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Doctors and Diversity: Using Interfaith Literacy and Interfaith Dialogue to Improve Patient Care

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Abstract

In an increasingly diversifying world, how can doctors and other health care professionals improve patient care? Dr. Diana Eck, Director of the Pluralism Project at Harvard University, claims that the United States has become the most religiously diverse nation in the world. Surprisingly, the medical field neglects discussion about how these changing religious demographics affect the practice of medicine. Currently, in spite of the fact that religious differences have the serious potential to create obstacles in developing the patient-doctor relationship, many doctors unfortunately do not understand how to approach religious differences, or recognize their effect on patient health. For example, what if a doctor who is ignorant of Islam's prohibition of the consumption of pork prescribes a Muslim patient Heparin, a porcine product? Would the patient unknowingly defile themselves, become noncompliant, or even pursue litigation? This paper, written by one of Concordia College's Interfaith Scholars, proposes that doctors must 1) acquire interfaith literacy in medical school through required courses and 2) learn the skills necessary to engage in interfaith dialogue with patients in their practice in order to provide the best patient care in areas with growing diverse patient populations. The author of this essay engaged in interfaith interviews with doctors from non-majority religious traditions such as Hinduism and Islam and researched the current status of medical education and the occurrence of religious dialogue between patients and doctors nationally. This paper uses the theoretical work of Dr. Eboo Patel, author of *Sacred Ground: Pluralism, Prejudice, and the Promise of America* to argue that interfaith literacy is necessary to understand different spiritual backgrounds and to build compassionate care for patients with religious differences. Interfaith dialogue is the best method for discussing a patient's religious background because it is non-conversional at its core and allows for patients to describe their own experiences and expectations, both of which may have a substantive impact on the care that they need or are willing to accept. This paper concludes that interfaith literacy and dialogue must be taught in medical schools and practiced by doctors, because institutionalizing this change will ensure improved and more holistic patient care for those of diverse religious backgrounds.

Keywords: Interfaith; Medical Education; Patient Care

"In an era riven with interfaith tension and crying out for positive engagement with religious difference, higher education's approach (or lack thereof) to religious diversity flies in the face of what should be its mission to nurture engaged and educated citizens for a pluralistic world."[1] *-Dr. Eboo Patel in The Chronicle of Higher Education*

1. Introduction

As a pre-medicine student who is also a religion major and Interfaith Scholar at Concordia College, I have deeply considered what students should learn in medical school in order to enhance their future practice of medicine. In my research, I discovered more about the growing needs of health communities. I soon recognized that because the United

States is diversifying**,** doctors must be able to address these growing cultural and religious differences. I was able to witness this growing diversity through my experiences interviewing and shadowing physicians in the hospital systems of Fargo, North Dakota. Dr. Diana Eck, the director of the Pluralism Project, argues, "The United States has become the most religiously diverse nation on earth."[2]

Rather than suppress this diversity, our society needs to celebrate it. We must move towards pluralism, which Dr. Eck describes as "the energetic engagement with diversity" including "the active seeking of understanding across lines of difference."[3] Medical practices must support these differences. However, cultural and religious differences have the serious potential to create obstacles in a patient's health care as well as hinder the development of the patient-doctor relationship. For example, what if a doctor who is ignorant of Islam's prohibition of the consumption of pork prescribes a Muslim patient Heparin, a porcine product? The patient could unknowingly defile themselves, become noncompliant, or even eventually pursue litigation. Currently, many doctors still do not understand how to approach cultural and religious differences, or recognize their effect on patient health.

As the United States increasingly diversifies, how can doctors improve patient care by discussing patients' religious beliefs and practices? By using textual as well as contextual research that included interviewing doctors who practice diverse religious traditions, I argue that doctors must acquire interfaith literacy in medical school through required courses and learn to use interfaith dialogue with patients in their practice to provide the best patient care for their diverse patient populations.

Dr. Eboo Patel, founder of the Interfaith Youth Core, defines interfaith literacy as "an appreciative knowledge of other traditions,… the ability to identify values that all religions share,… understanding of the history of interfaith cooperation in our nation and our world,… and developing your own theology of interfaith cooperation."[4] Interfaith literacy is necessary to understand different spiritual backgrounds and build compassion for religious differences that doctors may face. While using interfaith literacy, interfaith dialogue is the best method for discussing a patient's religious background because it is non-conversional at its core and allows patients to describe their own experiences.

2. The State of Medical Schools in the United States

For most patients, their religious or nonreligious backgrounds are an integral part of their lives. Surprisingly, the introduction of medical school courses that address patient spirituality has been very recent. In 1993, only three medical schools offered courses in spiritual topics.[5] In 2014, more than 75 percent of medical schools offered patient spirituality topics within their curriculum. This incorporation of spiritual topics may seem to indicate that graduating medical students are fully capable of meeting the religious needs of patients. However, these courses are most often electives and not required. Medical school curricula, therefore, still fail to prepare doctors to have conversations about patient's religious beliefs and practices, especially with patients from diverse religious traditions.

Even though the number of courses is rising, my research reveals that many new doctors graduating from these medical schools are still uncomfortable about the inquiry and incorporation of a patient's religious and spiritual beliefs into their medical practices. For example, at the Albert Einstein College of Medicine of Yeshiva University, which is renowned for its course on patient spirituality, researchers in 2010 performed an experiment to see how many of their students were able to discuss patient beliefs and religious needs. During a simulation of a patient visit, only 64 percent of third-year medical students asked the dying patient if they would like to speak with a chaplain, who then expressed interest.[6] The study also revealed a more troubling statistic that only 2 percent of their third-year medical students engaged in any discussion about the patient's religious beliefs and practices.[6]

This recent study clarifies that even with the introduction of predominantly elective courses in patient spirituality, many students still do not have discussions with patients about beliefs and practices. This may be because students were not required to take these classes as a part of their medical education. Medical schools that do not require these courses undermine the importance of patient spirituality. As a result, many medical students cannot address a patient's religion and have limited knowledge as to how to begin dialogue with patients' about their religious beliefs and practices. Even worse, many offered classes do not require students to build interfaith literacy through learning about religious traditions. Students are not prepared to treat patients from any tradition.

3. Medical Students for Change

In a survey of a major midwestern medical teaching institution, 46% of primary care residents felt that as future primary care doctors, they should have a role in patients' spiritual lives.[7] A group of students at the University of

Minnesota Medical School has demonstrated this desire to learn more and acted independently to fulfill their need for interfaith education. These medical school students recognized that spiritual and interfaith education is missing from their medical education. Two years ago, in response to a lack of formal education about patient religions in the medical school, "a small group of students from a variety of religious backgrounds" formed an ad hoc group known as the Interfaith Medical Student Interest Group.[8] After contacting the group, Gina Piscitello, one of its active leaders, in a private correspondence that their goal was "to create supplementary lectures to address this topic so we as medical students will be more comfortable addressing religious aspects of medicine that we will run into as physicians."[8] Prerana Bhatia, who is also an active leader of the group, stated that the events they organize are "meant to enrich the curriculum by bringing in topics regarding patient care that are not discussed in textbooks."[9] This group is doing just that, but medical schools must still be urged to directly address the lack of interfaith education. All medical schools must incorporate interfaith discussion of religious diversity in their curricula.

These students at the University of Minnesota Medical School have worked with local chaplains, faith groups, and doctors to teach medical school students about the necessary knowledge for different faiths. They successfully received grants for their events designed to teach students about serving patients from diverse religious traditions.[9] Their website also includes information regarding how patients of certain faiths may approach medicine. For example, the website has links to information about contraception for certain faith traditions.[10] In order to better understand the chaplaincy process and its purpose in the health care system, the group organized a chaplain-shadowing program for medical students.[10] All of these examples are great beginnings to a more inclusive medical school program and should be lifted up as models of what should be done more programmatically across the nation.

Medical students like the ones involved in the Interfaith Medical Student Interest Group are trying to convey to medical schools that the issue of discussing and respecting patients' diverse religious backgrounds is imperative. Piscitello stressed that these issues are "important to address since religion is a huge part of many patient's lives and may be especially important to them in times of sickness, and we as medical professionals should be somewhat knowledgeable about this and respect and acknowledge our patient's [sic] beliefs."[11] This interfaith group is doing important work for students, but students are not required to attend. Thus, the knowledge necessary for future doctors is only reaching a select group of students. Student groups such as the Interfaith Medical Student Interest group, though doing wonderful work to better patient care, do not solve the problem.

Students must take these groups further and advocate for intentional inclusion of interfaith education into the curriculum of all medical schools. Since medical students are incredibly busy though, problems arise. Medical school students already learn a tremendous amount of information during medical school. They most likely do not have time to begin a campaign for change by themselves. Current doctors and students must work together with faith directors and patients to promote full support of all religious beliefs and practices in patient care. Students need the help of faith leaders to advocate for the members of their faith community. Patients can work with doctors to change how the health care system respects their spiritual practice. With medical student interest and a renewed connection between spiritual and physical health, now is the time to change the health care system in regards to patient spirituality. Considering that 72% of cancer patients reported that "their spiritual needs were supported minimally or not at all by the medical system," significant changes still need to be made.[12]

4. The Dilemma and Responsibility

To add to this lack of understanding, historically, scientific and religious communities have argued that science and religion are necessarily separate antithetical entities that conflict. For the same reason, people have long believed that medicine and religion are at odds. This separation was not meant to intentionally harm patients. Initially, the distinction was thought to protect patients and maintain the integrity of doctors. Doctors are in a powerful position and must not use it to convert any patient to their religion, suggest a patient become more religious, or imply religion is not useful.[13] It may be seen as coercive and unethical for a doctor to suggest prayer or any religious practice during a patient visit. Due to the potential ethical repercussions, many doctors do not feel comfortable discussing the spirituality of patients from any religious tradition.[13]

This worry has led some doctors to avoid the subject altogether, or to solely refer patients to hospital chaplains. Doctors have an ethical responsibility to refer to chaplains when necessary.[14] However, a hospital chaplain represents not every religion, especially non-Christian traditions. Chaplains are not usually specifically trained in interfaith literacy, so even though chaplains are critical in the hospital setting, doctors cannot solely rely on them. Doctors must recognize their role in respecting the spiritual concerns and practices of patients from all traditions.

The Joint Commission on Accreditation of Healthcare Organizations assessed that hospitals should address a patient's spirituality when they are admitted to acute hospitals.[15] Not all doctors believe that change is necessary in

supporting patients' religious needs. In fact, some hold the opinion that doctors should not actively seek to have conversations with patients about their faith background. In one of my personal interviews with a doctor about the of topic religious dialogue with patients, he replied that doctors should not be involved and that patients will talk to doctors about their faith needs without prompting.[16] The research previously discussed disagrees with this opinion. Doctors must acquire interfaith literacy and then participate in interfaith dialogue with patients.

5. Interfaith Literacy and Dialogue

The current status of medical school education shows that much is missing. Medical education on patient spirituality still needs reform to introduce methods of dialogue between patients and physicians. For these conversations to be most effective during patient visits, doctors must have previous education before these discussions even begin. Dr. Stephen Prothero, author of *Religious Literacy: What every American Needs to Know and Doesn't,* found "the challenging conversations I coveted were not possible without some common knowledge."[17] Doctors must first acquire interfaith literacy.

As stated in the introduction, Dr. Eboo Patel defines interfaith literacy in four parts.

> The first part of interfaith literacy is an appreciative knowledge of other traditions… The second part of interfaith literacy is the ability to identify values that all religions share - compassion, mercy, hospitality, service. The third part is an understanding of the history of interfaith cooperation in our nation and our world. The final part is developing your own theology of interfaith cooperation, based on the texts, stories, and rituals of your own tradition.[18]

Each component of interfaith literacy is crucial to their application in the patient care model.

Appreciative knowledge is purposefully distinct from a general education about the facts of a religion (though arguably, most doctors today possess neither). Dr. Stephen Prothero defines general religious literacy as "the ability to understand and use the religious terms, symbols, images, beliefs, practices, scriptures, heroes, themes, and stories that are employed in American public life."[19] Until one is able to explore other religions and find values that correlate and reflect with their own, their interfaith education is incomplete. From this approach, appreciative knowledge is paramount because it has the most capacity for building relationships and subsequently facilitating change. Solely having knowledge of a religion does not suffice. Doctors must have a respect and appreciation for other religions. Appreciative knowledge then can create connections between physicians and patients.

The second part of Dr. Eboo Patel's definition of interfaith literacy is the ability to identify values all religions share. Doctors must have the ability to examine core values that religions have in common, like compassion. A consideration of core values is different from an attempt to claim that all religions are the same, or can be broken down to be the same. The knowledge of having something in common allows people to focus on those aspects rather than solely focusing on divisive differences. Identifying values also challenges doctors to focus on the aspects of religions that facilitate change in the world. This is one of the most important parts of breaking down stereotypes that, if present, will be carried into dialogue.[20] When commonalities are recognized, stereotypes can be broken down that impair relationships between physicians and patients from different religious groups that may have had animosity between each other in the past. Deconstructing stereotypes is valuable for everyone, even for those that do not consider themselves to be strong in their faith or do not practice a specific religion. Stereotypes are pervasive and are present in our everyday lives. Doctors must dissolve stereotypes, both cultural and religious, that hinder the best patient care possible.

The third part is to understand the history of interfaith cooperation in our nation and world. Historical knowledge may seem unnecessary for doctors. Why should they need to know about the history of interfaith if they just want to have conversations with patients? Past and current examples of successful interfaith cooperation can be used as evidence of interfaith success, even in situations that seemed impossible. An example of interfaith cooperation is when Martin Luther King worked with Jewish Rabbi Abraham Joshua Heschel to promote equal rights for all people during the civil rights movement.[21] Doctors can learn from these examples of interfaith literacy and dialogue, which they can apply to the medical field and patient care.

The fourth and final part of interfaith literacy is to develop your own theology or philosophy of interfaith cooperation, based on the texts, stories, and rituals of your own tradition. Some may argue that it may appear conversional for doctors to share too much of their own religious or non-religious background. However, in my view this step is imperative as a means of internalizing the method of interfaith literacy. By internalizing interfaith literacy, it becomes a doctor's orthopraxy, or right practice, in regards to treating patients' religious requirements. Memorizing

the previous three parts as a checklist is not a sustainable method because interfaith literacy does not become a component of their identity. Without reflection of what interfaith means personally within a doctor's own beliefs, whether they are religious or nonreligious beliefs, patients will be able to discern when doctors are not authentic in their effort to understand their religious or nonreligious backgrounds. Doctors must develop their own interfaith theology or philosophy in order to fully incorporate interfaith literacy into their patient care model and their identity as physicians.

If doctors do not reflect on why interfaith matters to them, interfaith literacy will not be used in high stress situations where doctors may forget to consider a patient's faith or become tense during conversations. All four parts of interfaith literacy work together. Doctors must implement interfaith dialogue in order to act upon their new knowledge of interfaith literacy, as it applies to their medical practice. As Dr. Eboo Patel writes, "Taken together, these four parts are a knowledge base for cultivating pluralism in a religiously diverse society."[22]

Interfaith dialogue is an intentional way of communicating about religion in possibly intense situations. Dialogue, as opposed to conversation, is meant to intentionally "broaden participants' understanding of a particular issue."[23] Also, the dialogue process varies from other forms of communication because "participants are asked to respectfully listen, learn, and share their experiences with others." [24] The same components of dialogue should be applied to discussions among people of different faith backgrounds through interfaith dialogue.

As an example, a group in Ireland working to promote dialogue between Muslims and Christians has implemented these components. This interfaith group provides the helpful definition that interfaith dialogue is "people of different faiths coming to a mutual understanding and respect that allows them to live and cooperate with each other in spite of their differences."[25] The United States Institute of Peace's David R. Smock in his book, *Interfaith Dialogue and Peace Building*, includes Mohammed Abu-Nimer's description of elements that must be present during interfaith dialogue. Abu-Nimer describes three core components of interfaith dialogue as "changing the head, then changing the heart and then change through the hand."[26] These three components beautifully complement Dr. Eboo Patel's definition of interfaith literacy.

Doctors must respect patients' religious needs by changing the head. Changing the head is building interfaith literacy to authentically embrace their own interfaith theology or philosophy and break down stereotypes with appreciative knowledge. The second step, changing the heart, is the development of a safe and trusting relationship between the patient and the physician where the best patient care begins. This relationship is a space without fear of persecution, judgment, or doctors coercing patients. Change through the hand is then using this information and relationship built on respect and trust to listen to patients' stories. Doctors then must make necessary changes to treatments, daily hospital care practices, and general health care to respect patients' religious practices. Dr. Patel wrote in response to one medical disaster, the Boston Marathon Bombing, "Imagine how much interfaith cooperation there was in the operating rooms of Boston hospitals last week, where medical professionals of all faiths were working together to save lives and limbs."[27] Doctors can respond to the worst of situations while still respecting patients' religious beliefs by acting on their interfaith literacy. Perhaps hospital rooms and doctors offices can be a site of interfaith dialogue and cooperation that our world so desperately needs.

In my research, I decided to apply interfaith literacy and dialogue, turning to local Muslim and Hindu physicians to learn how they address faith in patient care. I wanted to discuss this topic directly with the doctors who must adapt to the growing diversity of the Fargo-Moorhead area. I was first able to talk with Dr. Shamudheen Rafiyath, an oncologist and a Muslim. Through our own interfaith dialogue, Dr. Rafiyath helped me understand how a doctor of a minority faith in the area navigates the intersection between their religion and medical practice.

6. Interview with Dr. Rafiyath, A Muslim Physician

Dr. Rafiyath shared with me how his tradition of Islam affected his practice of health care once he moved to the United States from India. In his search, he discovered that the four principles of biomedical ethics are similar to ethics in Islam concerning causing suffering and harm. These four principles are beneficence, nonmaleficence, autonomy, and justice.[28] Each of these principles gives him questions to ask himself as he practices oncology, which is the study of cancer. He first asks about the possible positive outcomes or beneficence from, for example, prescribing a certain drug. Nonmaleficence asks if the drug has the potential for negative side effects, both physiologically and religiously. He also must consider the autonomy of the patient, and ask if any compulsion is present in a patient's health care. By answering these questions, he is able to consider the fourth principle of justice and ask if this is the right course to take for the patient. These principles of medical ethics are congruent with Islam.

After considering how Dr. Rafiyath's Muslim faith affected his medical practice, he became more involved in his faith and in his vocation. Many doctors would benefit from understanding how their own religious or non-religious

tradition affects how and why they practice medicine. However, doctors who consider their faith should not violate any medical ethics by converting patients to their own beliefs. This exploration should strengthen doctors' own reasons for providing health care and inform them of ways that their faith may or may not be congruent with modern medicine. Dr. Rafiyath had to research his own faith when considering the treatments and medications that are traditionally not allowed by Islam.

The Qur'an, the central religious text for Islam, prohibits the consumption of pork by declaring that "forbidden to you is carrion, and blood, and the flesh of swine."[29] However, many medical treatments use pig, otherwise known as porcine, products. Heparin, for example, is an anticoagulant that is derived from porcine materials.[30] Porcine heart valves are used to replace deteriorated or deformed heart valves in patients. Alcohol and opioids are also forbidden. Many medicines are alcohol based, and many pain medications are derivatives of opioids. These medications and treatments are in many cases medically necessary for a patient's health, but problematically may require Muslims to sacrifice their faith for their health. It is worth considering how many Muslims patients or any patients who practice religions prohibiting the consumption of pork, such as Orthodox Judaism, have violated their religion because of a doctor's uninformed medical decision.

Dr. Rafiyath researched in the Qur'an and other religious texts of Islam for evidence allowing the use of these items under medical circumstances. He found that certain *fatwas*, answers from Islamic scholars, explained that in necessary situations these rules could be broken without any religious consequences in order to reduce suffering or to survive.[31] In this way, Dr. Rafiyath was able to reconcile his faith and medicine. Other doctors in this situation would potentially want to tell patients that this is the true interpretation. Dr. Rafiyath does not coerce Muslim patients into believing his interpretation, but rather gives his patients information to research. Even though patients may not understand the specifics of a treatment, they are usually more than willing to research them. Patients of course may still refuse after researching the treatment, but then they have options that may not sacrifice their religious beliefs for their health or vice versa.

Dr. Rafiyath recognizes situations that will be problematic for Muslim patients, but doctors without knowledge of Islam do not. Many doctors in the Fargo-Moorhead area do not understand Islam.[31] In my analysis, this can be extrapolated to the entirety of the United States. Yet doctors and other health professionals must recognize situations where Muslim patients require accommodation. Muslim patients may prefer to have doctors and nurses of same-sex health care for them, especially during surgery. Muslim women may want to have a cap for modesty when a hijab cannot be worn.[32] Muslim patients may desire to face Mecca in order to pray, which is difficult when bed-ridden or in a windowless hospital room. [33]

Through my conversation with Dr. Rafiyath, I argue that without understanding Muslim traditions or asking the patient about their faith concerns, doctors do not know how to provide the best patient care for Muslim patients. Furthermore, doctors will violate Muslim patients' religious beliefs and practices. Simply knowing the right questions to ask and being able to ask them can improve patient care for Muslims. But these conversations are not happening now. Currently, in Dr. Rafiyath's view, doctors that want to have these discussions are not given adequate time in a patient visit to have them.

The business and hospital model of healthcare is growing. Private practices are slowly becoming a thing of the past. They cannot keep up with the costly and growing demands of the health care industry. Hospitals are increasingly scheduling doctors so that they have between only ten and thirty minutes to talk with patients.[34] Doctors barely have time to delve into a patient's medical issues during that time, let alone discuss a patient's religion in a meaningful way. This interview provoked the question of how can doctors have these crucial conversations with patients if hospitals and the greater health care system of which they are part of do not allow them to do so? How can doctors take time to address patient spiritual needs without potentially taking time away from other necessary conversations about their health?

Doctors like Dr. Rafiyath who understand the importance of these conversations take time from their own schedules in order to build meaningful relationships with patients. Building relationships includes allocating time to make sure doctors account for a patient's religious beliefs and practices when considering treatment plans. In my perspective, a doctor's interfaith orthopraxy includes consideration of time for these discussions. Doctors who build time into their own schedules are taking an individualized approach and trying to fill a need. Hospitals must systematically institutionalize formal policies that reflect the importance of discussing a patient's beliefs and practices, which could potentially affect their medical treatment. Hospitals must require their doctors to have background knowledge of different faiths and provide opportunities to acquire this knowledge if it is not already present. Doctors must be taught to recognize when difficulties may occur between religion and medicine, and how to address concerns through dialogue with patients.

Essentially, doctors must recognize when to have these discussions. This method would be time and cost effective. A twenty to thirty minute conversation about a patient's beliefs is much quicker and cheaper than dealing with the

potential medical and legal ramifications of giving a patient a treatment that their faith does not support. In order to help facilitate necessary interfaith dialogue between doctors and patients, hospital groups must extend a patient visit to longer than twenty minutes. After interviewing Dr. Rafiyath, I wanted to learn more about how other religions may need similar accommodations during their patient visits.

7. Interview with Dr. Anu and Vijay Gaba, Hindu Physicians

As refugee and immigrant populations across the nation grow, so the Hindu community in Fargo-Moorhead is also rapidly growing. Health care professionals must learn when to ask about cultural and religious differences that affect patient care. To learn about this, I interviewed Dr. Anu Gaba and Dr. Vijay Gaba, who are both Hindu doctors. Hinduism, a very large and diverse religion, is considered more of a way of life than strict set of beliefs.[35] For Dr. Anu Gaba, her faith applies to her oncology practice because Hinduism teaches practitioners to respect all life.[36] This deep respect for a patient's life enhances her medical practice of treating patients with cancer. To not cause unnecessary suffering is to respect life. In some situations, this includes aggressive treatment options. For patients with fatal illnesses, such as some cases of cancer, patients must decide how aggressive of treatment to use. With the Hindu understanding that aggressive treatment may in fact cause more suffering, it is important to discuss with patients and their family members the potential risks of such treatments, like intubation or chemotherapy.[36] Dr. Gaba would not refuse to complete these treatments because of her Hindu practice, but Hinduism enhances her perspective that some treatments may not be the best options in end-of-life care.

Indian and Hindu patients may also want to have many family members in their hospital rooms. This is both a cultural and religious tradition. Family members want to be supportive and included when their loved ones are in the hospital.[36] However, many hospitals have limits on the amount of visitors that a patient can have. This is for safety reasons and so nurses and doctors have room to work in the hospital room. During end-of-life care, it may be necessary to extend the limit of family members who can come into the room to comfort the dying patient during their last moments. In Hinduism as well, many times a family member will make medical decisions for the patient. Hinduism, in contrast to normative western culture, focuses on family over individualism.[37] When treating a patient that may be incapacitated or confused, it is important to ask the patient who they want making their health decisions.

Traditional naturopathic medicine in India developed because of the lack of medicine available both in the past and in modern times. For Indians and Hindus, patients have different expectations of what the visit will bring. In the traditional medical practice in India called Ayurvedic medicine, when a patient speaks to a health professional, the doctor should always include recommendations for diet or habit changes, such as meditating or doing yoga.[38] Patients may still expect this portion of their health to be discussed even with access to modern pharmaceuticals and treatments. In many ways, patients from many cultures are seeking for guidance on how to eat and act. Advice about diet and habits is expected and must be included for Indians and Hindus.

Diet is important in other aspects of Hinduism. Dr. Anu Gaba stated that many Hindus are vegetarian.[39] I know from personal experience that vegetarian food can be hard to come by in a hospital. Without asking if a Hindu patient is vegetarian, meals may be ordered during hospital stays that contain meat. As a part of their faith, along with being vegetarian, they may practice fasting.[39] Fasting can include not eating for one day of the week, or abstaining from a certain food item each day. For example, a Hindu patient may not eat sugar on certain days, or only eat fruits and vegetables on another day. Both of these practices of vegetarianism and fasting need to be respected unless medically harmful to a patient. These practices are not a part of the United States normative culture, especially in the Mid-West. Facilitating religious practices concerning food is an essential part of patient care.

Learning about Hinduism in particular became even more important because the Hindu refugee population grew incredibly within the last six years. In 2008, the United States government granted many Bhutanese people refuge from Nepal, where they were not allowed citizenship and were living in dire situations.[40] More than 66,000 Bhutanese refugees from Nepal came to the United States.[40] Fargo-Moorhead became home to more than 1,300 Bhutanese refugees by 2013. [40] Many of these Bhutanese refugees practice Hinduism and follow some of the same religious practices as previously outlined. This influx of refugees seen in Fargo-Moorhead is happening all over the United States as well. Susan S. Sered and Linda L. Barnes in *Religion and Healing in America* describe "factors that complicate current American understandings of the convergence of religion with health care include large-scale arrivals in the United States of immigrant groups from non-European and non-Christian countries and a related recognition of multicultural realities."[41] Patients from different backgrounds, like refugees, are constantly not having their faith-based needs met, not only in Fargo-Moorhead, but also across the United States. Doctors must have the competency necessary to treat refugees from across the globe.

These refugees need more time and consideration during patient visits in order to give the best possible care, especially concerning how to be respectful of their religion. As Dr. Vijay Gaba gained more patients that were refugees, specifically those from Bhutan, he desired to learn more about the refugees' specific beliefs and to learn how to respect them. Dr. Gaba believes that doctors in general are very adaptable and are more than capable of learning these new skills.[42] However, doctors who are interested in learning these new skills often do not know what to learn or what resources are available to them. Even though doctors have the ability to do this research, they may be too busy to fully learn about a new culture and religion that they have never had experience with before.

Refugees and patients from minority traditions are not the only patients whose are faith needs are not being met. The conclusions of research regarding how patients feel their needs are being met are not solely a reflection of patients of minority traditions or refugees. Thus statistics are inclusive for patients of all religions. Even though Christianity is the majority religious tradition in the United States, Christians' religious needs are still not being fulfilled.[43] Obviously our healthcare community still has difficulties treating patients of every faith background.

Dr. Anu Gaba, an oncologist, has approximately thirty minutes per patient visit. Dr. Vijay Gaba has about five minutes as an anesthesiologist. Five minutes leaves very little time for them to discuss a patient's beliefs. Dr. Vijay Gaba has to make sure that he shows the patient and their loved ones that he cares for them.[44] These five minutes are the patient's first impression of him, and in many cases the only time they will meet. In light of this, he makes sure to fully dedicate those minutes to them and address any concerns they have.[44] He has to choose the most important questions to discuss in order to make these five minutes count. In many situations, a discussion of religion may not be time sensitive. These conversations must begin at the preoperative level, which can then help other doctors advise patients in these small dialogue windows. Thus, all doctors have the responsibility to inquire about a patient's religion at the beginning of their relationship with a patient. Not discussing possible problems until the last minute can lead to a patient postponing surgery, which would waste the time, money and resources of all involved. In order for proper religious consideration to be achieved, doctors must be trained to have these conversations, as well as learn about other religions. The best place for learning about interfaith dialogue to occur is during medical school, where future doctors develop their ability to talk with patients.

The Fargo-Moorhead community is making progress in addressing the growing diversity. However, the burden of adapting to diversity has been mainly on doctors who are not from a majority religious tradition themselves, or have already been involved in the interfaith movement in the area. Doctors like Dr. Anu Gaba, Dr. Vijay Gaba, and Dr. Rafiyath have been working to support patients of their faith tradition along with others. The work of interfaith medicine should not be theirs alone. As more doctors gain interfaith literacy, they can all begin to work together to treat patients from religiously diverse backgrounds more effectively.

8. Conclusion

Doctors have a critical responsibility to appreciate their patient's religious and non-religious traditions and to keep them in mind when making medical decisions. If doctors do not acquire interfaith literacy or partake in interfaith dialogue, negative consequences for both doctor and patient will be inevitable. Health care professionals who are committed to their patients have a duty to respect their Muslim patient's desire to face Mecca during prayer or their Hindu patient's request to be bathed before eating or praying. Doctors who neglect this obligation fail their patients. Research is beginning to demonstrate the significance of doctors' commitment to their patients' religious requirements.

Research about the intersections between the fields of religion and medicine is growing. The University of Chicago Medical School now has an exemplary research center that is conducting a large portion of the research in regards to patient care and religion.[45] This research center is very encouraging to the growth in support of the connection between medicine and patient spiritual health. The growth in research has even warranted a national conference, The Conference On Medicine and Religion, which held its fourth annual convening in March of 2015.[46] This conference is where academics in both fields disseminate their research in hopes of bridging the gaps between the two fields. The climate is right for the cultivation of a new way of thinking about medicine and religion. Doctors and students in the medical field with the help of patients must continue to show the study of religion and medicine is important to patient care.

In addition to promoting interfaith education in medical schools, student groups like that of the University of Minnesota's Medical School, have great potential to further build relationships between medical students and the faith communities that they will be serving in the future. More student programs will benefit the effort to increase understanding of how faith affects patients' treatment and health care and further prepare these medical students to be

better doctors. Student groups also help medical students develop working relationships with chaplains and faith leaders to ensure patients of their faith traditions are supported. Doctors and chaplains work side-by-side with patients of faith. Shadowing programs like those available in this student group help to educate doctors about the role of a chaplain in patient care. As medical student interfaith groups spread to other medical schools across the country, hopefully this innovative doctor/chaplain shadowing program will spread as well.

The beginning of interfaith studies may also help the future growth of these discussions. Undergraduate opportunities, such as the minor that my undergraduate institution, Concordia College, has implemented, will teach students early on about interfaith dialogue. Also, masters programs in interfaith work, like that of the Interfaith Action masters program at Claremont Lincoln, will create a new brand of professionals who will be well versed in implementing interfaith programs in a variety of fields.[47] Each of these parts of the interfaith studies field will bring a new age of interfaith to the world of academia.

Through researching the topic of interfaith and medicine, I have learned a great deal about the connection between my own two fields of religion and medicine. We are at the beginning of a new era of modern medicine that treats patients holistically by considering all parts of their health, including spiritual health. If doctors can acquire interfaith literacy through education and implement interfaith dialogue along with further changes in intake forms and research, all communities will be better represented by their doctors and will develop better patient care.

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