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**MEDICAL, SOCIAL AND CHRISTIAN ASPECTS IN PATIENTS
WITH MAJOR LOWER LIMB AMPUTATIONS**

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Abstract: Lower limb major amputations are both life-saving procedures and life-changing events. Individual responses to limb loss are varied and complex, some individuals experience functional, psychological and social dysfunction, many others adjust and function well. Some patients refuse amputation for religious and/or cultural reasons. One of the greatest difficulties for a person undergoing amputation surgery is overcoming the psychological stigma that society associates with the loss of a limb. Persons who have undergone amputations are often viewed as incomplete individuals. The medical and physical consequences of amputation serve as the centerpiece in acute care and are commonly at the forefront of prosthetic rehabilitation. Prosthetic prescription aims to compensate for functional and/or cosmetic losses where possible. The aims of rehabilitation following amputation are to restore acceptable levels of functioning that allow individuals to achieve their goals, to facilitate personal health, and to improve participation in society and quality of life either with or without prosthesis. Our article aims at underscoring some medical, social and religious (Christian) aspects that can contribute to the wellbeing of patients who suffer a life changing event such as lower limb amputation.

Key Words: major lower limb amputations, medical, social and religious (Christian) aspects, body, illness, coping, well-being, self-image

Introduction

The major lower limb amputations represent invalidating procedures for patients which will change definitively their lives. We are speaking about the calf and thigh amputations, which in our surgical service are made for critical lower limb ischemia and diabetes. In the United States, 30,000 - 40,000 amputations are performed annually. There were an estimated 1.6 million individuals living with the loss of a limb in 2005.¹ The aim of amputation is to save the patient's life and to reduce debility. Part of a limb may be amputated because of trauma, infection (gangrene), burns, frostbite or disease of blood vessels. Removal of a limb may also be required to prevent the growth of bone cancer. However, amputations are not without problems such as thromboembolism from the surgery and prolonged immobilization, flexion contractures, neuroma, causalgia and phantom limb pain. Individual responses to limb loss are varied and complex, and are influenced by a range of personal, clinical, social, physical and environmental factors.

Religious habits help patients to deal with the stress caused by amputation, providing some acceptance of the act of surgery. The suffering of an amputation marks a crisis in a patient's life, a dramatic change in his/her life and "religion does not stand idly by (...) it provides guidance about where to go and how to get there."² Understanding spirituality's effects on patients' abilities to cope with amputation is an important component in rehabilitation of patients with limb amputations.

The World Health Organization's primary domains of QoL (quality of life) include (1) physical, (2) psychological, (3) level of independence, (4) social relationships, (5) environment, and (6) spirituality/religion/personal beliefs. Treating the mind, body, and spirit in patients with major lower limb amputation is important to the physical and psychological adjustment to illness and injury. With greater emphasis on evidence based practice in a cost-conscious health care system, health care workers, providers, and leaders of health care must be able to rationalize their actions with evidence generated by scientific research. Spiritual well-being in patients plays a significant role in coping with illness and demonstrates moderate to strong correlations with physical, emotional, and functional well-being.³

Medical aspects in patients with major lower limb amputations

The multiple pathways that may lead to limb amputation include disease (e.g. diabetes, peripheral vascular disease and malignant tumors), traumatic injury (e.g. motor vehicle and industrial accidents) and congenital causes.

The main problem for those patients is to accept the surgical intervention and to sign the informed consent for the amputation. The surgeon establishes the diagnosis and proposes the surgical intervention, as the last option in the treatment of the critical lower limb ischemia. It's not an easy decision and they are consulting the family.

On hearing of the word “*amputation*”, patients would go through stages of denial, anger, negotiation and depression before acceptance, a situation akin to what is applicable to patients who find out for the first time that they have cancer or are HIV positive. In many instances it is this delay in the decision making process that worsens the outcome. Doctors therefore must give prompt and adequate counseling to the patients before they take the final decision⁴. However in life-threatening situations particularly where patients present very late to hospital, urgent decisions should be agreed upon by patients and relatives to save their life. It is still better to be alive even without a limb.⁵

Usually the patients are suffering from pain for a few weeks and if initially they refuse to accept the amputation, finally they are begging the surgeon to perform that, because of the higher pain, fatigue, insomnia, social degradation and starvation. In this desperate situation they accept the amputation only to get away from that gnawing pain.

Once the consent has been signed and the patient was evaluated, the surgical intervention is done. Although a diseased limb can be removed quite readily, resolving the problem of the extremity, the care does not end there. The surgery must be performed well, to ensure that the patient is able to wear prosthesis comfortably. After that, the patient remains hospitalized for another 7-10 days and then is discharged home.

The concept of phantom limb pain (PLP) as being the pain perceived by the region of the body no longer present was first described by Ambrose Pare, a sixteenth century French military surgeon. Stump pain is described as the pain in the residual portion of the amputated limb whereas phantom sensations are the non-painful sensations experienced in the body part that no longer exists. Superadded phantom sensations are touch and pressure-like sensations felt on the phantom limb from objects such as clothing.

The medical and physical consequences of amputation serve as the centerpiece in acute care and are commonly at the forefront of prosthetic rehabilitation. Prosthetic prescription aims to compensate for functional and/or cosmetic losses where possible.

The initial prosthesis is applied only 3 months after the amputation. So this period is critical to our patients because they are compelled to live in difficult conditions, which they did not encounter before. They must rest in bed or in a wheelchair for a period of time, and often they depend on somebody's help.

Following the removal of a diseased limb and the application of an appropriate prosthesis, the patient can resume being an active member of society and maintaining an independent lifestyle. The patient must learn to walk with prosthesis, apply and remove the prosthesis, care for the prosthesis, monitor the skin and the presence of any pressure points, ambulate on difficult terrain, and use the commode at night. Because of the complexity of these issues, the treatment team should include the surgeon, the primary care physician, a physical therapist, a prosthetist, and a social worker.⁶

Social aspects in patients with lower limb amputations

Given the fact that “major depression and anxiety is a common psychological reaction in amputees”⁷ and that that has a major impact on the overall result of the rehabilitation program, it is important to investigate the manner in which the spiritual dimension affects the patients’ life after amputation. Depression and participation in daily living are two of the important modifiable factors that influence the quality of life after lower limb amputation. Thus, it is important to acknowledge the importance of addressing individuals’ emotional status to regain or maintain QoL.⁸

While depression and anxiety are common after lower limb amputation but resolve during patient rehabilitation, the incidence then rises again after discharge.⁹ Among the factors which can diminish depressive symptoms we can mention the proper management of pain and medical comorbidity and education about depressive symptoms.¹⁰ Furthermore, given the impact of the intervention on the patient’s life and “the high number of physical, mental and social problems in trauma patients, identifying and strengthening support sources can be effective in their adaptation with the disease and improvement of the quality of their life.”¹¹ Thus, the adaptation to disability is contingent not only to impairment, but also to the psychological and psychosocial factors.

The social impact of amputation can be substantial. Following amputation, the patient experiences long-term conditions such as fatigue, changes in recreational activities, economic burdens, medical costs and reactions of friends and family, in addition to a wide range of emotional reactions which can lead to non-adaptive reactions if they don’t receive enough support from the family and society.

One of the factors affecting the adaptation with the lower-limb amputation is social support. Khademi showed that people with high social support had lower levels of depression and anxiety.¹² According to the study conducted by Engstrom, family support can have a positive impact on adaptation with the amputation.¹³ Ziad’s study showed that

unmarried (single) patients and patients who had no social support have high levels of anxiety and depression.¹⁴

Various studies showed that symptoms of depression in people suffered from amputation increase with increased social isolation and decreased social support. Social support also had a direct impact on general adaptation with amputation among adolescents and young people. In a qualitative study, participants stated that one of the effective factors on the promotion of successful rehabilitation is family support.¹⁵ Many quantitative studies point out that more social isolation and less social support are associated with reduced quality of life and increased depressive symptoms. The general mechanism in the literature discussing social support (that increases mental health) is built around two theoretical axes: the buffer effect model, and the direct effect model. The buffer effect model claims that social support acts through the relationship between stressful life events and psychological distress; the direct effect model claims that the psychological health works with the stress-free process.¹⁶

Recovery and rehabilitation encompasses reintegration in the family, community, and for some, in the work place, and may require negotiation of evolving roles, relationships and identities. Major lower limb amputation which significantly compromises mobility may necessitate significant adaptations to the patient's home or transition into residential care.

Changes and restrictions in participation are commonly reported after limb amputation and may be related to personal (e.g. functional abilities, balance confidence, social discomfort, public self-consciousness, emotional impact of amputation, changes in goals and priorities) and/or external constraints (e.g. lack of accessibility, climate, transportation issues).

One of the greatest difficulties for a person undergoing amputation surgery is overcoming the psychological stigma that society associates with the loss of a limb. Persons who have undergone amputations are often viewed as incomplete individuals. Therefore, the decision to amputate and the subsequent management of such patients pose problems to the surgeon and socio-economic stress to the patient and the family.

Limb loss can be a psychologically stressful experience, rates of depressive disorders among persons with limb loss range from 21-35% compared to estimates of 10-15% in the general population.¹⁷

An amputation induces several limitations in performing professional, leisure and social activities. It disturbs the integrity of the human body and lowers the quality of life (QoL) due to reduced mobility, pain and physical integrity. Patients are affected psychologically and socially. Psychological issues range from depression, anxiety to suicide in severe cases.

The loss of a body part also affects the perception of someone's own body and its appearance.

Body image is a person's individual perception of his/her own body and is a multidimensional dynamic process being affected by internal factors such as age, sex, physical condition as well as external factors including social or environmental factors. Body image disturbance is the result of social values emphasizing vitality and physical appearance and fitness. Therefore amputation may be seen as a sign of failure. Amputees have to adapt physically, socially, and psychologically to alterations in structure, function, and body image. As time passes, the individual discovers how well he or she can cope with the newly found limitations and restrictions.¹⁸

The importance of the support provided by family and friends in the post-amputation recovery process has been emphasized by both rehabilitation specialists and patients alike. Social support is likely to help people adapt to limb loss in a number of different ways. Firstly, people with good social resources are likely to benefit from the assistance offered by these relationships in attempting to renegotiate their physical and social environments following amputation.

After amputation, patients face a number of challenges both within themselves and in the environment. Additionally, patients have problems with returning to work after lower limb amputation.

As regards returning to work, it was noted that higher amputation levels decrease re-employment rate. Amputation of a limb has an extensive effect on people's lives, with people losing many physical functions and abilities that were once taken for granted. Post-amputation jobs were generally more complex with a requirement for a higher level of general educational development and were physically less demanding. These factors indicate that re-integration may be more difficult.¹⁹

Religious aspects on limb amputations

In this context, the rehabilitation of patients with limb amputation implies, beside the minimization of handicap and the establishment of autonomy, the well-being of the patient living in the condition of disability. Spiritual beliefs help patients to establish a meaning for their debility²⁰. "Spiritual well-being in patients plays a significant role in coping with illness and demonstrates moderate to strong correlations with physical, emotional and functional well-being"²¹ Relevant to the inquiry into the importance of spiritual well-being in coping with disability in limb amputation is the distinction between existential well-being, built around the meaning of life, and religious spirituality, based on a meaningful relation with God. Existential spirituality "may be attained from a variety of states, of which it is more closely related to individual

religiosity” and is “a significant predictor of satisfaction with life, general health and social integration among amputees.”²²

The *religion-health connection* describes a complex relationship between religion and mental and physical health, underlying the protective role religion may play in health, in preventing health problems, in the recovery process and the relationships between religious factors and the central constructs of the life stress paradigm²³. Spiritual well-being in patients plays a significant role in coping and may affect outcomes of patients with limb loss.

Human reasoning seems to be adapted to apparently divergent lines such as science, philosophy, and religion. Rarely scientific speculations are made about religion and science; however, philosophical approaches to religion are frequently sought. All three have a common objective, which is the search for truth; however, religion does not try to express truth in the form of concepts but rather in a form of representation and feeling of faith.²⁴

Kenneth Pargament has been one of the most active proponents of religion as a strategy to confront diseases and stress factors, suggesting that difficult situations are an opportunity for spiritual growth. Moreover, he notes a fundamental similarity between religion and coping in times of stress, religion and coping being, in fact, a process, a search for significance.²⁵ For this reason, “religious beliefs and behaviors can be profoundly comforting and stress buffering”, and also, positive effects of religion and spirituality are easier to identify especially with more religious communities.²⁶

During 5 years (2010-2014) we conducted a prospective study on 49 patients aged between 36 and 87 years, with major lower limb amputations performed in the Second General Surgery Department, at the Emergency Clinical Cluj County Hospital, by a single surgeon. 49% patients were from rural area. There were 89.8% thigh amputations and 10.2% calf amputations. 22.5% patients were amputated bilaterally at thigh level. Only 28.6% of patients wear the prosthesis and have a medium/higher level of activity. During that time 22.5% of patients died by several comorbidities (cerebrovascular accident, myocardial infarction, etc.). 80% of our patients said that religion helped in their recovery after lower limb major amputation. The specific purpose of this study was to describe the role of spirituality in a sample of individuals with lower limb amputation and to determine whether spirituality is related to QoL in this population.²⁷

Some patients refused amputation for religious and or cultural reasons. Statements such as “*I would rather die than lose my limb*” and “*that is not my portion*” are commonly heard in our hospital. This is because amputation carries a stigma. It serves as a mode and mark of punishment for certain offenders in some parts of the world, and in some religions. It is

also believed to recur during incarnation. Most of these beliefs are based on ignorance and superstition.

There is a category of patients which do not accept amputation for different reasons. One of them, especially from the rural medium, explained the choice in connection to community and said *"What will other people say about me when I come to church Sunday morning?"* There was also a recent case in 2014 in the USA where a 43 years old patient, Orthodox Jew, was pursuing a lawsuit against a suburban Chicago hospital and a rabbi working there because his leg had been cremated after amputation below the knee, contrary to the mandate of his religion. The patient said that he wanted his leg preserved so it could eventually be buried with his body.²⁸

A Christian perspective on limb amputations

The Christian religious perspective on amputation of lower limbs should have its basis on the understanding of church as the mysterious body of Christ (according to I Co. 12, 12-27) and on the way God relates to a member through which the offense comes (according to Mt. 5, 29-30; 18, 8-9). The necessity of outlining such a Christian perspective results from the very fact that "the medical act no longer concerns only the patient and the doctor. The scientist, law maker, economist, manager, politician, *chaplain*, meet to various extents, particularly in the United States, by the patient's bed, where the latter's relatives are also often to be found."²⁹ Thus, when one talks about an illness and its treatment, amputation included, regardless of the choice that a Christian patient makes, it is obvious that it "cannot be but contingent, generated by a certain historical, social and cultural context or it is merely random."³⁰

If the choice an ill person has to make being faced with the prospect of having lower limbs amputated is not a random one but depends on a lot of factors, among which the religious one, it is obvious that the church has the mission to create the frameworks of a spirituality within which the person in question might refine and redefine itself.

Spirituality placed within the plan of horizontality and immanence will never be able to be satisfactory for a person having undergone an amputation, which is why it must be "a spirituality which successfully passes the test of the secular understanding of health and well-being. When life, sexuality, reproduction, agony, death and spirituality are articulated only in immanent terms, the role, place and meaning of medicine are fundamentally distorted."³¹ Such spirituality will obstinately repeat that this life is a mere preamble of the future one, that any perspective from this world pales before the eternal perspective, that the full meaning of human life is to be paradoxically achieved only after a man has passed away, that exactly as the provision for the flesh is primary in relationship with its members, the provision for the eternal life in God's kingdom must

also be primary in relationship with the ephemeral life from the kingdom of this world. Such spirituality channels a Christian's focus not so much towards body health, which is not neglected and is regarded as a means towards something superior, as it is channeled towards the spiritual health³². Thus, "postponing death, avoiding suffering and correcting invalidities must not become self-consuming projects" and "medicine and illness healing, ameliorating invalidities and postponing death must be placed within the seeking of the Kingdom of Heaven."³³

A biblical reading of illness

In what follows, we are going to make a pure descriptive perspective on how the New Testament envisions illness. However, we must bear in mind that here we have a literally reading without employing any axiological point. Inasmuch as illness seems to be related to sin, we must stress that we adopt the position by which illness can be viewed as a sort of spiritual pedagogy. But the fact that illness is related to sin, as we are going to show below, does not imply, in our reading, a cause/effect relationship, nor direct consequences of sins in our suffering (it may be that of illness or sorrow) but more of an ethical aim, i.e., in our reading, sin functions as a teleological trigger of ethics.

The fact that amputation comes as a result of an illness is something as natural as it can be, yet let us clarify the way the concept of illness was perceived in the Bible, in the life of church and how one should relate to it. Based on the episode when Jesus heals the man born blind (Jn 9, 1-41) one may understand the way illness was perceived by his contemporaries:

- 1) there is a strong relationship between sin and illness (Jn 9, 2)
 - a) personal sins lead to the apparition of illness. Jesus urges the man who was physically healed "to sin no more, lest a worse thing come upon you" (Jn 5, 14).
 - b) the parents' sins may have effects upon children. The Israelite was aware of the fact that his God was "a jealous God, recompensing the sins of the fathers on the children to the third and fourth generation" (Ex 20, 5).

2) Jesus adds another meaning of illness: God decides that someone become ill so that "the works of God" (Jn 9, 3) might be revealed in them.

3) Should one analyze the causes of illness in a broader context of the Scripture, one may see that there could also be other reasons "why a man becomes ill: for testing one's faith (Job 2, 4 ff.), so that one might return to God (Lk 13,2 ff.), as suffering on someone else's behalf (Col 1, 24), for the testimony full of authority among the ill and healthy people (Jn 5, 14; 2 Co 12, 9) and occasionally as a punishment (Acts 12, 23)"³⁴.

Rev. Prof. John Breck draws the attention to the fact that "the tradition of Eastern Orthodox Church regards suffering and pain as a

negative consequence of falling into sin, which God did not want, yet allows it as a sort of spiritual pedagogy”, therefore “it does not regard suffering either as an essential condition or imperative, as <a price which must be paid> for our forgiveness and salvation”³⁵. Taking into consideration these coordinates, one may make the following statements with regard to the understanding of illness from a Christian Orthodox perspective:

1) The cause-effect relationship between sin and illness is maintained due to the existence of sin.

- a) The Orthodox Hymnography makes one constantly aware of the fact that “no one living is without sin” (prayer from the Litany of the dead) and therefore it is natural that “From the great abundance of all our sins, ill be we in body, ailing also be we in soul.” (Tropary from Paraklesis to the Most Holy Theotokos).
- b) When talking about the sins of parents upon children, one needs to make some specifications. The external consequences of parents’ sins having effects upon the children’s bodies³⁶ must definitely be differentiated from the inner ones which concern the children’s soul.³⁷ While at the bodily level one may ascertain a cause-effect relationship between children and parents, to be found in various illnesses, when one talks about the children’s souls, the relationship has no longer a cause-effect pattern, but it implies the perpetuation of one’s sinful state which is ended by God after the third or fourth generation unless one repents.

2) Few of the contemporaries with the blind man heard about his healing and even fewer regarded this miracle “as the work of God” (Jn 9, 16). Via mass media one has nowadays the opportunity to see mothers taking care of their baby despite having their arms amputated at an early age³⁸, people born without arms and legs and who through their lives are an incentive for the healthy³⁹ still manage to keep their families.

Thus, illness is, in our reading, a sort of spiritual pedagogy with an ethical aim; a double mixture, evidently no less painful, where an individual can discover his/her self but where he/she can discover other selves. In the case of our patients, this double mixture (spiritual pedagogy/ethical aim) was presented to the extent that it helped them to cope with their suffering, but at the same time it created a sort of established self-image.

“Church as the body of Christ” and our body

The extent to which the church is entitled and in full knowledge to talk about amputation is emphasized by both the very biblical metaphor in which it is seen as “the body of Christ” (1 Cor 12, 12-27) and the experience of this Body over the centuries, having been faced with the

reality of amputation whenever that was necessary. If the Church has been regarded and understood as the mysterious Body of Christ, it is obvious that the reflections of one of its members upon human body and amputation within its framework may be pertinent and in full knowledge if one assumes this condition.

In order for one to talk about amputation, one needs to talk first about the body from which one member needs to be removed. According to the metaphor from 1 Cor⁴⁰ and to the various old references to this text, within the Body of Christ one may ascertain the following things:

a) members are different from one another suggesting thus a different value, yet it must not be understood strictly ontologically or functionally but also relationally⁴¹.

b) members are subordinated to the body, the whole is more important than the part, therefore community prevails over an individual⁴².

c) within a hierarchically structured body, the members are always coordinated by the head and under its command⁴³.

d) the reality of being part of a body does not limit one to “merely be in one place, while the other one is in another one - since this differentiation only takes into account the space - but to be united and in touch with the other ones”, in the same way as one not being part of a body “means that one cuts away and moves away from others”⁴⁴.

Taking into consideration these realities within the Body of Christ, we will apply them upon our body, emphasizing at the end the limits within which amputation might take place.

a) The different value of each member of our body is to be understood in relational terms. All the members of a body are important and their importance is given in the first place by God himself who placed them where they are. The differentiation between them is made not only through the specific function each of them has within the body but also through the relationship each has with the other members. It is the very amputation of a member whose absence is made up for by the others that confirms it. The member taking over some of the tasks of another one does not thus become that member, does not change its basic function which was assigned to it, but takes over new functions materialized in new relationships, even though the latter ones were not initially taken into account.

b) A member will never prevail over the body, no matter how important it might seem. Therefore, if gangrene affects one of the members and through the latter it may spread in the entire body, then in order to save the body which is much more than this member, one will give the latter up by having it amputated.

c) The decision of giving up a member of the body which was taken over by gangrene must be made by the part of a man which coordinates the entire activity of the body. The amputation of a member must thus be

a deliberate act, conscientiously assumed in order to save the body.

d) The status of a member of the body is normally an active one. Through it, the member cooperates, serves and gets involved making it possible for the body to function normally. The refusal of a member to cooperate, to serve and to get involved in the body reflects a passive and an unnatural quality which may be addressed from two perspectives: one concerning the hardening of the good functioning of the body yet not endangering it, when the member is not removed (as in the case of paralysis) and the other one concerning the compromise of not only the functioning but also of the existence of the entire body, when the member is amputated (as in the case of a gangrene which poses the risk of spreading to other parts of the body as well).

In the light of the aforementioned one may hold that each member of the body is unique in its own way and it is through the way in which it fulfills its function and relates to the other members that the uniqueness of the body is achieved. One may talk about the amputation of a member only when due to it the other members and ultimately the entire body are compromised. Its amputation has thus as an immediate effect the attempt to take over by the other members the compromised functions and relationships in order not to lose the uniqueness of the body. It is obvious that once a member has been amputated one can no longer talk about the same function ability, yet one may talk about the enhancement of the relationships between certain members, precisely in order to achieve to the furthest extent possible the primordial uniqueness of the body.

Whether interpreted symbolically or literally, amputation is a biblical reality which always aims to sacrifice a part for the salvation of the whole, the removal of a member of the body so that the other parts forming the body might gain the Kingdom of God. Based on the text from 1 Cor 12 one was able to clearly learn the relationship between the body and members, one being able to clearly notice a prevalence of the body over members, while the text from Matthew 5, 29-30; 18, 8-9 clearly outlines why this prioritization is necessary: sacrificing a member so that the body might gain the eternal life.

According to the Bible, the amputation of a member is possible and even recommended in some cases. However, one must state that the removal of a member from one's body must not be regarded only from the perspective of immanence, only for the purpose of saving the life of the body. It must also be regarded from a transcendental perspective, as one's possibility to purify from one's sins in order to get united with God, to advance spiritually and prepare even harder for the eternal life. "The practices of taking care of one's health - including amputations - focused on saving one's life at any price will cost too much: the spiritual lives of both the attendants and recipients will be jeopardized"⁴⁵.

Conclusions

For the patient, the main problem is to accept the surgical intervention, this acceptance allowing him/her to sign the informed consent for the amputation. The surgeon establishes the diagnosis and proposes the surgical intervention, as the last option in the treatment of the critical lower limb ischemia. The social impact of amputation can be substantial. Following amputation, the patient experiences long-term conditions such as fatigue, changes in recreational activities, economic burdens, medical costs and reactions of friends and family, in addition to a wide range of emotional reactions which can lead to non-adaptive reactions if they don't receive enough support from the family and society. The rehabilitation of individuals with amputation is the minimization of handicap and establishment of autonomy and well-being. Spiritual beliefs enable individuals with disability to establish meaning for disability and effective coping in response to loss related to disability. Removing an ill member which poses the risk of compromising the entire existence of the body may found its roots in the Bible.

The present article, built interdisciplinary at the intersection of medicine, social science and religious studies, aimed at highlighting some medical, social and religious aspects in patients with major limb amputation. This life changing event is challenging in a radical way: the entire human dimension is at stake. Not only the surgical intervention per se, the relationship between doctor and patient and the social aspects are challenging, but the core of being human, i.e. self-image and the relation with others, is at stake. The fact that self-image and the relation with others are so central ultimately places ethics in a pivotal position.

Notes

¹ K. Ziegler-Graham, E. J. MacKenzie, P. L. Ephraim, T. G. Travison, R. Brookmeyer, "Estimating the prevalence of limb loss in the United States: 2005 to 2050," *Archives of Physical Medicine and Rehabilitation* 89 (2008): 424.

² K. Pargament, *The Psychology of Religion and Coping: Theory, Research, Practice* (New York: Guilford Press, 2001), 5

³ O. Horgan, M. MacLachlan, "Psychosocial adjustment to lower-limb amputation: a review", *Disability and Rehabilitation* 26(14-15) (2004): 837-850.

⁴ An excellent description of the relationship doctor/ patient can be found in M.L. Iliescu, A. Carauleanu, "The Portrait of a Good Doctor: Conclusions from a Patients and Medical Students Survey," *Revista de Cercetare si Interventie Sociala* 47 (2014): 261-271.

⁵ J. C. Bosmans, T. P. Suurmeijer, M. Hulsink, C. P. van der Schans, J. H. Geertzen, P. U. Dijkstra, "Amputation, phantom pain and subjective wellbeing: a qualitative

study,” *International Journal of Rehabilitation Research* 30(1) (2007):1–8.

⁶ Behrouz Dadkhah, Sousan Valizadeh, Eissa Mohammadi, Hadi Hassankhani, “Psychosocial adjustment to lower-limb amputation: A review article,” *HealthMED* 7 (2)(2013): 502-507.

⁷ B. O. Ranti, O. O. Adebayo, Y. Saheed, A. Olukayode, “Early psychosocial impact and functional level following major lower limb amputations,” *International Journal of Development Research* 5(1) (2015): 3098.

⁸ M. Asano, P. Rushton, W.C. Miller, B.A. Deathe, “Predictors of quality of life among individuals who have a lower limb amputation,” *Prosthetics and Orthotics International* 32(2) (2008): 231–43.

⁹ R. Singh, D. Ripley, B. Pentland, I. Todd, J. Hunter, L. Hutton, A. Philip, “Depression and anxiety symptoms after lower limb amputation: the rise and fall,” *Clinical Rehabilitation* 23(3) (2009): 281–86.

¹⁰ B. D. Darnall, P. Ephraim, S. T. Wegener, T. Dillingham, L. Pezzin, P. Rossbach, E. J. MacKenzie, “Depressive symptoms and mental health service utilization among persons with limb loss: results of a national survey,” *Archives of Physical Medicine and Rehabilitation* 86(4) (2005): 650–58.

¹¹ S. Valizadeh, B. Dadkhah, E. Mohammadi, H. Hassanjhani, “The perception of trauma patients from social support in adjustment to lower-limb amputation: A qualitative study,” *Indian Journal of Palliative Care* 20(3) (2014): 229–38.

¹² M. Khademi, M. Gharib, V. Rashedi, “Prevalence of depression in the amputated patients concerning demographic variables,” *Iranian Journal of Public Health* 4 (2) (2012): 12-17.

¹³ Ziad M. Hawamdeh, Yasmin S. Othman, Alaa I. Ibrahim, “Assessment of anxiety and depression after lower limb amputation in Jordanian patients,” *Neuropsychiatric Disease and Treatment* 4(3) (2008): 627-633.

¹⁴ H. Senra, R. A. Oliveira, I. Leal, C. Vieira, “Beyond the body image: a qualitative study on how adults experience lower limb amputation,” *Clinical Rehabilitation*, 26(2) (2012): 180-91.

¹⁵ NICE Guidance. *Supportive and Palliative Care* (London: National Institute for Clinical Excellence, 2004).

¹⁶ M. R. Williams, M. D. Ehde, G. D. Smith, M. J. Czernieck, J. A. Hoffman, R. L. Robinson, “A two-year longitudinal study of social support following amputation,” *Journal of disability and rehabilitation* 26 (14-15) (2004): 862-874.

¹⁷ H. Dale, N. Hunt, “Perceived need for spiritual and religious treatment options in chronically ill individuals,” *Journal of Health Psychology* 13 (2008): 712-718.

¹⁸ C. A. Reyes-Ortiz, I. M. Berges, M. A. Raji, H. G. Koenig, Y. F. Kuo, K. S. Markides, “Church attendance mediates the association between depressive symptoms and cognitive functioning among older Mexican Americans,” *The journals of gerontology. Series A, Biological sciences and medical sciences* 63 (2008): 480-486.

¹⁹ T. D. Hill, “Religious involvement and healthy cognitive aging: patterns, explanations, and future directions,” *The journals of gerontology. Series A, Biological sciences and medical sciences* 63 (2008): 478-479.

²⁰ See, for example, Salomea Popoviciu, Delia Birle, Serban Olah, Ioan Popoviciu, “The role of religious beliefs and spirituality on the quality of life of rare diseases patients,” *Revista de cercetare și intervenție socială*, 36 (2012):144-161 and Corina Dima-Cozma, Cristina Gavriluță, Geta Mitrea, Doina-Clementina Cojocaru, “The Importance of healthy lifestyle in modern society. A medical, social and spiritual

perspective,” *European Journal of Science and Theology* 10 (3) (2014): 111-120.

²¹ Amanda H. Peirano, Randall W. Frantz, “Spirituality and QoL in limb amputees,” *International Journal of Angiology* 21 (1) (2012): 48.

²² Amanda H. Peirano, Randall W. Frantz, “Spirituality and QoL in limb amputees”, 51.

²³ Christopher G. Ellison, “The Religion-Health Connection: Evidence, Theory, and Future Directions,” *Health Education & Behavior* 25 (6) (1998): 700-720.

²⁴ José Maria Pereira de Godoy, Carla Rodrigues Zanin, Ocimar A. Fonte, Maria Cristina O.S. Miyazaki, Maria de Fátima Guerreiro Godoy, “Religious habits of patients submitted to amputation,” *Acta Angiologica* 15(1) (2009): 30-31.

²⁵ Kenneth Pargament, *The Psychology of Religion and Coping: Theory, Research, Practice* (New York: Guilford Press, 2001), 90.

²⁶ Harold Koenig, Dana King, Verna B. Carson, *Handbook of Religion and Health*, second edition (New York: Oxford University Press, 2012), 173.

²⁷ A prospective study of 49 patients aged between 36 and 87 years, with major lower limb amputations, conducted between 2010 and 2014, in the Second General Surgery Department, at the Emergency Clinical Cluj County Hospital.

²⁸ Shmarya Rosenberg, „Orthodox Man Sues Hospital, Rabbi, Over Cremation Of Amputated Leg”, *FailedMesia.com*, August 18, 2014.
http://failedmessiah.typepad.com/failed_messiahcom/2014/08/orthodox-man-sues-hospital-rabbi-over-cremation-of-amputated-leg-234.html

²⁹ Sebastian Moldovan, “Herman Tristram Engelhardt jr. și cheia biografică a bioeticii”, in H. Tristram Engelhardt jr., *Fundamentele bioeticii creștine: perspectivă ortodoxă*, translated from English by Sebastian Moldovan, Mihail Neamțu, Cezar Login, Ioan I. Ică Jr, (Sibiu: Deisis Publishing House, 2005), 7.

³⁰ Sebastian Moldovan, “Herman Tristram Engelhardt jr. și cheia biografică a bioeticii”, 7.

³¹ H. Tristram Engelhardt jr., *Fundamentele bioeticii creștine...*, 412.

³² Andrada Parvu, Gabriel Roman, Silvia Dumitras, Rodica Gramma, Mariana Enache, Stefana Maria Moisa, Radu Chirita, Catalin Iov, Beatrice Ioan, „Arguments in favor of a religious coping pattern in terminally ill patients,” *Journal for the Study of Religions and Ideologies*, vol. 11, issue 31 (2012): 88-112.

³³ H. Tristram Engelhardt jr, *Fundamentele bioeticii creștine*, 413.

³⁴ Gerhard Maier, *Comentariu biblic: Evanghelia după Ioan*, vol. 6-7 (Krontal: Lumina Lumii, 1999), 403-404.

³⁵ John Breck, *Darul sacru al vieții*, translated from English by PS Irineu Pop Bistrițeanul (Cluj-Napoca: Editura Patmos, 2001), 268.

³⁶ Gerhard Maier makes the following distinction between the external and inner consequences of sin: if the former ones, in the case of some venereal diseases, can transmit themselves over more generations, causing the blindness of the newly born, the latter ones which concern our personal relationship with God, always presuppose our personal commitment. For more details see Gerhard Maier, *Comentariu biblic: Evanghelia după Ioan*, 403.

³⁷ In his commentary to Jn 9, 2-3, Saint Cyril of Alexandria states that according to the Sacred Scripture, the passing on of sins from parents to children is not an unjust process, but occurs due to the fact that the latter remain in the sinful state of the former. For the entire argument, see Sfântul Chiril al Alexandriei, *Scrieri, Partea a patra, Comentariu la Evanghelia Sfântului Ioan*, PSB 41, translated by

Dumitru Stăniloae (București: Editura Institutului Biblic și de Misiune al Bisericii Ortodoxe Române, 2000). In the footnotes 1240-1242 (page 659) from the aforementioned commentary, Rev. Dumitru Stăniloae synthesizes the patristic thinking as follows: "God tolerates the parents who repent and also their offspring. And if they continue to sin generations after generations and do not repent, He further punishes the offspring to the 4th generation, even further... God's anger... does not reveal in real punishments until the 3rd and 4th generation".

³⁸ Barbar Guerra's case is an illustrative example in this regard, yet not the only one of this kind. For more details see

https://www.youtube.com/watch?v=AKA_hNsZdn0, accessed on 5.05.2015.

³⁹ Ion Benim or Nick Vujicic's case are highly illustrative in this regard. For more details see Laura Breană, „Video și galerie foto. Incredibil! Povestea omului fără mâini și fără picioare,” *Monitorul de Vrancea*, 2.07.2012.

http://www.monitorulvn.ro/articole/video-si-galerie-foto-incredibil-povestea-omului-fara-maini-si-fara-picioare_2_130775, accessed on 10.05.2015 and

<https://www.youtube.com/watch?v=qqPHYPH8RZY>, accessed on 10.05.2015.

⁴⁰ Richard Hays draws attention to the fact that this is not a mere metaphor, but rather a mystical reality through which the unification between Church and Christ and at the same time the taking part of us all in this unity with Him is explained; For more details see Richard Hays, *First Corinthians* (Louisville: John Knox Press, 1997), 213.

⁴¹ If there were an ontological difference between members, then a certain member would be more important than another one and therefore there would be an inequality of members before God, which is contrary to the message from 1 Corinthians 12; if there were only functional differences, one cannot explain why the same work is always performed by the same member if another one could perform it just as well, which is what happens when an amputation occurs. This is why I have introduced the concept of different value at relational level. Therefore a member is decided by God (ontological character) to fulfill a certain work (functional character) based on the necessity the Body has at that time (relational character). When a member is missing, the relationship between the other ones changes and the latter take over functions which have not been expressly decided in this way.

⁴² Wolfgang Schrage draws attention to the fact that although this subordination or prevalence exists, one must not overlook the fact that the diversity of the members and the unity of the body belong together; see Wolfgang Schrage, *Der erste Brief an die Korinther*, VII, 3, 1 Kor. 11, 17 - 14, 40, Verlag Benziger/Neukirchener, Zürich/Düsseldorf, 1999, p. 224.

⁴³ These three characteristics have been identified by Andreas Lindemann, *Der Erste Korintherbrief* (Tübingen: Mohr Siebeck, 2000), 275.

⁴⁴ Sfântul Ioan Gură de Aur, *Tâlcuiri la Epistola întâi către Corinteni*, translated by PS Teoosie Atanasiu (București: Editura Sophia, 2005), 315.

⁴⁵ H. Tristram Engelhardt Jr., *Fundamentele bioeticii creștine...*, 414.

References

*** *NICE Guidance. Supportive and Palliative Care*. London: National Institute for Clinical Excellence, 2004.

Asano, M, P. Rushton, W. C. Miller, B. A. Deathe. "Predictors of quality of life among individuals who have a lower limb amputation." *Prosthetics and Orthotics International* vol. 32, nr. 2 (2008): 231-43.

Behrouz, Dadkhah, Sousan Valizadeh, Eissa Mohammadi, Hadi Hassankhani. "Psychosocial adjustment to lower-limb amputation: A review article." *HealthMED* vol. 7, nr. 2 (2013): 502-507.

Bosmans, J. C., T. P. Suurmeijer, M. Hulsink, C. P. van der Schans, J. H. Geertzen, P. U. Dijkstra. "Amputation, phantom pain and subjective well-being: a qualitative study." *International Journal of Rehabilitation Research* vol. 30(1) (2007): 1-8.

Breană, Laura. „Video și galerie foto. Incredibil! Povestea omului fără mâini și fără picioare.” *Monitorul de Vrancea*, 2.07.2012.
http://www.monitorulvn.ro/articole/video-si-galerie-foto-incredibil-povestea-omului-fara-maini-si-fara-picioare_2_130775

Breck, John. *Darul sacru al vieții*. Translated by PS Irineu Pop Bistrițeanul. Cluj-Napoca: Editura Patmos, 2001.

Dale, H., N. Hunt. "Perceived need for spiritual and religious treatment options in chronically ill individuals." *Journal of Health Psychology* vol.13, nr. 5, (2008): 712-8.

Darnall, B. D., P. Ephraim, S. T. Wegener, T. Dillingham, L. Pezzin, P. Rossbach, E. J. MacKenzie. "Depressive symptoms and mental health service utilization among persons with limb loss: results of a national survey." *Archives of Physical Medicine and Rehabilitation* vol. 86, nr. 4 (2005): 650-8.

Dima-Cozma, Corina, Cristina Gavriluță, Geta Mitrea, Doina-Clementina Cojocar. "The Importance of healthy lifestyle in modern society. A medical, social and spiritual perspective." *European Journal of Science and Theology* vol. 10, no. 3 (2014): 111-120.

Ellison, Christopher G. "The Religion-Health Connection: Evidence, Theory, and Future Directions." *Health Education & Behavior* vol. 25, no. 6 (December 1998): 700-720.

Engelhardt, H. Tristram jr. *Fundamentele bioeticii creștine: perspectiva ortodoxă*. Translated by Sebastian Moldovan, Mihail Neamțu, Cezar Login, Ioan I. Ică jr. Sibiu: Editura Deisis, 2005.

Grad Nicolae-Ovidiu, Ionel Ciprian Pop, Ion Aurel Mironiuc. „Stem Cells Therapy and Research. Benefits and Ethical Challenges.” *Journal for the Study of Religions and Ideologies* vol. 11, issue 32 (2012): 190-205.

Hawamdeh, Ziad M., Yasmin S. Othman, Alaa I. Ibrahim. “Assessment of anxiety and depression after lower limb amputation in Jordanian patients.” *Neuropsychiatric Disease and Treatment* vol. 4, nr. 3 (2008): 627–633.

Hays, Richard. *First Corinthians*. Louisville: John Knox Press, 1997.

Hill, T. D. “Religious involvement and healthy cognitive aging: patterns, explanations, and future directions.” *The journals of gerontology. Series A, Biological sciences and medical sciences* vol. 63, nr. 5 (2008): 478-9.

Horgan, O., M. MacLachlan. “Psychosocial adjustment to lower-limb amputation: a review.” *Disability and rehabilitation*. vol. 26, nr.14-15 (2004): 837–850.

Iliescu, M. L., A. Carauleanu. “The Portrait of a Good Doctor: Conclusions from a Patients and Medical Students Survey.” *Revista de Cercetare si Interventie Sociala* vol. 47 (2014): 261-271.

Khademi, M, M. Gharib, V. Rashedi. “Prevalence of depression in the amputated patients concerning demographic variables.” *Iranian Journal of Public Health* vol.4, nr. 2 (2012): 12-17.

Lindemann, Andreas. *Der Erste Korintherbrief*. Tübingen: Mohr Siebeck, 2000.

Maier, Gerhard. *Comentariu biblic: Evanghelia după Ioan*, vol. 6-7. Krontal: Editura Lumina Lumii, 1999.

Pargament, Kenneth. *The Psychology of Religion and Coping: Theory, Research, Practice*. New York: Guilford Press, 2001.

Parvu, Andrada, Gabriel Roman, Silvia Dumitras, Rodica Gramma, Mariana Enache, Stefana Maria Moisa, Radu Chirita, Catalin Iov, Beatrice Ioan. “Arguments in favor of a religious coping pattern in terminally ill patients.” *Journal for the Study of Religions and Ideologies* vol. 11, issue 31 (2012): 88-112.

Peirano, Amanda, H. Randall, W. Frantz. "Spirituality and QoL in limb amputees." *International Journal of Angiology* vol. 2, nr. 1 (2012): 47–52.

Pereira de Godoy, José Maria, Carla Rodrigues Zanin, Ocimar A. Fonte, Maria Cristina O.S. Miyazaki, Maria de Fátima Guerreiro Godoy. "Religious habits of patients submitted to amputation." *Acta Angiologica* vol. 15, no. 1 (2009): 30–31.

Popoviciu, Salomea, Delia Birle, Serban Olah, Ioan Popoviciu. "The role of religious beliefs and spirituality on the quality of life of rare diseases patients." *Revista de cercetare și intervenție socială*, vol. 36 (2012): 144–161.

Ranti, BO, O. O. Adebayo, Y. Saheed, A. Olukayode. "Early psychosocial impact and functional level following major lower limb amputations." *International Journal of Development Research* vol. 5, nr. 1 (2015): 3095–98.

Reyes-Ortiz, C. A, I. M. Berges, M. A. Raji, H. G. Koenig, Y. F. Kuo, K. S. Markides. "Church attendance mediates the association between depressive symptoms and cognitive functioning among older Mexican Americans." *The journals of gerontology. Series A, Biological sciences and medical sciences* vol. 63, nr. 5 (2008): 480–6.

Rosenberg, Shmarya. „Orthodox Man Sues Hospital, Rabbi, Over Cremation Of Amputated Leg.” *FailedMesia.com*, August 18, 2014. http://failedmessiah.typepad.com/failed_messiahcom/2014/08/orthodox-man-sues-hospital-rabbi-over-cremation-of-amputated-leg-234.html

Schrage, Wolfgang. *Der erste Brief an die Korinther*, VII, 3, 1 Kor. 11, 17 - 14, 40. Zürich/Düsseldorf: Verlag Benziger/Neukirchener, 1999.

Senra, H., R. A. Oliveira, I. Leal, C. Vieira. "Beyond the body image: a qualitative study on how adults experience lower limb amputation." *Clinical Rehabilitation* vol. 26, nr. 2 (2012): 180–91.

Sfântul Chiril al Alexandriei. *Scrieri*. Translated by Dumitru Stăniloae. București: Editura Institutului Biblic și de Misiune al Bisericii Ortodoxe Române, 2000.

Sfântul Ioan Gură de Aur. *Tâlcuiri la Epistola întâi către Corinteni*. Translated by PS Teosie Atanasiu. București: Editura Sophia, 2005.

Singh, R., D. Ripley, B. Pentland, I. Todd, J. Hunter, L. Hutton, A. Philip. "Depression and anxiety symptoms after lower limb amputation: the rise and fall," *Clinical Rehabilitation* vol. 23, nr. 3 (2009): 281-6.

Valizadeh, S., B. Dadkhah, E. Mohammadi, H. Hassanjhani. "The perception of trauma patients from social support in adjustment to lower-limb amputation: A qualitative study." *Indian Journal of Palliative Care* vol. 20, nr. 3 (2014): 229-238.

Williams, M. R, M. D. Ehde, G. D. Smith, M. J. Czernieck, J. A. Hoffman, R. L. Robinson. "A two-year longitudinal study of social support following amputation." *Journal of disability and rehabilitation* vol. 26, nr. 14-15 (2004): 862-74.

Ziegler-Graham, K, E. J. MacKenzie, P. L. Ephraim, T. G. Travison, R. Brookmeyer. "Estimating the prevalence of limb loss in the United States: 2005 to 2050." *Archives of Physical Medicine and Rehabilitation* Vol. 89, (2008): 422-429.