

*Crit Care Nurs Q*  
Vol. 31, No. 2, pp. 119-126  
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# Gap Analysis of Cultural and Religious Needs of Hospitalized Patients

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**Purpose:** Identify patient and family needs specifically related to an in-hospital birth or death. This study aimed to perform a gap analysis between identified needs and current hospital practice, services, and resources. **Methods:** With the institutional review board approval, and purposive sampling using the demographics of a community hospital plus subgroups from problematic cases. Twenty-two semistructured interviews were audiotaped, and 6 lectures and 2 panel discussions were videotaped. Transcriptions were distributed to the research team and manually coded for gaps between current practices versus stated needs. Group process was used to form consensus regarding findings. **Participants:** The following subgroups were targeted: Muslim, Baha'i, Catholic, Protestant, Jewish, Buddhist, Mormon, Jehovah's Witness, Latino, Filipino, Chinese, African American. **Results:** Gaps in available resources, such as prayer books, rugs, and compasses, were identified. Knowledge gaps included many issues such as the Muslim preference for decreasing sedatives at end of life to be able to recite the sacred prayer while dying. Practice issues such as respecting plain-clothed clergy, the impact of "rule-orientation" on family needs, and the universal need to call clergy early were identified. **Key words:** *birth, culture, death, family needs, ICU, nursing, patient satisfaction, religion*

[AQ1]

## PROBLEM

This study was derived inductively from clinical practice. The index case involved a Jewish woman admitted to the maternal child health department to have a baby. It was day 2 of hospital admission and the woman was preparing for discharge. She became frantic when she realized her son had not been circumcised. The staff had difficulty locating a

physician to perform the circumcision in a [AQ2] timely manner. The social worker was called to intervene. He was Christian, himself, but knew that something was not right with the request. He called a local rabbi, who confirmed that Jewish boys should not be circumcised until the 8th day following birth. As described later in the interview with an orthodox rabbi, "The surgical procedure is not the circumcision, but it is done as a ceremony performed by a mohel . . . the child must be in perfect health and is gauged by the bilirubin count, so it is not to be elevated . . . what they do in the hospital does not fulfill the religious requirements." If the woman had succeeded in having her son circumcised in the hospital, the boy would have had to have a "pin-prick" and religious ceremony at home on the 8th day, which would have caused unnecessary discomfort for the child. The social worker at the time of this case thought to himself, "If we do not know this about something so

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*This study was funded in part by a grant from the Aetna Foundation. The study was performed with participants from the referral area of Pomerado Hospital, Poway, California.*

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[GQ1]

common as a Jewish circumcision, what else do we not know?" He assembled a team to talk about religious and cultural needs in the hospital. The team then decided to conduct this research project across both ends of the life cycle—birth and death.

[AQ3]

### PICO QUESTION

A PICO question is a form of research question, which includes the population of interest, the intervention, comparison group, and outcome.<sup>1</sup> In this case, the PICO question is—What is the gap between current services and staff knowledge versus perceived cultural and religious needs in hospitalized patients during birth and death among subgroups commonly admitted to this community hospital?

### EVIDENCE

National guidelines,<sup>2-4</sup> regulatory agencies such as the Joint Commission,<sup>5</sup> and nursing practice standards<sup>6</sup> all recommend that nurses provide holistic care inclusive of an assessment which drives care to meet the cultural and religious needs of the patient and their family. A misunderstanding of cultural differences may induce barriers to optimal care.<sup>7,8</sup> A person's experience, as seen through a lense shaped by culture and religion, affects how sense is made of health and illness, and responses to health concerns.<sup>9</sup> To identify cultural and religious needs, it is necessary to have a working knowledge of common issues.<sup>2,9-11</sup>

This project was structured to glean evidence regarding cultural and religious needs directly from the consumer. No attempt was made to compare and contrast findings with the literature. Instead, the findings from interviews were compared with one hospital's current services and general knowledge of the staff using a gap analysis.

### METHODS

[AQ4]

This study was performed with investigational review board approval using gen-

eral qualitative methods combined with the performance improvement strategy of gap analysis. The researchers received interview method training by the principal investigator. The research team developed an interview tool. Because the hospital system was planning on building a new facility, questions regarding cultural and religious structural issues were also addressed. The questions focused on rituals and customs at birth and death; however, the interviewees collectively steered discussions in a manner that yielded information regarding needs for all hospitalized patients.

### Sampling

Purposive sampling was performed by selectively choosing subgroups of interest. At first the demographic composite of hospital admissions was queried. The hospital collected data on subgroups only by census bureau subclassifications for ethnic breakdown and religion from an incomplete forced choice list on the admission screen. However, many of the questions that the team had were of groups within the "other" category. Therefore, the sampling method was changed to identify subgroups through review of problematic cases and an introspective review of new subgroups seen in the demographic area. Muslim, Baha'i, Catholic, Protestant, Jewish, Buddhist, Mormon, Jehovah's Witness, Latino, Filipino, Chinese, African American participants were solicited. A blend of religious leaders and community members were interviewed. Interviews were conducted at a location preferred by the participant, which included their homes, places of worship, and hospital conference rooms.

### Trustworthiness

The principal investigator attended at least 1 interview with each researcher. Audiotapes were reviewed for quality and feedback was provided. Integrity of data collection was maintained using 2 researchers for each interview. One researcher coordinated the interview, while the other maintained a log of

field notes. In addition to the interviews, the research team conducted an 8-hour conference. Religious leaders and community members were invited to speak. There were 6 lectures and 2 panel discussions. Each of the speakers was consented and given the same 19-point interview questions in advance. They were asked to consider the questions when formulating their presentations, but welcome to speak on anything that they felt would be important for the audience to hear. The conference was videotaped. A single investigator transcribed tapes verbatim.

The research team members were then each given a copy of the transcripts and reviewed them before a team meeting. To perform the gap analysis, the transcripts were first coded for *needs not known to be met by the hospital*. Next they were coded for *new knowledge*. Then the transcripts were reviewed to identify any themes that were unexpected given the structured nature of the interviews (findings not asked in the questions). All findings were derived using consensus.

#### **Limitations or obstacles**

Limitations to the methodology included the fact that not all findings were brought back to the participants for validation. Generalizability of findings is limited because 2 interviews per subgroup does not saturate the data. Also, efforts were not made to interview at similar points of acculturation within cultural groups. Generalizability cannot be assumed outside of this geographic area (southwestern suburban area of the United States).

One major obstacle was in finding participants for each subgroup inclusive of both genders. One set of interviews had to be deleted from the project because of poor audibility on the tapes (Buddhist). There was also a learning curve to using the tape recorder and downloading the audio to the computer. Because the grant was relatively small, the team decided to conduct interviews instead of hiring a focus group company, manually code the transcripts instead of purchasing a program, and transcribe the tapes manually instead of hiring a transcriptionist. These cost savings

measures were employed so that the money from the grant could be used for supplies after the gap analysis was performed. The decision to transcribe the tapes personally ended up to the benefit of the analysis, by allowing the principal investigator to become intimately familiar with each of the interviews.

## **RESULTS**

### **Religious items**

Despite the preliminary nature of this study, it became apparent that the consumers recommended many items the hospital did not have available. Although the purpose of the study was to disclose needs at birth and death, results that were relevant to meeting the needs of any hospitalized patient were also found and are reported here. Specific items not currently found in the hospital and advised by the participants included bibles or prayer books for more than just the Christian religion, bookcases for the chapel, inspirational texts, texts on grief and coping, and Spanish language bibles. It was requested that the hospital gift shop carry more prayer-related items included inspirational texts, cards, and prayer cards. Participants of the Catholic faith requested availability of rosaries, crucifixes, and holy water. Muslim participants requested prayer rugs and prayer compasses. The prayer rugs did not need to be a special prayer rug, but a clean rug that was not stepped on with shoes. They advised that Muslims might even use a clean bath blanket to kneel on to pray. The prayer compass could be something available through the chaplain's office, or, when building a new building, a tile marker could be inserted into each room to signify the direction in which to pray. Reformed Jewish participants stated that a Sabbath kit would be helpful with possibly a video of a Sabbath prayer service, kippot, and electric candles.

### **Dietary needs**

Muslim and Jewish participants brought up availability of Kosher and Halaal food. Muslims

stated that they often confuse the hospital staff by ordering Kosher food, which they do because people know what Kosher is. Kosher food meets all of the requirements for Halaal (but not the other way around). The real dilemma stated is when patients are on a clear liquid diet. Gelatin, if not specified Kosher, is made of protein from pig hooves. Participants stated that the menus should be marked to declare that the gelatin is Kosher to address this issue. They also noted that there was no true hospital Kosher kitchen in this region and that if a hospital built one it could affect the decision to choose a health-care provider.

### Modesty

Latino, Muslim, and Orthodox Jewish participants raised issues concerning modesty. A Mexican female stated, "Latino males will not like a male doctor taking care of women, prefers a woman to see the woman's private parts . . . he will get really upset . . . important that the wife not be touched and exposed—this really bothers them . . . it is very important that a female nurse to be present." She cautioned that modesty is more than being shy. It is a matter of great cultural importance. Both Muslim and Latino participants informed the team that they might request female only. They understood that females were not always available, but preferred female staff for female patients. The opposite (male staff for male patients) was not an issue. A reformed Jewish rabbi offered when asked about special roles of a man versus a woman during death, that gender touching is an issue even after death (done at the mortuary), "It is not the family who washes the body . . . that is only done by members of the same sex, washing and dressing the body . . . women touch women and men touch men."

Muslims further advised that Muslim men need their knees covered to pray and that traditional hospital gowns are too short. The hospital where this study was conducted did not routinely stock pajama pants on the floor, and as a result of the modesty and prayer con-

cerns, it was requested that the hospital routinely stock pants on all floors. They also explained that Muslims will not be interrupted in prayer for any reason. Prayer is considered a "conversation with God." If a nurse tries to interrupt a Muslim person praying, the nurse will not be acknowledged. This is not meant to be impolite and is instead a religious obligation.

### Blood

One of the most emotional laden interviews was when the Jehovah's Witnesses gave testimony to their experiences with healthcare workers. They relayed how they felt badgered and accosted because of the issue of blood transfusion. "There have been times in the past when we haven't had full cooperation as far as the blood situation is concerned. More of the doctors are coming to understand blood alternatives. Some even get nasty about it, 'well do you want to die?' (the doctor asks). Some will find out you are a Jehovah's Witness and if you refuse the blood transfusion, they refuse to treat you. Put you in a corner and let you hemorrhage to death. We ask that you understand that it is a religious matter." During the interview, it was stated that every hospital (in the country) is assigned a hospital liaison, who comes to visit hospitalized members of the faith with the purpose of running interference if the patients' wishes are not being honored. They explained that in Acts 15 of the scriptures the rule about blood transfusion exists. They brought forward the issue that Jewish people translate this message from God in Leviticus to mean that they should cook meat instead of taking it raw (bloody). A Jehovah's Witness further explained, "it is not the blood itself, there *are* blood transmitted diseases, it is that God prohibits the use of blood . . . it is a violation of God's law . . . we would rather give our life now than break God's law. We don't want to die . . . we would rather face death than transgress the law of God." They further explained that in this same section of the Bible, it is said to "abstain from things offered to idols, blood,

things strangled, and from sexual immorality. So you see we think about blood the same way as sexual immorality." At the moment of hearing this, it became suddenly clear why the Jehovah's Witnesses were so vehemently against transfusion. Turn around the sentence and think, "If a doctor came up to me and told me that I would surely live if I would only sex with that dog," would you do it? Most would say no.

### **Birth and death**

When asked what traditions people in their faith have specific to the birth of a child, two examples came forward that were previously unknown to the staff. There is a Muslim birth custom of having an adult male be the first person to speak to a child. This male, who becomes a special person in the baby's life thereafter, whispers a sacred blessing, "I bear witness that there is no God but Allah," in the ear of the child before anything else is said.

From the African American Baptists interviews this quote was given by an elderly woman of the faith, "One that sticks in my mind, and I'll play old school, is that when a child is born, you hold that child up as if it is given to God when it comes to the world, that way the baby is accepted by God. Hold the baby up to the sky."

Muslim participants also disclosed a death ritual that explains why some Muslims prefer to decrease sedation at the time of death. If the patient is heavily sedated, he cannot fulfill this religious obligation. It is the Muslim custom to say at the time of death the same blessing stated at birth. The blessing is supposed to be the first thing one hears at birth and the last thing one says at death.

The participants were asked 2 related questions about birth and death, which yielded surprising answers, unified across religions and cultures. In the first question it was asked whether they would appreciate having a lullaby played at the birth of a child, possibly the Brahms' lullaby. The lullaby would signify that a child had been born and allow the hospital staff a moment of reflection or joy in the mo-

ment. Most were not familiar with the Brahms' lullaby, but all stated that if the lullaby were of their own culture or faith that they would appreciate it. They often went on to hum or sing a lullaby. The African American women started singing in unison, "He's got the whole world in His hands." As a result, a CD of culturally diverse lullabies was created for use.

To the contrary, the participants were asked, "What would you think of us ringing a soft bell at the time of a death to let staff know that death has occurred. This way they could act more appropriately, and stop jokes or laughter in the area." No group accepted this idea. Most even cringed visibly at the thought.

Borrowing from the experience in newborn areas where stillbirth kits are common, the participants were asked whether they felt that a similar kit should be available for adults. The kit could include a handprint, lock of hair, and sympathy card to be offered to the family at the time of death. Jewish and Muslim participants said that it could be offered but not done until requested, and that most likely they would not want the handprint or lock of hair. Others stated that the same items found in a stillbirth kit would be appropriate in adult deaths.

On the topic of child deaths, the interviews with Catholic participants, as well as comments from the participants at the conference who work in labor and delivery departments, yielded an important unmet need. Nurses stated that the most difficult child deaths were of Latino Catholic women who did not know that Catholicism had reversed its stance on the issue of limbo. They described the women as inconsolable and that they did not have the knowledge or skill to deal with the situation. This was verified through interviews, and it was confirmed that many rural Mexican women did not know about the change that had occurred many years ago. The priests who were interviewed stated that the hospital should immediately inform the mother that her child would indeed go to heaven to be with Jesus. As a result of this finding, it was recommended that a brochure for these

mothers be developed, signed by a priest, and include a blessing with a picture of Jesus with a baby lamb and/or the Virgin Guadalupe. Images of Jesus with a baby lamb were found to be soothing for child deaths in all Christian religions. A picture of the Virgin Guadalupe was disclosed to be especially appropriate to comfort Mexican women who experience a crisis.

[AQ5]

In addition to these child death issues, new knowledge was gained regarding emergency baptism of a dying Catholic child. In contrast to Sacraments of the Sick, which can be delivered only by a priest, baptism can be performed by any person, regardless of religion. Delivery nurses in this hospital have the words preprinted to say and ready to use when needed. However, to register the infant as a Catholic in the church, the parents need to be given the day, time, and place of the baptism, as well as the name of the person who performed the baptism. As a result of this finding, preprinted cards were developed and put with a baptism kit.

A prayer group of African American Baptist women was interviewed. They warned the researchers that people of their faith often approach death quite differently than one might expect. "I'm answering based on my family. Join hands and pray. We would pray loud and hope our prayer was being heard. Our loved one has gone home with the Lord. Everyone agree? ['Yes, Yes' they all respond]. We do that in the dying process, we'll be there until the end unless the hospital kicks us out." When discussing the death of a child, there was disagreement among them:

1st woman: A child you need to rejoice. I need to live long enough to feel it that way, when they leave this world to live with God, that you need to rejoice.

2nd woman: Are you asking would I be able to rejoice?

3rd woman: You are answering from a biblical sense.

2nd woman: You are in a birth ward and the woman has just lost her child!

1st woman: It is a mournful state, but we are all striving to get to the place where we could

[rejoice], but we are not there yet. We ask for God for strength. We could say it is biblical, but there are many things that God asks us to do, but that's my answer [inferring that it is biblical to rejoice, but we may not be able].

2nd woman: If the child dies at birth he has no sin. That should be praised with a blessing.

Researcher: How can a nurse be sensitive to the African American mom who has lost her child?

All: Pray. Pray.

1st woman: The child is with the Lord, so there is a joy that is combined with the loss.

Their discussion back and forth reveals a biblical instruction to welcome death at the Lord's calling, and that joy and laughter might signify the most religious of those among them.

This issue of accepting death was also found in the Mormon interview, "There is a life after this one . . . we return to our savior Jesus Christ and we enter a realm where family members that have preceded us in death and others are awaiting our arrival. We view death in many aspects candidly like we do birth. It doesn't change the loss we feel . . . but we view that he has a joyous reunion after this life . . . we do not see death as the termination of life, it is moving from one sphere to another. Even though it is sad, it is an opportunity to move to paradise and join our savior and others."

The Filipino participants, however, explained that

The Filipino want to be at the bedside, with the dying person, the whole family. Everybody comes in to convey sympathy . . . want to die with a natural death, quiet in the room. We are aggressive with prolonging life . . . They want to be at the bedside 24 hours and want to do shifting . . . When someone dies you will see lots of shouting, and Filipino show their emotion and some of them will pass out because of the intensity of how close they were to the person, shows emotion and how close they were to the family member. The wife would be more demonstrative than a second cousin.

Both Jewish and Muslim religions have specific rules about how the body is to be treated

after death and how the funeral will occur. For this reason, only selected mortuaries can service them according to their traditions. Muslim participants requested that the phone number for the Islamic Center be added onto the mortuary list. They revealed that The Center serves all Muslim people to help coordinate the preparation of the body and the burial. Jewish religious leaders advised that there was only one mortuary in this region that performs a true Jewish funeral and preparations of the body. They requested that this one vendor be flagged for Jewish patients. They stated that even though they understand that the hospital cannot recommend one place versus another, if there is only one that truly meets the needs of the Jewish community, it would save people a lot of time if it were highlighted. Jewish religious leaders also taught us that Jewish people also have a ritual of deathbed confession that is done by a Rabbi, and that the Rabbi should be called before the patient is unconscious in critical illness.

### **Visiting**

In every interview, each culture and religion stated that visiting the sick is an important part of their role and core values. Clergy, family, and community members all have a duty to visit the sick, and in some cases a duty to participate in care. Limiting visitation prevents people from fulfilling their obligation.

### **Feedback: New buildings**

Feedback for building new hospitals included building larger family areas, separate conference rooms, a separate place for families visiting with children. Chapels should be large, light, airy, with windows or nature scenes, prayer materials, water or a fountain, and room for prostration. For Muslim participants, built-in compass points would be helpful. African American women offered that if pictures of people are in the lobby that it would make them feel better if the pictures included people of color.

One pastor brought up an interesting concept because he was familiar with the current building, where the hearses pull up to the back door of the hospital, also used as a public entrance. "Is there a place to pull up the hearse directly to the morgue that is out of the site of the average person on the street, so that there is a sense of privacy."

### **Unexpected themes**

Three unexpected themes were found in the data. The first was to respect plain-clothed clergy. The priest said it best when he stated, "You don't think I walk around the church wearing this thing [pointing to his collar]. I put it on so that I can get into the ICU. I am respected more when I wear it." Another stated, "If I don't wear the collar will they trust who I am, and welcome me in?" Other religions, such as the Baha'i and Mormon, do not have paid clergy. When someone calls on the phone to visit from the church, they look like any other visitor, but they are really there to perform just as an important function as the priest.

The second unexpected theme was in rule orientation. Latino participants told us that when they do not follow our rules it is not because they did not understand. The rules just do not meet their needs. They described that bringing children to the hospital to visit had nothing to do with daycare. The family is supposed to be together during these times. It is part of the cultural obligation to come together in big groups, inclusive of children. Filipino participants contrasted with the Latinos. They explained that the Philippines is a country that had been taken over by 3 different groups over time: the Chinese, the Spaniards, and the Westerners. Given this recurring oppression from external groups, they had become as a people used to be subservient. They explained that when they do not object to doing what you ask, it does not mean that they are happy with the rules or satisfied. It is their cultural norm to refrain from making trouble by complaining.

The third theme was to activate external support early. One pastor explained it as

follows: "We may not be the right person, but we perform a ministry of connection to patch parishioners up with each other. So if someone's son died in a care accident and I knew another family who had gone through the same thing, I could put them together." All religious leaders stated that they felt that nurses waited too long to ask the patient or family if their place of worship can be contacted. The clergy described that the places of worship all have support structures in place that can help the family going through crises. They felt that their help would decrease the burden on hospital staff if engaged earlier.

At the death of a Catholic adult, the two priests interviewed disclosed the same warning. Nurses call the priest too late. They explained that the Sacraments of the Sick (once called "Last Rites") is actually a healing prayer if given early enough in the illness. Also, if the nurse waits to call for Sacraments until the patient is unconscious, the patient receives only one of the three components of the ritual, which includes anointing with oil, confession, and communion. As one priest stated, "Sacraments is more than just greasing up the

forehead to help you slide through the pearly gates of heaven."

## SUMMARY

Qualitative research is hypothesis generating and performed when the current level of evidence for the body of literature is low. Performance improvement is done in answer to a known problem. Given the limitations described earlier, the results of this performance improvement gap analysis using qualitative methods cannot be generalized to the general population. However, several findings warranted immediate purchases and changes in practice. The findings provide fuel for further investigation. In the future, each subgroup could be studied across generations to explore the relationship between assimilation and needs. Interviewing greater numbers from each group would further validate findings. Additional religious and cultural groups could be studied. The process of interviewing consumers about their cultural and religious needs was fruitful and yielded many items, services, and considerations previously not addressed by this community hospital.

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#### **Author Queries**

AQ1: IRB is changed to institutional review board. OK?

AQ2: Would it be better to change the word "physician" to "surgeon"?

AQ3: What does PICO stand for?

AQ4: Would it be better to change the word "investigational" to "institutional"?

AQ5: Would it be better to change the word 'religion' to 'sects'?

GQ1: Check whether affiliations are OK as typeset.