perceived subcultures. Major differences have existed between the two throughout the centuries and continue to this day. These differences suggest significant po-



Fig. 21-5. The 5th Mobile Army Surgical Hospital (MASH), a US Army field hospital, at Ad-Damman, Saudi Arabia, during the Persian Gulf War (1990–1991). Artwork by SFC Sieger Hartgers. Courtesy of the US Army Center of Military Art.

tential for conflicts of values. The classic and parochial explanation, “doctors cure while nurses care,” only begins to explain the potential conflicts. One need only briefly examine the language each profession uses to discuss ethical problems to observe the significant potential for conflict between doctors and nurses. For example, in a study of Western-medicine-trained healthcare professionals, Scandinavian doctors and nurses were asked to give their responses to ethically difficult clinical cases. Doctors’ response themes included: disease, scientific knowledge, distance, paternalism, preserving life, opportunism, power, survival, and feeling isolated as an individual. Nurse response themes included: health and daily life, experiential knowledge, closeness to the patient, quality of life, pessimism, powerlessness, death with dignity, and being together with colleagues.⁵⁴ The study demonstrates radically different professional value perspectives between medicine and nursing. In addition, medicine and nursing lack internally homogeneous values within themselves individually. Doctors are far from agreed about medicine’s ends. The current physician-assisted suicide controversy involves major debate about medicine’s ultimate ends (eg, patient autonomy and relieving suffering vs. human health and wholeness) and dispels the notion that medicine is a homogeneous culture. The same is true for the nursing profession, which is currently debating the meaning of “caring”—nursing’s very heart—in the context of increased patient rights, enhanced technology, fewer players in “the doctor-nurse game,”^{55,56} feminist concerns, and similar issues.

The Culture of Physicians. In his article, “Cultural Influences on Physician Communication in Healthcare Teams,” Cali points out that physicians learn certain cultural values during their medical training.^{57(pp23–25)} They learn to value scientific objectivity while discounting the importance of emotional well-being or expression. Medical students are expected to “act like a doctor,” and use of medical jargon leaves no room for student objectivity. The acquisition of knowledge is above all other priorities. Emotional responses are to be handled in private. Beginning with the drive to gain admission to medical school, a professional omnipotence is developed. If successfully admitted, the new student learns that he or she is “set apart” from those unable to enter medicine’s inner sanctum. Physician instructors encourage and reinforce the drive to excel in medical school and to impress others with knowledge and mastery of facts. Medical students are taught to acknowledge that mistakes will



Fig. 21-6. Robert Thorn's recent painting depicts a religious nurse in a medieval hospital. These nurses were the forerunner of today's highly trained nursing professionals. The nurses were involved in the lives of their patients 24 hours a day, beginning the model of care persisting until modern times. Courtesy of Parke-Davis, Division of Warner-Lambert Company.

be made, but not to dwell on them and to develop a protective sense of omnipotence and omniscience (Figure 21-7). The use of medical jargon, class differences, and the withholding of information further enhance physician power. Part of this withholding of information occurs when physicians limit their availability to others. This causes other healthcare staff to spend a considerable amount of time tracking the physician's day-to-day patient management. In these situations, time with the physician readily becomes a prized commodity.

As with most skilled professionals, physicians develop heroes in their own profession. The recognition of admirable traits in other physicians occurs gradually. Often a physician is admired for a particular expertise (eg, possessing technical proficiency, achieving success with particular types of

cases, or demonstrating genuine compassion). The medical student often builds a personal repertoire of skills and values by selecting fragments of heroism recognized in these established physicians. Medicine also has its own rites of passage. For example, young physicians are taught to subordinate personal comforts and to endure a large degree of hardship. "House Officer Stress Syndrome," which involves episodic cognitive impairment, chronic anger, pervasive cynicism, family discord, depression, suicidal ideation and suicide, and substance abuse, is quite prevalent.⁵⁸

Even physician communication patterns are culturally learned. Minimizing or trivializing experiences helps the physician maintain an emotional distance and protects the sense of omnipotence. An example of this is found in a feature of life among



Fig. 21-7. This 19th century drawing of a physician holding death at bay reflects a cultural view of the role of physicians. Medical students tend to be indoctrinated into a culture of war, in which they battle death rather than focusing primarily on the needs of the patient. Reproduced with permission from Corbis, Inc.

surgeons called “the horror story.” These moral parables, so-to-speak, are “an element of the oral culture of medicine that remind all that healing is a difficult business that must always be done with care.”^{59(p103)} These stories are at times somewhat humorous with actions set in the past at an exact time that no one can recall and the participants in the story are ones whose names cannot be recalled. They usually come in two forms: the cautionary tale (drives home the need for caution, care, and completeness) and the story that communicates the shared difficulties that all surgeons face.^{59(pp103–104)} Naming and humor shields physicians from the awesome encroachments of suffering, death, and powerlessness. It doesn’t take long for the physician to learn how to control situations through communication behavior.

The Subculture of Managed Care. Four metaphors embody the meaning of American healthcare: (1) the ministry of healing, (2) the war against disease, (3) the defense of patients’ rights, and (4) the newest metaphor—“healthcare as an industry.”⁶⁰

Together they describe a culture rich in tradition, ripe with change, and filled with potential for increased conflict among the basic values undergirding each metaphor. The potential for the greatest conflict stems from the “healthcare as an industry” metaphor, particularly the burgeoning industry of managed care.

Under managed care, the doctor balances patients’ interests against one another in allocating limited resources among them with one clear objective—to cut costs. Bonuses and fee withholds encourage and enforce the physician’s cost-consciousness. Thus, patients’ needs compete directly with the doctor’s financial interests,^{61(p331)} with the result that managed care creates major potential conflicts within healthcare with two of healthcare’s four metaphors—the physician as benevolent healer and the patient’s rights.

Managed care may also be viewed as part of a larger healthcare subculture—health services delivery, or healthcare administration—a subculture with values that routinely conflict with healthcare’s

traditional clinical subcultures. Consider its values interaction with traditional physician values. Managerial values like total quality management, group activity, process focus, and cooperation are at odds with traditional physician values like professional autonomy, self-reliance, and independence. Regarding

patients' religious or cultural values, the culture of managed care with its cost-cutting focus may be less open and responsive to tailoring healthcare to an individual patient's religious or cultural values, particularly when honoring the patient's values costs more.

WELLNESS AND ILLNESS: TWO OTHER RELIGIOUS-CULTURAL VIEWS

Many cultures have developed at least an oral tradition that predates American culture. The values of these cultures share the same basic concern for the health and medical welfare of the patient and society as Americans do; however, the sources from which their values have evolved present a contrast to those found in this country. Two of these, Judaism and Islam, are religious-based cultures that provide an interesting contrast to American views of health and illness, and inform their medical ethics.

Judaism

For the purposes of the discussion in this chapter, two aspects of Judaism will be presented: (1) the view of life and illness, and (2) the principles of Jewish medical ethics.

Judaism's View of Life and Illness

Basic beliefs that form the basis of Jewish thinking concern life and the body, illness and healing. As with all religions, these beliefs are handed down from one generation to the next (Figure 21-8). "In the struggle for survival and the fight for life itself, Judaism assigns to individual human life an intrinsic value, probably higher than any of its cognate faiths."^{62(p75)} This belief is based on the passage in the Talmud (one of the primary sources of rabbinic discussions and decisions on medical matters in the ancient world) that describes the creation of Adam by God, in that "if any person causes a single life to perish, Scripture regards him as if he had caused an entire world to perish" (Sanhedrin 37a). Believing God created bodies as well as minds, emotions, and wills, the rabbis assumed that human bodies were God's property, which he leased for the duration of one's life. Thus, one does not have the right to destroy the body by suicide, but rather has the responsibility to take care of it.^{63(p45),64(p8)} In Jewish *halakah* (the Judaic legal system), virtually every religious precept, with the exception of murder, idolatry, and forbidden sexual relationships, is suspended in order to enhance even the remote possibility of saving a human life. Moreover, matters of

hygiene, diet, exercise, and sleep were subjects for legal obligations under Judaism.^{64(p10),65(pp17-19),66(p8)}

As the creator of everything, according to the Bible, God is ultimately the author of health and disease (Deut. 32:39). God is depicted in biblical accounts as visiting illness on people as a punishment for their sins and as a means of expiation (Deut. 28). This linkage between sickness and sin has been challenged even though it has been sustained in Jewish sources. The Book of Job (Figure 21-9) addresses this issue as does a popular book, *When Bad Things Happen to Good People*, by Rabbi Harold Kushner. Because it was difficult to explain the suffering of the Jews according to this view of sin and sickness, Judaism instead generally addressed the degradation, death, destruction, and exile that Jews suffered rather than physical illness. "Wounds and dismemberment suffered in the course of persecutions were all seen as a part of the broader question of how God would allow human beings to inflict suffering of all sorts on his covenanted people in the apparent absence of sin."^{64(p13)}



Fig. 21-8. "My students know nothing about being Jews," says Vladimir Zeiv, a teacher of Hebrew at the Moscow Synagogue. Judaism as a culture encompasses not only the religious aspects of life, but also every aspect of living. This rich tradition is passed down from generation to generation. Reproduced with permission from *National Geographic*. Feb 1991; 23.

The causative properties of sin did not prevent the rabbis of the Talmud from identifying the physical causes of illness or from seeking to cure them. The most widely held view was that blood was the chief cause of disease. Therefore, bloodletting was prescribed for various illnesses. Other carriers of disease mentioned in the Talmud include bile, the air, contaminated food or beverages, bodily discharges, clothing, bath water, animals, and insects. Lack of fluids, injury to the spinal cord, excessive eating, fasting, drinking of liquor, and sexual activity were also thought to cause disease. Psychological causes were also recognized. It is also notable that Jewish sources attributed sickness to the work of demons, although they rarely linked the demons to the previous sins of their victims. “Jews apparently acquiesced to the inconsistency of believing in both an omnipotent God and independent demons.”^{64(p14)}

Jewish belief in the obligation to save the life of an endangered person is derived from the Talmudic verse, “Neither shall thou stand idly by the blood



Fig. 21-9. The Purpose of Man's Being. “Job,” by Dutch painter Jan Lievens (1607–1674). The sufferings of Job, a man blameless before God, challenge the linkage between sickness and sin. Reproduced with permission from the National Gallery of Canada.

of thy neighbor” (Lev. 19:16). The Talmud and the various codes of Jewish law offer specific examples of situations in which moral obligation exists with regard to rendering aid—rescue of a person drowning in a river, assistance to one being mauled by a beast, and aid to a person being attacked by bandits.^{63(p46)} These examples mandated nontherapeutic interventions. What remained controversial in early Judaism was accepting the work of therapeutic practitioners to cure illness.

To counter the point that God is the source of all healing, and not man, the rabbis pointed out that God himself had authorized healing, in fact required it. This authorization and imperative was found in two biblical verses: (1) an assailant must ensure that his victim is thoroughly healed (Exodus 21:19–20), and (2) “you shall restore the lost property to him” (Deut. 22:2). The Talmud understood the Exodus verse as not only giving permission for the physician to cure, but making such treatment mandatory.^{63(pp47–48)} “On the basis of the extra letter in the Hebrew text of the Deuteronomy passage, the Talmud declared that the verse included the obligation to restore a fellow man's body as well as his property; hence there was an obligation to come to the aid of another person in a life threatening situation.”^{64(p15),67(p16)}

Other Talmudic instructions include the obligation of providing medical aid to encompass expenditure of financial resources (Lev. 19:16, previously mentioned), and the exemption of physicians from any liability for injuries they caused in the process of healing (“And you shall love your neighbor as yourself,” Lev. 19:18). It is assumed by the rabbis that this last reference infers that the patient, like the physician himself, would be willing to take some risk to be healed (Sanhedrin 48b). One other Jewish law forbade any person to live in a town in which there was no physician, for doing so would expose a person to an unacceptable degree of risk and would prevent them from fulfilling his or her obligation to receive medical care (*Yoma* 83-84, Sanhedrin 17b).^{67(pp37–38)}

Principles of Jewish Medical Ethics

Many of the aforementioned Jewish moral and halakic principles and rules have significant bearing upon the Jewish practice of medicine. These comprise what could be considered fundamental principles of Jewish medical ethics:^{68(p406),69(p66)}

- *Judaism subscribes to commitments, obligations, duties, and commandments commonly*

shared by all observant Jews. Jewish ethics subscribes to moral self-fulfillment through the obedience to moral-religious norms and requirements.

- *Judaism, in general, favors a casuistry approach, rather than a zealous adherence to general principles.* Each case is dealt with on its own merits, depending heavily on the specific and individual circumstances.
- *Judaism is against absolutizing any single precept, rather, a middle way is always advocated.* When conflicting values in medicine are encountered, each patient must be considered individually, and a solution is reached depending on the specific clinical and ethical circumstances.
- *The principal aim of studying ethics and Jewish law is to act accordingly.* The dictum is “to learn in order to perform,” and not to merely engage in intellectual exercise or academic analysis.
- *The physician–patient relationship is viewed as a covenant.* This relationship is not viewed as a negotiable contract in which the parties agree to the relationship beforehand and which either party can terminate without consequences. There is an obligation upon a physician to always extend help to those who are in need of his or her services.
- *Judaism views the seeking of medical attention by the patient as a moral imperative.* No one has the right to refuse medical treatment deemed necessary and effective by competent opinion.
- *Human life is sacrosanct and of supreme worth.* Any precept, whether religious or ethical (except idolatry, murder, and adultery), is automatically suspended if it conflicts with the interests of human life. Every human life is equally valuable and inviolable.

Thus, the Jewish view of life, illness, health, healing, and medical ethics is primarily based on *halakah*, and embraces Jewish laws, practices, and observances since the time of Abraham. Jews speak from within their own religious tradition that recognizes the sanctity and worth of human life, and the imperatives for the patient and the healthcare professional to seek and provide needed medical care. Yet, Judaism recognizes the limitations of medical science to heal or cure in every instance. Accordingly, one is neither to prolong the moment of death, nor hasten its arrival. Jews are keenly aware that the body, as the creation and property of God, is on loan for the duration of life.

Islam

Islam is the third of the monotheistic religions, commonly referred to as the Abrahamic religions, the other two being Judaism and Christianity. The three principal figures in these religions share the ancestry of Abraham: Moses and Jesus through his son Isaac, and Mohammed through his son Ismail. They all embrace the Abrahamic belief in God and His oneness. Uniquely, Islam recognizes the other two religions and proclaims itself as the last link of the long chain of God-sent messages.^{70(p57)}

Muslim writers emphasize the uniqueness of God’s revelation to Mohammed, in which religion and morality are seen as inextricably linked. Thus, Islam is not only a religion of dogma and theological statements, but it also influences deeply the behavior of every believer in all areas of his or her life.^{71(p174)} Islam has a framework of a total legal system to regulate and organize various aspects of human activities. “Law is a human necessity, and morals alone are not enough for actual government of society nor can they abound in a legal vacuum.” This total system of Islam is called the *Shari’a*, and although comprehensive, only a few rulings in it are fixed. It represents outlines that allow for flexibility and for new rulings to be evolved to suit new circumstances in changing times and places, but always within the general framework established by the *Shari’a*.^{70(p59)}

Islamic View of Wellness and Illness

The *Shari’a* is filled with rulings that reflect Islamic concepts of wellness and illness. Health and wellness are described not simply as the absence of disturbing factors such as illness, but as embracing the wholeness of human well-being. Wholeness, according to Islam, is granted by God, who is the cause of all wholeness, for “God gives food and drink, heals the sick, and makes persons die and live again” (26:79–81 [references in the *Quran* are noted in parentheses and follow this format]). Because God is the creator of everything, all evil is related to him insofar as it is caused to remind humans of misdoings in order to better the wrongdoer’s attitude. The Muslim knows that God’s will is somehow involved, either by directly causing suffering or allowing it to happen. “Suffering and illness clearly show that the originally intended wholeness has been disturbed either because God is punishing the wrongdoer or because humans must directly suffer the consequences of human sins.”^{71(p177)}

Moral education is seen as an important preventative measure to preserve a sane community and

to guarantee the individual's happiness within that community. "Medicine, hygiene, and regulations for healthy living together form the guidelines for good living according to God's will."^{71(p178)} To underscore this widely held Islamic belief, a book was written under the general theme of "medicine in the Koran."⁷² In it, the author clearly shows that medicine and health, in Islam, must be seen as integral parts of wellness in general.

In doing God's will and putting the divine principles into practice, historically, Muslims did not merely wait for God to act but encouraged their scholars to accumulate as much knowledge as possible. With regard to medicine, they integrated Greek and other foreign medical techniques in order to cure the sick, at least as far as God allows for success in curing, as no one dies unless it is God's decision (3:45). According to the *Quran* (5:32), saving and preserving life are among the highly regarded tasks. In practice, Muslims were among the first to build hospitals, engage in surgery, and use herbal and medicinal therapies for both corporal (Figure 21-10) and mental illnesses.^{71(p179),73(p158)}

Principles of Islamic Medical Ethics

As a means of incorporating Muslim beliefs and concepts in illness, healing, and specific religious obligations toward caring for the sick, the International Conference on Islamic Medicine, held in Kuwait in 1981, formulated a code of professional medical ethics. The code includes guidelines for the



Fig. 21-10. A pregnant woman, in the traditional Islamic clothing, receives a prenatal check-up. Islamic medicine has a rich and ancient heritage. It developed many innovative treatments while maintaining traditional modesty and values. Reproduced with permission from Martha Tabor.

Islamic physician's behavior and attitude, both at the personal and professional levels^{71,74,75}:

- *The Muslim physician must believe in God and in the Islamic teachings and practice, both in private and public life. He must follow the path of righteousness and always seek God's support.*
- *The physician has a professional requirement to acquire and maintain proper medical knowledge. Scientific or academic research is encouraged so long as it aims to solve a particular problem or to "reveal the signs of God in His creation" (20:114; 35:28; 39:9).*
- *The physician must abide by the legal rules regulating the profession, provided they do not violate Islamic teachings. Obedience to the law, both temporal and spiritual, is proper and expected (4:59).*
- *The care the physician provides to his patient must be in accordance with God's guidelines. Life is given by God, and cannot be taken away except by Him or with His permission (5:32; 25:3; 67:2).*
- *The physician has no right to terminate any human life under his care. Abortion is restricted unless the life of the mother is at risk. For all patients, when treatment carries no prospect of cure, it ceases to be mandatory, but no action should be taken to actively bring about a patient's death.*
- *The physician has no right to recommend or administer any harmful material to his patients. God makes good things lawful and bad things forbidden (7:157). Pain and suffering must be alleviated physically (by medication), as well as psychologically. Active euthanasia is forbidden.*
- *The physician must render the needed help regardless of the financial ability or ethnic origin of the patient. The advice given and the treatment rendered must consider both the patient's body and mind, always remembering to enjoin what is just and forbid what is wrong (76:8-9).*
- *The physician must protect patient confidentiality (23:8).*
- *The physician must adopt an appropriate manner of speech. It must be pure and uplifting (22:24).*
- *It is advisable that the physician examine patients of the opposite sex in the presence of a third person whenever feasible. This serves to protect both the patient and the physician (4:28; 24:30-31). Situations of this sort are*

always a test of the physician's moral character and his strength.

- *The physician must not criticize another physician in the presence of patients or health personnel* (4:148; 49:11).
- *The physician must refuse payment for the treatment of another physician or his immediate family.* There is no specific instruction for this in the *Quran* or in Islamic tradition. However, an analogy is drawn when God says: "Alms are for the poor, the needy and those employed to administer the funds..." (9:60). This is a situation where the persons providing a certain service are entitled to use the same service at the time of need. This also applies to physicians.
- *The physician must always strive to use wisdom in all his decisions and the reward will be great.* "To whom wisdom is granted, is granted a great deal of good" (2:269).

Islam, as a religion, has played a fundamental role in the creation of a culture that has nurtured the cultivation and development of medicine. Medical issues in Islam are not discussed in isolation apart from theology and religious law. Even though Islamic tradition held a high standard of ethical

conduct in medicine, it was not until 1981 that any real attempt was made to codify the teachings of the *Quran* into a code of ethics. Although this code is not endorsed by all Muslim physicians, it does clarify how different the moral reasoning is of one in the Muslim tradition from secular and Judeo-Christian medical ethical discussions.

American medicine and its ethics reflect the empirical science it guides: it values the pursuit of objectivity and quantification of experience, and is analytical, rationalistic, dialectical, and often secular in spirit.^{18(p191)} Though its roots run deep in the Calvinistic tradition, American medical ethics has evolved into a rights-based discipline that seemingly accords an inordinate amount of autonomy to the individual without regard to the consequences of that autonomy to the good of the community or society.

Within the Jewish and Islamic traditions, a person is seen as the creation and handiwork of God, as a member of the larger community of faith. What one does, as an individual, cannot be easily separated from the religious and social milieu in which one lives. One is less prone, as a Jew or Muslim, to make decisions without considering their impact on his or her standing in the church, the family, and the community.

ADDRESSING CONFLICTS ARISING FROM RELIGIOUS AND CULTURAL CONSIDERATIONS

As noted in the opening pages of this chapter, the American military is increasingly multicultural and multiethnic, just as is American society. Considering the various deployments of American military resources, it is only natural that American healthcare professionals will encounter individuals and cultures that can be considerably different from those in which they grew up. From the perspective of military mission, it is essential that religious and cultural consideration be given to each patient, in each circumstance, to maximize the medical benefits of an intervention. The first step is to understand the potential for conflict.

The Potential for Conflict

The greater the diversity of ideas and cultures, the greater the potential for conflict when people interact, especially at times of increased stress. The following examples reveal conflicts between healthcare professionals and patients and family members' religious or cultural values.

A Jehovah's Witness father states his religiously based demand: "No blood transfusions!" Engaged

in a desperate attempt to save the father's young son's life, the physician responds, "I may be sued, but I'll not be responsible for murdering this boy because of your beliefs!" Asked the number of pregnancies she has had, a Hispanic woman answers, "two." Later she mentions a third pregnancy—a miscarriage. In her Central American cultural background, miscarriages don't equate with pregnancies; only the successful pregnancies count.^{76(p256)}

The first example of religious value that creates a potentially high-drama conflict in patient care is easily identifiable. The second example involves a much more subtle conflict between different cultures' languages, and highlights the fact that "language differences between physicians and patients are indicative of cultural differences that significantly affect care."^{77(p727)} Likely, many American healthcare professionals routinely and incorrectly label such conflicts as resulting wholly from the patient's or family members' odd or aberrant religious or cultural values, with little or no recognition of the role of the healthcare professionals' corporate (let alone personal, religious, or cultural) values in the conflict. Viewing the conflict as health-

care versus the patient's (or loved ones') religious and cultural values is overly simplistic. It fails to acknowledge that the patient's religious and cultural values may indeed be another concept of healthcare. It also fails to understand that American healthcare is permeated with its own cultural values.

Some Caregiver Guidelines

The following discussion highlights five guidelines that healthcare professionals should employ in addressing conflicts in patient healthcare decision making that result from religious or cultural considerations or both.

Develop an Awareness of the Potential for Conflict

Leininger describes her observations of an American nurse with a Philippine female patient in her first stay in an American hospital. Having placed a small towel over the patient's breasts, the nurse attempted to wash the rest of the patient's almost naked body. During the washing, the patient was tense and struggled to cover her nakedness with blankets. She told the nurse, "I am clean and do not need this bath. Please leave me alone." The annoyed nurse stopped the bath and left the room. Later, family members helped the patient to wash herself.⁷⁸ Privacy and modesty are very important to Philippine female patients. In the preceding example, the patient communicates these values to the nurse as best she can. Clearly, the nurse's lack of awareness about this cultural factor contributes directly to the conflict over the care being provided.

Approaches to developing an awareness of the potential for religious- or culture-based conflict in individual patient care decisions may differ. A minimalist approach is that until the patient communicates the potential for a problem, the caregiver need have little concern for potential conflict. This approach would likely have strong support in the cost-conscious, time-constrained managed care setting, where cost-cutting efficiencies compete with patient autonomy for highest priority. An advocate for honest and complete informed consent communication between doctors and their patients,⁷⁹ however, would likely say that caregivers have an ethical duty to actively pursue and develop an awareness of the potential for conflict.

The practical and/or ethical duty owed the patient may lie somewhere between the two positions. Given a general awareness of the potential for such

conflicts, the caregiver should "screen" (triage) patients: (a) seeking to understand the patient in the larger context of his or her religion or culture and (b) sorting out for additional inquiry those patients with higher risks of care decision conflict grounded in religious or cultural values.

More than listening to patients' or family members' words is involved. Patients and their families express their religious and cultural beliefs in a variety of behaviors and actions. Helpful clues about their religious or cultural values may be found in areas such as: (a) communication (eg, eye contact, idioms, first names, demeanor, expressions of pain); (b) social custom (eg, clothing, symbols, dietary practices, colors, ways of expressing grief); (c) family relationship (eg, visiting patterns, self-care issues, gifts, kinship); (d) gender issues (eg, women and authority, male dominance, female circumcision, virginity, female purity and modesty); and (e) folk medicine (eg, coin rubbing, cupping, folk healers, scars, fat).

In developing the awareness under discussion, the caregiver must actively listen to the patient, approaching him with a "help me understand why" mind-set. Where a conflict involves language differences, improved translation alone may be inadequate to resolve the conflict. Any interpretation of the translation needs to be understood in the context of the patient's religious or cultural value system.

See Patients as Individuals Rather Than Stereotypes

Providing healthcare to an individual patient within the framework of a religious or cultural stereotype suggests potential infringements upon the patient's religious or cultural autonomy. For example, although Jehovah's Witness patients generally refuse blood transfusions, stereotyping all Jehovah's Witness patients as individuals who will refuse blood products without asking how the broad prohibition applies to an individual Jehovah's Witness patient could violate the patient's autonomy. People accept or comply with "official" religious or cultural beliefs or practices in varying degrees. Thus, for example, some Jehovah's Witness patients while refusing whole blood will accept products made from blood fractions.

A fine line exists, however, between framing one's understanding of the patient by using stereotypes as compared to appropriately using generalizations. For example, a stereotype such as, "Mrs. Gonzalez is a Mexican; she must be Catholic; she must have a large family," may well preclude further and open discussion. It fails to focus on Mrs.

Gonzalez specifically. Using a generalization like, "I think many Mexican Catholics have large families; I wonder if Mrs. Gonzalez has a large family," opens the discussion to an appropriate, personalized focus on Mrs. Gonzalez's cultural situation.

Understand the Impact of Religion and Culture on Patient Autonomy

Religious and cultural considerations can actually change the concept of "patient autonomy" that is so important in modern American healthcare practice and ethics. American healthcare deems the competent, informed adult patient "autonomous." Generally speaking, any patient can choose or reject medically indicated treatment or therapy even when it involves serious health risks, except where there is appreciable risk of serious harm to a third party. Consequently, obtaining the patient's informed consent is essential in American healthcare jurisprudence and ethics. However, as in the case of Leah, sometimes autonomy or its derivative—*informed consent*—runs afoul of the patient's religious or cultural values. A patient's cultural or religiously grounded view of "authority" may have serious implications for the patient's understanding of his autonomy, determining whether the patient views his role in the healthcare setting as either an active or a passive participant in treatment decisions.

Develop an Awareness of One's Own Religious or Cultural Values

The healthcare professional must be aware of his or her personal or professional religious or cultural values as they relate to the patient and the patient's autonomy. Cultivating this awareness is very important. Where those values differ significantly from the patient's, the caregiver may have an ethical duty, and possibly a legal duty, to disclose his beliefs to the patient. In some cases, the caregiver's appropriate action may be to transfer the case to another caregiver and to withdraw from the case.

A classic conflict situation involves the physician who, because of religious beliefs, refuses to grant a terminal patient's request to withdraw life support. A recent survey of 301 Texas physicians suggests that doctors' religious beliefs can ultimately influence their clinical decisions. The survey produced a profile of the physician who is likely to deny medical futility while treating patients who are clearly dying or persistently unconscious. The profile details the following characteristics: male, attends religious services,

defines failure as "not doing all you can do," low fear of legal consequences, uncertain about efficacy and benefit of treatment for terminally ill patients, and emotional detachment from patients.⁸⁰

It seems obvious that a doctor should not force his patients to accept his (the doctor's) personal religious views. In December 1989, the American Psychiatric Association approved the following guideline to that effect for its member psychiatrists:

Psychiatrists should not impose their own religious, antireligious, or ideologic systems of beliefs on their patients, nor should they substitute such beliefs or ritual for accepted diagnostic concepts or therapeutic practice.^{81(p543)}

However, simply adopting rules like the above may insufficiently protect patients from their psychiatrists' religious or cultural values. This is because Western psychotherapy, according to Torrey, is steeped in Western values. "[It] ... is culture bound."^{82(p219)} Post, in his review of Torrey's position, goes on to note that psychotherapy has "middle class values such as self-reliance, individualism, enhancement of wealth and social status, and rationalism."^{83(p219)} He acknowledges the significant conflict these values have with "the many forms of religious devotion, self-denial, and spiritual discipline that reject these values."^{83(p219)} (Post,⁸³ for instance, discusses the problem of psychiatric involvement in faith breaking ["deprogramming"] and notes that some psychiatrists view religious conversion as pathological. This is a clear example of how Western psychotherapy's culture rejects religious fundamentalism.) Consequently, regardless of the individual caregiver's personal religious or cultural values, the professional cultural (and arguably religious) values he embodies may conflict with the patient's religious or cultural values.

What about the a-religious caregiver? One can envision the physician who wholly embraces the philosophy of science and/or secular humanism as his value system. Such a caregiver might project hopelessness, fatalistic surrender, or faith in nothing beyond medical science upon the patient. Considering the general rule in medicine that a physician should not abandon the patient, such behavior might inflict serious pain and psychological harm on the patient, resulting in emotional and psychological abandonment of the patient.

To illustrate the point further, evidence exists that more African-Americans and Hispanics, as compared to non-Hispanic whites, want their doctors to keep them alive regardless of how ill they are, while more

non-Hispanic whites agree to stop life-prolonging treatment under some circumstances compared to African-Americans and Hispanics.^{84(pp157-158)} Whether or not these differences are due to cultural dynamics alone or to both cultural and religious considerations, one can envision possible conflicts when a physician who zealously pursues science's ends aggressively seeks to persuade an African-American or Hispanic patient or family to acknowledge medical futility and stop life-prolonging treatment.

Be an "Honest Broker" of Others' Values

When a patient's or others' religious or cultural values conflict with a caregiver's personal or professional values, the caregiver must appropriately "broker" the patient's values, using honesty and

integrity in addressing the conflict. The "honest broker" caregiver consciously seeks to avoid using religious or cultural stereotypes that preclude additional and open discussion about the patient's specific beliefs and values (Figure 21-11). He encourages healthy, positive dialogue with patients and others designed to clarify and understand their views. He facilitates rational discussion of all relevant values that allows for even-handed persuasion and precludes manipulative or coercive dialogue or behavior. He encourages focusing the discussion on how patients' decision-making processes are influenced by their culture and faith traditions (Figure 21-12) and away from a singular focus on clinical "certainties."

Caregivers, patients, families, and others (eg, hospitals, other patients) have vested interests in the



Fig. 21-11. Wedding belle Hayat Tawil was born and raised in the United States but met and married her husband, Eyad, during a visit to the West Bank. Photograph courtesy of JoAnna Pinneo; reproduced with permission. Photograph originally appeared in *National Geographic*. June 1992; 110.



Fig. 21-12. Blinking back tears, Elga Pahkel listens to the Estonian National Anthem. Photograph courtesy of Larry Davis, reproduced with permission. Photograph originally appeared in *National Geographic*. November 1990; 3.

outcomes of the conflicts. At times it may be very difficult or impossible for the healthcare professional with a stake in the outcome to address the patient's or other parties' values with honesty and integrity. Caregivers who become entrenched or take sides in the dispute, who "demonize" the patient and the patient's values as "extreme" or "irrational," or who are unwilling or unable to remain open to the patient and his values, cannot serve as honest brokers. They need help to accomplish this guideline. In addition, some value conflicts are so serious that even if the caregiver is fully aware of all parties'

values and is truly seeking to function as an honest broker of those values, additional help is needed.

Some of the sources available to help the caregiver address the conflict include: (a) other healthcare professionals, (b) institutional ethics committees, (c) trained healthcare ethics consultants, (d) ethical decision-making models, (e) consultation with religious or cultural authorities, (f) conflict resolution strategies, training, and expertise, (g) participation in healthcare ethics or religious/cultural awareness programs, and (h) caregiver self-education.

CONCLUSION

Healthcare and its ethics have a long tradition that has largely taken on the values, beliefs, and practices of Western religious and cultural heritage found in America. Yet, Americans are increasingly interacting with persons—both patients and healthcare professionals, in this country and abroad—who are from different cultural backgrounds and who profess different religious beliefs. As the proliferation of medical science and technology increases, and as more patients from different backgrounds come to the United States for help, healthcare professionals must avoid an ethnocentric view of what is best for their patients. They should instead make a good faith effort to identify, understand, and be sensitive to all patients' religious and cultural needs as it affects their healthcare decisions. In addition, healthcare professionals

should be aware of their own religious, cultural, and professional heritage and how they influence personal and professional perceptions, beliefs, and actions in their relationships with others.

As the world grows smaller and Americans become more aware of the differences that exist among various groups of people, including the multiplicity of subcultures within the United States, it is important for all people to understand and appreciate that wanting to have health, to be free from pain and suffering, and to live and die with dignity are universal wants that transcend religious, cultural, and national boundaries. As military healthcare professionals provide the means to help each other meet these goals, the diversity and richness of each other's personhood and heritage should be celebrated.

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