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Religious Practice of the Patients and Families during Illness and Hospitalization in Bhutan

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Abstract

The purpose of the study is to explore the demand and extent of religious rituals performed by patients and families during illness and hospitalization in Bhutan. The study has used a convenience sample with quantitative method. The survey questionnaire was administered to a total of 106 patients and families who were admitted to the hospital at least for three days. Simple frequency count and percentages were used to interpret the findings of the study.

The study reveals significant religious rituals performed during the illness and hospitalizations. 105 (99.1%) of the sample performed religious rituals/prayers when someone in the family is sick. Of 105, 43 (41.3%) performed ritual/prayers to gods, evil spirits, local deities, and simply as ritual. Of 88 respondents, 31 (35.2%) who performed the rituals/prayers before they came to hospital did for the cure or recovery from the disease. The extent of religious practice during illness and hospitalization were assessed. In addition, information about the benefits of religious rituals/prayers and the religious facilities needed in the hospitals were explored. The results of the study suggest that religious care is considered important for Bhutanese people and integration of the religious care in the health care system would enhance the quality of health care services.

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Introduction

When caring for sick and dying, religious practice has a long tradition in the Bhutanese society. When faced with serious illness, individuals often display more outward signs of devotion to their religion than they did in everyday life. People frequently attend to religious concerns within religious communities through the use of traditional religious practices, beliefs, and values that reflect the cumulative traditions of their religious faith. Further, many believe in its capacity to aid in the recovery from disease. A large body of research in the west and Asia has found that most people pray or perform rituals during their illness and hospitalization in order to cope with serious adversity. It has also suggested that the religious practice is associated with a wide range of health related outcomes, including mortality and several dimensions of psychological well-being (Chattopadhyay, 2007).

Background

Religion

Religion is believed to be universal; however it is considered differently by different people (Rao, 2001). The word 'religion' is known to be derived from the Latin word 'religare', which means to bind or tie together. Religion is defined as 'a set of beliefs, practices, language and behaviour based upon belief in a deity or god of a community (Astrow et al, 2001). Religion is considered as faith, beliefs, something to help with the problems of life where in most cases a religion involves gods/ goddesses or spirits (Bassette, 2000). Religion thus focuses on defined structures, rituals and doctrines of a group of people (Chattopadhyay, 2007; Rao, 2001). Religious practice or care therefore refers to the degree of involvement to the beliefs and practices of an organized religion (Muller et al, 2001). Religious practice or care includes listening, rituals,

prayers, exorcisms, and other special rituals commemorating death.

Religious care and its relationship with health care

When facing a crisis and strikes with illnesses, people often turn to their religion for consolation and peace of mind. Many believe in its capacity to help in solving the problem and the recovery of diseases (McNichol, 1996). It is believed that the art of healing is a prerogative of the gods and plays a significant role when a cure is not possible and the person questions the meaning of life. Religious care as a part of health care in general, aims at integrated care that includes the patient's environment and the circumstances of his/her life. Thus, religious care contributes in providing holistic care to the patient.

As caring for the sick and dying, religious care has a big role in the modern health care system. Religious beliefs and practices were known to be associated with a positive outcome in health care. People find their religion helps them maintain health and to cope with illnesses, losses, and life transitions by integrating body, mind and soul (spirit) (Meador, 2004; Kalkhoran & Karimollahi, 2007). Recent evidence indicates that both patients and families consider religious care to be important in end-of-life care, which includes the spectrum from some sense of an emotionally sensitive care of the 'human spirit to a highly ritualized religious care incorporating very specific rites for the dying and a multitude of possibilities in between (Meador, 2004; Lee & Newberg, 2005). Further, religious care is said to enhance pain management, improve surgical outcomes, protect against depression, and reduce risk of substance abuse and suicide (Larson & Larson, 2003).

In the recent survey study by Tzeng & Yin (2006) to learn about the current hospital allocation and management of religious services and facilities in Taiwanese hospitals

revealed that the religious rites and ceremonies are known to provide comfort, meaning, hope and solace to patients and their family. Further, the different studies by Siegel & Schrimshaw (2002) and Feudtner, Haney, & Dimmers, (2003) to find out the specific benefits individuals perceive they receive from the religious belief and practices revealed that the religious practices during illness and death not only provides relaxation, it also helps to reduce or offset the potentially deleterious effects of stress on health and well being of the people. The later study also revealed that most of the participants pray to 'God' for their well-being and strength.

The qualitative study by Krause et al (2002) among the Japanese elderly to see whether the religious practices buffer the effect of death of a significant other or change in self-reported hypertension over time, revealed the protective effect of religion on patients' morbidity, mortality, symptoms of depression, and overall psychological distress in the population. It is also revealed that religious practice is especially useful for helping people to cope with illness and the death of the loved one by eliciting the relaxation response.

Further, a study by Clark et al (2003) to investigate the link between providing religious/spiritual care and patient satisfaction in the USA showed that there was a strong relationship between overall patient satisfaction and the extent to which staff addressed patients' religious needs. The study further suggested that health care services should include the availability of religious resources and hospitals should have a team dedicated to evaluate patients' experience with religious care services to improve the emotional and religious care of patients.

In a study by Narayanasamy et al (2004) to investigate health care providers' perceptions of their role in addressing older people's religious needs in the UK found that the participants identified patients' religious needs in four ways: religious

practices or belief; seeking comfort, reassurance, healing power and connectedness through religion; absolution; and seeking for the meaning and purpose of life. They also identified the strategies to meet their patients' religious needs: by supporting and having respect to patients' religious beliefs and practices including privacy, listening to patients' concerns and providing appropriate reassurance and comfort; helping patients to connect with their religious beliefs by using health professionals' own religious beliefs to assist the patients; and assisting the patients to complete unresolved religious issues.

Religious practice in Bhutan

In Bhutan, the people's way of life is greatly influenced by religion that remains a part of everyday Bhutanese life. Buddhism and Hinduism are the two main religions practiced in Bhutan.

It is evident that prior to the establishment of the modern health care the Bhutanese did consult the doctors where the doctors in this instance were of the shamans, lamas, and other traditional healers who practice wisdom of health called 'Sowa Rigpa' or 'the science of healing' (Ministry of Health, Royal Government of Bhutan, 2008). The 'Sowa Rigpa' incorporates ancient medical practices connected with magic and religion, which is based on Indian and Chinese traditions. Treatment is elaborate with many tantric 'anti ghosts' rituals and religious medicines or herbal treatment. The essence of this great art respects the principles of Buddhism and Hinduism, which encourages understanding the way of the universe, man and sickness. Buddhists and Hindu believes in life after death and they engage in performing many kinds of religious prayers, rites and ceremonies all the time.

Religious rites and prayers are considered as an essential component of patients' and their family members' coping

strategies for dealing with the physical and emotional distress resulting from illness in Bhutanese society. As it is often believed that the illnesses are caused by the demons, evil spirits, black magic, or bad action that upset gods or deity, practices began to take on ritualistic qualities in order to appease a local deity or cast away the demon or black magic. Apart from a good deal of rituals and worship taking place in the home, where people often maintain Buddhist or Hindu altars, divination and monastic ritual services have become significant component of resolving issues of morbidity through traditional practices. With these, many Bhutanese people including government officials (in a personal capacity), visits temples to worship the gods and perform rites and rituals at home. Some pray to the 'god or god of medicine', some appeal to the known deity, ghosts or evil spirit, and others practice ritual ceremonies such as conducting 'shamans' and sacrificial activities for exorcism to please the gods, ghosts, local deity and others. Rituals like taking 'Jabthrue' or 'thruesoe' (bathing with blessed water in order to cure diseases), changing the patient's name and temple ceremonies were performed to diminish the harmful effects of the disease. An interesting fact is that many Bhutanese offer prayers to the god because they believe that praying to god will result in more blessings and help cure the disease.

The present study explored the extent of religious practice carried out during illness and hospitalization in Bhutan. This study provides and discusses some implications for health care reform, research and education.

Method

The study was conducted in the 200 bedded National Referral Hospital, Thimphu, Bhutan in late 2009. A purposively selected convenience sample with quantitative method was used. Patients and family who were admitted to the hospital for at least three days from various wards (JDWNRH) were

used as sample in this study. The patients included covered both physical and mental illness.

Instrument

We collected the research data by a written questionnaire in English designed by the researcher specifically for this study. The questions were closed-ended (dichotomous, multiple-choice, cafeteria, and rating questions). It consists of seventeen questions which make seven variables all together:

Variable 1: Extent of religious practice during illness and to whom they pray for

This variable was indicated to investigate the extent of religious rituals/prayers the people perform when someone is sick and to whom they pray for. Six indicators such as God; ghost or evil spirit; local deity, just as ritual ceremonies; all of the above; and others were identified because of their popularity in Bhutan. However, 'others' in this item is indicated to any other indicators in case if the samples pray for any other unique elements other then above mentioned.

Variable 2: Extent of religious ceremonies carried out before hospitalization and its reasons

This variable was intended to investigate the extent of religious rituals/prayers carried out before they were admitted to hospital and for what reason. Seven indicators such as: for help and wellness; hope; solace/comfort; as a culture, belief and custom; for strength and control; cure and recovery of disease; and all of the above were identified in this item.

Variable 3: Extent of religious ceremonies carried out after hospitalization and its benefits

This variable was indicated to investigate the extent of religious rituals/prayers carried out after they were hospitalized and what benefits they get from religious ceremonies. Seven indicators such as: cope with illness; enhance the sense of hopefulness; decrease painful feelings; enhance physical well-being and decrease stress; help resolving religious conflicts and doubts; all of the above; and others were identified in this item. However, 'others' in this item is indicated to any other indicators in case the samples were experienced through prayers/rituals they performed.

Variable 4: Hospital staffs' support for religious practice and its requirement in health care system

This variable was designed to ascertain whether the hospital staffs are supportive towards the patients' religious ceremonies during their hospitalization, whether the patients want the religious ceremonies to be considered as part of the medical care, and patients want the health care staff to understand and discuss the religious matters during their hospitalization.

Variable 5: Religious facilities required in the hospitals

This variable was designed to explore what kind of religious facilities the patient and family would like to have to help meet their care. There were seven choices: room/space to pray and carry out religious ceremonies; access to 'Lama' for fulfilling patients' religious and spiritual needs; room/space for family to keep sick patients; collaboration with religious agencies/organizations to provide religious and spiritual services; social work office to provide access to religious services; referral system for religious care and services within hospital; and all of the above.

Variable 6: Possible roles and responsibilities of 'lama' in the hospital

This variable was intended to find out what should be the roles and responsibilities of a 'lama' in the hospital and how a 'lama' could help the patient during their hospitalization. There were seven choices: provide religious counselling; read Buddhist scriptures, provide religious support/guidance; facilitate religious rituals and practices; and help patient/family identify the values regarding end-of-life treatment choices; all of the above; and others. Others in this variable mean the roles and responsibilities that the patient/family feel is important to help them during their hospitalization.

Variable 7: Importance of religious care to enhance quality of health care services

This variable was intended to explore whether the patients and family feel that the religious care is required in the health care system and whether it is considered important to promote quality health care. Participants were given five options to choose: extremely important; very important; important; not important; and don't know. This variable was also intended to investigate how the religious care will help improve the quality of health care. For this, dichotomous question were used.

Procedure

Following ethics approval from Research Ethics Board of Health, Ministry of Health, Bhutan, data were collected from patients and relatives, who were admitted in JDWNRH, Thimphu for at least three days during the month of October, 2009. A brief verbal explanation of the study, anonymity and confidentiality of participants with a packet of questionnaire (in English) which contained an informed consent form (both in English and Dzongkha) were provided to the participants during data collection. The researcher personally assisted to

complete the questionnaire for those who were not able to read English. Participation was voluntary and participants were made to sign the consent form which was retained by the researcher. The data was entered and processed using Statistical Package for Social Sciences (SPSS) version 16.0 software. Simple frequency count and percentages were used to interpret the findings of the study.

Results

The total sample consisted of 106 participants who were admitted to the ward for three days prior to data collection. Of 106 participants, 105 (99.1%) admitted that they perform religious rituals/prayers when someone in the family is sick; 88 (83.0 %) of the participants has performed religious rituals before they came to hospital; 69 (65.1%) participants performed the rituals/prayers after coming to hospital. Of 105 who perform religious rituals, 43 (41.3%) performed these rituals for all (god, ghost or evil spirit, local deity, and just as ritual ceremonies). All 88 participants who did perform religious rituals before they came to hospital, performed at least once before they came to hospital. Thirty six (40.9%) performed rituals more than five times. Thirty one (35.2%) performed the rituals for 'cure or recovery of the disease [see table 1].

Among the participants who performed the rituals/prayers after coming to hospital, 64 (92.8%) performed the rituals outside hospital (either at home or religious place). Sixty two (89.9%) of those who performed rituals performed by themselves, four (5.8%) performed with the permission of the 'Nurse on Duty', two (2.9%) with the permission of 'Concerned Doctor', and only one (1.4%) with the permission of the 'Hospital Authority'. Twenty one (29.2%) said that the rituals help them to cope with illness; enhance the sense of hopefulness; decrease the painful feelings; enhance physical well-being and decrease stress; and help resolving religious conflicts and doubts (all of the above) [see table 2]. Seventy

five (75.8%) indicated that the hospital staff are supportive for religious rituals, 93 (88.6%) indicated that the religious matters should be considered as part of their medical care, while 96 (90.2%) wants health care providers to understand and discuss the religious matters during their hospitalization.

Table 1: extent of religious practice during illness and before hospitalization (n=106)

Indicators	Frequency	Percentage
Extent of religious practice during illness and to whom they pray for		
Not answered	02	1.90
God	40	38.5
Ghost or evil spirit	04	3.8
Local deity	15	14.4
Just as ritual ceremonies	01	1.0
All of the above	43	41.6
Others (*as per the lama's advice*)	01	1.0
Extent of religious ceremonies carried out before hospitalisation and its reason		
Not answered	18	17.0
For help and wellness	18	20.5
For hope	02	2.3
For solace/comfort to patient and family	05	5.7
As culture, belief and custom	04	4.5
For strength and control	02	2.3
For cure or recovery of disease	31	35.2
All of the above	26	29.5

Table 2: How do the rituals and prayers help with the illness? (n=106)

Indicators	Frequency	Percentage
Not answered	34	32.1
Cope with illness	03	4.2
Enhance the sense of hopefulness	09	12.5
Decrease the painful feelings	10	13.9
Enhance physical well-being and decrease stress	16	22.2
Help resolving religious conflicts and doubts	12	16.7
All of the above	21	29.2
Others (to tolerate/endure the situation)	01	1.4

Ninety eight (92.5%) participants felt that the hospitals in Bhutan should have religious care facilities. Among them 52 (53.6%) would like to have: space to pray and carry out religious ceremonies; access to a 'Lama' for fulfilling patients' religious and spiritual needs; space for family to keep deceased patients (dead body); collaboration with religious agencies/organizations to provide religious and spiritual services; social work office to provide access to religious services; and referral system for religious care and services within hospital (all of the above) [see table 3]. Of 103, 42 (40.8%) felt that the lama should provide religious counselling; read Buddhist scriptures, provide religious support/guidance; facilitate religious rituals and practices; and help patient/family identify the values regarding end-of-life treatment choices (all of the above) [see table 3].

One hundred and five (99.1%) participants have answered the question '*how important do you think the religious care is to enhance the quality of health care services?.*' 54 (51.4%) felt the religious care was extremely important to enhance the quality of health care services [see table 4]. Further, 91 (86.7%) of 105 participants agrees that religious care would help improve the quality of health care by increasing patient/family satisfaction, four (3.8%) disagree with the statement, while ten (9.5%) said 'I don't know'.

Discussion

This study explored the extent of religious practice of the patient and family during their illness and hospitalization. The study revealed a significant amount of religious practice carried out during the illness and hospitalizations. Rituals/prayers were found to be carried out for gods, ghosts or evil spirits and local deities to appease them, indicating that the people believe in evil spirits causing the illness. This indicates that most of the Bhutanese people resort to help from the religious community before they come to the hospital. This may be due to their strong trust or beliefs in

religion that help them feel secure, complete and fulfilled (Begley, 1994). Perhaps, it could also be argued about the adherence with hospital treatment regimens (Siegel & Schrimshaw, 2002).

Table 3: Religious facilities the participants would like to have in the hospitals and Lama's roles and responsibilities in the hospital (n=106)

Indicators	Frequency	Percentage
Religious facilities the participants would like to have in the hospitals		
Not answered	09	8.5
Room/space to pray and carry out religious ceremonies	18	18.6
Access to 'Lama' for fulfilling patients' religious & spiritual needs	13	13.4
Room/space for family to keep deceased patients (dead body)	03	3.1
Collaboration with religious agencies/organizations to provide religious and spiritual services	05	5.2
Social work office to provide access to religious services	00	0.0
Referral system for religious care and services within hospital	06	6.2
All of the above	52	53.6
Lama's roles and responsibilities in the hospital		
Not answered	03	2.8
Provide religious counselling	18	17.5
Read Buddhist scriptures	09	8.7
Provide religious support/guidance	05	4.9
Facilitate religious rituals and practises	20	19.4
Help patient/family identify the values regarding end-of-life treatment choices	07	6.8
All of the above	42	40.8
Others	02	1.9

Table 4: Importance of religious care in enhancing quality of health care services (n=106)

Indicators	Frequency	Percentage
Not answered	01	1.9
Extremely important	54	51.4
Very important	27	25.7
Important	19	18.1
Not important	03	2.9
I don't know	10	9.5

The main reason to perform the religious rituals or prayers during illness is found to be for the cure or recovery of the illness. This might be because the Buddhist and Hindu tradition recognizes religious care as a key part of healing. Many believe in its capacity to aid in the recovery from illness. (McNichol, 1996). Further, the study indicates that the religious rituals/prayers help the patient and family: to cope with illness; enhance the sense of hopefulness; decrease the painful feelings; enhance physical well-being and decrease stress; and help resolve religious conflicts and doubts. The findings lend yet more support to the theory that religious beliefs and activities often play a central role in individuals' attempts to cope with stressful life events by eliciting the relaxation response (Pargament, 1997; Krause et al 2002; Bearon & Koenig, 1990).

The data obtained from this study shows that the religious ceremonies during hospitalizations has been carried out by the patient and family themselves at home. Only few had carried out with the permission of doctor, hospital authority and nurses on duty. This might be because the religious practice in the hospital is restricted or because of lack of religious facilities in the hospital. Nevertheless, the study revealed that the hospital staffs were generally supportive in religious practices during the hospitalizations. The findings also suggest that the religious issues and matters be considered as part of the medical care and the medical staff to understand and discuss the religious matters during

medical care. This indicates that the health care providers should be competent enough to provide appropriate religious care to the patient. It is noteworthy, that apart from supportive staff in religious care, religious matters or issues were considered important for patient care.

The study suggests that the hospitals in Bhutan should have religious resources such as: room for praying and religious ceremony; access to a 'Lama'; room for deceased; collaboration with religious organizations; social work office; and referral system for religious care within the hospitals in order to fulfil patients' religious and spiritual needs.

According to the study the 'Lama', if available in the hospital, should take the extra responsibilities such as: religious counselling; reading Buddhist texts; providing religious support/guidance; facilitating religious rituals; and helping patient/family identify the values regarding end-of-life treatment choices. The study also revealed that the religious care would help improve the quality of health care by increasing the patient/family satisfaction thus considering the religious care to be extremely important to achieve the quality of health care services in the health care system. Thus, the finding of this study suggests the importance of incorporating religious or spiritual care in the health care system to increase the quality of health care services.

Limitations of the present study

The present study has a number of limitations. First, the sample was not representative of all the Bhutanese population. Moreover the demographic characteristics of the respondents have not been explored. Second, the use of self reported mixed questions (dichotomous, multiple-choice, cafeteria, and rating questions), did not allow for detailed interpretation of the findings. This raises obvious questions regarding self-report bias. Third, only seven variables were used in the present study to assess which may not cover all

religious care measures, as a religious care is a vast concept that contains a large number of domains and a wide range of a specific attitudes and behaviours. Fourth, the construct reliability and content validity of the questionnaire is not assessed in this study.

Implications for health care service reform, research and education

Despite education and access to free health care services in the country, religious practice during illness and hospitalization remains high. The findings of the relatively high incidence of religious practice during illness and hospitalization have major implications for reform in the health care services. Religion is clearly considered important to many patients and families. Further, it demonstrates that people in Bhutanese society are considered not merely physical bodies that require only mechanical care. For health care organizations, it is important to accept this unique characteristic of religious behaviour as respecting the religious needs of patients is the key to delivering high quality and holistic health care. Further, it indicates that promoting quality health care in Bhutan will need to address religious care which respects the patients' values and beliefs in the health care system. Religious care may encourage or forbid certain behaviours that impact health care.

Religious care plays a significant role when cure is not possible and people question the meaning of life (Meador, 2004). It helps patients feel complete, secure and fulfilled (Begley, 1994). Moreover, offering, religious care to patients and families during patients' hospitalization, as non-intrusive health care services, would create more patient satisfaction and better medical outcomes (Johnson, 2005). Therefore, health organizations are obligated to respond to religious needs as patients have the right to such services to safeguard their personal dignity, respect their cultural, psycho-social, and religious values. Taking care of patients' religious

concerns would promote ethical care and encourage a more holistic approach to health care.

However, it is not easy to build a patient-centred health care delivery system that promotes holistic care that covers the whole care continuum and involves family members and the entire health care team. Nevertheless, health organizations should try to provide patient care with collaboration from different indigenous support systems such as religious organizations. Collaboration with these resources could potentially alleviate some of the myths and misconceptions that are attached to the modern medical treatment seeking process. Further, religious care is important in health care organizations when allocation of limited resources leads to moral, ethical and spiritual concerns (Rumbold, 2007). The religious care would also contribute to a healthy organizational culture whereby religious resources would serve as integral members of health care teams as they move across disciplinary boundaries taking care for staff members themselves who experience the stress of patient care.

Implications for future research includes data collection from more representative samples, by means of longitudinal studies incorporating the use of multidimensional measures, in order to facilitate explanation of the relationship between health care and utilization of religious care. It is also suggested to incorporate the demographic characteristics of the participants to investigate if any response differences exist across different groups of the people.

Future research is also needed to address whether the benefits of religious/spiritual coping are associated with greater psychological adjustment overtime. Further, research is needed to see whether the religious practice is really related to the improvement of individual health, for example, to see whether religion affiliation or presence in the health care system really have an effect on individual health. It is also needed to compare the perspectives of health care providers,

patients, families and administrators on religious care for the purpose of developing religious sensitivity of health care providers in health care system.

Finally, in order to incorporate religious care in the health care system one needs to be competent in providing religious care without affecting the modern medical treatments and care. It is also critical for health care providers to learn how to respect patients, and family members' religious needs, such as traditional practices through the life cycle and death. We need to educate both the health and religious people in order to more ably work as a team in the provision of holistic care to patients.

Improving health care providers' knowledge and attitudes about religious care and about making referrals for religious services to religious people would enhance and enable the delivery of quality care to the patient and family. Educating health care providers in certain protocols such as a model of religious/spiritual care would be valuable in guiding health care interventions. Further, the optimally trained and wise 'Lama' who provides religious services would foster a sense of care for one another that acknowledges the interdependency of the provider, the family, and the patient in this work of living and dying.

Conclusion

This study marks the first investigation of the demand and extent of religious practice of the patient and family during their illness and hospitalization in Bhutan. Although, the findings of this study cannot be generalized, it reveals that a significant religious practice is carried out during the illness and hospitalizations for cure or recovery of the illness. It also indicates that the religious rituals/prayers help the patient and family: to cope with illness; enhance the sense of hopefulness; decrease the painful feelings; enhance physical well-being and decrease stress; and help resolve religious

conflicts and doubts. Resources like a room for praying and religious ceremony; access to a 'Lama'; room for deceased; collaboration with religious organizations; social work office; and referral system for religious care within the hospitals in order to fulfil patients' religious and spiritual needs were found to be required in the hospitals.

The study also found that the religious care is considered to be extremely important to achieve the quality of health care services by increasing the patient/family satisfactions, indicating the importance of incorporating the religious or spiritual care. Integrating religious care would potentially alleviate some of the myths and misconceptions that are attached to the modern medical treatment seeking process and facilitate patient-centred holistic care in the health care system. Nevertheless, it is important to investigate whether the religious practice is really related to the improvement of individual health. It is also necessary to compare the perspectives of health care providers, patients, families and administrators on religious care for the purpose of developing the religious sensitivity of health care providers.

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