June 2003 Articles of the Month

This month's article selection is by Chaplain John Ehman,
University of Pennsylvania Medical Center-Presbyterian, Philadelphia PA.

Kuzu, M. A., Topcu, O., Ucar, K., Ulukent, S., Unal, E., Erverdi, N., Elhan, A. and Demirci, S. [Departments of Surgery and Biostatistics, University of Ankara, Turkey]. "**Effect of sphincter-sacrificing surgery for rectal carcinoma on quality of life in Muslim patients**." *Diseases of the Colon and Rectum* 45, no. 10 (October 2002): 1359-1366.

Margolis, S. A., Carter, T., Dunn, E. V. and Reed, R. L. [Department of Family Medicine, United Arab Emirates University, Al Ain, United Arab Emirates]. "**Validation of additional domains in activities of daily living, culturally appropriate for Muslims**." *Gerontology* 49, no. 1 (January-February 2003): 61-65.

SUMMARIES AND COMMENTS: Here are two recent articles from the growing body of material about Muslim patients that is indexed in American health care literature data bases. They are valuable not only in that they address issues pertinent to Muslims but also in that they address a general concern for any religious patient: the effect of illness and/or treatment on religious practice--a concern familiar to chaplains but little explored in research.

In the study by **Kuzu, et al.**, 178 Muslim patients completed a series of questionnaires during an interview conducted a mean of three years after colorectal carcinoma surgery. The measures focused on health-related quality of life (HRQL), and included the widely used Study Short Form 36 Health Survey (SF-36, which has been validated in Turkish patients with chronic diseases) and an original instrument that contained questions about religious worship: prayer rituals, fasting during Ramadan and almsgiving--three of the five "pillars" of Islam. The authors were particularly interested on the effect of sphincter-sacrificing surgery (requiring the patient to wear a colostomy bag permanently) on prayer rituals, in light of Islamic requirements for cleanliness for prayer. [Note: While the passing of gas or feces would normally void the ablution required for prayer, a person with a permanent colostomy would be considered to have a "legitimate excuse" (p. 1359), and the requirements for ablution could be altered appropriately.]

Results indicated that the presence of a stoma (i.e., a permanent colostomy) significantly affected aspects of HRQL and was associated with decreased prayer ritual activity--both in mosques and in private--and decreased fasting during Ramadan, compared with colorectal carcinoma patients with sphincter-saving treatment. The authors conjecture that patients stopped praying in public because of "social isolation and poor physical function" (p. 1364), and in private because of "the perception of insufficient cleanliness or the lack of knowledge about the validity of ablution in patients whose stool is emitted in an involuntary manner during the prayer interval" (pp 1364-1365). They further conjecture that the practice of fasting was "likely affected by psychological regression" (p. 1365). They conclude by suggesting that preoperative counseling for patients

having stoma surgery "should include knowledge about religious life alteration," and that patients "should be offered religious education and counseling" regarding the kinds of problems identified in the study.

The article by **Margolis, et al.**, reports a validation study of a measure of Activities of Daily Living (ADL) specifically aimed at assessing physical capacity for prayer activities by Muslims that are not normally covered by ADL measures. It is a good example of the process by which measures may be validated, but it is worthy of note here as another consideration of how illness affects religious life. The measure itself looks at three issues: the physical movements for prayer (i.e., the ability to pray kneeling on the floor), the content of prayer (i.e., the ability to perform rituals and recite words correctly), and washing for prayer (i.e., the ability to wash in preparation for prayer). The authors suggest adding this prayer domain to standard ADL measures that assess for such things as dressing, bathing, grooming, toileting, transferring, walking, eating, and continence; in cases where prayer is a "relevant feature" (p, 65) of a Muslim patient's lifestyle.

While this second article looks at assessment for Muslims, it implicitly raises a more general question of assessment of any religious patient's physical capacity to carry out prayer or other ritual activities important for that patient's activities of daily living. For chaplain researchers, this may hint at the potential of partnering with physical therapists and occupational therapists to develop further assessments for other religious groups.

Both articles might be taken by chaplain researchers as a challenge to think of partnering with various allied health professionals for whom insight into patients' religious lives may be valuable for exploring the religion-and-health connection in their respective fields. Moreover, with so much attention being given in the general literature to the role of religion/spirituality on health outcomes, it is worthwhile to remember that research into how patients' religious lives are affected by illness and treatment speaks to concerns of diversity, patients' rights, and holistic care that are also crucial to modern health care. Research in this area could affect clinical practice in important ways (and relatively quickly, at the level of the local institution), for example, influencing the sort of counseling urged by Kuzu and colleagues.

Suggestions for the Use of the Articles for Discussion in CPE:

For non-Muslim students, these articles could serve to raise awareness of possible concerns of Muslim patients, based upon Islamic religious practice. They could further be a point of departure for a general discussion of the how the physical effects of illness and treatment may influence patients' ability to participate in religious activities that they understand as vital to their lives. Chaplaincy students might talk about how they could work to "improve the capacity of impaired people to pray and...help them cope with this loss [of capacity]"--to use the words of Margolis, et al. (p. 65). For students well versed in research, each article offers good descriptions of data collection methodology and statistical analysis. While the statistics used by Margolis, et al. to validate the prayer ADL domain may be too advanced for most students, the tables included by Kuzu, et al., to present statistical material are quite understandable with a little effort. Nevertheless, the articles can be read without getting bogged down in statistics, for those who are not so familiar.

Related Items of Interest:

Bashir, A., Asif, A., Lacey, F. M., Langley, C. A., Marriott, J. F. and Wilson, K. A. [Pharmacy Practice Research Group, Aston University, Birmingham, England]. "**Concordance in Muslim patients in primary care**." *International Journal of Pharmacy Practice* 9, no. 3 Supplement (September 2001): R78. [This recent study of 50 Muslim patients and 34 Muslim physicians takes the common approach of examining the influence of religion on health and treatment--in this case the influence of Islamic beliefs and customs on medicine concordance--and finds that only 26% of the patients surveyed "indicated that they would take a medicine if they were unsure as to whether it was halaal or not," and 42% "stated that they would not take any medicines that they were not sure was halaal." Moreover, 58% of the patients "stated that they would stop taking a medicine if they found out that it was haraam" (R78). The report is short, at less than a full page.]

[ADDED 8/19/08]: Easterbrook, C. and Maddern, G. [Department of Surgery, University of Adelaide and the Queen Elizabeth Hospital, Australia]. "**Porcine and bovine surgical products: Jewish, Muslim, and Hindu perspectives**." *Archives of Surgery* 143, no. 4 (April 2008): 366-370, with Invited Critique on p. 370. [Because the authors of this intended literature review found so little published material on the subject, they sought religious leaders' opinions, which they summarize briefly. The article works from--and speaks to--the Australian context, but it does have some wider applicability.]

[ADDED 12/26/07]: Kumar, N. and Jivan, S. [Department of Ophthalmology, Royal Liverpool University Hospital, UK; nishant6377@gmail.com]. "**Ramadan and eyedrops: the Muslim perspective**." *Ophthalmology* 114, no. 12 (December 2007): 2356-2360. [(Abstract:) PURPOSE: To assess views of Muslims with regard to the use of eyedrops during fasting periods of Ramadan and to determine if demographic, religious, and educational factors or the perceived severity of an ocular condition influence these views. DESIGN: Cross-sectional survey. PARTICIPANTS: Two hundred adult Muslims. METHODS: A questionnaire-based survey. MAIN OUTCOME MEASURES: The main outcome measures studied were the proportion of respondents who believe that the use of eyedrops during fasting hours of Ramadan would break the fast and the proportion of respondents who would use drops during fasting hours of Ramadan. RESULTS: Of the 200 questionnaires collected, 10 were excluded because of incomplete data entry (n = 190). Among respondents, 63.7% (n = 121) believe that using eyedrops during fasting periods of Ramadan would break the fast, and only 34.2% (n = 65) would use drops during this period. A further 34.2% (n = 65) would continue their regular treatment, 35.8% (n = 68) would use drops for a nonpainful eye condition, 66.8% (n = 127) for a painful eye condition, 35.3% (n = 67) for a condition that did not affect vision, and 75.8% (n = 144) would use drops during the fasting period for an eye condition if vision was affected. No significant association was noted when comparing views of respondents based on gender, occupation, education, and number of days the fast is observed. Statistical significance was reached when comparing the views of Muslims who would fast additional days if a fast was broken compared with those who would not (P<0.001). CONCLUSIONS: Ramadan could be an important cause for noncompliance with prescribed ophthalmic treatment. This study provides an insight into views of Muslims regarding use of eyedrops during Ramadan. The results suggest that extensive misuse of prescribed drops should be anticipated during Ramadan.]

[Added 2/10/05:] Sattar, S. P., Ahmed, M. S., Madison, J., Olsen, D. R., Bhatia, S. C., Ellahi, S., Majeed, F., Ramaswamy, S., Petty, F. and Wilson, D.R. "**Patient and physician attitudes to using medications with religiously forbidden ingredients**." *Annals of Pharmacotherapy* 38, no. 11 (November 2004): 1830-1835.

[Added 6/22/04:] Sattar, S. P., Ahmed, M. S., Majeed, F. and Petty, F. "**Inert medication ingredients causing nonadherence due to religious beliefs**." *Annals of Pharmacotherapy* 38, no. 4 (April 2004): 621-624. [This *non*-research article makes a good companion piece to the work by Bashir, et al., presenting four cases illustrating how religion-based dietary issues may lead patients to discontinue medications. The cases involve Muslim, Orthodox Christian, and Seventh Day Adventist patients.]

Though not reports of research, the following articles highlight Muslim patient issues from the perspective of care across lines of cultural/religious diversity and might suggest topics for future research:

Al-Kassimi, M. [King Abdulaziz University Hospital, Jeddah, Saudi Arabia]. "**Cultural differences: practicing medicine in an Islamic country**." *Clinical Medicine* 3, no. 1 (January-February 2003): 52-53. [This listing of a dozen frequently asked questions about working with Muslim patients covers key points from a physician perspective.]

al-Shahri, M. Z. [Department of Oncology, King Faisal Specialist Hospital and Research Center, Saudi Arabia]. "**Culturally sensitive caring for Saudi patients**." *Journal of Transcultural Nursing* 13, no. 2 (April 2002): 133-138. [This article is aimed at introducing non-Muslim health care workers to basic issues for care of patients in Saudi Arabia, covering the topics of spiritual healing, cleanliness, patient dignity, modesty, worship rites, gender-specific considerations and terminal illness. It is a brief but competent overview with potential for generalization to Muslim populations beyond Saudi Arabia.]

Gatrad, A. R. "**Muslim customs surrounding death, bereavement, postmortem examinations, and organ transplants**." *BMJ: British Medical Journal* 309, no. 6953 (August 20-27, 1994): 521-523. [This older overview from one of the most published authors on the subject in England is brief and practical, focusing on issues of death, funerals, bereavement, and organ transplantation. Dr. Gatrad is a pediatrician.]

McKennis, A. T. "**Caring for the Islamic patient**." *AORN Journal* 69, no. 6 (June 1999): 1187-1196. [This very instructive article covers a wide array of issues and concludes with a case illustration with perioperative nursing in mind.]

Sheets, D. L. and el-Azhary, R. A. [Mayo Medical School]. "**The Arab Muslim client: implications for anesthesia**." *AANA Journal* 66, no. 3 (June 1998): 304-312. [The authors consider preoperative, intraoperative, and postoperative issues and concerns about death and about childbirth, including the pertinence of some folk beliefs. They also offer an English-Arabic anesthesia assessment.]

Sheikh, A. and Gatrad, A. R. ***Caring for Muslim Patients***. Abingdon, England: Radcliffe Medical Press, 2000. [This is perhaps the most complete and practical source on the subject, coming from two authors who have been leading voices in the literature in recent years. The target audience is clearly one of British physicians, but most of the material is of general value to all health care providers.]
