Faith, Ethics, and Medicine: A Bridge Over Troubled Water

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Co-Sponsor: Spiritual Care Leadership Group, KP NCAL
March 2012
Objectives

• Demonstrate awareness of specific religious and cultural perspectives to help bridge gaps between healthcare and faith when ethical dilemmas occur.
• Gain skills in understanding, identifying, resolving and preventing spiritual conflicts in healthcare settings.
• Examine and discuss spiritual assessment tools as resources for use when faith and ethical issues arise.
• Workshop I: Panel Discussion
• Workshop II: Case Study
Chaplains are professionally trained to assess, counsel, and administer spiritual care for patients, family, and staff of all faiths and those of no faith affiliation.

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- So. Sacramento  Arthur Lillicropp, M.Div., M.S., BCCC  (916) 688-6488
- So. San Francisco  Lana Sandahl, DC, M.Div., BCCC  (650) 742-3739
Guest Speakers

- Minister David Grajeda, Chair
  Jehovah's Witnesses Hospital Liaison Committee
  Oakland, CA
  Email: medical.drg@sbcglobal.net

- Father Joseph Benedict, S.T.D., Pastor
  St. William Parish Catholic Church
  Los Altos, CA
  Email: jbenedict@dsj.org

- Imam Mohammed Abdul Azeez, MD, PhD
  Director, Sacramento League of Associated Muslims
  Sacramento, CA
  Email: azeez@salamcenter.org
Survey Results

- 44.18 % Muslim
- 39.53 % Jehovah's Witnesses
- 32.50 % Catholic
- 30.23 % Buddhist
- 25.50 % Christian, Jewish
- 16.27 % Hinduism
- 11.6 % Sikhism
- 6.40 % Seventh Day Adventist
- > 3.0 % Christian Science, Atheist, Agnostic, Humanist, Non-Christian, Native American
Survey Results

68.9% - Major issues in faith & religion that are ethical concerns at the end-of-life
62.2% - How faith addresses issues when the healthcare team has deemed treatment to be medically ineffective or futile
42.2% - How can healthcare providers better understand faith & miracles, when medicine no longer seems helpful
Discussion Topics

End-of-Life Issues Pertaining to:

• Prayers & Miracles
• Blood Transfusions
• Medical Futility
• Withdrawing Life Sustaining Treatments
Importance of Spirituality

Spirituality Provides:
- Hope
- Healing
- Purpose
- Meaning
- Religion
- Solitude
- Comfort
- Guidance
- Recovery

- Faith
- Peace
- Trust
- Strength
- Stress Relief
- Belief Systems
- Rituals & Traditions
- Coping Mechanism

- Fulfillment
- Well-being
- Confidence
- Foundation
- Motivation
- Relationships
- Understanding
- Encouragement

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Conflicts

When the treatment team refuses to:

- Accept beliefs
- Acknowledge beliefs
- Include deeply held beliefs in the care plan
- Hear the spiritual and human concerns of the patient/family
Conflicts

Patient and/or family:
- Refuse to accept medical:
  - advice, opinions, guidance, recommendations, warnings
- Have negative views of medical team
- Have expectations for miraculous recovery outcomes
- Have an inaccurate or vague understanding of their own faith teachings
- Have trust issues and/or emotions that interfere with rational thinking
- Are in denial
Medical Team Challenges

– Understanding complicated belief systems
– Uncomfortable with spiritual conversations
– Lack of available resources
– Establishing truthful & meaningful patient-physician relationships
– Time involved in taking a spiritual history
Catholic

- Monotheistic and Trinitarian Religion: One God in Three Images: God the Father, Jesus the Son, and the Holy Spirit
- The Virgin Mary:
  - Mother of Jesus and Recipient of Intercessory Prayer Requests as in Rosary: “Pray for us sinners, now and at the hour of our death.”
- Authority received from Holy Bible, Holy Spirit, and Tradition
- Place of Worship: Mass held in Catholic Church
- Hierarchical: Pope, Bishop, Priest, Deacons
- Priests provide the Anointing of the Sick
- Eucharistic Ministers provide Holy Communion
- Rosary prayers with Rosary Beads
- Holy Days: Christmas, Ash Wednesday, Easter
- Healthcare guidance received from “Ethical and Religious Directives for Catholic Health Care”
Jehovah’s Witnesses

- Jehovah is the Almighty God, Jesus is His only begotten son
- Bible Preference: New World Translation of the Holy Scriptures
- Place of Worship: Kingdom Hall of Jehovah’s Witnesses
- Publishes Watchtower magazine in 194 languages & Awake Magazine in 84 languages
- Observes the Memorial of Jesus’ death annually
- Abstains from Blood transfusions
- Advocates for a multimodality approach which includes pharmaceuticals, and equipment and surgical techniques
- Desires the best healthcare available, without the use of red cells, white cells, plasma or platelets
- Have own Advance Healthcare Directive
Islam

- Monotheistic: Muhammad is Allah’s prophet
- Authority received from Holy Qur’an
- Place of Worship: Mosque
- Prayers must be performed five times a day
- Pilgrimage to Mecca at least once in lifetime
- Holy Month: Ramadan (fasting dawn to dusk)
- Personal hygiene needs related to prayers
- May have dietary restrictions (no pork)
- Islam both a faith and a legal system
- Respect for modesty and privacy
- Prefer same gender provider
- Special needs during fasting
Why Assess Spirituality?

“Spirituality is an often overlooked, yet still an important element of patient assessment and care. Addressing and supporting patients’ spirituality can not only make their health care experiences more positive, but in many cases can promote health, decrease depression, help patients cope with a difficult illness, and even improve outcomes for some patients. In addition to the potential medical benefits, patients want their health care providers to discuss spirituality with them. In one study, a majority of patients indicated that they would like their physicians to ask whether patients have spiritual or religious beliefs that would influence their medical decisions if they became gravely ill. Another study found that 40% of patients felt that physicians should discuss pertinent religious issues with their patients, however only 11% of physicians frequently or always did.”
Spiritual Assessment Tools

**HOPE** *(Anandarajah & Hight, 2001)*
- H - Sources of hope, meaning, comfort, strength, peace, love, connection
- O - Organized religion
- P - Personal spirituality and practices
- E - Effects on medical care and end-of-life issues

**FICA** *(Puchalski & Romer, 2000)*
- F – Faith and Belief
- I – Importance
- C – Community
- A – Address in Care

**FACT** *(LaRocca-Pitts, 2008)*
- F – Faith
- A – Availability
- C – Coping
- T – Treatment
Case Study

Morris is a 64 year old male with incurable lung cancer. He presented in ED 35 days ago with SOB as tumors were compressing both lungs. He was emergently intubated, admitted to the ICU, and given ventilatory support which has now continued for more than a month. Aggressive treatments have failed to shrink the tumors, and the ICU physician and oncologist are both convinced that his condition will not improve. Efforts have been made to awaken him to discuss his treatment options, but he remains too confused and unable to engage in any meaningful conversation. He has no Advance Directive or POLST. Because of his extremely poor condition, and exhausting all standards of care, his clinicians believe continued aggressive medical treatment is ineffective. Pt has slowly become anemic as his condition progressively worsens. His only son and his wife have consented to all medical treatments so far. The family was given information about his poor prognosis, terminal condition, and possible imminent death. Now they are unwilling to consider or even discuss any limited treatment options, insisting that he remain in the ICU, on ventilator support, with aggressive treatments, and a “full code” status. They stated that their deep religious faith required them to do everything possible to preserve life, and they were counting on God to perform a miracle. They report that the patient was also a man of deep faith who would likewise insist on this approach.

1. Identify the facts
2. Identify relevant ethical principals
3. Identify spiritual beliefs and values in relation to: prayer & miracles, blood transfusions, medical futility, and withdrawing life sustaining treatments
4. Identify the dilemma and conflicts that exist between family and providers and state why
5. Identify a presenter to share your group’s recommendations
Recommendations

1. Create opportunities for faith, ethics, and medicine to co-exist when conflicts occur
2. Include professional clinical Chaplains in complex cases
3. Remember the Platinum Rule "Treat Others the Way They Wish to be Treated"
4. Build trust with a caring attitude showing a concern for respect, autonomy, dignity, compassion, justice
5. Be mindful of signs of spiritual insensitivity: indifference, unconcerned, apathy, unresponsiveness, adversarial, coldness, judgmental, confrontational, and lack of interest
6. Use an inviting, non-judgmental and non-condemning tone of voice and body language
7. Spirituality should never be ignored, overlooked, devalued, disregarded, or disrespected
8. Deal effectively with spiritual challenges faced by providers
9. Open difficult spiritual conversations with care and empathy
Recommendations

10. Understand Advance Directives specific to different faiths
11. Be a good listener and mindful of patient’s experience
12. Work together with patient/family to develop solutions
13. Understand importance of spiritual assessments
14. Be willing to learn from patients and/or family
15. Seek spiritual diversity learning opportunities
16. Promote positive spiritual communication
17. Acknowledge privacy and confidentiality
18. Avoid known causes of spiritual conflicts
19. Understand patient and/or family wishes
20. Learn to take a spiritual history
21. Step out of your comfort zone
22. Avoid stereotyping
- KP NCAL Spiritual Leadership Team; Dept. of Medical Ethics; and Diversity Program
- Association of Professional Chaplains
- Association of Clinical Pastoral Education
- National Association of Catholic Chaplains
- The College of Pastoral Supervision & Psychotherapy
- Yale Center for Faith & Culture, Yale University, New Haven, CT
- George Washington Institute for Spirituality & Health, Medical Center, Washington, DC
- Center for Spirituality, Theology and Health, Duke University Medical Center, Durham, NC
- University of Washington School of Medicine: Department of Bioethics & Humanities