Journal of Intercultural Management and Ethics

JIME

ISSN 2601 - 5749, ISSN-L 2601 - 5749

published by

Center for Socio-Economic Studies and Multiculturalism
Iasi, Romania
www.csesm.warter.ro

Special Editor

Professor Beatrice Gabriela Ioan, PhD, MD
Grigore T.Popa University of Medicine and Pharmacy of Iasi, Romania
E-mail: ioanbml@yahoo.com

TABLE OF CONTENT

Editorial ……………………………………………………………………………………..…. 5
Beatrice Gabriela Ioan

There Is a System in the Madness. The 7 Mental Images of National Culture and the Corona Virus ………………..……………………………………………………….……………… 7
Huib Wursten

Cultural Perspectives on Vaccination - An Ethical Dilemma? ……………….…………… 19
Cătălina M. Luca, Doina Azoicăi, Ioana Harja Alexa, Andrei Vâță, Natalia Cucoș, Andreea Pascariu, Ioana M. Hunea

Ethical Issues Regarding Off - Label Administration of Antibiotics ………………………. 29
Ioana Hunea, Cătălina Luca, Irina Eșanu, M. Hurmuzache, Carmen Manciuc, Irina Dima, A. Vâță, Egidia Miftode

Ethical Aspects of Antimicrobial Resistance ………….……………………………...……. 39
Ioana-Florina Mihai, Andreea-Luiza Palamaru, Alina-Andreea Macovei, Andreea Pascariu, Roxana Palade, Stefana Luca, Mihaela Cătălina Luca

Patients' Religion and Spirituality in an Ethical Approach ….…………………………….. 45
Elena Toader

Ethical Aspects and Mechanisms of Psychological Adaptation in Case of Patients Diagnosed With Incurable Diseases ……………………………………...……………………….. 51
Andreea Clim, Minela Aida Mărănducă, Nicoleta Dima, Roxana Gănceanu Rusu, Ioana Adelina Clim, Ionela Lăcrămioara Șerban

Ethical Aspects of the Non-Resuscitation Discussion with the Patient and Its Family in Palliative Care ……………………………………………………………………………... 57
Nicoleta Dima, Elena Rezuş, Ana-Roxana Gănceanu-Rusu, Codruţa Bădescu, Daniela Tănase, Anca Ouatu, Andreea Clim, Ana-Maria Pop, Minela Aida Mărănducă, Ciprian Rezuş

Life Quality in Patients with Head and Neck Cancers …………………………….……….. 65
Vlad Covrig, Cristian Budacu, Constantin Mihai, Victor Costan, Mihai Ciofu, Adrian Zaharia, Ionut Chirap, Beatrice Ioan

Ethical Issues of Diagnosis in Gynecological Malignancy ……...……………………..….. 71
Mihaela Camelia Tîrnovanu, Bogdan Toma, Loredana Maria Himiniuc, Ştefan Dragoş Tîrnovanu, Cerasela Mucileniţa, Alexandra Iov, Vlad Gabriel Tîrnovanu

Ethical Matters Regarding Fertility Preservation Strategies in the World of Assisted Reproductive Medicine ……………………………………………………………...….. 77
Adina-Elena Tănase, Mircea Onofriescu

Ethical and Legal Issues of Preimplantation Genetic Diagnosis in IVF Couples ………….. 83
Mihaela Camelia Tîrnovanu, Ștefan Tîrnovanu, Alexandra Iov, Vlad Tîrnovanu, Bogdan Ciuntu, Daniel Timofte, Bogdan Toma, Loredana Himiniuc

PATIENTS' RELIGION AND SPIRITUALITY IN AN ETHICAL APPROACH

Elena Toader
"Grigore T Popa" University of Medicine and Pharmacy Iaşi, Romania
Faculty of Medicine, Department of Bioethics and Medical Deontology
Institute of Gastroenterology and Hepatology Iași, Romania
E-mail: toader.elena@yahoo.com

Abstract

Contemporary medical practice provides increasingly more evidence and arguments which substantiate the fact that patients' religion and spiritual practices are factors that exert a strong influence on many patients confronting serious illnesses or are having difficulties in taking ethical decisions regarding treatment options or healthcare at the end of life. The challenges of this medical context suggest that within the framework of the interaction between doctor and patient, doctors avoid approaching the religious or spiritual contents. This aspect is justified by the lack of adequate education for the manner in which the spiritual side of the patient should be managed, for the doctor cannot be expected to understand beliefs and practices of so many different religious communities. In order to clearly understand the modalities in which religious belief systems of the patients may be integrated in the medical act, we aim to follow, within medical ethics boundaries, the manner in which the spiritual beliefs of the patients are engaged in the healthcare process.

Key words: religion, spirituality, ethics, healthcare

Introduction

Throughout history, religion and spirituality were interconnected with medicine practice. Within this context, many religions embraced caring for sick people as a primary mission and many medical institutions perpetuated spiritual origins or adopted religious traditions in order to help those fighting with disease and suffering, or in order to promote a healthier lifestyle. Due to the empowerment capacity to induce a state of good and comfort, religion and spirituality generated major interest both for doctors and patients. Therefore, religion and spirituality became a framework with an important role, a source on which patients, as well as healthcare providers, rely, when they appeal to religious or spiritual services in order to obtain answers which medical sciences cannot always provide for existential questions (Puchalski, 2001; Rumun, 2014).

Religion and spirituality, signification and terminology specifications

The word *religion* comes from the Latin word "*religare*", which means "to bound together" and is a multidimensional construct, including specific beliefs, rituals, behaviors and ceremonies about life after death and rules regarding the actions of the individual within a social group. They may be held or practiced in private or public institutions, deriving from traditions established and developed over tine within a community (Mueller, Plevak & Rummans 2001). Religion often implies the mystical element or the supernatural, comprising beliefs, practices and rituals related to the transcendent, whether it is God, Allah or HaShem (Koenig, 2012). The religious involvement of a group or individual refers to the degree of participation or adhesion to the beliefs and practices of an organized religion, within which collective or individual religious experiences facilitate closeness with the transcendent and favor a better understanding of the responsibility emanated by the relationship between the

individual and the other members living in a community which adheres to a system of belief and religious practice.

The term *spirituality* comes from the Latin word *spiritualitas*, which means *breath*, and is a concept wider than religion which, from the point of view of personal experience, manifests itself as a dynamic process. A characteristic of spirituality is the fact that it connects differently to values, moral, humanity, sacred, transcendent and mental health (Roth et al., 2012). Spirituality states the transcendent which coexists both outside the self but also within the self, expanding beyond organized religions, making the passing towards the supernatural by moving along a path implying the conversion from non-belief to firm belief, or from devotion to submission. Supported by the preoccupation to seek and discover the transcendent, spirituality concentrates on discovering the sense and establishing purpose, searching for the mystical element which comes in a simple manner to fulfill the spiritual needs of the patients (Neal, 2018). An example is represented by the sources of spiritual care in chapels available for doctors who wish to approach the spiritual needs of the patients.

Religion and spirituality in theoretical approach and in medical practice

In the scientific approach, religion and spirituality were deemed for a long time too personal in order to receive special attention. Although they are recognized as resources of welfare in healthcare, religion and spirituality are not investigated or used at full capacity in an organized framework. In the opinion of Oman, religious and spiritual approaches concentrated on *facing disease* risk promoting a iatrogenic culture in healthcare imposed by faith which exposes to invalidity induced by certain healers (Oman & Thorensen, 2003). Moreover, such as they are presented in the literature, current trends tend to focus on the emotional factors that disease generates, most of them changeable or placed under the control of an authority individual. Within this context, the association between the manner of perception of the disease within the spiritual and religious construction receives limited attention from specialists. Moreover, difficulties and even the impossibility of using scientific methods generated several issues in the empirical research on religion and spirituality, underlined by Miller, with critical accents on theoretical approaches, whose limited acceptance was justified by the lack of conceptual concentration (Oman & Thorensen, 2003).

In current practice, religious phenomena present a limited familiarization of the context in real world, generated by the connection between medicine, the health concept, disease and medical demography. Furthermore, application of untested religious explicit theoretical models in the field of healthcare was confronted with difficulties similar to those encountered in the domain of scientific research, causing difficulties and controversies in the development of a spiritual investigation in healthcare. Available data state that healthcare which benefit from religious and spiritual support correlate with positive results regarding morbidity, mortality, physical and mental health, healthier lifestyle, less appeal to healthcare, improvement of coping abilities, welfare, diminishing of stress and prevention of disease. With respect to personal opinions, most doctors believe that spirituality has a positive effect on the physical and mental welfare of the patients, while patients believe that spiritual health is as important as the physical one (Park, Sherman, Jim & Salsman, 2015). It is as well the main reason for which patients desire to have spiritual conversations with doctors, which happen rarely in real life. This statement may be retained as a substantiation of the wide variation, from 13% to 75% in the patient population for the eagerness to make their religious orientation known within their discussions with the doctor (Christensen, Cook & Arnold, 2018; Stern, 2011). This affirmation is joined by the position of the doctor, in whose opinion the religious and spiritual approach focuses on issues regarding deviation from the field of professional expertise or promotion of a non-medical agenda, while they do not have an adequate spiritual training. In daily practice, the ethical consideration of the action of the

doctor in the area of spiritual counseling with the possibility to *do good* is confronted with lack of time, confidentiality issues but also with the difficulty of identification of patient who desire such an approach. For a holistic patient-focused evaluation of spiritual and religious beliefs it is necessary to accept spiritual discussions in a wide range of clinical scenarios which would permit the formulation of observations referring to the identification of the reasons for which doctors wish to find out the religious conviction of the patients and which would be their impact at the demographic level (McCord et al., 2004).

Religion and spirituality in correlation with medical demographics

Many spiritual investigations reveal the fact that in healthcare the spiritual factor and religious beliefs or patients proved to be correlated with a series of demographic indicators evaluated through variables such as increased welfare, a healthier lifestyle, less healthcare required, improving adjustment abilities, reduction of stress, prevention of disease, diminished morbidity and mortality (Stallard, 2007; Yashin, Stallard & Land, 2016). In terms of definition, the demographics of human populations includes all aspects regarding the dimension, the geographical distribution and composition of populations, as well as modification of these characteristics. The medical dimension of demographics uses in the assessment of morbidity, invalidity and mortality the concepts, models and techniques of the scientific domain (i.e. demographics), outlining an area where there are activities specific for health, disease, accident, invalidity and death. In the literature, the domain is defined by the signification of the statistical data and the evaluation of the dynamics of the consequences that demographic indicators exert on the structure and construction of the population, as well as by their impact in the political, economical and social territories. Towards this end, medical demographics confirm and concurrently justify the concern for the results, correlations and effects cumulated with risk factors, both at the individual level and at the level of the community (Samson & Dormont, 2008). This consideration generates interest also from the point of view of reproducing, multiplying and translating these effects over generations, and mostly of assessing the manner in which the demographic scale could reflect the influence exerted on health and longevity. Therefore, knowing the role and the involvement of medical demographics would justify, in the series of argumentation, the appeal, activation and efficiency of healthcare systems at an optimal level, which would allow the elaboration of effective control measures for the elimination of these factors. This approach brings medical demographics to epidemiology and appeals to mutual support in the issue of disease control and healthcare issues in populations. Within this relationship, the list of the factors involved becomes remarkable, including religion and spirituality together with well- known factors in medical demographics assessment, such as age, alcohol, education, gender, healthcare behavior, and income sources (Isaac, Hay & Lubetkin, 2016).

Religion and spirituality – domain of application

The question to be asked is *why many patients are religious?* One of the reasons for which patients adopt religious behavior is due to the fact that religion is largely spread and the importance granted to this conviction increases constantly with age. It is not surprising that most patients with serious health issues are elderly and religious as well. Moreover, religious conviction is a common state among patients who appeal to religion, even if before becoming sick they had no religious adhesions (Swihart & Martin, 2019). It seems that the importance of religion increased in the belief of patients confronting disease, and became a manner to manage stress and suffering. In Koning's opinion, the thematic construction of healthcare on an axis involving religious and spiritual influences are best reflected in the field of *mental health, health behaviors and physical health*. The author, in his work *Religion, Spirituality, and Health: The Research and Clinical Implications* (Koenig, 2012) summarizes

the informational flux form online sources (PsycINFO, MEDLINE, etc., key words "religion", "religiosity", and "spirituality"), completed with interviews with experts in this field and literature summaries, cumulating data from over 3300 studies covering 75% from the research dedicated to the relationship between religion and spirituality (1200 studies between 1872 and 2000 and 2100 studies published between 2000 and 2010). It is to be noted that in 80% of the studies the influence of religion and spirituality is manifested in relationship with mental health, even if it is well known that psychological, social and behavioral aspects are closely connected with mental damage, more than with physical health. Due to the contribution in stimulating positive emotions and neutralizing negative emotions, as well as due to the role as resource for adaptation and consolidation of life, religion and spirituality exert direct or indirect effects through psychological, social, and behavioral pathways on healthcare.

In the field of *mental health*, *depression as case study* provides explanatory answers referring to the significant impact of religion and spirituality both on mental and on physical health. If, from the ethical point of view, depression damages autonomy, self-respect and, implicitly, quality of life, from the point of view of religious influence a spiral is created due to which increasing the culpability feeling could accentuate the depressive state (Schieman, Bierman & Ellison, 2013; Montero-Marin et al., 2019).

In the field of *physical health*, taking as an example the cancerous diseases, the approach from the ethical perspective, with an emphasis on aspects referring to benefaction and do-no-harm principle valued by religious and spiritual practice, registers the welfare, a better prognosis and even a diminished risk to develop cancer in the risk population. These observations provide empirical explanations for the positive results correlated with the adoption of healthy behaviors, such as diminishing exposure to smoking, alcohol abuse, or increased levels of stress.

The most impressive research regarding the relationship between religion, spirituality and physical health is in the mortality area, where these beliefs and convictions are significantly correlated with longevity and longer survival rates (Koenig, .(2012 Available data also show that the religious services attendance frequency is equivalated to the effects of drugs that lower cholesterol or physical exercise heart recovery therapies after myocardial infarction.

Health behavior. Most religions promote pro-social behaviors playing a role in stress buffering or support in need or difficult times. The emphasis placed on love, compassion and other altruist actions are encouraged during religious social events, where human virtues are promoted, such as honor, forgiveness, gratitude, patience and viability, which contributes to the maintenance and consolidation of social relationships. It is a modality through which religion could help people avoid life stressful events, generated by divorce or separation, difficulties with the children, financial stress or diseases induced by unhealthy behaviors (Strawbridge, Shema, Cohen & Kaplan, 2001).

Conclusion

Religion and spirituality campaign for a healthy lifestyle, for a better physical and mental health and a higher longevity. Although recognized as resources for welfare in healthcare, religion and spirituality are not investigated or either used at full capacity and in an organized framework. Integration in medical assistance of elements derived from religious convictions presents a limited familiarization with healthcare provision, which determined a difficult and controversial development of the medical act. Among professionals in the medical field, avoiding conversations about spiritual beliefs, needs and interests is motivated by lack of time, lack of familiarization with the subject of spirituality, or lack of knowledge and experience with the diversity of religious expressions in our pluralist culture. Doctors

recognize that they have no training in managing such conversations with multiple ethical and professional implications, or that they avoid this type of situations, in order to not create the impression that they are imposing their own opinions and personal beliefs on patients. However, there are doctors who believe that sharing their own beliefs with the patient is opportune, or praying with a patient in special circumstances, but there are also non-religious doctors who expressed anxiety when a religious patient asks them to pray together. Certainly, modern medicine will generate new issues and will rise other valuable questions, filled with religious and spiritual signification, worth to bring into a dialogue with the patients. Thus, the religious and spiritual influences reflected in the field of mental health, health behaviors and physical health will contribute to the thematic construction of healthcare disturbing aspects such as prolonging life through artificial means, using drugs in the management of pain in palliative care or the therapy of dignity at the end of life.

References

1. Christensen, A. R., Cook, T. E., & Arnold, R. M. (2018). How Should Clinicians Respond to Requests from Patients to Participate in Prayer?. *AMA Journal of Ethics*, 20(7), E621-629
2. Isaac, K., Hay, J., & Lubetkin, E. Incorporating Spirituality in Primary Care. *J Relig Health,* 55(3), 1065–1077
3. Koenig, H. G. (2012). Religion, Spirituality, and Health: The Research and Clinical Implications. *ISRN Psychiatry*, *2012*, 1–33. doi: 10.5402/2012/278730
4. McCord, G., Gilchrist, V. J., Grossman,S. D., King, B. D., et all. (2004). Discussing Spirituality With Patients: A Rational and Ethical Approach. *Ann Fam Med.,* 2(4), 356–361
5. Montero-Marin, J., Perez-Yus, M. C., Cebolla, A., Soler, J., Demarzo, M., & Garcia-Campayo, J. (2019). Religiosity and Meditation Practice: Exploring Their Explanatory Power on Psychological Adjustment. *Front Psychol*, 10, 630
6. Mueller, P.S., Plevak, D.J, & Rummans, T.A. (2001). Religious involvement, spirituality, and medicine: implications for clinical practice. *Mayo Clin Proc,*76(12), 1225-1235
7. Neal, J. (2018). Overview of Workplace Spirituality Research. In S. Dhiman, G.E. Roberts, & J. Crosmann (Eds), *The Palgrave Handbook of Workplace Spirituality and Fulfillment* (pp. 1-56). Cham, Switzerland: Palgrave Macmillan
8. Oman, D., & Thoresen, C. E. (2003). Spiritual modeling: A key to spiritual and religious growth?. *International Journal for the Psychology of Religion*, 13(3), 149–165
9. Park, C. L., Sherman, A. S., Jim, H. J., & Salsman, J. M. (2015). Religion/Spirituality and Health in the Context of Cancer: Cross-Domain Integration, Unresolved Issues, and Future Directions. *Cancer,* 121(21), 3789–3794
10. Puchalski, C.M. (2001). The role of spirituality in health care. *Proc Bayl Univ Med Cent,* 14(4), 352–357.
11. Roth, D. L., Mwase, I., Holt, C. L., Clark, E. M., Lukwago, S. N., & Kreuter M. W. (2012). Religious Involvement Measurement Model in a National Sample of African Americans.
J Relig Health, 51(2), 567–578
12. Rumun, A. J. (2014). Influence of religious beliefs on healthcare practice. *International Journal of Education and Research*, 2(4).
13. Schieman, S., Bierman, A., & Ellison, C. G. (2013). Religion and Mental Health. In C.S. Aneshensel, J.C. Phelan, & A. Bierman (Eds), *Handbook of the Sociology of Mental Health.* Dordrecht: Springer Science Business Media
14. Stallard, E. (2007). Introduction to Medical Demography, Society of Actuaries 2007. *Annual Meeting Washington,* DC

15. Stern, R. M. (2011). Jewish Physicians' Beliefs and Practices Regarding Religion/Spirituality in the Clinical Encounter. *J Relig Health,* 50(4), 806–817
16. Strawbridge, W. J., Shema, S. J., Cohen, R. D., & Kaplan, G. A. (2001). Religious attendance increases survival by improving and maintaining Good health behaviors, mental health, and social relationships. *Annals of Behavioral Medicine,* 23(1), 68–74.
17. Swihart, D. L., & Martin R. L. *Cultural Religious Competence In Clinical Practice*. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK493216/
18. Yashin, A. I., Stallard, E., & Land, K. C. (2016). *Biodemography of Aging Determinants of Healthy Life Span and Longevity*. Dordrecht: Springer Netherlands.