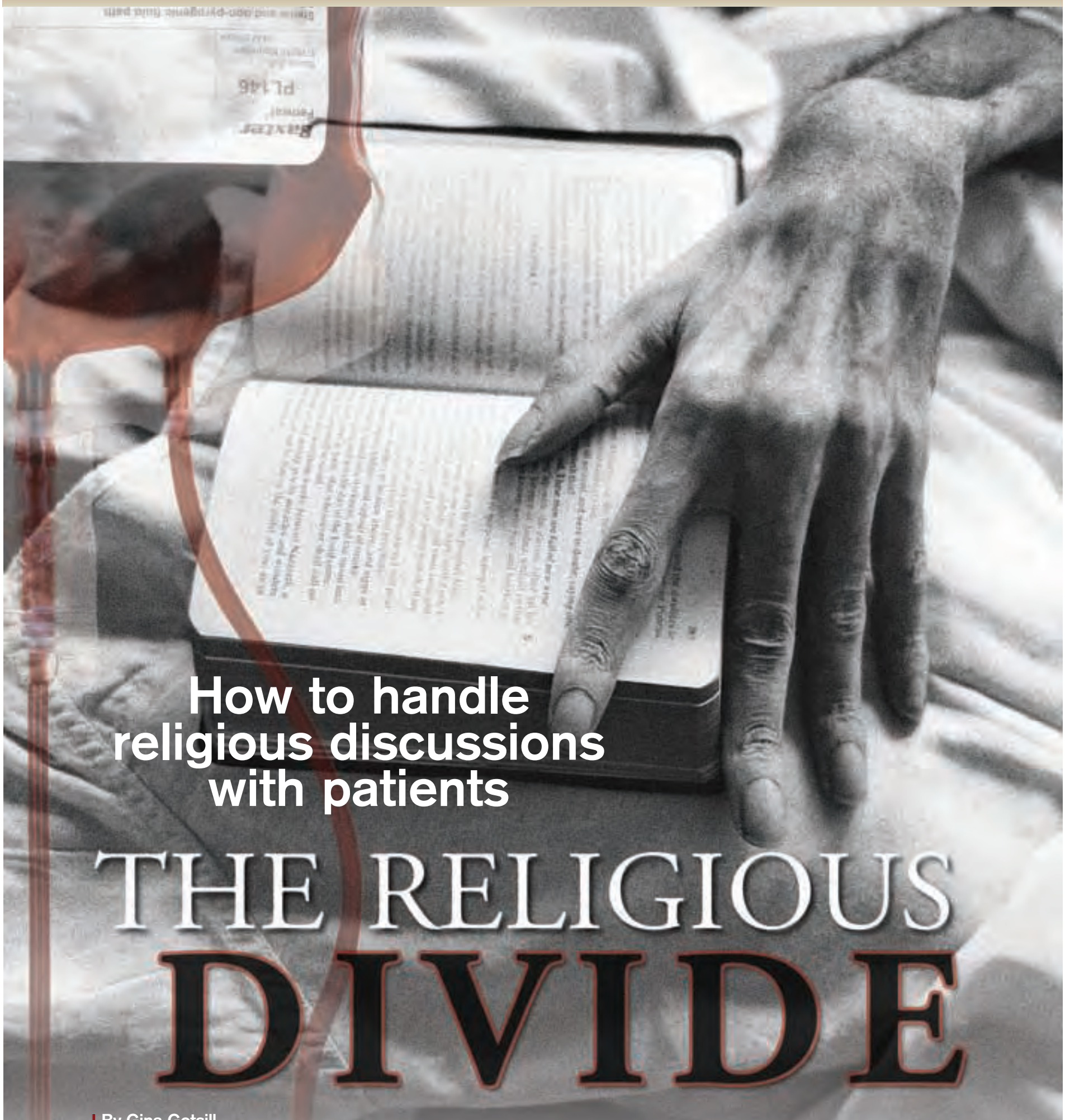

How to handle religious discussions with patients

THE RELIGIOUS DIVIDE

By Gina Gotsill

Several years ago, a patient at Virtua West Jersey Hospital Marlton, in Marlton, N.J., was diagnosed with metastatic colon cancer with spinal metastases. The patient was septic, bleeding from a spinal wound, and was experiencing kidney failure. Hospitalists recommended stopping treatment and moving the patient to hospice care. The patient's family refused, and told hospitalists that, according to their Christian faith, suffering was the only true path to heaven. Hospitalists kept the patient as comfortable as possible, but blood pressure problems and hypotension made it difficult for them to administer pain medication.

Hospitalists held numerous meetings with the family and medical and nursing staff to discuss the ethical implications of the situation. Two months later, the patient suffered cardiac arrest and died.

"The medical staff and family were continuously at odds because the patient was suffering so much," says Marianne Holler, DO, a hospitalist at University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine, who was part of the patient's medical team. "We were never able to discontinue life support throughout [the patient's] hospital stay."

Whether planning a routine procedure or end-of-life care, hospitalists may be called into religious discussions with patients, their families, spiritual advisors, and hospital chaplains. While many hospitalists have received ethics and other professional training to prepare them for these conversations, some say the intersection of religion and medicine remains a challenging and multifaceted aspect of their practice.

A Hospitalist's Belief

Hospitalists' brief relationships with patients may influence the degree of knowledge they have about an individual's religious beliefs, says Scott Enderby, DO, a hospitalist at Alta Bates Summit Medical Center in Berkeley, Calif. Over the years, primary care physicians may become less involved with a

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patient's acute medical needs as they use hospitalist services to manage their inpatients, Dr. Enderby says. This means hospitalists must discuss patients' wishes regarding code status and resuscitation, end-of-life care, and other necessary treatments.

When discussing religion and treatment, hospitalists must put aside their personal beliefs, and this may not always be easy, says Dr. Thomas McIlraith, MD, medical director of Hospital Medicine at Mercy Medical Group in Sacramento, Calif. Dr. McIlraith recalls a Jehovah's Witness patient who cited religious beliefs when refusing a blood transfusion following a massive post-partum hemorrhage. The patient was severely anemic, and her hemoglobin levels plunged dangerously to 2 gm/dL. Leaders from the patient's church asked Dr. McIlraith to try hemoglobin substitutes, but he was unable to do so because these substitutes still were experimental and associated with significant complications, he says.

Dr. McIlraith had to act fast. He instructed the obstetrician on the case to stop drawing hemoglobin levels; the patient needed every drop of blood she had to carry oxygen. He administered erythropoietin and iron to stimulate red blood cell production. He also put the patient on high flow oxygen to help saturate the plasma. The patient survived without a blood transfusion or significant complications.

"I didn't think [the patient] was going to make it," says Dr. McIlraith. "This was a very difficult situation because I knew they would have benefited from a blood transfusion. But, I presented them with their options and respected their wishes."

Religious Diversity

Religious diversity can be another challenging aspect of patient care. In its 2008 U.S. Religious Landscapes Survey, the Pew Forum on Religion and Public Life interviewed 35,000 Americans age 18 and older and found "religious affiliation in the U.S. is both very diverse and extremely fluid." The survey also found "people who are unaffiliated with any particular religion (16.1%) also exhibit remarkable internal diversity."

Asking questions is the key to understanding a patient's religious and spiritual needs, says the Rev. Peter Yuichi Clark, PhD, chaplain administrator at Alta Bates Summit Medical Center in Berkeley, Calif., who works closely with medical teams to assess and respond to these needs.

"I don't assume I know what a patient's religious needs are—even if I know what religion they profess to be," Clark says. "Some patients may be very devout but do not practice certain aspects of their religion, while others follow a religion in name only but look for religious support during a time of crisis."

Manish Patel, MD, a hospitalist and assistant professor with the division of General Internal Medicine at University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School, says it is impossible to predict an individual's religious beliefs and how that may affect their hospital stay—even when the physician practices the same religion as the patient. For example, Dr. Patel knows that some, but not all, Hindus observe a strict vegetarian diet and that Vitamin B12 deficiencies are more prevalent in vegetarian populations. However, diet may not be the cause of this deficiency if the patient is not a vegetarian. Rather than assume, it's important to ask Hindu patients if they observe a vegetarian diet, Dr. Patel says.

Some hospitalists find it difficult to engage patients in conversations about religion. In a study published in the June 2007 edition of the *Journal of Palliative Medicine*, researchers found physicians' knowledge of factors relating to end-of-life care, which included patients' religious and spiritual concerns and whether they affect decisions regarding end-of-life care, is poor.[1]

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Hospitalists don't have much time to get to know the person, so it's even more important for them to have conversations about religion and end-of-life-care, says the study's lead author Susan DesHarnais, PhD, of Pennsylvania State University's Hershey Department of Public Health Sciences, Milton S. Hershey Medical Center College of Medicine. As important as these conversations are, Dr. DesHarnais learned hospitalists rarely have them.

When asked why she thinks these conversations rarely occur, Dr. DesHarnais said the research did not directly address that question, but she suspects the physicians don't have a lot of time. Also, end-of-life decision-making is difficult, and some people are not comfortable talking about it, she says.

"Another factor may be that hospitalists are used to using technology for medical intervention more than they are used to working with people when not much more can be done," she says.

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Dr. Holler, who worked as a social worker before attending medical school, agrees that many physicians are uncomfortable with end-of-life decisions.

"Many physicians are 25 to 30 years old during their training," says Dr. Holler. "They have been in school for many years. Some are discovering their own spiritual identity at the same time they are dealing, or learning to deal, with patients and families and where they are spiritually or religiously. Many haven't dealt with these issues in their own personal lives yet."

While Dr. Holler says she believes most doctors are caring and compassionate, end-of-life and religious discussions use different skill sets than those that preserve and extend life. "Often times we are not taught when enough is enough and how to convey that to patients and families," says Dr. Holler. "Many doctors are afraid that they are conveying that they are giving up or that it isn't worth it in the long run. So, many physicians find it easier to 'keep going.' "

The Medical Community's Response

The medical community is responding to shifting cultural and religious demographics, and more doctors are paying attention to religious diversity, Clark says. But a 2003 Joint Commision study of 60 public and private hospitals across the country, "Hospitals, Language and Culture: A Snapshot of the Nation," found that hospitals still have work to do in this area.

"We found that hospitals are collecting data on patients' religion, but it's just not clear how they use it to improve services," says Amy Wilson-Stronks, project director for health disparities with the Joint Commission and principal investigator of the study.

The current Joint Commission standards require hospitals to respect patients' spiritual needs, beliefs, and values. Spiritual care issues first appeared in the 1969 accreditation manual and were adopted into standards in 1992, Wilson-Stronks says.

Accomodating Patients

Awareness and communication can benefit patients, hospitalists, and medical staff as a whole. For example, Alta Bates Summit's intensive care unit staff in Berkely, Calif., turned to Chaplaincy Services about Muslim patients' requests to continue their daily prayers, which include thorough washing of their hands, forearms, and other parts of their bodies (even when intravenous lines are attached). Chaplaincy Services reached out to an Islamic network group for advice and learned patients could rub a stone across their bodies to wash themselves. Chaplaincy Services now makes these stones available for staff and patients, Clark says.

Medical staff also works with Chaplaincy Services to accommodate Muslim patients' wishes to face in the direction of Mecca during prayer, which can require maneuvering beds and other equipment, he says.

Some patients and their families may not understand how their religious tradition addresses code status, resuscitation, and when it is appropriate to withhold treatment, says Richard Rohr, MD, vice president of medical affairs at Cortland Regional Medical Center in Cortland, N.Y. While working as a hospitalist, Dr. Rohr suggested moving a terminal patient to palliative care and seeking a do not resuscitate (DNR) order. The patient's family refused, and told Dr. Rohr they were Catholic and a DNR would violate their religious beliefs.

According to Dr. Rohr, DNR status and palliative care are described in the code of ethics adopted by the Catholic Health Association, and this type of care is generally provided at Catholic hospitals.

"I gently told them that this was within their religion, but they said no to palliative care and the DNR," Dr. Rohr says. "The patient eventually died but it was much more difficult for them. They were subjected to active treatment that they couldn't really benefit from."

Families often seek the advice of spiritual advisors when making difficult decisions about code status and DNR orders. Barbara Egan, MD, a hospitalist at Memorial Sloan-Kettering Cancer Center in New York City, recalls treating an Orthodox Jewish patient who was suffering from end-stage disease. Death was imminent, and hospitalists recommended palliative care. The patient's family members balked at the recommendation and insisted hospitalists "do everything possible" to treat their loved one. Soon after, the family's rabbi arrived to counsel the family. After visiting the patient and speaking to medical staff about the prognosis, the rabbi urged the family not to pursue further treatment or artificial resuscitation. The patient was moved to a palliative care unit and passed away within a few days.

"The family's rabbi told them exactly what I had: that there were no useful medical interventions for the

patient," Dr. Egan says. "But they really needed to hear it from him before they could come to an agreement on a DNR."

Physicians' reactions to religion at the bedside have evolved the past 25 years, says Kenneth Patrick, MD, ICU director at Chestnut Hill Hospital in Philadelphia. Physicians were more paternalistic then, and believed they knew what was best for their patients—and their families—regardless of their patient's religious beliefs.

While serving as a fellow at Memorial Sloan-Kettering Cancer Center, Dr. Patrick worked with a terminally ill Buddhist patient in the intensive care unit. When death was imminent, the ICU director allowed Buddhist monks to light candles and pray in the room during the hours leading up to the patient's death. At the time, this was not something that was normally done in a hospital, Dr. Patrick says. While the ritual may have kept medical staff from checking vital signs as often as they would have normally, he says this did not affect the patient's treatment.

"I believe it is incumbent on the hospitalist to adjust his or her beliefs to be more accepting of our patients' values," Dr. Patrick says. "I can agree to any request I find to be reasonable and in the patient's best interest, even if it is different than what I believe." TH

Gina Gotsill is a journalist based in California.

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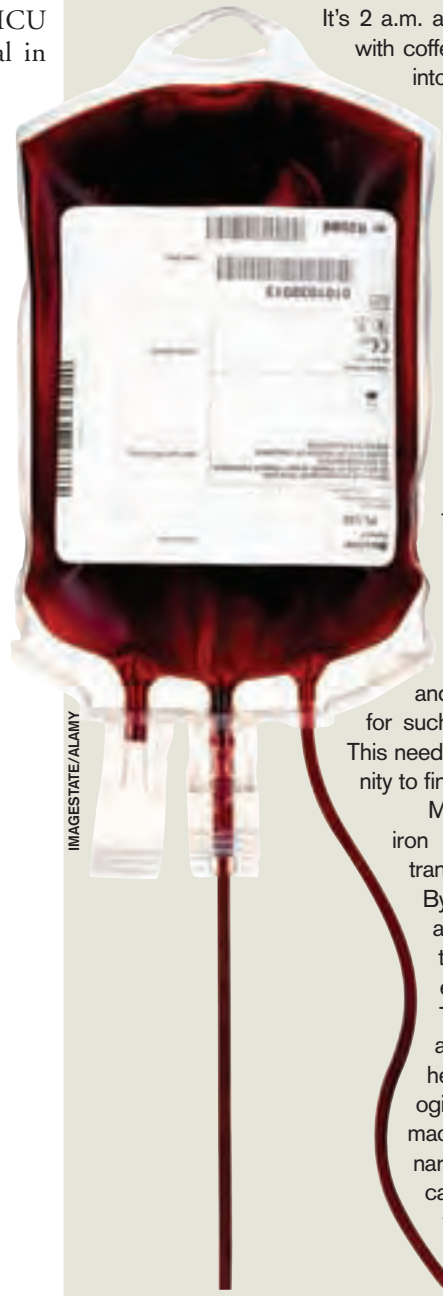
HOW RELIGION HAS PIONEERED BLOOD CONSERVATION TECHNIQUES

By Susanne Mierendorf, MD



IMAGESTATE/ALAMY

It's 2 a.m. and you're admitting a 45-year-old with coffee-ground emesis that just turned into bright red blood. The patient grabs your arm, "I am a Jehovah's Witness," he says. Then he calmly and decidedly says "no" to your advice to perform a blood transfusion.

This patient's belief about transfusion comes from a Bible verse (Acts 15:19-21: " … abstain … from blood."). In general, Jehovah's Witnesses have a firm religious directive not to accept blood products. Some are open to receiving their own blood and fluids back (e.g., autotransfusion and perioperative cell-saver devices). Some also accept pooled protein products.

As hospitalists, we need to find out what is acceptable to our patients prior to transfusion and (in some cases) modify practices for such patients as Jehovah's Witness. This need has spurred the medical community to find alternative therapies.

Many countries use pre-operative iron and erythropoietin (EPO), autotransfusion, and cell-saver surgeries. By minimizing iatrogenic blood loss and optimizing cardiac and respiratory support, most patients can tolerate anemia, even in acute illness. The situation may call for a team approach with the hospitalist, hematologist, surgeon, anesthesiologist, interventional radiologist, pharmacist, and nurse. Each clinical scenario requires an individualized clinical management plan that respects the wishes of any patient who refuses blood transfusion.

BACKGROUND

Physicians have had to be concerned with Jehovah's Witnesses' refusal of blood transfusion for decades. Surgeries with high potential for blood loss (e.g., coronary bypass and total joint replacement) have forced healthcare providers to rethink and strategize other methods.[1] These include early surgery or embolization, cautery, fibrin glue products, positioning the patient perioperatively to allow permissive hypotension, and normothermia. Some even phlebotomize before surgery, keeping volume isovolemic with saline. The idea is the blood lost perioperatively will be at a lower hematocrit—this is the hemodilutional technique.[2] Some Jehovah's Witnesses accept blood back postoperatively.

Physiologically, an otherwise healthy patient can tolerate a hematocrit down to 15%. In a landmark article in the *New England Journal of Medicine* in 1999, Hébert, et al., compared the outcomes of restrictive transfusion (hemoglobin 7-9 g/dL) with liberal transfusion (hemoglobin 10-12 g/dL) in critically ill patients.[3] The mortality rate during hospitalization was significantly lower in the restrictive strategy group (22.2% vs. 28.1%, p=0.05). Hemoglobin levels at 7 g/dL have not been linked to increased myocardial oxygen consumption, poor wound healing, nor localized tissue hypoxia. In most cases, this level of anemia does not justify transfusion, as long as circulating volume can be maintained. More liberal transfusion to higher levels may have a paradoxical effect on microcirculation, increasing viscosity and decreasing better outcomes.

In most cases, you will not be able to transfuse a Jehovah's Witness patient. In these cases, we offer several viable alternative therapies.[4]

1. **Decrease blood loss.** First, consider decreasing the amount of blood loss. This can include reducing the frequency of blood draws because the usual reason for these checks is to detect the threshold for transfusion, using pediatric or small volume tubes for phlebotomy and avoiding other unnecessary blood draws.
2. **Consider alternatives to anticoagulant prophylaxis** for DVT prophylaxis, such as intermittent pneumatic compression devices, and avoid medications that may have the adverse effects of anemia and thrombocytopenia. These include aspirin, NSAIDs, platelet aggregate inhibitors, and some antibiotics. *Example:* Substitute a proton pump inhibitor for an H2 blocker. If there is a strong clinical indication, such as aspirin, in cerebrovascular accidents, discuss the risks and benefits with the patient.
3. **Use non-blood volume expanders**—even before the patient shows clinical signs of blood loss. Crystalloids are the first line for volume replacement, including normal saline and ringer's lactate. Colloids and starch solution have not been proven effective and may even be detrimental. As part of the ABC management of any acutely ill patient, oxygenation is essential. This includes optimization of cardiac output by improving preload, afterload, and possibly inotropic therapy. Also consider interventions that minimize oxygen consumption, such as appropriate analgesia and sedation or muscle relaxant, in the mechanically vented patient.
4. **Treat anemia:** Regardless of the EPO level, critically ill patients respond to high-dose EPO therapy. The use of EPO 330 u/kg daily for five days and then on alternate days for at least two weeks reduces the need for blood transfusion.[5] Iron therapy has proven useful in maximizing the response to EPO. Hemostatic drugs, such as aprotinin, may decrease blood loss and prevent the need for blood transfusion. Other pharmacological agents that may enhance hemostasis include tranxexamic acid, epsilon-amino caproic acid, desmopressin, conjugated estrogen, and prothrombin complex concentrate. Vitamin K may also be useful in patients with malabsorption, on antibiotics or anticoagulants, or patients with liver disease.
5. **Reduce the risk of blood loss:** Recombinant activated factor VIIa has been shown to reduce blood loss in nonhemophiliac patients who are acutely ill.[6] Doses ranging from 60 mcg/kg to 212 mcg/kg have been successful in published reports.[7] Factors VIIa, VIII, and IX are available as recombinant products.

Fresh frozen plasma is separated from blood and may be acceptable to the Jehovah's Witness. These proteins are indicated in coagulopathic patients, those with liver disease, and those requiring warfarin reversal. Cryoprecipitate includes factors VIII, XIII, fibrinogen, von Willenbrand factor, and fibronectin. This may be useful in a low-fibrinogen coagulopathy. Some surgical patients may accept a cell-saver device perioperatively that salvages their blood and fluid from the surgical site, filters it, and returns it to the patient.

If a patient becomes hemodynamically unstable (even after adequate intravenous fluid resuscitation) you must consider surgical intervention. It may be as simple as applying fibrin glue topically, or more invasive, such as removing an organ or sewing off a femoral artery laceration from cardiac catheterization to control hemorrhage. Angiographic embolization is commonly used in these circumstances as it is expeditious and generally a less-invasive way to stop bleeding. Risks and benefits from the loss of an organ, such as a kidney, or loss of fertility, as with a hysterectomy to stop bleeding, must be outlined.

Studies have shown that restrictive transfusion strategy in acutely ill patients has decreased morbidity and mortality. There are other risks of transfusions, such as transfusion reactions, lung injury, allergic reactions, sepsis, circulatory overload, and transmitted infections.

Dr. Mierendorf is associate residency program director for Kaiser Permanente in Santa Clara, CA, and clinical associate professor of medicine at the Stanford University School of Medicine.

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