

Hospitals in a New Era

Summary: Hospitals work to actively engage in pluralism by creating educational programs that introduce future medical professionals to different religious communities, bringing in clergy and other faith leaders to provide support for patients and their families, and changing the physical space within hospitals to accommodate worship, meditation, and prayer. Hospital leaders aim to recognize the importance of varied religious practices around sickness and death and to attempt to honor them, while simultaneously providing optimal medical care.

As early as 1995, nursing students in Boston were visiting the mosque in the South Shore suburb of Quincy to learn more about Islam. There, Imam Talal Eid, a Muslim chaplain at Massachusetts General Hospital and the founder of the Islamic Institute of Boston, would give introductory remarks and answer students' questions. During these visits, as noon approached, student nurses often would be invited to take off their shoes, cover their heads with scarves if they were women, and follow the imam upstairs to the large prayer room. There, the students would join more than 100 Muslims from the surrounding neighborhood for midday prayers.

Today, learning about Islam with some first-hand experience of the Muslim community has become no less important; indeed, such experience is essential as nurses train to be caregivers in a diverse society. Over the past twenty years, organizations dedicated to cultural competency have begun to compile resources for different patient populations and organize trainings for healthcare professionals. The Cross Cultural Health Care Program, for example, focuses on bridging the gap between medical institutions and the cultural and religious communities of their patients. They understand the role of a medical interpreter to be a translator not only of language but also of culture, tradition, and religion. Boston University School of Medicine's Boston Healing Landscape Project examines the intersection between the therapeutic and religious landscapes in America. They focus not only on cultural and religious competency education, but also on the role of religiously based approaches to healing and how these can be responded to and incorporated by the existing medical community. Religious communities also are more forthcoming about their own needs. The Islamic Circle of North America, for example, published an educational brochure for hospital administrators and staff, specifying some of "The Needs of a Muslim Patient." For those who do not have the opportunity or can't take the time to visit a mosque or speak with an imam, such a brochure provides critical information about Muslim beliefs, practices, and diet.

Hospitals across the country are seeking ways to accommodate their growing multireligious patient population and medical staff. As early as the mid-1990s, the Metropolitan Chicago Interreligious Initiative launched a pilot project with the Good Samaritan Hospital of Downers Grove to find ways “to enhance access to religious and spiritual resources in order to meet the varied needs of persons in a hospital setting.” As the planning documents for the initiative make clear, new models for hospital care are needed in this multireligious America. At the Boston Children’s Hospital, known worldwide for its excellence in children’s medical care, a 1993 study led to a reorganization of the chaplaincy and religious facilities. After a study of patient data, including the religious affiliations of patients and their families, the hospital hired an imam for its chaplaincy staff. It also redesigned a chapel area to include prayer rugs facing in the direction of Mecca. Today, Buddhist, Jewish, Muslim, Catholic, and Protestant meet regularly for worship and meditation; the chapel also offers devotional literature from multiple traditions and in several languages. In 2010, the University of Michigan Health System led a study on the creation of hospital and community health partnerships with imams to improve the health of the American Muslim community and to deliver religiously sensitive, high quality care to patients. The research outlined potential roles for an imam who seeks to promote a community’s health; these included performing religious rituals associated with life events and illnesses as well as encouraging healthy behaviors through scripture-based messages in sermons.

The impact of this increasing religious diversity is nowhere more evident than in the physical spaces of hospitals themselves. From interfaith chapels and meditation rooms to conference rooms turned prayer halls and peace gardens, hospitals and their often multi-faith team of chaplains are seeking to meet the religious and spiritual needs of patients, their loved ones, as well as the medical personnel who care for them. The multi-year research project, “Multi-Faith Spaces: Symptoms and Agents of Change” highlight these spaces around the world.

The time of death—the hours before and the hours after—is embedded in meanings and rules for different religious groups making it a prime example of the importance of cultural and religious competencies. In 1994 American Jewish Committee, the Episcopal Diocese of Massachusetts, the Hospice Federation, and Tufts University School of Medicine hosted a conference in Boston entitled “The Last Hours.” During the conference, professionals from medicine, psychology, nursing, social work, and chaplaincy gathered to discuss the spiritual needs of both the dying and their loved ones. A Protestant minister, a Catholic priest, a Jewish rabbi, and a Muslim imam each explained the special

expectations and traditions people in their faith community might have for the last hours of life. Case studies topics included the limits of religious objections to invasive medical examinations like an autopsy. In one instance, an elderly Jewish man died from an apparent heart attack in the ambulance on the way to the hospital and the attending doctor requested an autopsy to confirm. The son of the deceased insisted that the autopsy would violate his father's Jewish religious convictions, which included the sanctity of the body. The doctor pressed the son to change his mind, compounding the distress of the son in the hour of his father's death. Religious objections to autopsies have been at the center of many cases, and courts have at times halted the procedure when it violates the religious convictions of the next of kin, although, as this case demonstrates, consideration of this accommodation can vary widely.

Religious objection to autopsies was also at the center of a 1990 Rhode Island District Court case (*You Van Yang v. Sturner*) in which a Hmong couple, immigrants from Laos, brought suit against the state's chief medical examiner for having violated their right to the free exercise of religion by performing an autopsy on the body of their son. The 23-year-old had suffered a seizure, was rushed to the hospital, and never regained consciousness before dying three days later. An autopsy was performed against the parents' wishes. During the court case, it was clearly established that Hmong religious beliefs prohibited the mutilation of the body that would occur during an autopsy. The medical examiner insisted the autopsy was performed to comply with a state law requiring autopsy in cases of death "in any suspicious or unusual manner." The Rhode Island judge, however, ruled in the couple's favor, noting there was no "compelling state interest" that would outweigh the First Amendment protection of the Hmong couple's religious beliefs.

A similar case emerged in 2011 when 54-year old Brian Grobois, an Orthodox Jew, died on a solo snowshoe hike in Pierce County, Washington. His family objected to the performance of an autopsy on religious grounds, stating it would violate Jewish law, which requires that the body be returned to the earth complete and as quickly as possible. The Pierce County medical examiner argued that state law empowered him to investigate unnatural deaths and that an autopsy was needed to address unanswered questions about Grobois' death. In court, a judge upheld an appeal preventing the medical examiner from conducting an autopsy on Grobois because of the family's religious objections. The case prompted the creation of Washington Senate Bill 6068, a measure that prevents medical examiners from

performing an autopsy if an objection is raised on religious grounds by a family member or close friend and there is no compelling “public necessity” for such a measure.

In her 2013 book *Paging God: Religion in the Halls of Medicine*, Wendy Cadge notes that “hospitals are microcosms for such questions [as how people from different religious and spiritual backgrounds live together in contemporary United States]—likely made more intense by the life-and-death issues that arise within them.” Multifaith chaplaincy programs, culturally competent medical professionals, adaptable chapel spaces, and legal decisions bring to light the new tensions and increasingly complex relationships among religious liberties and patients, medical professionals, hospitals, and health care policy in a religiously diverse America.