Bridging Religious Identity in Health Care: The Time Is Now

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Anne Fadiman's book, *The Spirit Catches You and You Fall Down*, tells the true story of a three-month-old girl, Lia Lee, in Merced, California, who began to shake uncontrollably.[1] Her parents, immigrants from Laos, took her to a hospital where a team of highly committed doctors did everything you would expect: They stabilized the patient, drew blood and ran tests. They diagnosed little Lia with epilepsy and prescribed a complex cocktail of drugs for the parents to administer at set intervals.

Lia's parents were part of the Hmong community and believed in a faith tradition that, in its simplest terms, would be described as shamanist. Based on their religious beliefs, they had a different understanding of her condition. Their view was that an evil spirit had captured her soul. They also had a cure: The right animals must be sacrificed, in the right ceremonies, with the right religious leaders present, and the souls of those animals traded to this evil spirit in return for Lia's soul.

Most of the doctors at the hospital knew little about this Hmong belief and practice, but they were devoted to Lia's health. What they knew was that her parents were not giving Lia her medicine, which concerned them deeply.

Her parents were frustrated, too. They believed that some of the hospital's practices — waking babies up when they are sleeping to run tests, giving medicine that makes babies sluggish, and separating children from their parents — made Lia's condition worse. They also disliked the hospital's cultural practices. In Hmong culture, you speak to the father first. You inquire about how the family is doing before launching into conversations on more serious topics.

A combination of Lia's parents' mistrust and lack of clear understanding meant they were inconsistent at best in administering her medication. Over the course of her early years, her condition got worse. The doctors called child protective services and had Lia removed from her parents' home. It is a tragic story with a tragic ending. Lia fell into a vegetative state and lived that way for the next 26 years of her life until her death at the age of 30.

At the end of the book, the author looks at Lia Lee's original intake file at the hospital and is taken aback to find that under the category "Religion" the box "none" had been checked. In a way, this one detail symbolizes the entire calamitous story: However good the doctors might have been, their inability to engage constructively with Lia's family's faith identity contributed to the terrible outcome.

Just as this story offers a cautionary tale about

the dangers of disconnecting health care from religion, it offers an invitation to bridge that divide in ways that strengthen health outcomes for all, especially the most vulnerable. While Lia was not at a Catholic hospital, faith-based health care systems may provide some practices that illuminate a path forward to better build on religious diversity to strengthen care. After all, on their best days, Catholic institutions operate from a core understanding of the religious dimension of the human journey. At a Catholic hospital, the intake process might well have brought to light the ways the family's Hmong culture shaped their view of Lia's condition and her path to healing.

MAKING THE CASE FOR INTERFAITH ENGAGEMENT

Several factors raise the stakes when it comes to taking faith traditions seriously in health care settings. For one thing, despite the rise in the religiously unaffiliated, it is still the case that more than 70% of Americans say religion is very or somewhat important in their lives.[2] Moreover, demographic shifts in the U.S. landscape lead researchers to predict both the decline of Christian identity and the steady increase of those identifying with minority traditions — such as Judaism, Islam and Buddhism — in coming decades.[3]

Despite this growing awareness about the vital importance of engaging faith in health settings, doctors and other clinicians still feel ill-equipped to cross what they perceive to be a "religion-science" divide in their patient interactions.

At the same time, a growing body of evidence suggests that attending to patients' religious or spiritual identities in caregiving settings makes a difference in health outcomes.[4] In fact, a recent article, titled "Spirituality as a Determinant of Health," highlights the promise of engaging our nation's religious diversity as a key strategy in person- and community-centered policies and practices.[5] After all, groups that have historically faced more barriers to high-quality care — and thus harbor suspicion or mistrust when they seek it — tend to index their religious or spiritual identity more highly than other groups. That makes engaging our nation's religious diversity a matter of health equity, as we see in the case of Lia's immigrant family.

Despite this growing awareness about the vital importance of engaging faith in health settings, doctors and other clinicians still feel ill-equipped to cross what they perceive to be a "religion-science" divide in their patient interactions.[6] For some, it's the pressure to shorten time spent with patients, which curbs meaningful interaction; for others, it's an understandable discomfort about discussing a topic they've often been told, somewhat ironically, is "taboo."

CATHOLIC HEALTH CAN LEAD THE WAY

Here's the good news: There may be no group of health providers better positioned to bridge the faith and health divide than those rooted in the Catholic tradition. With its timeless commitment to uplifting human dignity in service to the common good, and its missional attentiveness to Pope Francis' call to a "culture of encounter," Catholic health leaders embrace their vocation as vessels of healing for all people, regardless of a patient's faith tradition or worldview. As the *Ethical and Religious Directives for Catholic Health Care Services* makes clear, this isn't "despite" Catholic identity — it's "because" of it.

Our organization, Interfaith America, is a relative newcomer to the health care landscape. But we've been working for decades to help campuses train the next generation of civic leaders to engage religious diversity well. Along the way, it's been Catholic institutions, from universities like Georgetown to DePaul to Dominican, that have led the way, tapping into their distinctive Catholic roots as inspiration for fostering pluralism in the classroom and beyond.

Over the last four years, Interfaith America's Faith & Health sector has applied a similar approach in health-related spaces. We're partnering with leaders from health care, public health, higher education and other professional settings to embed interfaith learning across platforms — ranging from wellness to diversity, equity and inclusion (DEI) initiatives to curricula and grand

rounds — all to bridge religious and spiritual divides to strengthen health outcomes for all.

KEYS TO BRIDGING THE FAITH-HEALTH DIVIDE

Our growing partnerships have highlighted what it takes to bridge the faith and health divide. From Lia's story, we know that "to bridge" can lead to outcomes that literally mean the difference between life and death.[7] There are a variety of ways to build and strengthen these bridges in health care settings.

1. Leadership Matters

Health system leaders — from CEOs and their teams to floor- or practice-level leaders — can prioritize the training that equips their teams to engage religious diversity well by connecting that work to institutional mission. In the case of Catholic health, leaders can clearly articulate the religious values that undergird their commitment to the care of people, not just their diagnosis and treatment. They can ensure their team benefits from opportunities to build understanding and skills related to religious diversity and can invest in cross-team initiatives designed to bridge the faith and health divide. They also can take the lead in measuring the impact of such efforts on health outcomes and vital human flourishing by integrating such assessments into existing protocols. In other words, leaders can provide the visionary and strategic motivation, as well as the resources, that helps ground Catholic health to its origins.

2. Systems and Protocols

Part of bridging the faith and health divide successfully means integrating religious diversity as a factor across the systems and protocols that ensure quality care. For example, we're all familiar with such intake questions as "How often do you wear your seat belt?" or "How many servings of alcohol do you consume?" But how much do clinicians know about what matters to their patients when it comes to how they approach questions of disease, healing, life and death? A growing number of health systems are adopting tools such as the FICA Spiritual History Assessment Tool[8] to position practitioners as companions on patients' health care journeys — not just as transactional experts prescribing medications and procedures.

Similarly, how do we account for religiously inspired dietary restrictions in the menu options provided to patients? For patients near the end of life, Catholic hospitals are well-equipped to ensure last rites for patients who seek them, but what about equally thoughtful attention to patients whose native sacred practices entail a smudging ceremony, an indigenous ritual that typically entails the burning of sage and prepares one for the end of life? Thoughtful attention to religious factors, wherever systems account for social determinants of health, can strengthen the integration of spiritual caregiving across health protocols.

3. Training and Education

Of course, getting serious about caring for patients' diverse religious identities depends on a workforce with a baseline understanding of how to bridge the faith and health divide in constructive, not destructive, ways. That means ensuring that teams are equipped with what we call a "radar screen for religious diversity" and foundational skills to respect, relate and cooperate with one another across differences.

Imagine what might have happened if Lia's care team had just attended a grand rounds highlighting the religious diversity of the immigrant community that was increasingly showing up in their emergency rooms. They might have taken an approach to her care that made room for Hmong practices and beliefs, even without compromising their commitment to Western scientific methods. They might have engaged Lia's parents as partners in her care, and they might have established further trust throughout the community in doing so.

Better yet, imagine that the lead physician had attended a "spiritual generalist" training[9] and, in the process, learned more about the value of compassionate presence. Even when the clinicians found themselves frustrated by the family's tepid response to medical interventions, they might have had the wherewithal to reach out to a chaplain with the skills to navigate the faith-health divide.

4. Asset Mindset on Religious Diversity

Every hour, in hospitals across our nation, doctors and nurses treat patients threatened by traumatic injuries, health emergencies and diseases. They're lifelong Catholics, avowed atheists, devout Muslims, contemplative Buddhists, liberal Jews and progressive Methodists. Surgical team

members are invariably inspired by their own religious or secular values, but they set aside differing views on end times or the value of prayer or Sabbath practices for the sake of their shared cause: saving a human life. When it comes to differences that might get in the way of healing, that's a good approach.

Increasingly, though, health systems are recognizing that it's not just their patients' religious identities that affect health outcomes. Their religiously diverse workforce is also an underrecognized asset when it comes to delivering quality care. As employers, health systems ultimately benefit from ensuring that health workers can perform their required tasks in ways that honor their religious identities. By offering employee resource groups, or other affinity groups, that provide structured support, or by creating opportunities for employees to interact with teammates around deeper questions related to purpose and meaning, leaders can foster a more profound sense of belonging and value, especially among employees whose cultural practices and religious beliefs are not in the majority of a workplace or region.

Perhaps it goes without saying, but hospital chaplaincy programs are a key asset too often disconnected from other facets of care. The COVID-19 pandemic initiated change in that, as chaplains are increasingly included in care teams, and their value in caring for staff has proven indispensable.

5. Community Connection

Increasingly, clinicians and health leaders recognize that the clinical encounter or hospital visit is but one brief point in their patients' health stories. That means that life outside the clinical setting plays an even more critical role in their flourishing. Health systems can forge connections to diverse faith leaders in their communities as partners in personal and public health.

During the pandemic, a health system in rural Pennsylvania reaped the benefits of connections they'd spent the previous decade forging with diverse faith community leaders. By listening to these leaders, they learned about community misinformation regarding COVID-19, its treatment and vaccination. They also learned about issues related to access on all fronts. Together, health system leaders, public health officials and community leaders from a range of traditions and ideologies charted a path toward safeguarding the public's health.

By investing in relationships with community partners — faith-based and otherwise — that are aligned in purpose around human well-being, they can reap immense rewards that go beyond financial returns to foster vital conditions across their neighborhoods.

As nonprofit organizations, Catholic health systems take seriously their commitment to playing a constructive role in their communities. By investing in relationships with community partners — faith-based and otherwise — that are aligned in purpose around human well-being, they can reap immense rewards that go beyond financial returns to foster vital conditions across their neighborhoods.

6. Research

Finally, health systems can help bridge the faith and health divide by supporting research to inform and refine decisions related to engaging religious diversity in health settings. A growing body of evidence points toward the efficacy of engaging religious diversity when it comes to improved health outcomes, but more studies are needed. What is the return on investment in terms of compliance, repeat hospital visits and other metrics when patients' religious identities are taken seriously during the course of their care? How does creating a workplace where religious diversity is an asset affect burnout and retention rates? How does engaging community partners in the continuum of care strengthen access and outcomes for all people?

These and other questions can spur us to greater understanding and, ultimately, a reinforced connection to the purpose for which Catholic health institutions were established: to promote human flourishing for all.

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NOTES

1. Anne Fadiman, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* (New York: Farrar, Straus and Giroux, 1997).
2. "How Religious Are Americans?," Gallup, March 29, 2024, https://news.gallup.com/poll/358364/religious-americans.aspx.
3. "Modeling the Future of Religion in America," Pew Research Center, September 13, 2022, https://www.pewresearch.org/religion/2022/09/13/modeling-the-future-of-religion-in-america/.
4. Dr. Tracy A. Balboni et al., "Spirituality in Serious Illness and Health," *JAMA* 328, no. 2 (July 12, 2022): 184–97, https://doi.org/10.1001/jama.2022.11086.
5. Katelyn N. G. Long et al., "Spirituality as a Determinant of Health: Emerging Policies, Practices, and Systems," *Health Affairs* 43, no. 6 (June 2024): 783–90, https://doi.org/10.1377/hlthaff.2023.01643.
6. Ángela del Carmen López-Tarrida, Rocío de Diego-Cordero, and Joaquin Salvador Lima-Rodríguez, "Spirituality in a Doctor's Practice: What Are the Issues?," *Journal of Clinical Medicine* 10, no. 23 (December 2021): 5612, https://doi.org/10.3390/jcm10235612.
7. Balboni et al., "Spirituality in Serious Illness and Health"; Nambi Ndugga, Drishti Pillai, and Samantha Artiga, "Disparities in Health and Health Care: 5 Key Questions and Answers," KFF, August 14, 2024, https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/.
8. Dr. Christina Puchalski, "Clinical FICA Tool," The GW Institute for Spirituality and Health, https://gwish.smhs.gwu.edu/programs/transforming-practice-health-settings/clinical-fica-tool.
9. "Spiritual Generalist Training for Healthcare Clinicians," Chaplaincy Innovation Lab, https://chaplaincyinnovation.org/current-opportunities/spiritual-generalist.

QUESTIONS FOR DISCUSSION

Interfaith America works to unlock the potential of America's religious diversity. When reflecting on this article by Interfaith America's Eboo Patel, PhD, and Suzanne Watts Henderson, PhD, consider how their points and suggestions resonate with your own day-to-day health care responsibilities.

1. Does your intake process gather sufficient information to begin to respond to the spiritual needs of your patients? To what extent do you or others in your workplace tend to the spiritual needs of patients and their loved ones?

2. How do you approach the importance of religious or spiritual identity as a health equity matter? What more can or should be done to consider the importance of spiritual care in the provision of whole-person care? How can an awareness of spiritual needs influence a patient's health care decisions?

3. In what ways does your health care environment respect or support the faith traditions of health care workers? Are there changes that would be helpful to employees and care providers?

4. What educational opportunities do you currently offer staff so that they are better prepared to understand and appreciate the critical role that religious diversity plays in caring for patients and families?

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