**Case Study # 2**

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**04/18/2012**

1. **What changes could the nurse make within this health care system to provide spiritually competent care for the client?**

Spirituality and religiosity are often fundamental to the way patients face life-threatening diseases, dying, and death. Spirituality and religiosity are integral to holistic care and are important considerations. Particularly since spirituality may be a dynamic in the patient’s understanding of his disease and way of coping, and religious convictions may also affect healthcare decision making (Puchalski, 2001). According to Matzo and Sherman (2010), although spirituality and religion are often used interchangeably in common conversation, spirituality is a broader concept than religiosity. Spirituality refers to the energy in the deepest core of the individual. It is encompasses a person’s search for meaning, relationships with a higher power, with nature, and with other people. According to Zerwekh (2006), religious systems and needs are not universal and are different for each person. Spiritual needs are essentially the same for everyone. The way individuals meet these needs are different and may change over the course of a person’s life, but the core spiritual needs are universal.

The concepts of spirituality and religion influence the health and lives of the patients and nurses must be knowledgeable about them. According to Zerwekh (2006), nurses often view spirituality and spiritual care in religious terms and as the responsibility of chaplains or other religious leaders. They worry about the ethics of health professionals entering into discussions that may be construed as religious in nature, or the implied risk of imposing their own beliefs on patients. Conflicts may occur when nurses are faced with caring for a patient whose beliefs differ from their own. Many nurses struggle with these issues and this has been identified as one of the reasons they may be hesitant or uncomfortable with spiritual care.

Spiritual care should not be provided by the nurse or any other member of the caregiving team in isolation. It is always enhanced by a strong spiritual counselor or chaplain. Spiritual counselors are essential members of hospice teams are often included in palliative care team. The chaplain is a healthcare professional who has been trained to offer spiritual care to all people of any or no religious tradition and whose primary focus is spiritual needs of patients, families, and staff. Chaplains are alert to the expressed needs of the patient. As counselors, they take time to listen, discern the significance of the words spoken, intuit what is the importance of what is unspoken, and affirm the value of silence (Matzo & Sherman, 2010). An effective spiritual counselor will sit with the dying person to help them discover their own spiritual end-of-life journey (Zerwekh, 2006).

Patients and their families experience spiritual support when interdisciplinary team members actively listen to their anxiety and allow discussion of the question, “Are we doing the right thing here?” Health professionals can also provide support by silent witnessing, as well as serving as a liaison with other health professionals in addressing physical, emotional, and spiritual needs. Humor also has an effect on the spiritual aspect of healing, as many patients and family members find humor “spiritually uplifting”. Spiritual uplifting in the present moment can also occur as a practitioner attempts to create meaning and a source of pleasure in the present moment (Matzo & Sherman, 2010). The assigned nurse should offer Rabbi Silverstein to call synagogue and arrange spiritual counseling for him by another Rabbi from his community.

Cultural and spiritual assessments have to be done for Rabbi Silverstein. It is essential to complete individualized assessment of the cultural influences on the life of Rabbi Silverstein. Cultural assessment will guide individualized care planning. Standardized interventions may not be helpful and could contradict deeply held cultural ideologies. Cultural misunderstanding is a major barrier to providing emotional, spiritual, and physical comfort at the end-of-life. Spiritual beliefs and religious practices are often inseparable from end-of-life cross-cultural practices. A brief spiritual assessment is integral to cultural understanding (Matzo & Sherman, 2010). Obtaining a spiritual history involves simply listening to patients as they express their fears, hopes, and beliefs. A spiritual assessment is intended to bring out information about the core spiritual needs and how the nurse and other members of the health care team can respond to them. To conduct spiritual assessment of Rabbi Silverstein a nurse should use the mnemonic FICA (Mazanec & Tyler, 2003) to remember to ask the following:

* Faith. Ask whether faith plays a significant role in the person’s life. A fundamental question is “What gives your life meaning?”
* Influence. Ask how faith influences the person’s thoughts about experiences with the current illness. “How is your faith influencing the way you are living?”
* Community. Determine whether the person is a member of a faith community and whether the community is supportive
* Address. Inquire whether the person has spiritual concerns that they would like to discuss. To whom would they like to speak?

1. **In general hospital settings, with no religious affiliation, what limitations are presented to the nurse in providing spiritual care for a client of Jewish faith?**

Judaic laws can lead to some misinterpretation by nurses and other health care providers. According to Feldaman (1992), although Orthodox Jewish patients live in modern society their values and actions seem inexplicable and irrational to outsiders. Their way of life is based on the *Talmud,* a collection of laws and commentary on the five books of Moses. After the Talmud was codified a Halacha and Responsa literature – based on individual decisions made by rabbis – was developed; it covers key precepts in every life situation.Many Orthodox Jewish patients find themselves misunderstood and embarrassed by the ignorance of health care professionals.

It can be difficult to follow Judaic laws in the absence of support from the health care system For example, Orthodox Jews celebrate the Sabbath every week of their lives. The Sabbath is celebrated from sunset on Friday to sunset on Saturday evening. The Sabbath is the day of rest, and many activities are forbidden on this day (Matzo & Sherman, 2010). It can be problematic for an Orthodox Jew to follow this ritual in the hospital setting without the religious affiliation.

Therefore, medical procedures should not be scheduled during the Sabbath or religious holidays (unless they are life-saving), nor should hospital discharges be planned during such times without the consent of the patient (Ehman, 2007).

Jewish holidays are usually highly significant for patients, especially Passover in the spring and Rosh Hashanah and Yom Kippur in the fall. These holidays may affect the scheduling of medical procedures and may involve dietary changes (related to a need for special food or to a desire to fast). All Jewish holidays run sundown-to-sundown (Ehman, 2007).

Jewish patients often request a special kosher diet, in accordance with religious laws that govern the methods of preparation of certain foods (for example, beef) and prohibit certain foods (for example, pork or gelatin) and combinations (for example, beef served with dairy products). During the holiday of Passover, an important distinction is made between food that is merely kosher and that which is specifically kosher for Passover. Hand washing before eating may have a religious significance (Ehman, 2007).

Jewish religious laws pose a complex set of restrictions that can affect medical decisions, and patients or family members may request to speak with a rabbi to determine the moral propriety of any particular decision. Exceptions are often made to the normal application of the religious laws when an action is understood in terms of "saving a life," such as with emergency surgery during the Sabbath. The value of "saving a life" is held in extremely high regard in Jewish tradition. Questions about the withholding life-sustaining therapy are deeply debated within Judaism, and some patients or families are strongly opposed to the idea. Family members often wish to consult with a rabbi about the specific circumstances and decisions regarding end-of-life care (Ehman, 2007).

1. **What religious practices would the nurse expect to see in this case?**

As there are commandments that control living for the Jew, there are also commandments that control dying. These commandments are usually followed strictly only by Orthodox Jews, but some of the behaviors that the nurse may see in other Jews are a result of the cultural knowledge that these commandments have created (Giger & Davidhizar, 2008).

According to Jewish law, a person who is very ill and considered to be dying should not be left alone. Therefore, the Jewish tradition imposes the obligation of *biqqur holim –* visiting the sick (Dorff, 2005). One reason for this law is that the spirit is believed to depart from the body at the time of death, and if no one were present, the soul would feel alone and desolate. To satisfy this commandment, family members will often take turns sittingwith critically or terminally ill client. Asking family members to leave may cause family distress (Giger & Davidhizar, 2008). According to Dorff (2005), the visitors should sit on the same plane as the patients, enable the patient to talk about the illness, ensure that a will has been prepared, engage the patient in discussion of usual topics they share (politics, sports, etc.) and pray with and for the patient.

Jewish law also dictates that a client should be informed that death is near. However, because of two controversial passages in Torah, some rabbis believe it is important to inform a dying individual about serious illness but not that death is near. Informing a person about a serious illness allows the individual time to put worldly affairs in order. However, to tell a person that death is imminent removes all hope, and some Jewish people fear that this information may hasten death (Giger & Davidhizar, 2008).

Some Jewish patients may strictly observe a rule not to "work" on the Sabbath (from sundown on Friday until sundown on Saturday) or on religious holidays. If so, this religious injunction against "work" --which includes prohibitions against using certain tools or engaging in tasks such as those that initiate the flow of electricity-- would be problematic to tasks like writing, flipping a light switch, or pushing buttons to call a nurse or to activate a patient-controlled analgesia (PCA) pump. Medical procedures should not be scheduled during the Sabbath or religious holidays (unless they are life-saving), nor should hospital discharges be planned during such times without the consent of the patient (Ehman, 2007).

According to Giger and Davidhizar (2008), Judaism teaches that it is important to lead a good, decent, and helping life on earth. Since good deeds must be done on earth, the law requires a Jew to ask God to forgive those deeds that may have been against God or not in keeping with God’s commandments. To fulfill this commandment, the dying person is encouraged to recite the confessional. If the individual is too sick to say the whole confessional, the individual is encouraged to say the recite the affirmation of faith, the Shma. If the dying person cannot repeat any of the confessional, the law says that it is up to the family and friends who are with the person to recite it. The recitation of the confessional is usually seen only with observant Jews.

Should the client pass away in the hospital there are religious practices that a nurse have to expect to observe. Once death has been established, the eyes and mouth are closed by the son or nearest relative. In some Orthodox Jewish families, it is customary to remove the body from the bed and place it on a straw mat on the floor, with the person’s feet toward the door through which the body will be taken. The dead body is viewed by Orthodox Jews as being contaminated and is placed on the floor because the bed is viewed as being defiled by contract with the dead body; however the ground is not considered defiled by contract. This custom is rarely seen in most hospitals, but the nurse should know the meaning of it should it occur. Also, a candle is placed at the person’s head to symbolize the “light”, or joy and love the departed brought to others while alive. A sheet is placed over the person’s face because it is disrespectful to the dead to permit others to see the ravages of death on the face. Autopsy is not allowed by Orthodox Jews unless it is required by governmental regulations. If an autopsy is performed, all parts that are removed must be buried with the body (Giger & Davidhizar, 2008).

1. **What dietary practice would be expected?**

Although the nutritional content of food is an important consideration when planning a diet, and individual’s food preferences and habits are often a major factor affecting actual food intake. Habits about eating are influenced by ethnicity and culture. According to Berman et al. (2008), Orthodox Jews observe kosher customs, eating certain foods only if they are inspected by a rabbi and prepared according to Jewish law. For example, all blood must be drained from meat when preparing to cook the meal. Kosher meal is usually salted to help drain all the blood. This process presents a problem for a client on a low-salt diet unless the meat is soaked in water to remove as much of the salt as possible. Orthodox Judaism prohibits pork and shellfish. Dietary laws govern killing, preparation, and eating of foods. Meat and milk are not eaten at the same time; dairy substitutes (e.g., margarine) are permitted. Orthodox Jews have to wash hands before eating. The nurse should plan care with consideration of such religious dietary practices.

According to Giger and Davidhizar (2008), it is important for the nurse to consider what can be done for the Jewish client following a kosher diet if the hospital does not have a kosher supplier nearby. In this case it is possible to serve any fish that meets the dietary requirements of having fins and scales. It is also possible to serve dairy products as long as they are not contraindicated on the person’s diet. These meals should be served on paper plates with plastic utensils because meat and milk products or dishes prepared with milk products should not be mixed.

Yom Kippur (the Day of Atonement) and Passover are two holidays that require special consideration. On Yom Kippur, Jewish people are required to fast for 24 hours. If this fast is considered physically or medically dangerous, however, the individual is required by law to put aside the law and eat. Passover required that special foods be served. Passover, which falls in or near the spring of the year, is an eight day holiday. During these eight days, certain foods must be “kosher for Passover”. In addition, there are other foods that are forbidden, including any foods with leaving (bread, cakes made with baking soda or baking powder) or foods made with even a small amount of a grain product of by-product that is not specifically prepared for Passover. This prohibition includes many drugs and medications, such as those containing starch or grain alcohol. These drugs may be refused by the client unless they cannot be replaces and are urgently needed by the client (Giger & Davidhizar, 2008).

1. **What accommodations could immediately be made to make the client feel more comfortable? (15 points) Be specific and thorough in your response.**

Some Jewish patients may have culturally-based concerns about modesty, especially regarding treatment by someone of the opposite sex. However, Jewish tradition holds the expertise of medical practitioners in high regard, and this fact may assuage any concerns about treatment by persons of the opposite sex (Ehman, 2007). Rabbi Silverstein is noticed to prefer the care of the male unlicensed assistive personnel over the female nurse. Therefore, if possible male nurse should be reassigned to this client, or the female nurse should work in collaboration with male unlicensed assistive personnel. Patient education can be conducted by male physician.

According to Giger and Davidhizar (2008), the use of touch varies among Jewish people. The use or nonuse of touch can be a critical issue with Orthodox Jew and must be carefully considered by the nurse. Overexposure of or touching the parts of the body associated with sexual activities can cause a great deal of distress. When caring for strict Orthodox Jewish clients of the opposite sex, the nurse should use touch only for hands-on care. To touch the client at any other time could be offensive because of the sexual connotations attached to the casual touch.

According to Ehman (2007), it is common for Jewish patients to wear *yarmulkes* (skull caps), especially for prayer, but some people may wish to keep them on at all times. Patients or family members may also wear prayer shawls and use *phylacteries* (two small boxes containing scriptural verses and having leather straps, worn on the forehead and forearm during prayer). There may be a request that at least ten people (a *minyan*) be allowed in the patient’s room for prayer. Therefore, if possible, the patient should be transferred into the private room to avoid the disturbance of the other patients in the room.

According to Giger and Davidhizar (2008), elderly Jewish clients in non-Jewish hospitals or nursing homes may adjust better with other Jews around them. Therefore, it is advantageous to have Jewish clients room together or at least in proximity. This closeness will allow for increased comfort and offer the Jewish client the chance to interact with someone who understands him better.

Medical procedures should not be scheduled during the Sabbath or religious holidays (unless they are life-saving), nor should hospital discharges be planned during such times without the consent of the patient (Ehman, 2007). Kosher food should be made available for Jewish clients.

1. **How should the nurse approach teaching the client about his condition?**

Nursing interventions for Rabbi Silverstein should be based on Erikson’s Epigenetic Theory of Personality. Also, it is essential to complete individualized assessment of the cultural influences on the life of Rabbi Silverstein. Cultural assessment will guide individualized care planning and effective teaching of the client. Standardized interventions may not be helpful and could contradict deeply held cultural ideologies. Cultural misunderstanding is a major barrier to providing emotional, spiritual, and physical comfort at the end-of-life (Matzo & Sherman, 2010). Patient and family education will include information on disease process, medications, palliative care, and spiritual care considering the culture and religion of the client.

Death confronts dying people with issues related to hope, meaning, reconciliation, and transcendence. Nursing goals at the end-of-life should foster hopefulness, meaningfulness, reconciliation and transcendence. Nurses should take this task in collaborations with the entire healthcare team, particularly the spiritual counselor or chaplain if accepted by the patient. There are four central spiritual domains at the end-of-life: hope, meaning, reconciliation, and transcendence.

Palliative interventions should be offered in the context of hope rather than as a response to a hopeless situation. Caring relationships characterized by unconditional positive regard, encouragement, and competence help patients feel loved and cared about, thus inspiring hope. Nurses may need to help the family focus on goal directed interventions that emphasize what the patient still wants to accomplish. Nursing interventions that foster hope (Ersek, 2001) are as follows

* Control symptoms
* Encourage patient and family to become involved in positive experiences that transcend their current situation
* Foster spiritual processes and finding meaning
* Promote connection and reconciliation
* Help in the development of realistic goals
* Focus attention on the short-term future

Spiritual meaning is central to the dying person and should receive greater emphasis by health professionals. The Stephenson study (2003) suggests nurses ask questions that encourage life review. The following are examples

* + - Tell me more about your life.
    - What has been most meaningful in your life?
    - How have you found strength throughout your life?

The sense of connectedness through relationship is a spiritual need that contrasts with the sense that many people have of being alone and isolated from others and from God (Zerwekh, 2006). Terminal illness brings that loneliness and need for connectedness into sharp focus. Related to the need for connectedness, there is an opportunity for reconciliation at the end-of-life. Reconciliation involves healing past estrangements from other people and from God (Zerwekh, 2006). Rabbi Silverstein should be offered religious counsel and ritual that brings him opportunity for reunion with the transcendent.

Transcendence is defined by philosophers and theologians as going beyond the limits of lived human experience. It involves detachment and separation from life as it has been lived to experience a reality beyond oneself and beyond what can be seen and felt (Zerwekh, 2006). Nurses should have open minds and listen carefully when they hear stories of transcendence or witness the unexplainable.

Spiritual distress at the end-of-life is an impaired ability to experience meaning, hope, connectedness, and transcendence. Spiritual distress at the end-of-life commonly involves an intensification of alienation and disconnection, while dying forces a progressive series of separations and detachment from life itself (Zerwekh, 2006). Nurses should look for manifestations of spiritual distress and address them.

Rabbi Silverstein’s treatment and nursing care will depend on age, life expectancy, overall health status, prostate-specific antigen level, Gleason score, and tumor size and spread. High-grade prostate cancer, particularly the percentage presence of Gleason grades 4 and 5, is associated with adverse pathologic findings and disease progression. Conversely, low-grade prostate tumors can also be biologically aggressive. In many men with early and localized tumors treatments increase curative rates, while treatments for more advanced disease are more beneficial to shrink tumors larger in size, palliative symptoms, and possibly increase survival time (Darmber & Aus, 2008). The least complex interventions at the end-of –life care affordable and manageable should be chosen. The main goal of palliative care in Rabbi Silverstein’s case is to decrease his level of discomfort trying different approaches.

Although prostate cancer has a high cure rate if detected and treated early, prognosis for the late stages is very unfavorable. Hospice care is often appropriate and beneficial to the patient and family. Common problems experienced by the patient with advanced prostate cancer include fatigue, bladder outlet obstruction and ureteral obstruction (caused by compression of the urethra and/or ureters from tumor mass or lymph node metastasis), spinal cord compression (from spinal metastasis), severe bone pain and fractures (caused by bone metastasis), and leg edema (caused by lymphedema, deep vein thrombosis, and other medical conditions). The assigned nurse should explain the patient the disease process and possible signs and symptoms of it. Nursing interventions must focus on all of these problems. However, management of pain is one of the most important aspects of nursing care for these patients. Pain control is managed through ongoing pain assessment, administration of prescribed medications (both opioid and non-opioid agent), and the use of non-pharmacological methods of pain relief (Lewis, Heitkemper, Dirksen, O’Brien, & Bucher, 2007). The assigned nurse should explain the indication of every given medication and what are the possible side effects of it.

An additional consideration is the psychological response of the patient to a diagnosis of cancer. The nurse should provide sensitive, caring support for the patient and his family to help them cope with the diagnosis of cancer. Prostate support groups are available for men and their families to encourage them to be active, informed participants in their own care. Family counseling for a terminally ill patient with an anticipated poor outcome is crucial to avoid any unreasonable expectations from arising. In addition, any experimental treatment modalities must be clearly outlined, with risks and potential benefits (Lewis, Heitkemper, Dirksen, O’Brien, & Bucher, 2007).

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