INTERFAITH DIALOGUE IN MEDICAL SETTINGS:

BRIDGING THE DIVIDE

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“Interreligious Dialogue”
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The relationship between medicine and religion is a convoluted one; laced with "phony television faith healers, medieval torture of scientists and healers, execution of Jews accused of spreading the plague in 14th-century Europe, bombing of family planning clinics, misinformed consumers who substitute sketchy new-age therapies for validated medical treatments, and more."[1] Unfortunately history has sustained such persistent stigmas and stereotypes, many of which are contrary to modern academic findings and sadly contribute to present-day misconceptions around religion and science. These on-going stressors have made it difficult for various medical providers and a multitude of faith backgrounds to work in tandem, often preventing the wellbeing of patients and staff alike. However, to combat this unhelpful dynamic, a growing interfaith dialogue movement has developed which aims to break down these long standing barriers. According to Professor Pourfarzaneh, PHD, Interfaith dialogue may be described as, "Making space for active engagement between and among practitioners of different religious and spiritual traditions."[2] That said, the overarching goal of such dialogue surpasses any expected exchange of niceties, rather it aims to bolster "mutual collaboration addressing the moral and ethical issues with a unified voice."[3] In this way, "Interfaith dialogue has the potential to pull us out of our individualism and, in focusing on our relationships, create a new sensibility about being human."[4] This essay will unpack the interwoven history of medicine and religion in order

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[1] Jonathan Kopel, Donald Mackenzie, Carmine Gorga, and Donald Wunsch, "Interfaith Dialogue in Medicine," *Baylor University Medical Center Proceedings* 33, no. 1 (01, 2020): 140-3, http://dtl.idm.oclc.org/login?url=https://www.proquest.com/scholarly-journals/interfaith-dialogue-medicine/docview/2355959239/se-2?accountid=202487.
[2] Som Pourfarzaneh, PHD, class lecture, February 7, 2022
[3] Kopel, Mackenzie, Gorga, Wunsch, "Interfaith", 140-3.
[4] Kopel, Mackenzie, Gorga, Wunsch, "Interfaith", 140-3.

to better understand the challenges interfaith dialogue may face in a clinical environment. By drawing upon case studies as well as testimonials from Doctors and patients, the benefit of integrating interfaith dialogue in medical settings can be better understood. It is hoped that this essay will particularly benefit chaplains of all religious backgrounds in better navigating interfaith dialogue in hospital settings and providing support to medical staff, patients, and themselves.

There is a long standing relationship between medicine and religion that precedes interfaith understanding. “Throughout human history, religious institutions established the first hospitals and clinics across Buddhist, Hindu, Islam, and Christian traditions.”[5] The link between religion and health is in many ways forged from the ancient belief that disease and spirit act together. This is especially true in regard to psychological afflictions. Many religious beliefs concerning mental illness led clinicians, scholars, and religious practitioners to prescribe highly risky treatments that were mostly ineffectual. In this way, “...the history between religion and medicine evokes controversy and contention.”[6] However convoluted this dynamic may seem, the Baylor University Medical center has encouraging data and states that, “The interplay between religious tradition and medicine is multifaceted and evolving with the social, political, and cultural changes of each generation.”[7] So what could this mean for the future of religion and medicine?

There is a present day movement geared toward fostering intentional harmony between medicine and religion. As of 1995, The World Health Organization, determined

[5] Kopel, Mackenzie, Gorga, Wunsch, “Interfaith”, 140-3.
[6] Kopel, Mackenzie, Gorga, Wunsch, “Interfaith”, 140-3.
[7] Kopel, Mackenzie, Gorga, Wunsch, “Interfaith”, 140-3.

the importance of spirituality in a patients' quality of life.[8] Spirituality and religion may help many who are facing illness or end of life find meaning. According to Anne L. Dalle Ave, MD, MS and Daniel P. Sulmasy, MD, PhD, authors of a 2021 article *Health Care Professionals' Spirituality and COVID-19 Meaning, Compassion, Relationship*, "Whether asked overtly or not, profound questions about meaning, value, and relationship are posed by illness and death, questions that are transcendent, stretching beyond what can be known empirically."[9] Other authorities in the medical field have come to similar conclusions as well.

According to Francis S. Collins, the former director of the Human Genome Project, "..the voices that are arguing that science and faith are incompatible are actually quite loud — even shrill at times"[10] and he believes that this "conflict is an unnecessary one"[11] Collins states that he was not raised with faith and as such the gravity it can carry for some, was not readily apparent. When he studied graduate level chemistry, he adopted a view that "...the only thing that really mattered was the scientific approach to understand how the universe worked; everything else was superstition."[12] However his cosmology started to shift when he went to medical school and "discovered that those hypothetical questions about life and death and whether God exists weren't so hypothetical anymore."[13] Francis found that by engaging in the field of medicine he

[8] The World Health Organization Quality of Life assessment (WHOQOL): position paper from the World Health Organization. *Soc Sci Med.* 1995;41(10):1403-1409. doi:10.1016/0277-9536(95)00112-K
[9] Dalle Ave AL, Sulmasy DP, "Health Care Professionals' Spirituality and COVID-19: Meaning, Compassion, Relationship." *JAMA,* 2021;326(16):1577–1578. doi:10.1001/jama.2021.16769
[10] Tom Rosentiel, "Religion and Science: Conflict or Harmony," *PEW*, May, 4, 2009, https://www.pewresearch.org/2009/05/04/can-science-and-religion-coexist-in-harmony/
[11] Rosentiel, "Religion."
[12] Rosentiel, "Religion."
[13] Rosentiel, "Religion."

was forced to contend with any and all scientific and religious tensions, as they were part of his everyday dialogues and held such great consequence.

Similarly, other providers have found that they are able to offer more empathetic patient centered care if they apply their religious practices in their work. This not only supports those they treat, but themselves, often deepening their own faith and commitment to their vocation. For example, Shagufta Yasmeen, MD, who is a Muslim practicing in Sacramento California, states,

> Islam teaches us to provide care to anybody who's sick. It does not discriminate between anybody if they are Christian, Jewish, or atheist. We are all human and have some implicit bias. In the clinic I try to remove the implicit bias against any race, religion, gender, or around other issues which may separate us from each other. We might not provide the same care to everyone if we don't practice our faith.[14]

This statement is compelling because Shagufta has found that by adhering to her religion within her role as a doctor, she is able to fully care for patients outside of her faith. As previously stated, there is a misconception that religion and the sciences are incompatible, but testimony such as Shagufta's demonstrate that there is more complexity than a binary answer can provide. Like doctors, patients too feel that integrating religion in medical settings is important.

The *Cultural Religious Competence in Clinical Practice* found that, "Religion and spirituality are important factors in a majority of the patients seeking care. Unfortunately, health providers may not take religious beliefs into account when they are dealing with difficult medical decisions for patients and their families."[15] Many academics have attributed religious beliefs as a reason for underutilization of health services.[16]

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[14] Shagufta Yasmeen MD, "A Place for Faith: Doctors bring spirituality to work", ed.Patrick Boyle in AAMC, https://www.aamc.org/news-insights/place-faith-doctors-bring-spirituality-work

[15] Swihart & Martin, 2020

[16] Suzie S. Weng, "Race and Religion in Social Services." *Race and Social Problems* 9, no. 2 (06, 2017): 150-62,http://dtl.idm.oclc.org/login?url=https://www.proquest.com/scholarly-journals/race-religion-social-services/docview/1899817872/se-2?accountid=202487.

Specifically people with a high religiosity may believe that any emotional distress is strictly a spiritual problem rather than one which requires medical or psychological intervention. When examining this perspective through the lens of evangelical Christians, data shows that they prefer religion as part of their medical counseling and believe someone in their tradition would best meet their needs. Research has found that patients are best able to express themselves in environments in which they feel understood and supported, and a perceived religiosity gap could affect this. Patients who believe their provider has a different religious belief from themselves, or have fear of being dismissed due to their beliefs, are in general less likely to seek help. With so many religious practices today, sensitively attending to this need is no small task.

Dr. Diana Eck, author and a leader of the Pluralism Project at Harvard University, asserts that the United States is one of the most religiously diverse nations to date. As discussed, most doctors do not have a basis for how to handle religious differences, or understand their effect on patient health outcomes. Due to the plethora of religious diversity and the critical importance it may hold for patients in times of diminished health, there is a growing recognition that religious competency and understanding of the “religious others” is paramount. Interfaith dialogue is one way to help medical providers meet this need. Though there is no one right way to conduct interfaith dialogue, there is a general framework that can help guide such exchanges.

According to Catherine Cornille, contributor to the *Wildey-Blackwell Companion to Interreligious Dialogue*, “Dialogue, in its ideal form, involves a conversation or exchange in which participants are willing to listen to and learn from one another. It is the possibility of mutual learning which makes dialogue more than a luxury or

benevolent pastime for the curious, and renders it a matter of internal religious necessity or opportunity."[17] It has already been established that interreligious dialogue applied to the medical field, has a gravity that transcends luxury. That said, the Baylor University Medical Center has determined the following five steps that interfaith dialogue may progress through in a medical environment. This includes "...moving beyond separation and suspicion, inquiring more deeply, sharing both the easy and the difficult parts, moving beyond safe territory, and exploring spiritual practices from other traditions."[18] Primarily this begins by both sharing personal stories and listening to them. Through this type of exchange, dialogue is able to broach upon meaningful issues which create a sense of union and simultaneously decrease suspicion. As these conversations continue, so does "a sense of oneness, love, compassion, and forgiveness within and beyond our religious traditions and political affiliations."[19] This naturally leads to new ways of collaborating without skirting over the parts of a tradition that may be more challenging to speak about.

Unfortunately most medical schools do not offer religious education to their students nor do they stress the importance of interfaith dialogue. Often the burden of spiritual care falls on nurses when a chaplain is not available. To this end, not all chaplains are trained to offer interfaith spiritual care nor do they necessarily have a background in interfaith dialogue. Without the use of interfaith dialogue in clinical environments, spirituality may continue to be designated as a taboo topic and viewed as inconsequential to affect the well-being of patients and staff. The following two case

[17] Cornille, Catherine. *The Wiley-Blackwell Companion to Inter-Religious Dialogue, First Edition*. New York: John Wiley & Sons, Ltd, 2013.
[18] Kopel, Mackenzie, Gorga, Wunsch, "Interfaith", 140-3.
[19] Kopel, Mackenzie, Gorga, Wunsch, "Interfaith", 140-3.

studies will demonstrate common scenarios in the medical field where interfaith dialogue could have been implemented, but was not. By unpacking these instances, the impact that interfaith dialogue could have in medical settings, may begin to be better understood.

The first case study comes from the book, *Interfaith Spiritual Care, Understanding, and Practices*, edited by Reverend Daniel Shipiani and Leah Dawn Bueckert. In this instance a Jewish patient named, "Mrs. Wheatley", is admitted to the hospital and faces the simultaneous death of her brother-in-law. A Christian chaplain who offers her counseling is unable to meet her needs as he is distracted by the religious differences between them. When the chaplain asks, "Does your brother-in-law's death conjure up memories and feelings from when your husband died?" Mrs. Wheatley replied "some." This short answer should have been a clue to the chaplain that this topic, although not invalid, was off the mark. Instead of honoring Mrs. Wheatley's desire to speak about her present grief, the chaplain continues to redirect the conversation to areas where there may be less religious difference, or rather, more familiarity for himself.

Interfaith dialogue may have supported this chaplain in moving beyond his discomfort around the religious other, allowing for curiosity about the Jewish tradition and his own faith. In debriefing the exchange

> The chaplain openly expressed conflict in ministering to Mrs. Wheatley. He wanted to reach out to her but felt hindered by theological differences…The chaplain does feel a sense of relating to Mrs. Wheatley's grief. He does not know how to go about bridging the gap, however.[20]

[20] Daniel S. Shapini and Leah Dawn Bueckert, *Interfaith Spiritual Care Understanding and Practices,* (Ontario: Pandora Press, 2009), 18.

Only by delving into his “conflict” would the chaplain have been able to truly be with this patient and adequately perform his role. By integrating interfaith dialogue into this practitioner's education, not only would this have created a container and means to address some of the discomfort which the chaplain felt, it would have grounded him more firmly in his Christian tradition. He may have felt more capable in naming the religious differences between himself and the patient or possibly asking if Mrs. Wheatley would have liked to speak with a Rabbi. Instead there is a vague rigidity and a missed opportunity to witness and be present to the needs of the patient. Chaplains are not the only medical staff that interfaith dialogue could impact positively.

Nurses are often on the front lines of providing spiritual care, and similar to other medical providers, have little training in this area leaving them woefully unprepared to meet these complex needs. The second case study will consider an excerpt a nurse gave in an interview for Claire Beidenharn’s dissertation on the nurse's role in providing spiritual care. Beidenharn’s focus on nurses comes from their noteworthy desire to serve patients, and general feeling that the vocation is more of a calling than a paycheck. However, because nurses are typically overworked, these sentiments can easily get buried. In the example below, a nurse struggles to separate their own religious needs from patient’s.

> He was ready to die but he hadn’t addressed his faith or anything. Nothing like that. I was able to share with him, but it was discouraging because he was just like, ‘Well, that’s fine.’ But as a believer I couldn’t let it go. It’s like ‘No, you need to address this~ This is not worth giving up on.’ It was just discouraging because I know this guy is going home to die. And to be not adamant but nonchalant like ‘That’s fine if Jesus is for you’... This is not something to just casually blow off”[21]

It is obvious that the nurse is overtly focused on their missional need to proselytize to

[21] Beidenharn, *Heart*, 46.

the dying patient. The patient clearly and repeatedly communicated that they were not receptive to the nurse's theological framework at that time. Unfortunately the nurse was unable to find satisfaction in the patient's response because they were not in dialogue with the religious needs of the other, only their own. In essence the nurse was seeking religious validation through the patient, which is neither appropriate nor rewarding. It can only be surmised that the patient had a similarly negative encounter, or at very least one in which that was neutral.

If this nurse had previous training in interfaith dialogue, they would have had the opportunity to engage with other religions and philosophies first hand and grapple with differences in an appropriate environment. How may have this meeting been different if the nurse had previously been in dialogue with someone of another faith background where they were able to unpack the nurse's need to convert? How might on-going feedback around their need to proselytize have affected their relationship to patients' religious differences? Interfaith dialogue could have aided this nurse to better navigate the exchange and possibly have a more satisfying outcome for both parties while deepening the nurses own faith.

The case studies, testimonials, and general desire for religious competence from medical staff, demonstrate that engaging in interfaith dialogue is critical in offering robust healthcare. The notion that religion and medicine cannot work together is antiquated and in fact, the opposite is likely closer to the truth. "If medicine involves the recovery of the body, then spiritual care…involves a recovery of the patient as a person. These areas do not sit in contention, but aim to complement each other and serve to remind us that there is no profit in curing the body if in the process we destroy the

soul."[22] As such, interfaith dialogue should be employed to "...enhance the practice of spiritual caregivers in the hospital and other settings as they encounter the growing plurality of faith traditions and expressions among care receivers and colleagues."[23] In this way "Physicians can unshackle themselves from destructive thinking and better prepare their minds to live a larger life dedicated to service, love, and compassion."[24] But how can this be implemented effectively?

Doctors, nurses, and other medical providers already have such unreasonable demands placed on them and it would be an unrealistic ask to require these professionals to prioritize interfaith dialogue. That said, chaplains are in a unique position to both emphasize interreligious dialogue, as well as offer consulting and education to medical personnel. The chaplain has the opportunity to form meaningful relationships with staff, as Beidenharn notes, "It's like serving a church as a minister. The staff are your Sunday regulars and the patients are the visitors. The patients come and go, but you build long relationships with the staff."[25] Through the lens of a hospital chaplain attending to the spiritual needs of medical professionals in an on-going manner, interreligious dialogue can be integrated into the culture of a medical environment. Through this essay and further research, it is hoped that hospital administration will begin to realize the immense importance of interfaith dialogue both to their staff and clients. This vantage should reinforce the importance of the chaplain's role in medical settings and would encourage more funding to be allocated to retaining

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[22] Claire Beidenharn, *Heart to Heart: Spiritual Care Through Deep Listening,* (Page Beyond Press, 2029), 25.
[23] Daniel S. Shapini and Leah Dawn Bueckert, *Interfaith Spiritual Care Understanding and Practices,* (Ontario: Pandora Press, 2009), 18.
[24] Kopel, Mackenzie, Gorga, Wunsch, "Interfaith", 140-3.
[25] Beidenharn, *Heart*, 25.

them. But, there is still yet another perhaps more wide reaching conclusion, as to why chaplains should facilitate interreligious dialogue in medical settings.

Interfaith dialogue in a sense is much like a perpetual quest or pilgrimage; one in which faith and systems of belief are constantly being refined while simultaneously seeking their own truth.[26] According to Sir William Osler, A physician who exemplified many aspects of interfaith dialogue in his clinical practice, it works to dissolve the barriers between people, helps us develop empathy for others, and move to a more unified perspective. As Eck states, we must liberate our diversity rather than flatten it. In this way we direct ourselves toward pluralism or “The engagement that creates a common society from all that diversity.”[27] “The goal of such interfaith dialogue is the inclusion of all religious and nonreligious beliefs to build bridges of dialogue, understanding, and progression towards addressing the challenges faced around the world.”[28] By ensuring interreligious dialogue is inundated in medicine, humanity takes one step closer to building bridges of understanding, equity, and union.

[26] Kopel, Mackenzie, Gorga, Wunsch, “Interfaith”, 140-3.
[27] President and Fellows of Harvard College and the Pluralism Project at Harvard University
[28] Kopel, Mackenzie, Gorga, Wunsch, “Interfaith”, 140-3.

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