Religious Diversity and Health Care in Canada
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Introduction

Religious beliefs and practices which are existentially important for human beings, cluster around the interconnected transformations of life; birth, sexuality and death. These transformations are also central to medical/healing practices in virtually all cultures. However, the meaning associated with such life-crisis events is immensely variable and may be associated with conflicts both within, and between religious traditions. Canada, with its population diversity, multi-cultural government policies and legal charter of rights and freedoms, is a nation which confronts many challenges in dealing with the health care of adherents to many distinctive religious traditions.

Birth, for example, immediately opens up questions about abortion, fertility drugs, in-vitro fertilization, artificial insemination, and women’s rights. Sexuality is associated with questions about STD’s, paternity, circumcisions, birth control and infertility. And death reveals most profoundly our many ways of understanding and questioning the meaning of life itself. Not surprisingly death is associated with medical dilemmas where religious opinion is strongly felt, and often deeply divided. Post-mortem examinations, life extension through organ transplantation, euthanasia, palliation and pain are all areas where religious views and practices take precedence in people’s decision making—as patients, family members, religious advisors, care givers and medical professionals.

Suffering is an embodied experience which opens up questions about the meaning of life itself and, perhaps as a consequence, religious beliefs and practices often appear to converge with medical concepts and practices around questions about the body itself. When illness is experienced, the body is altered and it generally doesn’t function properly; it may develop new growths, change color, temperature, stiffen, lose mass, etc. The body is also very much a concern
for religious traditions which emphasize ritual bathing, postures, scarification (including tattooing, circumcision, genital cutting), and the shaving of heads, or alternatively, letting hair grow without cutting. All of these activities, and others, are concerned with “purity” which is construed in opposition to illness, which is often conceptualized as defilement (Douglas, 1973).

An analytical framework which may help us to understand the most basic connections between religion and medicine centres on the anthropology of the body itself (Scheper-Hughes and Lock (1987). Mortality is fundamental to the body. Diseases, which are inscribed upon the physical body by social and environmental forces, call into question the meaning of existence. The transformations of pregnancy, and birth (new bodies) and death (the culmination of bodies) ramify throughout both religious practices and beliefs about medicine. Thus, the body is a kind of contested arena where life processes meet with both religion and medicine (Csordas, 1993). When people of different ethnic traditions, holding dissimilar or even contradictory religious beliefs about the meaning of life come together to make decisions about the care and treatment of those who are suffering, the experience may be fraught with difficulties. The contested body may reflect a collision of cultures rather than a helpful consultation over the course of treatment, especially where life is transformed either through renewal, or death.

Many non-western systems of belief do not emphasize a clear division between the body and the mind and this can have profound consequences for understanding and treating mental illness in cross-cultural contexts. Some systems of religious belief and practice make special use of meditation, chanting, and deprivation (fasting) in order to induce altered states of consciousness as well. This may be understood in many ethnic groups to have beneficial consequences for overall health—of the body as well as the mind. Religious belief and practice can also be brought into question after migration to a new country with different standards of behaviour and cultural norms, so religion is often bound to mental well-being, and to suffering as well.
Migration is a stressful event, and forced migration especially so. Refugee mental health issues are therefore often paramount in dealing with ethnic and religious minorities. Personal histories of suffering and loss characterize many people who are forced to flee their homelands, and this impacts family life, generational interaction, community solidarity (or the lack of it) and affects religious belief—either as a loss of faith, or sometimes its reaffirmation. Religion can be a source of solace and religious personnel can play important roles in treating post-traumatic stress syndrome, for example. However, it can not always be assumed that religious authorities will be trusted or helpful in assisting those in mental distress. One of the most severe set of mental health problems experienced by refugees (and some immigrants) is a history of torture and residence in refugee camps (Allodi and Stiasny, 1990; Beiser et al, 1989)

Changes in mental health status can and do occur even without abnormal stress, and how various ethnic, religious and professional communities respond to this varies greatly. Behaviour which does not make sense is also occasionally ignored as simple cultural difference by professionals and, as well, unfamiliar cultural or religious practices can be mistaken for deviance. In each of the sections of this chapter, the major mental health issues for several ethnic and religious communities are introduced, along with some common misunderstandings and interventions and practices which may help mitigate them. One of the most important issues in mental health for all Canadians, which impacts refugees in particular, are policies which have led to reductions in funding for welfare, hospitals and community agencies which serve inner-city, including large numbers of refugees and recent immigrants (Steele, et al, 2002). By far the most common factors associated with increased rates of depression associated with being a new arrival in Canada are unemployment and discrimination, and its alleviation is also associated with simply finding work (Beiser and Hou, 2001; Beiser et al, 1993; Williams and Berry, 1991).

A primary theme of this chapter concerns the ways in which such problematic and unsatisfying experiences can be alleviated in practice. Another
important theme concerns how the clinical encounter between people of different religious and ethnic backgrounds may come to influence policy making in positive ways. This is in contrast to policy which is “top down”—created without reflection on the ways in which people actually experience and encounter conflict and attempt to resolve it in "real life" clinical contexts. Many examples are used to illustrate both themes, and are drawn both from the literature, and the experiences of the author as a clinically applied medical anthropologist.

The major traditions treated in this book are dealt with under separate sections below in order to highlight areas which appear to be most problematic in the Canadian Health care system. There are, of course, also areas of congruence within and among groups and these will be discussed as well. They are critically important, because such areas of agreement form the basis for cooperation and the development of an inter-cultural religious dialogue on health care ethics in Canada, and around the world.

Chinese: Buddhism, Daoism and Confucianism

The Chinese minority in Canada is the largest of the groups considered here; over one million having arrived in the past 20 years. Most migrants prior to the 1990’s were Cantonese speakers but Mandarin speaking people from Taiwan and Northern China have recently arrived in large numbers. The Chinese population holds diverse health care beliefs depending upon their ethnic, geographic, linguistic, and religious background. There are, however, some strong similarities which grow out of non-institutionalized folk religious beliefs which subsume many of the differences within the Chinese population associated with Buddhism, Daoism and Confucianism (as well as those who have adopted Christianity).

Traditional Chinese medicine (TCM) contrasts radically with Western allopathic biomedicine (WAB) due to its emphasis on maintaining health via the integration of body, spirit and soul within a framework which comprehends
humanity as interdependent with a wider environment (nature). Western traditions explain disease as a physical malfunction of the body and attempt to eradicate it; health in WAB is only a residual category—it is the absence of disease. Attempts to refocus WAB on “wellness” have been made in recent years, but they remain quite marginalized by mainstream western medicine. The general Chinese world view of the cosmos rests on three concepts: a vital force (Ch’i); complimentary opposites (Yin/Yang) and five elements (Wu-hsing) which comprise the universe (including human beings). As Bowman and Hui state, “a person enjoys perfect health when she or he has a strong and unobstructed flow of ch’i, is under the influence of well-balanced yin-yang forces and is in harmony with the 5 elements” (2000:1482). Many Chinese (from both China and elsewhere in SE Asia) have absorbed knowledge of WAB and it plays a major role in their medical decision-making in Canada. However, this knowledge is often subsumed under the Yin/Yang classification itself and both systems of medicine are often utilized sequentially with WAB understood to be Yang (or “hot”) when contrasted with TCM which is relatively Yin (or cool) by comparison (Stephenson, 1995:1636). Both WAB and TCM are understood to have many Yin/Yang distinctions within their specific traditions; but they are also understood to be in a contrasting dialectical relationship themselves. For example, I have found Chinese from Vietnam living in Victoria to alternate between traditional herbs and prescription drugs for treatment of chronic conditions such as diabetes and dermatitis (Stephenson 1995:1637-1638). Chinese who have lived in Canada for multiple generations, however, have often absorbed a great deal of WAB and physicians and nurses from Chinese backgrounds are a common site in Canadian hospitals and clinics. Such individuals may still have some understanding and respect for TCM, but it may not play a major role in their lives. Understanding the degree to which individuals may have adopted Canadian practices and beliefs is especially helpful.

When severe forms of mental illness develop in Chinese families there is a pronounced tendency to keep the individuals at home, and consequently help is
not sought as quickly as in most other Canadian ethnic groups (Lin et al., 1978).
The elderly are most affected by help seeking patterns of behaviour which confines people to care within the family. The elderly in Chinese communities are those most likely to suffer from clinical depression, and loneliness often strongly associated with a lack of meaningful roles within the family in Canada, where they are often dependant upon their adult children (Mackinnon et al., 1996). Attitudes towards mental health in the Canadian Chinese communities partly reflect the relatively low priority given to mental illness in medical school curricula and health service planning in China itself. Personality and behaviour disorders are considered to be social or community matters in China and only persons with psychoses, and very severe neurotic illnesses are hospitalized (Allodi and Dukszta, 1978). Many symptoms associated with depression are somatized by Chinese patients—that is, they are experienced as physical symptoms, especially associated with chest or heart pain. This can be quite problematic and frustrating in diagnosis, where psychological depression is often masked by physical chest pains which can not readily be attributed to coronary disease. Traditional Chinese Medicine practitioners generally view mental illnesses as “emotional diseases” and frame treatment within the parameters of the notion of restoration of “balance”. Understandings of mental illness are therefore grounded in emotional disturbance, rather than simply cognitive dysfunction—illnesses are viewed as problems in how people feel more than simply as difficulties in how people think (Wu, 1984).

The nature of personhood differs significantly in traditional Chinese thinking and social life from that which is the North American norm and this has important ramifications for both birth and death. The concept of personal autonomy is central to western bioethics, jurisprudence, politics and the consumer economy (Stephenson 2001; Fox 1991:206). However, as Bowman and Hui (2000:1481) have recently emphasized, the Chinese highly independent notion of the self is in marked contrast with the interdependent Chinese “relational self” which often overrides self-determination in the interests of family
and community, where moral meaning rests.

Conception as associated with the beginning of a being which is already connected to a wider circle of family, clan, community and the natural world. Indeed, procreation is itself part of a duty to that wider circle; especially to the Confucian patriarchal family. In Buddhism, where killing any living creature is prohibited, abortion is rarely sanctioned. However, Buddhism also teaches compassion and consequently threats to the mother’s life, which would effectively kill both the foetus and the mother, can be cautiously approached.

Death, in the tradition of Confucian thought, is understood in terms of worldly accomplishments. Thus, it is only when one’s moral duties in the cultivation of Jen (positive human attributes such as charity) have been fulfilled that a death may be understood to be “good” (Bowman and Hui, 2000:1483). This in turn means that both patients and their families may strongly resist the suggestion of a withdrawal of treatment where further intervention is thought by physicians to be futile. The children of dying elderly patients who are brain dead or no longer lucid may be very uncomfortable with the termination of “treatment” because to do so would demonstrate a lack of filial devotion and great disrespect for the life of their parent. Even when a person retains the capacity to make autonomous decisions, the family may still make decisions on her or his behalf because their sense of duty takes precedence. This makes the issue of informed consent especially problematic in dealing with many Chinese patients—the patients’ families may be the preferred decision-makers with respect to diagnosis and treatment rather than the patients themselves (Pang Mei-chi, 1999; Feldman et al, 1999). Health care professionals, however, may sometimes feel that the family is acting out of their own sense of guilt and denial, rather than in the best interest of the patient.

In the Daoism death has very conflicting representations. On the one hand it is resisted due to belief in a corporeal survival in a potentially negative afterlife of eternal suffering; thus maintenance of youthful health is idealized. On the other hand, philosophical Daoism teaches acceptance of death as a natural
event. Therefore, discussion of “advance directives” with regard to persons whose religious beliefs derive from Daoism, as well as Buddhism and Confucianism can become highly problematic.

Although consent and autonomy are highly valued in western biomedical ethics, they can become areas of potential conflict with the families of Chinese patients. This can be mediated to certain extent through negotiation which focuses closely on the Chinese emphasis on “beneficence”—in terms of kindness, humane treatment and freedom from pain. For example, Bowman and Hui (2000) provide the example of a still lucid elderly Chinese man whose condition meant that he would no longer be able to live without the support of a ventilator. The man’s son, who had been designated as the key decision-maker, asked the physician not to disclose this critical information to his father because “it would take away his hope, terrify him and, in turn, make him sicker” (Bowman and Hui 2000:1481). The son felt that informing his father would be cruel. After consulting with the family, the father was once again asked if he wished to play a role in decisions about his treatment and he declined. Subsequently, with the family’s agreement, he was kept on the ventilator for several days and then gradually it was withdrawn and replaced with high priority palliative measures to reduce discomfort until his death. It is most important to involve family in decision-making and to focus on areas where agreement can be reached and lead to negotiated treatment goals that all parties can share.

South Asians (Hinduism and Sikhism)

Numbering close to half a million, South Asians from India, who are mostly Hindu or Sikh, form a very large religious and ethnic minority within Canada. There are great differences in religious history and practice which divide Hinduism, an ancient religion extending back nearly 4500 years, from Sikhism which is a relatively recent religion that began about 500 years ago. However,
there are also areas of strong similarity common to both groups; especially notions of rebirth associated with *Karma*. As well, critical decisions are made on the basis of duty and respect rather being grounded in ideas of individual rights associated with contemporary bioethics. The Canadian population includes roughly equal representation of both groups; although Sikhs represent a relatively small regionalized minority within India itself. Sikhs in particular have a long immigration history in Canada which began in the earliest years of the 20’Th century while the majority of Hindus have arrived in the last fifty years. One may find people who are highly westernized, particularly among some families of Sikh origin, as well as those who are relatively unassimilated and do not speak English or French. Depending on level of education, degree of expression or religious conservatism, rural or urban origins and contact with mainstream Canadian society, people may experience varying degrees of potential conflict within the health care system. As well, people of different generations within families may have differing interpretations of what are appropriate medical decisions in existential contexts.

Birth has a very special role to play in cultures where reincarnation is fundamental to religious belief and behavior. In both Hindu and Sikh traditions people are thought to be reborn and the notion of *Karma* plays a central role in the cycle of rebirth. What one does during a lifetime creates a kind of precedent for following lives—strong tendencies to behave in certain ways are thought to persist over many generations and this forms a person’s *Karma*. From this perspective, there is really no permanent death; there is instead an extension of life over many generations. Indeed, conception represents the re-arrival of a complete person whose body has simply yet to develop. Abortion in such a system of beliefs is problematic but refractory: it is essentially the murder of a person but it may also be permitted in some instances inasmuch as the individual spirit will simply be reborn, yet again, in another form.

There is a very strong preference for male children in both religious groups associated with the patriarchal nature of Indian society and religious
obligations at the death of a patriarch which must be performed by the oldest son. However, as Coward and Sidhu (2000) point out with several well-chosen examples, this preference for male children may play out in many different ways when a woman becomes pregnant. In one case a termination ensued after a routine ultrasound because, despite the viability of the foetus, the woman and her husband strongly desired a male child. They refused counseling, and traveled to the United States where they paid for the abortion. In a very different case, a female infant with potentially life limiting problems who was born prematurely received intensive intervention at her parent’s instance, which saved her life—against the recommendations of the neonatology group. In the second instance the parent’s strong religious stance regarding the beginning of life clearly took precedence over any desire they may have had for a male child.

Death, like birth, is also understood as part of an eternal cycle of life where death is a mere interlude. Older individuals are valued members of family and community and consequently the duties of younger people towards them emphasize respect and care. Medical decision-making associated with old age and the onset of incompetence rests with the oldest son and care for seniors is performed by the family, but the burden of care falls on the daughter-in-law who is subordinate both to her husband, and particularly to her mother-in-law. This can create significant tension in families between generations and spouses; it needs to be very carefully addressed in care plans. For a full examination of abortion and euthanasia and its relationship to Karma and notions of purity, see Coward et al (1989).

Sexuality is associated with modesty and seclusion of women; hence the use of same sex health care professionals (including interpreters) is very important once people have passed puberty. This is imperative when dealing with traditional women. As well, during examinations of Sikh men who wear a turban to cover their hair, special attention can be paid in order to avoid confusion or resentment. The turban is not only a key religious symbol itself, and a means to control symbolically uncut hair; it also carries a strong element of
personal privacy and intimacy. Removal of the turban for purposes of surgery, or in medical imaging can easily be accomplished when approached carefully and with courtesy. I am familiar with a case in which accidental trauma to the head required surgery of a Sikh man, who upon regaining consciousness was mortified to find that his turban had been removed, and that a significant portion of his head had been shaved without his prior knowledge or consent.

Traditional *Ayurvedic* medicine is an ancient tradition that has its roots in herbal medicine, and many *Ayurvedic* remedies are associated with the consumption of certain foods which have the capacity to cure if prepared and spiced appropriately (See Kahar, 1982). Although *Ayurvedic* practitioners are found in all major Canadian urban areas, much of this knowledge is also kept by women and practiced as household medicine (Koehn, 1993). Wherever possible, the inclusion of *Ayurvedic* medicines can be considered in treatment of Hindu and Sikh patients. Food preferences and restrictions—especially vegetarianism among Hindu people—can also be accommodated in most hospital diets.

The ideal for mental health among Sikh’s comes from the scriptures, especially the Adi Granth and is called *Sahaja*. Although the concept is religious and mystical it has can be interpreted as an ideal of balance and harmony both within the person, and between the person and wider environments. Mental health problems associated with South Asian populations are very similar to those of the general population. There is some strong evidence, from the UK, that elderly South Asian women immigrants adapt far better to life in extended families than in nuclear families and that problems associated with old age, especially depression, are mitigated by being imbedded in larger social groups. Children, as well, appear to profit from this experience and it helps them in their adaptation to social life in a new place (Sonuga-Barke and Mistry 2000, Guglani et al, 2000). While this has not been researched in Canada, the situation is likely to be very similar.

The emphasis that both religions place on the duties that individuals owe
to others should always be considered when issues requiring consent associated with autonomy arise in treatment, especially in existential contexts. As with other groups where treatment goals and medical decisions are embedded within group processes (particularly those of the family) conflicts can occur with medical caregivers who strongly associate ethical decisions with patients' rights rather than filial duties. Another way to understand this is as conflicting duties—those practitioners and family members feel toward the patient. Reconciling such differences is challenging, and can best occur when all parties reflect on what the patient may require in terms of palliation in order to alleviate suffering. This is far more constructive than struggling over who really represents patient's best interest.

**Islam**

In 1999 there were approximately 550,000 people of the Islamic faith living in Canada, drawn from at least one billion Islamic people world-wide. The Canadian Muslim population is young, predominately urban and growing quickly. While most are of middle-eastern origin, others come from SE Asia and Europe (especially the Balkans); hence, there is significant religious and ethnic diversity within the population. This is expressed in terms of place of origin, level of education, and particular Islamic tradition—*Shariah, Sunni* and *Shia* to which people may belong. In general, Islamic communities that come from the Middle Eastern countries and Pakistan may be somewhat more conservative than those drawn from Eastern Europe and East Africa and this may bear significantly upon health care beliefs, practices and medical decision-making in Canada (Daar and Al Khitamy 2001:61).

One area of potential conflict centres on “ensoulment” of the foetus prior to birth. While most Islamic scholars consider that the foetus becomes a person when it is entered by the soul at about 120 days, others hold that this takes place only 40 days after conception. However, all Islamic religious authorities agree
that abortion should not take place after “ensoulment”. An exception may be made to save the life of the mother. Reasons for abortion prior to “ensoulment” include rape and the physical health of the mother. Serious foetal anomalies are not widely accepted as sufficient reasons for abortion, but are allowed by a minority of liberal Islamic religious authorities (Muslim World League of Jurists, 1990). Therefore discussion of abortion will likely vary significantly depending on the religious tradition of the pregnant woman, her family and her community. The Canadian context of these discussions also means that the potential for generational conflict can be quite pronounced, and stems from different levels of assimilation experienced by parents and children. As well, some Canadian migrants may be quite liberal with respect to their particular tradition, having migrated precisely to escape restrictive religious laws.

Death, like birth, is associated with the soul and its connection to the body. Death is understood to take place when the soul has departed. In the Qur’anic tradition the physical body is resurrected after death and consequently it should not be mutilated or cremated. This makes organ transplantation a difficult subject for many Islamic people (Daar, 1997; Goolam, 2002). Kidney donations from living relatives are, however, now widely practiced. While some Islamic scholars allow organ transplantation from cadavers (the source of all hearts, lungs, eyes and over half of kidneys in Canada) and it is apparently increasing in the Islamic world, most traditions still prohibit this. Routine autopsies are also forbidden under Islamic law in most Muslim countries, although those required in criminal cases are sometimes permitted (Daar et al, 1997; Habgood, et al, 1997; Yaseen, 1995; Al Bar, 1995; Moosa 1999; Shaheen, 1996). In Canada, autopsy is quite a routine hospital procedure and it may be accepted by more assimilated families without much difficulty. However, it is important to inquire before proceeding in order to avoid great anguish where the procedure is not acceptable and essentially unnecessary.

Ideally, burial is required on the same day as death in Islamic traditions. Therefore requests for organ “harvesting” as well as autopsy are fraught with
potential difficulty, and the issue of requests from hospital personnel should be handled with a level of sensitivity beyond that normally extended to the bereaved. Similarly, amputation is problematic for some Muslims. Traumatic injury (from accidents or violence), gangrene associated with advanced diabetes, infection by antibiotic resistant bacteria and bone cancer are all conditions which can lead to conflict or refusal of treatment by some patients. One physician (Donalson, personal communication) has reported several cases where death resulted from a refusal of treatment for conditions that required amputation. This can be very difficult for physicians, whose life’s work is devoted to saving lives, and reducing suffering.

Sexual maturation has occasioned considerable debate in Canada around the issues of “female circumcision” practiced by some North African ethnic groups, most of whom are Muslims. However, it is important to recognize that the practice is not a religious requirement, and also that it is a cultural practice found among other religious groups from the region as well, including Christians, Jews and followers of other indigenous African religions (Morris, 1999). The practice is variously termed FGC (female genital cutting) or more commonly FGM (female genital mutilation) in the medical literature. I will refer to it as FGM, as the practice is without medical value, but creates serious health complications for the women who have experienced it. Recently FGM has also been found to affect the risk profiles of newborns. The practice has been opposed by both the World Health Organization, and the World Medical Association for several decades. While the reasons for opposing FGM are clear, the treatment of women who have experienced it is a different matter and involves both gaining clinical knowledge, and sympathetic (but not condescending) case management techniques (Lalonde, 1995).

Medical categorization of FGM depends on the severity of the custom and is generally categorized as levels 1 (removal of the clitoris); 2 (partial or complete removal of the clitoris and partial or complete removal of the labia minora); 3 (infibulation—usually both of the previous, plus sewing together of most of the
vaginal opening). The practice is over 2,000 years old, affecting over 130 million women worldwide, in more than 30 countries today (Epstein, et al 2001). The vast majority of women from some countries (Somalia, for example) have experienced FGM, and they constitute large numbers of immigrants, especially in Toronto, and Montreal.

There are many serious gynecological and obstetrical complications resulting from FGM which include: infection, chronic infection, problems experienced during urination, incontinence, painful intercourse, and dangerous and difficult childbirths. There is also some recent evidence that the health of babies born to mothers who have been subjected to FGM may be at greater risk. Principally due to longer labor, Hakim (2001) reports that infants may have lower average APGAR scores at birth. Rates of fetal distress can be dangerously high among infants born to women with FGM, and increased potential for pre-labor fetal deaths has also been found (Vangen, et al, 2002). Although there have been some studies which show that support for FGM remains relatively strong in parts of North Africa, after emigration many women appear to change their perceptions about the practices (Johansen, 2002). As well, second generation Canadian immigrant women often do not support the practice, which may place them in conflict with their parents.

Health care and legal policy in Canada prohibits the practice of FGM, but many immigrant women have experienced one or more of the procedures and they require (but do not always receive) sympathetic management when hospitalized, especially during childbirth. For example, Chalmers and Hashi (2000) conducted interviews with over 400 Somali women in Ontario (mostly Toronto) who had previously experienced FGM to discover what their experience during hospitalization was like. The women reported widely unmet needs in were unhappy with the quality of care they received. This kind of experience is relatively common and results from a lack of training, and marginalization of women with FGM by care-givers, especially poorly trained nurses.

Recently arrived immigrants from regions where FGM is practiced may
also wish to send their daughters back to have the procedure, and this can cause a great deal of turmoil in families where daughters do not wish to undergo the procedure, but are subordinated to parental authority. These cases are difficult for both social workers and medical personnel to manage. The rights of children are paramount in these instances and sensitivity in case management notwithstanding, the practice of FGM creates many health problems about which people should (and can) be informed in ways which are informative, but not condescending (Gibeau 1998).

The mental health concerns which are especially relevant for Islamic populations are the very high rates of psychological trauma experienced by children of Palestinian origin. Long term exposure to political violence, refugee camp living, and poverty associated with life in the Gaza strip have led to very high levels of post traumatic stress symptoms. The most severe expression of these problems appears to be in adolescent boys. However girls, particularly young mothers, may also be deeply affected (Thabet and Vostanis, 2001; Thabet et al, 2001; Miller et al 1999; Elbedour et al, 1998; Khamis, 1998). The degree to which the experience of the political violence which has characterized so many young lives may affect communities in Canada has not yet been studied. Certainly the impact must be considerable and studies in other countries (the UK, Australia, France) and the experiences of other refugee groups in Canada suggests that significant long term damage will frame many peoples’ lives in the Islamic communities of Canada. Policy and treatment plans will have to be developed quickly for people from the region when they begin to arrive in significant numbers. Other regions where Islam is the dominant religion have also experienced political violence (Indonesia, Sri Lanka, Algeria, etc.) and people from those regions should be considered at risk for many post traumatic problems. At least one study (Tobin, 2000) has suggested that mental health rehabilitation theory is not suitable for the Arab speaking population of Australia largely due to cultural factors. There is often a fatalistic approach to suffering enunciated as, “it is the will of Allah” which renders the notion of an efficacious
self problematic for therapies which rely of re-building self esteem. This is the case with many fundamentalist religious groups, and is certainly not restricted to Islamic people, or characteristic of all of them. It is, however, a problem likely to be encountered in many clinical encounters.

Other areas of concern in hospitalization and treatment of Islamic people include dietary laws that forbid consuming pork and alcohol (which, however, can be applied topically) and among religious conservatives consuming meat slaughtered in the *halal* tradition is a requirement. Fasting during Ramadhan is not a duty for those who are ill, although patients may request it because it is thought to have therapeutic value. Modesty is extremely important to many people in physical examinations where genitalia and breasts need to be touched or viewed. A strong preference for same sex physicians and nurses is common to many Muslim people, and the presence of a chaperone is often very useful where circumstances prevent a same sex health care worker from performing an examination or procedure. Religious observances in hospital ideally require water for performing ablutions, and a quiet spot where people may pray five times daily for a short period. Body discharges are viewed as ritually unclean, and should be removed quickly (Daar and Khitamy, 2001).

Many authors have concluded that the principal of consent in Islamic religious thought is highly similar to that held in the Christian and Jewish traditions as well. It is also similar to the practices of contemporary bio-medical ethics in Canada. Consequently a strong basis for negotiated agreement exists in areas where conflicts are likely to occur. As long as people are informed of their rights and are approached with respect they need not feel coerced even where expectations and practices differ. Potential conflicts over autopsy, cadaveric organ transplantation, abortion and transplantation can be partially defused by emphasizing patient consent within the context of both religious practice and medical ethics. However, since organs for transplantation are scarce and demand for them is always pressing, a strong sense of conflict may still develop in some hospital settings where undue care is taken and family
members are approached in haste, or without religious sensitivity.

**Judaism**

The Jewish population of Canada was approximately 360,000 in the 1990 Census and of that number almost 40% identified themselves as “orthodox” and another 40% as “conservative”. Only 20% self identified as “reformed” (liberal) in their orientation towards Judaism. There are also many “nonreligious” Jews, whose ethnic backgrounds derive principally from European Judaism but who do not practice the religion in any systematic way. The non-religious group nonetheless often seeks guidance from traditional Jewish teachings when transformations of life and death occur, or where they confront serious ethical dilemmas in decision-making.

For traditional Jewish people medical decisions are just a sub-class of *Halacha* (literally, “the way”), which derives from thousands of years of teaching and guides all the activities of living. The *Halacha* represents a strong duty-based code of behaviour which focus on the performance of good deeds (*Mitzvot*) grounded in the old testament of the bible (especially the five books of Moses which constitute the *Torah*) and the *Talmud* which is a series of commentaries on the bible and other texts written by the most respected Jewish rabbis between the second and fifth centuries. Subsequent codification into a legal code based on the *Torah* took place through the middle ages. One of the most influential of all thinkers involved in this codification was a physician-scholar named Maimonides, who created the codification called the *Mishne Torah*. Much interpretative work continues and is maintained in the *Responsa* literature—more contemporary commentaries responding and meditating on the Bible and *Talmud* as guides for living (see Goldsand et al, 2001).

The emphasis in the Jewish tradition is strongly legal in orientation. It is a code that people in perpetual Diaspora could carry with them and represents a history of adapting to conditions in many different societies over time. It has
been critical to Jewish survival throughout history in lands other than one they could call their own. Although it represents a law-based codex, Jewish thinking is deeply grounded in notions of duty, both to one another and to God (Freedman, 1999). They emphasize that human beings (specifically their bodies) belong to God (not to one’s self) and reflect this in a focus on the preservation of life. Thus, “in general, traditional Judaism prohibits suicide, euthanasia, withholding or withdrawal of treatment, abortion when the mother’s life or health is not at risk and many of the traditional “rights” associated with a strong concept of autonomy” (Goldsand, et al, 2001: 220). However, non-religious (or secular) Jews, and reformed Jews may hold more flexible attitudes towards all of these issues. As with all other religious groups, it is crucially important to understand where individuals and their families situate themselves with the tradition (see, Feldman 1986; Meier 1991).

The focus on end-of-life decision-making in many Jewish families and in Jewish hospitals lies in determining that point where intervention is futile. Death is viewed as normal and inevitable and so artificially prolonging life is contrary to Jewish teaching and so is ending it prematurely. This means that Jewish families often require as much information as possible in their decision-making when a loved one is in the last stages of their life. It also means that their decisions are only reached after serious deliberation and discussion. Where timeliness may be critical in palliative care, conflicts can develop because indecision often flows from a need for more information in quickly changing medical scenarios associated with medical emergencies and the end of life. Goldsand, et al (2001) provide a thought provoking illustration of the difficulty of making a decision where there is a collision of the obligation to support the life of an older patient through insertion of a new gastric feeding tube (to replace a faulty one) and the requirement to not impede a natural death. The care team wished the tube to be replaced, the daughter of the patient was unsure of her obligation and did not wish her mother’s suffering to be prolonged and thought that not replacing the gastrostomy tube might represent a natural death. In the end, the tube was
replaced and a stronger palliative treatment programme was drawn up. The patient died within months of pneumonia.

Birth in the Jewish tradition is supposed to be accompanied by the circumcision of infant boys. This is not a medically necessary procedure, and it is variably performed by Jewish specialists in both secular and Jewish hospitals in Canada, depending on the province and city. There has been significant agitation about this from the anti-circumcision movement which argues that this is not only medically unnecessary, but also represents the physical abuse of infants, often with little or no anesthetic. The practice is very central to Jewish identity, and is unlikely to be abandoned in the near or even intermediate future, although there are now reformed Jewish families who do not circumcise their infant boys. The practice seems destined to become practiced outside of medical contexts. There can be damaging medical consequences (including death) which derive from infant circumcisions, and the long-term consequences of the practice are under-studied.

Dietary laws (eating Kosher foods) are extremely important in Jewish life, and eating pork, seafood, or mixing dairy and meat products are forbidden. Eating meat that is slaughtered according to Jewish law is required. As well, after consuming dairy products traditional Jews are required to refrain from other foods for a period of six hours. Special foods are associated with religious celebrations at Passover and food is an especially important religious requirement in the treatment of the ill. This makes treatment of person suffering or dying of gastrointestinal diseases problematic because feeding may cause additional distress and even traditional foods may cause discomfort and lead to vomiting, cramps, diarrhea, etc.

Modesty in orthodox people is associated with traditional dress, the wearing of wigs (by women) in public and the growth of beards and sideburns in men and boys. Removal for examination or treatment of clothes or hair can usually be done without problem when there is a full explanation of why this may be necessary.
The notion of consent is well developed in Judaism and is explicitly encoded in Jewish legal opinion. Problems generally ensue when people are no longer able to make decisions for themselves, and others who are obligated to act on their behalf may experience internal conflict over what is right. In these situations many people find assistance by consulting Jewish experts in ethics—especially rabbis. Their inclusion in treatment plans is often most helpful in resolving indecision which families may feel.

It is also extremely important to understand that among the oldest Jewish people living in Canada (anyone over 70) there are a disproportionate number of men and women who survived the holocaust death camps and subsequent deportation camps when they were merely children (Cohen et al 2001), or more problematically, adolescents (Sigal and Weinfeld 2001). This group also includes people who never knew their identity (Amir and Lev-Wiesel, 2001; Dasberg et al 2001; Dasberg 2001). Their experiences have made them generally distrustful of institutions like hospitals, with their regimentation, authoritarian hierarchies, uniforms, and other patients who may be emaciated and in pain. As well, those who suffer from various forms of senile dementia—Alzheimer’s disease for example—often live very much in their past. It is, however, a past from which they can rarely escape because they retain only short-term memory functions that trap them in memory events, which repeat themselves over and over again. Acknowledging that their past becomes their present and it may be terrifying beyond the capacity of most caregivers to comprehend is important. Such patients may often horde food, hide, lie about their identity, resist treatment, struggle in showers, become furtive and try to escape (see Trappler et al, 2002; Schmotkin, 2002; Bernick, et al 2001; Sadavoy, 1997). They may have frequent terrible waking nightmares or disrupted patterns of dreamless sleep ( Yaari et al, 1999) and characteristically experience higher pain levels (Yaari et al, 1999) than comparison groups of seniors. Very special care can be taken not to remind such patients of the institutional nature of their surroundings, and if they act strangely it can usually be accepted with an attempt to understand the origin of
the behaviour. Jewish hospitals and homes for the aged are especially important in the lives of such older Jewish people. Many small symbols of care and love may help such people to live without continually re-experiencing terror and assist them to find peace. Euthanasia as a subject is difficult for us all, but for holocaust survivors it has profound implications (Leichtentritt, 1999). The question of withdrawal of treatment from holocaust survivors living in such emotional distress is particularly poignant as well as extremely difficult for all—family, caregivers, the Jewish community and Canadian society as a whole.

Conclusion

What I have called transformative experiences—birth, sex and death—often frame conflicts in the health care system when religious belief and practice come into play and intersect with ethnicity. These are both medical events, and the transformations of life where religions offer explanatory meaning and to which moral principals are attached. In all of the major religious traditions described here, there are varying degrees of what may also be termed “social imbeddedness” of the person in a web of family and ethnicity. Those who are more incorporated into western norms that valorize the individual as paramount in Canada’s “rights based” system of ethics, may not come into great conflict with the health care system. However, they may still come into conflict with elements of their own religious group, or with their own families. Many people from the religious groups examined here comprehend the individual as part of a larger group to which they belong. Thus autonomy or individual rights are often secondary to group requirements; that is, they become subordinated to duties. The debate over prolonging life with heroic measures, or ending it without further intervention is always troubling and can lead to problems in any family or religion. In those religious traditions where consent is associated with family groups rather than individual patients, the need for negotiation becomes critically important. All
parties can benefit by maintaining a focus on the requirements of the patient for a relatively pain free, dignified and respectful transition to death. Emphasizing what the various parties have in common in their ethical and religious traditions, rather than struggling with what divides them can help to achieve the goal of successful treatment. There is a general invocation against causing suffering in all medical traditions, and this may assist in leading to the best possible treatment plans even where opinion is strongly divided among practitioners and families.

Abortion and attendant questions about what kind of death the termination of pregnancy represents is problematic for society as a whole; and the addition of various religious traditions makes the issue even more complex. As well, many religious traditions—including those discussed here—carry with them a strong element of patriarchal power. This means that the rights of women and children are often subordinated to the responsibility that men are taught and expect to assume over them. Infertility and abortion are particularly problematic in a familial arena where men's decisions and women's lives intersect with a health care system that affords women and adolescents more rights than are accorded them within their own religious traditions. This problem is certainly not restricted to the minority religions of Canada discussed here—it is a strong element in the Christian experience as well. There is no clear resolution to this problem other than that which may emerge in Canadian society as a whole, and within particular ethno-religious enclaves in particular instances. These kinds of changes are already underway as women of minority faiths increase their participation in the wider society with the new opportunities that living in Canada often affords them. This means that to be Hindu, Sikh, Muslim, Daoist, Buddhist, or a member of any other religion takes on a particular Canadian sense over time.

There is also a great deal to be learned from the duty-based notion of ethics and health care decision-making. It is not simply a burden or problem to be overcome by the erosion of principal differences over time. Although the
group context of some systems of belief and ethics may seem to overwhelm the rights of individuals, the reverse can also be the case. Obsessive concern over the rights of individuals can easily distract us from the obligations and responsibilities which society as a whole owes to subordinated groups of people, especially those who are poor, isolated and distinctively different in terms of ethnicity, disability, or religious belief (Stephenson, 2001). The straightforward fact that Canada’s health care system represents a form of socialized medicine that is part of our national identity means that access to it differs markedly from that found in the United States, for example. There is also a greater collective interest in the issue of cultural diversity and appropriate care than one finds in some other more homegenous regions that lack significant ethnic and religious diversity, such as Scandinavia. This text is an illustration of the simple fact that diversity need not breed chaos and conflict; and that cultural pluralism can be viewed as a challenge which, if met, constitutes strength rather than a liability for Canadian society.
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