Common bond
On the limitations of a shared faith

BY BESMA JABER

There is a special feeling I get when I walk into a room and encounter a Muslim patient. I see warmth and immediate trust in their eyes. No matter what language you speak or what country you call home, sharing something as personal as religion creates an instant bond.

As an Arab-American Muslim woman, I am acutely aware of the fact that I am in a unique position to build rapport with Muslim patients, to engender trust and understanding. I’ve felt this on every one of my rotations, but I became especially aware of it in obstetrics and gynecology, where the sensitivity of the subject matter makes it difficult to truly put patients at ease. Even so, having such a connection doesn’t ensure a patient will follow your advice.

The 30-year-old Somali woman, G2P1 at 39 weeks with a history of severe preeclampsia in her last pregnancy, came into triage one Friday afternoon. She was sent down to the hospital’s labor and delivery department from clinic for a preeclampsia work-up. It was immediately obvious that she and her husband were excited to see me walk into the exam room. The hijab on my head is an unmistakable clue that I am Muslim. They asked me all kinds of questions about my ethnic background and about how many years it would be until I was officially a doctor. I scooped up their toddler, who had sidled over to me and held out her arms, and proceeded to conduct my standard patient interview and exam. I explained why we were concerned, that we would be running some important tests, and that a resident and I would be back to see them shortly.

The labs indicated the patient was preeclamptic, and the indications for induction were clear. But the woman and her husband wanted to wait and go into spontaneous labor. I listened as the chief resident talked to them about why that decision would be against medical advice. I quietly stood next to the woman and nodded my head in agreement as the resident described seizures and fetal demise and all sorts of complications that would terrify me if I were the patient. I also listened as the woman and her husband explained that this pregnancy was different. The woman, who had been highly symptomatic the last time, said she felt fine this time.

I listened as the woman and her husband demonstrated clear understanding of the risks of going home. I watched them as they smiled at the resident and profusely expressed their appreciation for the concern and care we were offering. I nodded while the...
husband said they would not hesitate to return if any new symptoms arose, and I listened as he explained that they wanted to err on the side of caution, but did not want to be induced. I did not agree with their decision, but I accepted it.

As the resident gathered the paperwork, I stood at the patient’s bedside and held her hand. I told her I was worried about her and the baby. She said, “I know, but the baby is OK now, right?” and I said, “Yes, right now, the baby is OK.”

I encouraged her not to miss her clinic appointment the following Monday. Then I watched them leave with mixed feelings. I worried about what might become of them and the baby, and I wondered what else I could have done to convince them to stay. Ultimately, I felt frustrated. In spite of my best efforts to communicate the gravity of the situation, they made the decision to leave.

This was not the first time I disagreed with a patient’s decision and it will certainly not be the last. But this encounter will stay with me because it is an example of a concept I struggle with when caring for some of my Muslim patients who have cultural backgrounds different than mine. In some cultures, it is believed that no intervention will prevent what has been destined for you by God. Although this concept is present in Islam, most of the Muslim world also believes that God wants us to do everything in our power to achieve our desired outcomes and that only after exhausting all options should we leave the rest to God. I try to convey to my patients that allowing for medical intervention does not mean they are interfering with God’s plan. It can be hard to explain this to some, but I feel obligated to try.

I feel I have a solid grasp on Islamic teachings and can put things in a context my patients can understand. Yet I know a five-minute conversation with me is not going to override generations of cultural influence. Ultimately, I cannot tell people what to believe. I would find it unacceptable if someone did that to me. I will have a powerful role to play as a physician, and I am already proud of the times I have been able to convince my Muslim patients to get Pap smears, pelvic exams and routine vaccinations by making it “OK” for them. But with every patient interaction, I realize again and again that I have a lot to learn about knowing when to step back and accept an individual’s wishes without letting my emotional investment consume me. It is a work in progress, but I am able to take something away from every patient interaction I have, and I hope my patients are able to do the same.

About a week after I saw the woman and her husband, they returned to the hospital, the woman in spontaneous labor, sweaty and exhausted, with her seemingly ever-upbeat husband at her side. They warmly welcomed me into the room, and the woman clasped my hands and told me she was happy to see me again. No happier than I was to see them moving toward the healthy, natural birth they so desired. In all honesty, relief is more apt to describe my emotion at that time. If only every patient outcome could be this joyful.

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