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IS RELIGIOSITY HELPFUL FOR PATIENTS WITH HEART FAILURE? IMPLICATIONS FOR MEDICAL ETHICS

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ABSTRACT. The present study aims to underline the current discussions on the religiosity-health outcome relation, highlighting the tensions that may arise in the course of the medical practice on the following questions: a) Is religiosity itself an (independent) factor capable to affect the outcome of patients with heart failure, or is the association between religiosity and health benefits mediated by other social and psychological factors?; b) To what extent do religious beliefs conduct to illness avoidance or acceptance and to adequate treatment commitment, in other words those beliefs support or contradict the medical approach?; c) What measures on social policies and medical counselling level would be more effective and appropriate for the Romanian system?; d) In which of the following policy areas could the bioethical dimension be more flexible and efficiently integrated: the doctor-patient relationship, the steps of the medical act, the curative decision making and/or the long-term support of the patient? A large understanding and evaluation of the ethical and legal frame regarding the patient's information, treatment and healthcare is required for the medical practitioners as long as the shared decision making between patient and clinician is one based on modern medical principles followed by clinicians.

Key words: coping, religion/spirituality, support, health care, medical ethics.

Introduction

The role of religiosity in healthcare has been highlighted by many specialists (sociologists, psychologists, physicians, theologians, representatives of health policies organizations, etc.). The ability of religion experienced at individual level to provide a

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sense of life and to engage psychologically and socially in support of professionals in the realm of medicine, health counselors, psychologists and medical sociologists, derives from multiple mechanisms of individual engagement (coping, resilience, social adjustment) between his/her struggle in the context of illness and the achievement of individual wellness. At the social level, religion offers the framework for social control, assures the homogeneity of values and attitudes, and - morally - legitimizes the support of the community in the case of illness of a member. So, in a competitive, materialistic and stressful world, religiosity offers a way to achieve a sense of spirituality at the individual level, while the community obviously empowers the effect of religion by its own principles (human life as a positive value, altruism, mutual help in community through emotional and social support etc.), thus legitimizing them.

Scholars (Oman & Thorensen, 2002) have proposed several perspectives from which religion as a spirituality pathway can influence health: (i) the 'psychobiological' perspective - claims that spirituality in health outcomes is manifested by psycho-neuro-immunological or psycho-neuro-endocrine mechanisms; (ii) the 'psycho-behavioral' route of interpretation - considers that religion as an anchored spirituality may influence health by certain psychological characteristics, stronger motivation on care and social support; (iii) the 'super-empirical' assumption - assumes that religiosity as a dimension of spirituality functions as a high empirical trigger to health, based on established health behaviors and psychological states; (iv) 'any pathway' - a broad view through spirituality / religion combines the four patterns of their psychological and social indicators (psychological states and tested psychological and social influences). We consider that the latter perspective on the relationship between religiosity as a spirituality dimension and psychosocial indicators in terms of demonstrated benefits on health outcomes can offer a better insight on this matter.

The study is structured in two main parts. The first part focuses on the empirical knowledge regarding the relationship between religiosity / spirituality and other elements of social support and illness / health, in order to clarify the meaning and the multiple influences on social and spiritual (religious) aspects of health in general, and cardiovascular health in particular. The second part focuses on the bioethical implications of the relationship between the treatment and care of long term (cardiovascular) patients in the light of religious aspects, pointing out the need for an integrated approach of the significant variables involved in the bio-medical and psycho-ethical domains of medical act, treatment and support. In this respect, the current approach on the medical practice encourages clinicians to involve medical ethics in the “traditional” evidence-based perspective. Therefore,

the resources will be used more reasonably and will meet the expectations of the today patient (Kirkpatrick, Fields, & Ferrari, 2010).

Religiosity and / or social factors? A map of overlapping influences

Religion as an individual experience has five basic components: intellectual, ideological, public and private ritualistic, and religious experience / experimentation. These components can be aggregated by two dimensions: the ideological-experiential (as a source of individual motivation) and the ritual-community (individual engagement in social relations in the community - as an external motivation - and support offers from the religious community). Such mixed categories could be seen as ways of activating personal religious constructs and their intensity describes the likelihood of a central position of the constructivist-religious system in personality (Huber & Huber, 2012). Since Romanians attach great importance to religion as a support in everyday life, as indicated by the national barometers, this analytical route deserves to be investigated more closely by addressing chronic patients, especially patients with cardiovascular disease.

Medical studies (Farcaș, Stoia, Anton et al., 2017) largely demonstrated that the prognosis and evolution of heart failure patients depends on both physical factors (clinical, hemodynamic, biological, etc.) as well as psychosocial factors: anxiety, depression, stress and perception of stress (Farcaş & Năstasă, 2014). The last decades have brought an increasing focus on the impact of psychological and socio-economic factors both in the evolution of patients with heart failure and in the quality of their lives (Uchino, Cacioppo, & Kiecolt-Glaser, 1996). In this light, among the psychological factors, the interference of the religious dimension is important to be considered throughout medical process ((Farcaş & Năstasă, 2011) and ethical management in hospitals (Agheorghiesei & Copoeru, 2013).

A convincing series of data supports the major negative effects of stress and negative emotions (depression, anxiety, anger) on health, healing or life expectancy (Goidescu, Farcaş, Anton et al., 2017; Kubzansky & Thurston, 2007; Russ, Stamatakis, Hamer et al., 2012; Segerstrom & Miller, 2004). At the same time, social support has been shown to protect against illness and increase longevity (Hemingway & Marmot, 1999; Holt-Lunstad & Smith, 2012; Schwarzer & Rieckman, 2001). Religiosity influences the type of support and care that patients receive once they return home, and also affects their commitment to medical treatment. The existence of a religious community will provide a very important social and instrumental support to the patient at home (household

services and care, psychological support, the encouragements to make medical checks regularly etc.).

But systematic studies proving the benefits of religiosity through direct mechanisms of health in its objective parameters are relatively inconclusive and even contradictory. Literature reviews indicate very weak ties in measurable parameters - associations being mainly produced by intrinsic psychological / subjective mechanisms - between religious adhesion and health benefits. Some researches in the area of heart disease and hypertension show no significant statistical associations between health and religion variables as "taken for granted" (Medscape, 2010; Richard & Sloan, 2002). This relationship seems to be mediated by different social factors (often superposed with religiosity), other than religion itself, such as: social and financial status, familial and communitarian context, cultural and psychological background, psychological characteristics of the individual etc. (Uchino, Cacioppo, & Kiecolt-Glaser, 1996).

There seems to be a generally assumed evidence: at the subjective level, the empirical findings show that both patients and caregivers declare various benefits from spirituality and religiousness by the involvement of better coping with illness consequences, lower perceived symptoms, and increased quality of life (Butter & Pargament, 2003; Chang, Noonan, & Tennstedt, 1998, Farcaş & Năstasă, 2011; Pargament, Koenig, & Perez, 2000).

At the objective level, different studies based on epidemiological trends and statistics, morbidity and mortality in different types of societies point to the conclusion that the lack of / decreasing social support increase the levels of disease and mortality. With or without a healthy lifestyle and other protective factors (housing, medical care, poverty / welfare), literature suggests that familial-social isolation has become an indicator of poor prognosis in health outcomes and mortality, both on short and long term (Cockerham, 2007; Wenger, 1984). The role of social network seems to be essential for these results, facilitating the share of care and resources.

Relations between the treatment and care of heart failure patients in the light of religious/spirituality aspects (bioethical implications)

The set of religious beliefs and practices are commonly used by patients to deal with illnesses and other stressful changes in life. Studies have shown that patients with terminal illnesses have mostly unsatisfied spiritual needs, so care for patients with chronic illnesses also requires attention to these needs (Koenig, 1998). Failure to do so can negatively affect health and increase mortality

independently of mental, physical or social health (Ehman, Ott, Short, Ciampa, & Hansen-Flaschen, 1999; Pargament, Koenig, Tarakeshwar & Hahn, 2001).

Patients' religious beliefs / spirituality can affect (even opposed to) decisions about medical treatments, influencing their compliance, especially in serious medical conditions (Balboni, Vanderwerker, Block et al., 2007; McCord, Gilchrist, Grossman et al., 2004). Also, religious beliefs of physicians often influence the medical decisions they make and affect the type of care they provide to patients, including decisions on the use of palliative or analgesic medication (Curlin, Lawrence, Chin & Lantos, 2007), and those decisions are often not discussed with the patient, an issue which raises other deontological problems. In this context, doctors need to be aware of all the factors that influence health and healthcare of their patient, so along with information on smoking, alcohol use, etc., they should ask for information regarding various life beliefs of individuals, and also about their religion. An intimate dialogue between physician and patient is necessary to ensure that the patient recognizes that there are complex compromises to be done (involving the recognition of diagnostic uncertainty, advance care planning and preparation for aggravation and/or death) when faced with medical decisions for both the clinician and the patient.

Bioethics deals with the moral issues raised by medical research and practice; every stage of man's existence has a deep ethical significance. Bioethics has four basic principles:

1) respecting patient autonomy - recognizing an individual's right to self - determination. Under these circumstances, the medical team provides the patient with all the information necessary to make a decision, helping the patient understand and apply this decision, but the team must be sure that the decision was freely taken by the patient and not imposed by another person. At the same time, the team must respect the choice made by the patient, even if it does not agree with it, and can intervene only if there are suspicions about the nature of the available information to the patient, his/her ability to understand and if the decision was forced. Respect for autonomy also requires recognizing the patient as a distinct personality, who has his/her own purposes, beliefs and reasons for making choices and planning the future. Thus, respect for the patient's autonomy goes hand in hand with human dignity.
2) well-being - the physician must act in the best interest of the patient to prevent harm and contribute to the well- being of the patient.

3) non-harm - the first thought of the doctor should be to avoid harming the patient ("do not harm" - *primum non nocere*), then do good;
4) justice - requires medical staff to treat each person equally, regardless of race, sex, marital status, social status, economic status, religious belief of the patient, etc.

Despite these general regulations, it is not easy to make a distinction between an ethical and a legal approach in the field of medical practice. The practitioners should face different constraints due to both legislation and rules of their system (Tay & Tay, 2010) and social-cultural requirements of the individuals (values, beliefs, attitudes, preferences, and goals – in other words, a patient-centered health care – see Lampert, Hayes, Annas, et al., 2010) in the shared / informed decision making process and in the course of the treatment.

The decision making process in the medical act should involve clinicians who fully inform the patient about the risks and benefits of treatments, taking into account patients' goals, values and desires (Lauridsen, 2013). Making joint decisions that require regular discussion between clinician and patient with chronic illness, such as advanced heart failure patients (Tanner, Fromme, & Goodlin, 2011), about patient preferences and promoting high-quality and shared decision-making health care is the best and most appropriate means of implementing patient-centered health care.

REFERENCES

Agheorghiesei (Corodeanu), D.T. & Copoeru, I. (2013). The Management of Ethics – A Prerequisite in Hospitals. Strategies and Ethics Programmes. *Studia UBB Philosophia*, vol. 57, no. 3: 43-53.

Balboni, T.A., Vanderwerker, L.C., Block, S.D. et al. (2007). Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. *Journal of Clinical Oncology*, vol. 25, no. 5: 555-560.

Butter, E. M., & Pargament, K. I. (2003). Development of a model for clinical assessment of religious coping: Initial validation of the Process Evaluation Model. *Mental Health, Religion & Culture, 6*: 175-194.

Chang, B., Noonan, A. E., & Tennstedt, S. L. (1998). The role of religion/spirituality in coping with caregiving for disabled adults. *The Gerontologist, 38*: 463-470.

Cockerham, W.C. (2007). *Social Causes of Health and Disease*. Malden, MA: Polity Press.

Curlin, F.A., Lawrence, R.E., Chin, M.H., & Lantos, J.D. (2007). Religion, conscience, and controversial clinical practices. *New England Journal of Medicine*, vol. 356, no. 6: 593-600.

Ehman, J.W., Ott, B.B., Short, T.H., Ciampa, R.C., & Hansen-Flaschen, J. (1999). Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill? *Archives of Internal Medicine*, vol. 159, no. 15:1803-1806.

Farcaş A.D. & Năstasă L.E. (2011). Coping in patients with heart failure. *Bulletin of the Transilvania University of Brasov*. Series VII: Social Sciences – Law. 4 (53): 65-72.

Farcaş, A.D., Năstasă, L.E. (2014). Factors Influencing the Perception of Stress in Patients with Heart Failure. *Procedia-Social and Behavioral Sciences*, vol. 127: 144-148.

Farcaş A.D. & Năstasă L.E. (2013). Update in the management of patients with heart failure. *Studia UBB Philosophia*, vol. 57, no. 3: 37-42.

Farcaş, A.D., Stoia, M.A, Anton, F.P., Goidescu, C.M., Ianos, R.D., Suşcă-Hodja S, Gavrilă, I.L., Luţac, D., Burian, I.I., & Vida-Simiti, L. (2017). The lymphocyte count and neutrophil/lymphocyte ratio are independent predictors for cardiac events in heart failure only in ischemic heart disease patients. *REV. CHIM (Bucharest),* vol. 67, no. 10: 2091-2094.

Goidescu, C.M., Farcas, A.D., Anton, F.P., & Vida Simiti, L.A. (2017). The Pattern of Ventricular Remodeling Influences the Level of Oxidative Stress in Heart Failure Patients. *REV.CHIM. (Bucharest), v*ol. 68, no. 7: 1506-1511.

Hemingway, H. & Marmot, M. (1999). Psychosocial factors in the aetiology and prognosis of coronary heart disease: Systematic review of prospective cohort studies. *British Medical Journal 318*: 1460-1467.

Holt-Lunstad, J. & Smith, T.B (2012). Social relationships and mortality. *Social and Personality Psychology Compass*, vol. 6, no. 1: 41-53.

Huber, S. & Huber, O.W. (2012). The Centrality of Religiosity Scale (CRS). *Religions*, 3: 710-724.

Kirkpatrick, J.N., Fields, A.V., & Ferrari, V.A. (2010). The Art of Medicine. Medical ethics and the art of cardiovascular medicine. *The Lancet – Perspectives*, vol. 376, Aug. 14 (2010).

Koenig, H.G. (1998). Religious beliefs and practices of hospitalized medically Ill older adults. *International Journal of Geriatric Psychiatry*, vol. 13: 213-224.

Kubzansky, L.D. & Thurston, R.C. (2007). Emotional vitality and incident coronary heart disease: benefits of healthy psychological functioning. *Archives of General Psychiatry*, vol. 64, no. 12: 1393-1401.

Lampert, R., Hayes, D., Annas, G., et al. (2010). HRS Expert Consensus Statement on the Management of Cardiovascular Implantable Electronic Devices (CIEDS) in patients nearing end of life or requesting withdrawal of therapy. *Heart Rhythm 7*: 1008-1026.

Lauridsen, C. (2013). Ethics of Shared Decision-Making for Advanced Heart Failure Patients. *Online Journal of Health Ethics 9*(1):1-12. http://dx.doi.org/10.18785/ojhe.0901.05

McCord, G., Gilchrist, V.J., Grossman, S.D. et al. (2004). Discussing spirituality with patients: a rational and ethical approach. *Annals of Family Medicine*, vol. 2, no. 4: 356-361.

Medscape (2010). *Religion, Spirituality Not Associated with Better Cardiovascular Health*, online Feb 05 2010.

Oman, D. & Thorensen, C.E. (2002). 'Does religion cause health? Differing interpretation and diverse meanings. *Journal of Health Psychology, 7*: 365-380.

Pargament, K.I., Koenig, H.G., & Perez, L. M. (2000). The many methods of religious coping: development and initial validation of the RCOPE. *Journal of Clinical Psychology, 56*: 519-543.

Pargament, K.I., Koenig, H.G, Tarakeshwar, N. & Hahn, J. (2001). Religious struggle as a predictor of mortality among medically ill elderly patients: a 2-Year longitudinal study. *Archives of Internal Medicine*, vol. 161, no. 15:1881-1885.

Richard, P. & Sloan, E.B. (2002). Claims about Religious Involvement and Health Outcomes. *Ann Behav Med, 24*(1): 14-21.

Russ, C., Stamatakis, E., Hamer, M., Starr, J.M., Kivimaki, M. & Batty, G.D. (2012). Association between psychological distress and mortality: individual participant pooled analysis of 10 prospective cohort studies. *British Medical Journal*, vol. 345, Article ID e4933.

Segerstrom, S.C. & Miller, G.E. (2004), Psychological stress and the human immune system: a meta-analytic study of 30 years of inquiry. *Psychological Bulletin*, vol. 130, no. 4: 601-630.

Tanner, C.E., Fromme, E.K., & Goodlin, S.J (2011). Ethics in the Treatment of Advanced Heart Failure: Palliative Care and End-of-Life Issues. *Congestive Heart Failure, 17*: 235-240. Wiley Periodicals, Inc. doi: 10.1111/j.1751-7133.2011.00245.x

Tay, C. & Tay, L. (2010). *Medico-legal and ethical issues in cardiology and general medicine: Case scenarios* (first ed.). Tokyo (Asia): McGraw-Hill Education.

Uchino, B.N., Cacioppo, J.T., & Kiecolt-Glaser, J. (1996). The Relationship Between Social Support and Physiological Processes: A Review with Emphasis on Underlying Mechanisms and Implications for Health. *Psychological Bulletin 3,* Vol. 119: 488-531 (available at: http://psych.utah.edu/people/people/uchino/Publications/1996%20Uchino%20PB.pdf).

Wenger, G.C. (1984). *The Supportive Network. Coping with Old Age*. London: Allen and Unwin.