CULTURAL COMPETENCE AND END-OF-LIFE CARE:
RELIGION, SPIRITUALITY AND HEALTH CARE DECISION-MAKING

BY

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>iii</td>
</tr>
<tr>
<td>Introduction</td>
<td>iv</td>
</tr>
<tr>
<td>Chapter 1: Religion in Health Care: A Brief Review</td>
<td>1</td>
</tr>
<tr>
<td>Chapter 2: Religious and Atheistic Views of End-of-Life Care</td>
<td>12</td>
</tr>
<tr>
<td>Chapter 3: Addressing Culture and Religion in Medical Education</td>
<td>26</td>
</tr>
<tr>
<td>Chapter 4: The Future of End-of-Life Care</td>
<td>46</td>
</tr>
<tr>
<td>References</td>
<td>54</td>
</tr>
<tr>
<td>Curriculum Vitae</td>
<td>60</td>
</tr>
</tbody>
</table>


Abstract

The changing demographic of the U.S. population has shed new light on the importance of providing all patients with the highest standard of care possible. An increase in the number of foreign-born residents with diverse religious backgrounds requires health care professionals to know strategies for understanding and responding to patients who practice less common religions as spiritual beliefs and practices may influence health care decision-making. Despite research that shows the importance of providing culturally competent care, little standardization exists for cultural competency education for health care professionals.

This thesis will begin with a review of how the U.S. population is changing and how the spiritual lives of patients can influence care at the end of life. The second chapter gives brief overviews of general beliefs that people who practice common religions and who profess atheism hold about end-of-life care. The third chapter describes and analyzes the curricula for cultural competency education in American medical schools and argues for the Promoting, Reinforcing and Improving Medical Education (PRIME) curriculum as the model curriculum for cultural competency education. In the closing chapter, recommendations for continued improvement in cultural competency education are proposed.
Introduction

The idea for this thesis was rooted in my background in theology and the passion that I have for promoting the immeasurable value of diverse backgrounds and for bioethics. As a graduate student at Wake Forest University, I learned about the importance of patient spirituality and about the influence that it can have on health care decision-making, particularly at the end of life. As I spoke with friends who have received medical training, I was struck by the lack of education that they received in how spirituality and religious backgrounds can affect patient care and how to provide culturally competent care to diverse patient populations. In response to the insufficient education that they received, I sought a model curriculum that provided what I believe to be the best educational techniques and necessary educational standardization to ensure that all health care professionals are adequately prepared to provide culturally competent care to all patients.

In order to find such a curriculum, I began with a literature review, seeking to learn about how the relationship between medicine and religion has evolved and the role of spirituality in medicine. I also wanted to learn about how the U.S. population has changed over time and how population demographics are expected to change in the near future. The results of this literature review are presented in Chapter 1. Most of the available literature is focused on providing patient-centered care and how medicine has evolved from a paternalistic discipline to an autonomous patient model with discussion about where people in the United States die and the negative effects of ignoring the patient’s spiritual life when providing care. For the purposes of this thesis, the focus of discussion is on how the mind, body and spirit of the patient are all important to consider
in health care. Ignoring one facet of the patient’s self can cause suffering and prevent a peaceful dying process.

Chapter 2 describes common beliefs of some of the religions that are practiced throughout the United States with emphasis on their beliefs about care at the end of life. The communities I present, atheism, Christianity, Islam, Judaism and Buddhism, offer perspectives on what care should look like at the end of life and show how patients from different religious backgrounds may prefer to be treated differently. Although generalized knowledge of communities can lead to stereotyping and other negative consequences, the knowledge about how different communities view the dying process offers insight into why it is important to understand patient beliefs. This chapter serves as a reference for why delivering individualized care should be paramount for health care professionals.

Chapter 3 explores the research that was conducted beginning in the late 1990s by U.S. governmental agencies with regard to teaching health care professionals how to deliver culturally competent care. The model that was proposed, called Promoting, Reinforcing and Improving Medical Education (PRIME), offers medical schools the ability to find areas where cultural competency could be taught in their existing curricula. The majority of this chapter is devoted to describing the PRIME curriculum and the benefits of implementing it in medical education. The PRIME model curriculum enables cultural competency to be taught throughout the entirety of medical education, including clinical rotations whereas other models focus this education during the first two preclinical years. It also offers standardization which requires that students meet certain criteria before being able to practice and ensures that all health care professionals are trained to deliver adequate care to diverse populations.
The fourth and final chapter of this thesis argues further for the importance of identifying and addressing spirituality in end-of-life care. This recognition can help health care professionals alleviate suffering in all facets: physical, mental and spiritual. To accomplish this goal, I emphasize the value of implementing the standardization that the PRIME curriculum offers as the increasingly diverse population ages, requiring medicine to be equipped to handle spiritual diversity at the end of life. In this chapter, I discuss the potential risks of failing to provide spiritual care to patients in the dying process and how holistic care enables patients to die good deaths.

The purpose of this thesis is to bring to light how the spiritual and religious beliefs of patients should be considered when delivering end-of-life care and to evaluate and propose more widespread introduction of the PRIME model curriculum into medical school curricula in order to equip health care professionals to provide culturally competent care to all patients.
Chapter 1

Religion in Health Care: A Brief Review

In contemporary Western society, many consider religion and science as proceeding on two parallel tracks: never crossing, operating separately and at different speeds. But, this has not always been the case. For centuries, doctors and priests were indistinguishable, ministering to the mind, the body and the spirit of their patients. The relationship between these three parts of the person is still something that is largely under-examined as Western medicine has focused mainly on the body, and often neglected the mind and spirit.

As Dr. Daniel Sulmasy writes, “Religion is the oldest form of medical practice. The shaman was the traditional tribal healer, whose treatments were religious rituals” (Sulmasy, 2012). In many places around the world, inhabitants do not distinguish between illnesses of the mind, body and spirit; instead, they may view illnesses as punishments by a deity for spiritual wrong-doing. Western science and medicine, however, have shown a trend away from the marriage they once had seen with religion. Some scientists reject the theory of the existence of a higher being, and some still cling to the idea of a spiritual healer, but the relationship between science and religion is strained to say the least. The strain can be traced back to the Enlightenment, when many scholars began to trust science more than religion. But a more recent phenomenon has emerged: some scientists are calling for the complete removal of religion from science or medicine as “harmful to medical progress and good clinical care” (Sulmasy, 2012).
On the other side of the spectrum, another shift in the wind of medicine has occurred, blowing medicine back to the mindset of “patients as people” rather than “patients as diagnoses.” Attention to how a disease affects the patient’s daily life, including matters of the mind, body and spirit and how daily life affects the course of the disease, has resurfaced and patient-centered care is once again becoming the standard rather than the exception. Although this shift is occurring, biomedical answers are still often given to transcendent questions. In other words, sometimes when a patient asks “why is this happening to me?” physicians may respond with medical information about the disease, but medical answers may be insufficient for this existential question.

A working strategy for helping health care professionals to understand and promote “healing” at the end of life must not be taken lightly. The change from trying to cure a person’s disease toward alleviating pain and suffering and promoting quality of life can be difficult for health care professionals to face. Near the end of life, the more valuable focus is no longer on curing the patient’s disease; rather it is to alleviate patient suffering in any sphere: spiritual, emotional, social and physical. To achieve this goal, health care professionals must gain knowledge of the patient’s needs and respond accordingly.
Dealing with Diversity

The U.S. population continues to grow more diverse each year and with this diversity come new challenges for healthcare professionals to relate to their patients and alleviate their suffering. Some predict that more than 78 million people or 19 percent of the total U.S. population will be foreign-born by the year 2060, an increase of more than 82 percent from 2014 (Colby, 2013). These immigrants bring with them different religious traditions, customs and views on health care.

The religious majority in the United States is Christian with around 71 percent of the population identifying as such in 2014 (“America's Changing Religious Landscape”). In recent years, however, the number of U.S. residents of non-Christian faiths has risen. A 2014 survey performed by the Pew Research Centers found that members of non-Christian faiths made up approximately six percent of the U.S. population, while people who considered themselves religiously unaffiliated were more than 20 percent of U.S. residents (“America's Changing Religious Landscape”). According to Putnam and Campbell (2012), about 40 percent of the U.S. population reported that they attend church services on a weekly basis and more than 58 percent said that they prayed weekly. These numbers indicate a strong connection of a majority of Americans to their spiritual lives.

A newer trend in the United States is for people to identify as “spiritual but not religious,” something that was not very common before the start of the 21st century. Much like the trend in medicine toward a patient-centered approach, spirituality is an individualized expression of personal ideologies. Spirituality focuses on the individual, moves away from institutionalized religion, and seeks to give meaning to life, attending
to the basic human needs for love, hope, relatedness, value and dignity ("Religion, Spirituality and End of Life Care"). This understanding of spirituality has very few boundaries and can extend into anything concerned with transcendent life, sacredness and an individual’s philosophy of life. It has been described as an “inner world of values, vital beliefs, strings and goals” (Karff, 2009).

Though they are related concepts, there are important distinctions between spirituality and religion. Religions typically have canonical rites, beliefs, practices, symbols, sacred texts, and doctrines or laws that are affirmed by a community of faith. Where spirituality focuses on an individual’s inner journey, religion offers fellowship with others and shared viewpoints on living life according to that faith tradition (Hill, et al., 2000). The terms are not mutually exclusive: a religious person has a spiritual life and a spiritual person might also have a religious life. No matter whether people have a specific religious affiliation, or what tradition they may embrace, I believe that it is always important to consider their spiritual views in accordance with their wishes for health care.

Given the great diversity of religious views in the United States, the blurred lines between denominations and sects, and the significant variation in individual beliefs within denominations, it can be very difficult, if not impossible, for health care professionals to have a working knowledge of all religious practices and beliefs. As the population continues to change, the strategies for providing holistic, patient-centered care should change along with it. It is more crucial than ever before for health care providers to remember that death, though unavoidable, raises different issues for different people. People of different religions view death differently, particularly in terms of health care
and post mortem rituals (Ford, 2012). If there is an understanding of religious or spiritual preferences at the end of life between the health care professional and the patient, the transition can be made much easier, for both the patient and for his or her family members. In this thesis I will argue that active communication and more thorough educational training in cultural competence for health care professionals is essential to promote an environment of healing.

Dealing with a topic that is often deeply personal, such as religion, can cause conflict. Sometimes the patient’s beliefs are different from those of their family members, and the decisions that the patient may make because of their beliefs may be different that the decisions their family members would make. In other cases, the patient’s religious beliefs may conflict with those of their health care provider, and there can be conflict in that relationship, too. Because of the conflict, health care professionals must learn how to deal with situations in which they may be uncomfortable.

Because the patient’s religion and spirituality can have immense influence over health care decision-making and well-being, health care professionals are well advised to have a strategy for handling situations of unfamiliar religious or spiritual beliefs, values and practices. As has long been the case, the majority of older Americans continue to die in institutional settings. As recently as the 1980s, nearly 75 percent of Americans died in some kind of institution, including hospitals, mental institutions, nursing homes and other long-term care facilities (Field, 1997). More current data reflects similar, but improved numbers: in 2005 a Centers for Disease Control (CDC) study found that half of Americans died in a hospital, while 70 percent died in some type of institutional setting.
Roughly one in four Americans died at home, but seven in ten would have preferred to do so ("How We Die").

Although many people still die in a health care facility, the role of religion-specific end-of-life care has not been widely studied. Many studies provide a broad overview of major religions, but not much focus has been brought to individual religions. Given the number of people who continue to die in institutional settings, more research is needed regarding how religious beliefs are honored and how religious practices are carried out near the end of life in these institutions. As the U.S. population ages, end-of-life care continues to be at the forefront of discussion in bioethics. By the year 2030, more than 20 percent of people in the United States will be aged 65 or older. This increase is due in part to improved preventive measures and life-sustaining medical treatment (Ortman, 2015). The growing number of elderly patients approaching the end of life and the growing diversity of their religious and spiritual beliefs suggest a need for increased attention to patients’ beliefs regarding death and dying in health care professional education.

There are limitations to accommodation of religious practices in the hospital setting. Sometimes, hospitals have guidelines and regulations in place that prevent religious rites from being carried out. For example, if a rite requires a lit candle, the institution may not allow this rite because it poses a fire hazard. The safety of patients and those around them must be taken into account before allowing the rite to take place. When possible, compromises should be made to accommodate religious practices. For example, instead of allowing a lit candle, a battery-operated candle may be substituted in order to carry out the rite and keep others safe. At other times, though, compromises are
not able to be made, and the health care provider may have to conscientiously refuse to allow a religious practice because of institutional rules and guidelines.

The final days of people’s lives are often a time of great vulnerability: it is a time when they are confronted with questions about suffering, the value of their life, who they are as a person, the relationships that they had during their lifetime and what it means to die a good death (Sulmasy, 2009). These questions are likely to arise whether or not a person has a specific religious faith or set of spiritual beliefs. It is common for people approaching the end of life to reflect on their life and attempt to draw meaning from the spirituality or religious beliefs that they have clung to during their lives. For some, it even helps them to understand the purpose of living (Sulmasy, 2009). All of the questions that a patient encounters at the end of life may contribute to mental, spiritual and even physical well-being or distress for the patient. Health care professionals who are committed to helping to alleviate the patient’s physical and existential suffering can thus pursue this goal more effectively if they understand the role of religion or spirituality in their patients’ lives.

Providing appropriate end-of-life care continues to be a difficult issue in the United States, as dying patients often find themselves torn between cultures of prolonging life and of letting go. The wishes of the individual ought to be paramount, no matter what his or her belief system is. One palliative care nurse argues that the ideal patient-professional relationship would entail listening to patients’ needs and wishes, assisting patients with obtaining necessary spiritual resources and guidance, and encouraging reflection on what the end of life means for them and what they will expect after dying (Amoah, 2011). Failure to assist in these aspects of care may result in serious
issues in the dying process. If people fail to discover a meaning or purpose by the end of their life, they might be plagued by guilt and uncertainty as to whether they fulfilled their duties in life (O’Brien, 2007). The emotional distress may even cause physical complications because of the interconnectedness of the mind, body and spirit. Most patients experience three spiritual needs when it comes to the dying process: identifying the meaning of life, dying in a dignified manner and finding hope for after death (Doka, 2010).

While the patient’s individual dying process ought to be the focus of care, many patients have similar needs and interests. Stepnick and Perry (1992) showed that while the dying process is unique for everyone, most patients experience a need for alleviation of depression, provision of comfort and an ability to obtain support. Potential other spiritual needs may include a need to “get right with God,” a feeling of forgiveness from and for others, and being surrounded by family and friends throughout the process. Ira Byock says that four simple phrases, “Please forgive me,” “I forgive you,” “Thank you,” and “I love you,” contain some of the most powerful words in the English language and give a clear path toward emotional wellness, something that is important during the dying process (Byock, 2004).

Another issue in caring for terminal patients is that it can be difficult for health care professionals to separate their own beliefs from those of the patient, particularly if the patient’s religious beliefs diverge very far from the health care professional’s own beliefs. McCormick (2014) writes that health care professionals should not impose their own beliefs on the patient, particularly at the vulnerable time of their terminal illness. Health care professionals need to take their cues from the patient with open
communication so that the patient does not feel uncomfortable speaking about spiritual issues and needs. Regardless of the beliefs of their patients, health care providers will have difficulty providing adequate emotional and spiritual support for patients without knowing what it means to respect their patients’ spiritual and religious needs.

**Statement of the Problem**

The U.S. population continues to age and grow more diverse every year. In order to provide adequate spiritual care for dying patients, there is a direct and urgent need for health care professionals to be more culturally sensitive. Professionals must be able to identify and appreciate diverse patient attitudes and beliefs toward religion when caring for patients in all stages of life, but particularly at the end of life. Because of the continued prevalence of death in institutional settings instead of at home, where most patients would prefer to die, staff must be aware of important cultural beliefs and practices in order to best serve the needs for their patients, especially with increasing religious diversity in the United States.

Though it is an uncomfortable topic for many health care professionals, there is a pressing need for open communication and acceptance of a variety of religious perspectives. Because of an unwillingness to communicate and general unease discussing less familiar religions, an inequality has developed for patients who practice non-Western religions in access to culturally competent or sensitive care and even to palliative care (Bosma, Apland & Kazanjian, 2010). However, new and continued conversation can aid
in increasing the morale of all those involved in end-of-life care, including family members, patients and health care professionals (Sinclair, 2011).

More research is being conducted on the effects of religiosity and spirituality in end-of-life care. On the one hand, because of the diverse population of both patients and health care providers, it would be difficult to require all providers to have a working knowledge of all of the religions and spiritual practices of those they may encounter. On the other hand, there is a notable increase in patient satisfaction when caregivers have some knowledge of patient backgrounds and the ability to provide competent spiritual care, even when patients do not have a religious affiliation (Johnson, 2006; Vail, Arndt, & Abdollahi, 2012).

Strides to increase patient satisfaction and increase culturally sensitive care have been made in recent years, but a gap still remains, leading to dissatisfaction in end-of-life care and avoidable suffering for patients and families. Increased communication must be made a priority in the patient-physician relationship so that health care professionals can become aware of patient expectations and needs and can alleviate the suffering of those patients.

An overall lack of understanding of how to deal with unfamiliar cultures and religions may also be a contributing factor to discord and dissatisfaction in care. In order to remedy the situation, cultural competency training should be made a priority so as to prevent unnecessary suffering for patients. Additional education about these diverse religious beliefs and practices would enable health care professionals to provide more effective care for patients approaching the end of life.
Throughout this thesis, I will be arguing for more effective cultural competency training for health care professionals. Although there are other terms that convey similar ideas, such as cultural sensitivity or cultural humility, cultural competency is the term used in most of the articles that I used in researching this topic. I have decided to keep the same terminology as the authors instead of replacing it with one of the other terms.

In summary, I have argued in this chapter that patients have a variety of different religious beliefs about death and dying and suggested that these beliefs can have a significant influence on care near the end of life and on patients’ dying experiences. In subsequent chapters of this thesis, I will review some of these beliefs and suggest a strategy for including this information in the undergraduate medical curriculum. I will argue that physicians can provide more sensitive care if they identify these beliefs and understand them better, and therefore this subject should become a standard part of medical training.
Chapter 2

Religious and Atheistic Views of End-of-Life Care

Religious belief plays a significant role in attitudes toward death and dying, and thus in medical care near the end of life. Religion enables believers to confront death in a distinctive way; for example, some faith traditions offer the prospect of spiritual immortality after physical death. The varied perspectives on end-of-life care of different religious traditions present challenges for health care professionals seeking to honor patient values and beliefs and to alleviate physical, social, spiritual and emotional suffering. To achieve these goals in an increasingly diverse society, health care professionals must recognize and respond to a variety of patient beliefs, values, goals and practices.

Christianity is by far the most widely practiced religion in the United States ("America's Changing Religious Landscape"). Other religious groups, including Jews, Buddhists and Muslims, account for less than 10 percent of the U.S. population all together. Since the majority of adults spend the last portion of their lives in institutional health care settings, and elders living at home often receive care from home health or hospice workers, health care professionals play a large role in aiding patients and their families in the dying process (Field, 1997). No matter what the patient’s religious affiliation or if they have none at all, a health care provider with a working understanding of an individual’s wishes will be more likely to provide the individualized care necessary to alleviate distress.
As Western medicine continues to develop, the focus has shifted toward treating and curing ailments, treating death as something to be avoided at all costs (Ortman, 2015). When patients receive a diagnosis of a terminal illness, they often experience physical, emotional, social and spiritual pain. In recent years, more research has been done on whether a person’s religion or spirituality can help him or her cope with a diagnosis of a terminal or chronic illness. One study found that religion in elderly patients helped to reduce depression (Koenig, 1992). This realization suggests that health care providers with knowledge of and sensitivity toward a person’s spirituality can affect their patients’ outlook on health and treatment. Professionals equipped with this knowledge can understand their patients better and more effectively respond to different types of suffering.

A person’s spiritual life can aid in the process of accepting difficult news and of dealing with grief or uncertainty about the future. Support from their religious communities reminds patients that they are not alone. For patients who are not religious but engage in individual spiritual practices, their spiritual life may remind them that they are part of something bigger than themselves and that there can be comfort in these times (Koenig, 1992).

In the remainder of this chapter, I will provide an overview of the beliefs of four common religions in the United States and atheism. The overviews, though broad, provide insight into the diversity of beliefs that are represented by various common religions in the United States. The value of health care professionals having a basic understanding of these religions is two-fold. First, understanding the diverse beliefs and recognizing their bearing on health care decision-making is crucial for providing
culturally competent care, particularly at the end of life. Health care professionals who understand that patients may have different views on health will be less likely to impose their own beliefs on patients or assume that the treatment plan they believe is best will align with patient values. Second, a basic overview of major religious beliefs and practices regarding death and dying can help professionals anticipate how people of different religions might make decisions about health care at the end of life. An ability to anticipate and respond to patient concerns can improve the care these patients receive.

**Atheism, Agnosticism and Non-Belief**

For my purposes in this thesis, I will group atheism and other similar belief systems under the general term “atheism.” I will also define atheism broadly as a lack of belief in a god or gods. According to a Pew Research Census in 2014, the number of people in the United States who chose the option “none” as their religious affiliation rose nearly seven percent from 2007 ("America's Changing Religious Landscape"). Although there was an increase during these years, atheism continues to represent a small portion of the U.S. population, and therefore it is likely that atheist patients’ belief systems will be different from those of their health care providers. It is important for health care professionals to recognize that it is the patient’s right and choice to have no religious affiliation and to consistently respect that choice.

Atheism dates back to skeptics of the supernatural in ancient times, as seen in Greek philosophy. Atheists often base their convictions on appeals to reason and empirical observation, sometimes citing Darwin’s theory of evolution and philosophical
attacks on religion and the supernatural (Vail, 2012). A survey designed to learn about the wishes and expectations of atheist patients in end-of-life care found that respondents’ most important concerns included: “pain and symptom management, clear decision making, preparation for death, completion, and affirmation of the whole person” (Smith-Stoner, 2007). Survey responders also cited a strong desire for health care professionals to respect their beliefs by refraining from praying for or attempting to convert them, as those actions put unwanted strain on them in the dying process (Smith-Stoner, 2007).

Atheist patients at the end of life stress things that are common issues for religious people, as well. Their main concern is peace, pain relief and comfort provided by health care professionals. It is also important to provide the patient with a care team that is focused on providing individualized care that takes into account patient beliefs and practices. In order to grasp the role of spirituality and other facets of the patient’s life, health care providers and chaplains may employ a list of questions that make no religious assumptions, but may aid in the process of providing individualized care for the non-religious patient. Questions proposed by Thiel (2015) include:

1. What is important in your life?
2. Where are your significant relationships?
3. What values are most important to you?
4. What gives you strength in challenging times?
5. What is disrupting access to these resources right now?

A central responsibility of the health care professional is to ameliorate patient distress. Raising these questions shows that the health care professional is focused on the
individual patient and offers a chance to use the patient’s own language in developing a
treatment plan.

**Christianity**

By far, Christianity is the most widely-practiced religion in the United States. From its beginnings around 2,000 years ago, Christianity has split into three basic divisions: Roman Catholic, Eastern Orthodox and Protestant. These three primary groupings include specific denominations, each bringing differing perspectives, practices and beliefs, including beliefs and practices regarding end-of-life care (“Christianity”). At the end of life, Catholics may wish to receive the Sacrament of Anointing of the Sick while asking God for forgiveness of their sins. Protestants, in contrast, may prefer that a clergy member recite biblical passages and sing hymns as they transition.

Christianity promises eternal life through belief in Jesus Christ, and this promise provides comfort for many Christians. The holy book, the Bible, consists of the Old Testament, written before the birth of Jesus, and New Testament, written in the time leading up to and after Jesus’ death. Jesus is believed to be the Son of God and through believing in him, Christians gain passage to eternal life. Jesus’ example is especially important in times of suffering and dying because of Jesus’ own compassion and suffering. It is through Jesus’ suffering and crucifixion that Christians obtain salvation, so in times of suffering, they look to his image and find solidarity with him in their faith (“Christianity.”).
Though most Christian denominations express beliefs about health, health care and dying, little research has examined how Christians apply these beliefs to decisions about at the end of life. Contributing to the lack of research about how Christians apply their beliefs to end-of-life care is disagreement between the Christian denominations in terms of end-of-life care. The different denominations have widely varied beliefs about the use of life-prolonging or life-sustaining measures, organ donation and other end-of-life issues. The variation of beliefs is also intra-denominational: there is sometimes disagreement about end-of-life between people who belong to the same denomination. Because of the variation, it is important to learn from the patient what is important to them and what their goals for care are.

One common theme for end-of-life practices in Christianity is that the presence of religious ministers is comforting for patients, as they can perform end-of-life rituals and that ensure after-death practices are followed (Puchalski, 2005). Ministers can offer prayers, hear confessions and perform other religious rites prior to and immediately following the patient’s death, easing the dying process for patients and their family members.

For Christians, death is merely a transition from their earthly life to the next life, and their relationship with God continues after death. Religious rituals and rites can be a way of easing the tension as the Christian gets ready for the next life. Prayers and other practices that are performed at the end of life vary from patient to patient, and conversation should be continually open between the health care provider and the patient and family to allow patients and families to achieve their important religious goals.
Islam

In recent years, immigration has significantly increased the number of Muslim residents in the United States. To provide more effective health care for an increasing number of Muslim patients, health care professionals may need to learn how Muslims’ beliefs and practices can affect their care. Muslims worship Allah as the one and only god and recognize the prophets Adam, Abraham, Moses, David, Jesus and Muhammad. Muslims believe that the prophet Mohammed received revelations from Allah during his lifetime, which were then written down to form the Qur’an, the sacred book of Islam (Puchalski, 2005).

Muslims also believe that there are five basic pillars of Islam: declaration of faith, praying five times a day, giving money to charity, fasting and a pilgrimage to the sacred sites in Mecca, Saudi Arabia. Muslims believe in predestination, the doctrine that Allah knows the fate of all living things before they are born. In the context of dying, Muslims recognize that all human beings will die eventually and, much like Christians, see death as a transition to the next life (“Islam”).

Sarhill, LeGrand, Islambouli, Davis, and Walsh’s research (2001) reports that Muslim patients must have their care handled by someone who is of the same gender as the patient. Because of the recognition that death is inevitable and death is the beginning of their eternal life, Muslims do not believe that life support should be employed if death is inevitable in the near future. Before death, ritual prayers are said and certain sacraments are administered. The prayers state the belief in one God, Allah, and give a testimony of faith. Especially important to the Muslim patient is the care immediately after death. The patient’s eyes and mouth must be closed, the patient’s head must be
turned toward Mecca and the body must be covered with a white sheet. Autopsies should not be done because there is to be as little handling of the body as is possible, and the body is not to be disfigured.

Islam teaches that forgiveness and redemption are possible through having a strong faith and a lifelong adherence to the five pillars. Repentance and lifestyle changes are the only ways to receive redemption. However, Muslims do also believe that Allah’s mercy can be sought just before they die (“Islam”). Adherence to the five pillars is also less important in the time leading up to death. If a person is diagnosed with a chronic illness, they may become fixated on their pilgrimage to Mecca until that is accomplished. But, fasting, prayer and bathing are excused if the patient is unable to perform these actions. Instead, others surrounding them pray for the patient. Another key tenet of Islam is that the male head of the family is authorized to make decisions for other family members, and they are expected to adhere to those decisions. All decisions about the body and religious apparel should go through him (Puchalski, 2005).

Judaism

Judaism is one of the world’s oldest living religions. The Jewish holy book, the Torah, expresses their religious beliefs and practices, including the Ten Commandments as revealed to Moses. The fundamental Jewish teachings, halacha in Hebrew, are based on the 613 commandments of the Torah. Judaism emphasizes ritual purity. The Torah gives strict orders about dietary restrictions, daily life, cleansing rituals, and adherence to the teachings. The three major divisions of Judaism, the Orthodox, conservative, and
reform traditions, all have different practices and beliefs about end-of-life and after-death care (Puchalski, 2005).

Although God is the Healer in Jewish culture, Jews believe that doctors are agents of God and are encouraged to visit doctors when they are sick. The traditional Jewish perspective recognizes terminal illness in two ways. The first is defined as having one year or less to live while the second means that a patient is actively dying. A patient who is actively dying experiences labored and erratic breathing and is described as someone whose “time has come” (Kinzbrunner, 2004). In the second state, it is prohibited to touch the body in any manner, even to administer medical treatment, as the slightest touch may hasten death. Hastening death in any form is punishable as murder in Jewish law.

The body is very important to Jewish people. They are mandated to seek health care as life is a gift given by God to be preserved at all costs. Because of this belief, many Jewish people seek extremely aggressive medical care, even if the disease is incurable. In times where death is imminent, a rabbi, or Jewish holy person, may allow for the withdrawing or withholding of life-support systems or artificial hydration and nutrition. Paramount for the Jewish person is cleanliness of the body, as caring for the body is a way for the person to honor God’s creation (Puchalski, 2005). Hygiene is of the utmost importance, especially in times of illness.

For Jewish people, the body is meant to be cared for as a temple of God, and there are many rules regarding handling of the body for religious purity. Some Jewish traditions are stricter than others with regard to purity. For example, Orthodox Jews do not believe in organ donation while other Jewish communities allow it. After a person has died, the body is unclean and may only be handled by certain members of the
community. Jewish law also states that the body is also never to be left unattended and if a family member is unavailable, arrangements must be made for someone to guard the body immediately following death (Loike et al., 2010). Close to the time of death, a prayer is said either by the patient or those who are close to him or her, asking for God’s forgiveness and accepting God’s judgment.

Buddhism

There are many forms of Buddhism around the world, but all of them are committed to following the teachings of Buddha. Buddha is not a god to be worshipped, but an enlightened teacher. Meditation is very important to Buddhists, as it is a form of detachment with the goal of reaching a point of enlightenment, called nirvana. Buddhism affirms the law of Karma. Karma is about cause and effect where a person’s actions in life will have an effect in their afterlife (Lundberg and Rattanasuwan, 2007). Staying positive in both mind and behavior will have a positive effect on life and the afterlife, and poor, negative actions lead to harmful effects on the individual who performs them.

Buddha also taught Four Noble Truths. The first, dukkha, means suffering because people learn to love and hold onto impermanent and unsatisfactory things of this world, leading to pain. The second, sameudaya, is a thirst for more of the impermanent things of this world. The thirst keeps people trapped in a cycle of death and rebirth, only leading to more dissatisfaction. Nirodha is the end of dukkha, when a person no longer craves the things of this world and reaches nirvana. The person no longer experiences
rebirth after reaching nirvana. Lastly, *Magga*, is the path that leads to nirvana. The path includes personal restraint and practicing meditation (Buddhism).

Much like their counterparts in other religions, Buddhists see death as a transition from this life into the next. A 2010 study performed by Braun and Nichols investigated religious and cultural values of Americans of Asian and Pacific Islander origin who practiced Buddhism. The investigators interviewed people from China, Japan, Vietnam and the Philippines. The study found that there were significant differences in belief and practice among national groups regarding post-mortem care and bioethics topics such as organ donation and suicide. In the case of organ donation, some Buddhists do not agree with the Western acceptance of brain-oriented criteria for death that make organ donation possible in many cases, while others view organ donation as a way of preserving life in another person. Suicide is also ending a life, which is a violation of the first of the Four Noble Truths, but death is also seen as a transition to another life. Thus, individual Buddhists hold different views on suicide (Puchalski, 2005).

When a person is dying, there is a concentration on the energy surrounding the patient. Family members and those close to the patient are encouraged to maintain positive energies and states of mind as the patient’s state of mind can affect his or her level of rebirth. The peacefulness of the environment and the family members’ willingness to remain calm can affect the person’s death as any disturbances can stop the soul from departing. No one should mourn and the patient should not be left alone, in order to promote the environment of peacefulness (Kongsuwan, Chaipetch and Matchim, 2012).
A Review

This chapter reviews beliefs and practices regarding death and dying of four major world religions and of atheism, and it considers how those beliefs may inform the health care choices of members of those groups. Though general in scope, the information in this chapter is crucial for understanding nuances in the various religious traditions and the importance of having a basic understanding of the beliefs and practices of these religions and atheism. Although general information is insufficient because beliefs vary significantly from person to person even in the same religion, it is an important starting point for appreciating diverse points of view. It is also important to remember that although patients may belong to a particular religious denomination, their individual beliefs may not coincide with the official doctrines of that denomination.

Health care professionals must learn strategies for interviewing patients to learn more about patient needs. Notably, the studies presented in this thesis all used interviewing techniques with qualitative and open-ended questions. For example, Vail, Arndt, and Abdollahi (2012) interviewed atheists using qualitative questions to gain insight into the spirituality and needs of patients at the end of life. Braun and Nichols (2010) took a similar approach, interviewing American groups of Asian and Pacific Islander descent to learn about differences between beliefs in different geographical locations. These studies enabled the authors to gain insight into the spectrum of beliefs and practices among people from the same religious tradition.

Of the four religions examined above, all have some things in common. First, all of the religions, with the possible exception of Judaism, believe in an afterlife. This belief gives them hope that their lives have allowed them to find favor with god, decreasing fear
of death. Second, all of the religions emphasize the role of the religious leader at the end of life. The ministers enable the patient and family members to perform specific prayer services and rituals to help the dying soul transition more smoothly and alleviate suffering. Third, religions originating from similar backgrounds tend to have more practices in common than those with disparate origins. For example, Islam, Christianity and Judaism are all Abrahamic religions, that is, all recognize Abraham as a common forefather. All three religions emphasize the importance of the body to God.

Although there are similarities between the religions, each tradition has its own beliefs and practices. Christians may wish for the Sacrament of Anointing of the Sick or for hymns and prayers to be sung as the patient dies (Puchalski, 2005). Jews believe that if a person’s death is imminent, the slightest touch may hasten death and is therefore punishable under Jewish law. Jews also believe that the body should never be left unattended. Muslims require that their heads always point toward Mecca after death and emphasize care provided by someone of the same sex as the patient. Buddhists believe that no one should mourn in the presence of the dying patient and that touching of the body should be kept to a minimum to promote the dying soul’s ability for a better rebirth. Finally, atheists request that health care professionals respect the patient’s lack of belief and offer care appropriately, being careful to utilize the patient’s language and offering no religious bias.

It is also important to understand that a generalized knowledge of the beliefs of common religions can be dangerous. Simply because people classify themselves as members of a specific religious community does not mean that they agree with the general beliefs of that religion. It is necessary to speak with each individual patient about
what he or she values and what his or her goals for care are so that the health care professionals can apply that knowledge to the patient’s care.

Despite the need for health care professionals to be informed about religious beliefs and practices at the end of life, they currently receive little practical training about these patient beliefs and practices. Without training in how to gain this information, through interviewing the patient, for example, health care professionals may be unable to provide adequate culturally competent care. In the following chapter I will describe and recommend a model for medical schools to incorporate into their existing curricula that offers students training in how to provide care for patients from diverse cultures.
Chapter 3

Addressing Culture and Religion in Medical Education:

The PRIME Curriculum

The changing makeup of the U.S. population has prompted American medical schools to re-evaluate their training for students. Cultural competence has gained attention in recent years as a way to combat physician ignorance of religious and cultural differences among patients. As these cultural and religious differences can have a direct impact on health and health care, it is crucial for health care professionals to have some familiarity with the perspectives they will likely encounter.

As aging Americans develop various chronic and acute illnesses that require health care, physicians and other health care professionals will be confronted with diverse religious beliefs and practices more and more often. According to Betancourt et al. (2005), the topic of cultural competence emerged for three reasons. First, the aging population brings diverse perspectives on health to their interactions with health care professionals. For example, people from different backgrounds may present symptoms differently, they may not speak English and have to communicate through an interpreter, and they may have different beliefs about how closely they should adhere to health care professionals’ recommendations. Second, if sociocultural differences are ignored and there remains a large knowledge gap, the affected population or populations, likely to be minority populations, will suffer from poorer health outcomes. Finally, two reports from the Institute of Medicine emphasized the importance of cultural sensitivity for patient-centered care.
The first Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, recommended an overhaul of the American health care system and provided direction for policy makers and health care professionals to help to close the quality gap between majority and minority populations and ensure that all patients receive the same standard of care (*Crossing the Quality Chasm*, 2001). The second report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, found that regardless of health insurance, members of ethnic and racial minorities often do not receive even routine medical procedures and experience an overall lower quality of health care (Smedley, 2002).

By the time that these reports had been released, work had already begun on creating standards for educating clinicians about cultural practices and about disparities in health and health care. In 1998, the U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA) and Bureau of Health Professions’ Division of Medicine and Dentistry developed a program called Promoting, Reinforcing and Improving Medical Education (PRIME). PRIME’s goal was to create and test a cultural competency curriculum that could be used nationwide in post-graduate programs (Cultural Competency in Medical Education, 2004).

The DHHS, along with the Human Services National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, also promoted the need for standards for educating medical professionals in cultural competence. The Liaison Committee on Medical Education (LCME) has the responsibility to develop standards for undergraduate medical education throughout the United States and Canada. The Committee periodically evaluates each undergraduate program and is responsible for
accrediting or denying accreditation based on its evaluation. Though there have been many different proposed models, the LCME introduced a standard in 2000 for cultural competency training in both medical schools and other post-graduate programs. It says, “The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery, while considering first the health of the patient” (Standards for Accreditation, 2007).

This standard led to a re-evaluation of the American undergraduate medical school curriculum to more effectively educate students on issues of multiculturalism and diversity. Ultimately, the goal was to develop an understanding of the potential and realized outcome of medical care that is given with attention to culture and diversity and to improve medical school curricula to promote training in this area.

The Research

In 2003, the Association of American Medical Colleges (AAMC) commissioned the help of three experts in the field of cultural competence to aid in developing a tool for integrating cultural competency content into medical schools. The first of the commissioned authors, J.R. Betancourt (2002), divided training in cultural competency in medical schools into three conceptual approaches that focus on attitudes, knowledge and skills. Betancourt argued that each of the three approaches is crucial to train medical professionals in providing holistic care to patients.

The first approach, called the “Cultural Sensitivity/Awareness Approach,” focuses on attitudes such as humility, empathy, curiosity, respect, sensitivity and awareness of the outside sources that influence the patient, such as social and cultural factors. This
approach teaches health care professionals self-reflection and invites them to consider their own culture and the biases, beliefs and behaviors they have that could have an influence on patient care. Betancourt proposed that this dimension of cultural competence be taught in the early years of a medical professional’s education to promote reflection in later periods. This approach has its limits: although training programs can teach these practices, it is difficult to test whether the health care professional is doing them appropriately because the approach does not provide a standard model that works for everyone. The students must learn what works and is comfortable for themselves individually.

The “Multicultural/Categorical” approach focuses on the knowledge of the health care professional. It seeks to increase the knowledge of the health care professionals about attitudes, beliefs and behaviors of patients from a multitude of backgrounds. This approach does not come without risks: this method may encourage stereotyping and assuming that all people of certain backgrounds are the same. In a study performed by Shapiro and Lenahan (1996), it was found that the tendency to stereotype because of approaches such as this one could be very detrimental to a patient’s health; it may encourage students to assume that, because patients belong to a particular culture, race or religion, they hold all the same beliefs as others belonging to that community. However, this approach emphasizes the importance of patient tendencies toward common spiritual practices, common diets, disease incidence and the history of specific cultures, among other types of knowledge. Because of this emphasis, it allows health care professionals to have a working knowledge of backgrounds and religions that can enable them to start a conversation with the patient about what is important to him or her. Like the Cultural
Sensitivity model, this approach also requires some inward reflection throughout their preclinical and clinical education.

The final, “Cross-cultural” approach teaches communication skills that help health care professionals communicate with patients and be aware of sociocultural issues and beliefs about health care. The method also provides a framework for how to proceed with medical treatment once they have spoken with patients about beliefs. Through communication and interviews with the patient, the health care professional is able to gain an understanding of how they view their illness and how they wish to proceed with treatment. This approach allows for more patient-centered care, as patient beliefs, values, religion and practices are at the forefront of coming up with a treatment plan. The health care professionals are therefore less likely to generalize about specific cultures and ethnicities, protecting the patient from receiving care that does not align with their views on health and death.

The second commissioned author, Melanie Tervalon (2003), was also fundamental in the development of cultural competency education for health care professionals, particularly in undergraduate medical education. Tervalon states many reasons for the importance of cultural competency education for undergraduate students, including the changing demographics of the U.S. population, negative health impacts when culture is dismissed as a factor in health and studies that have proven that cultural competency education can contribute to the narrowing of the health care gap between racial minorities and majorities.
Tervalon argues for the importance of understanding patients’ cultural views on death and dying and the role that their spirituality plays in health care. Instead of asking students to learn a list of the core values for each of the major cultures and subcultures represented in the United States, Tervalon states, “Emphasizing core cultural issues avoids the problematic approach of presenting detailed lists of traits or characteristics associated with particular cultural groups as knowledge items for students,” (Tervalon, 2003). Asking students to memorize lists of cultural information increases the likelihood that generalizations and stereotypes will be used during treatment, potentially negatively affecting the treatment that the patient receives. Tervalon’s approach is less focused on memorizing beliefs and more on the issues that are within the culture of the individual patient, such as how his or her cultural group interacts with members of other cultures.

Interview skills are also crucial to the development of a culturally competent relationship between patients and health care providers. Enabling patients to ask questions about their treatment is paramount to delivering appropriate care. In this case, patients are the experts in care because they are the ones who should determine how much their cultural beliefs and values should influence health care decision-making. The provider’s role is to gain information about patients’ goals and views of health directly from the patients themselves when possible, to use sociocultural profiles during the interview process and to reflect on how patients’ cultural beliefs will affect the care that they will receive and how they will influence the provider’s decision-making. For example, a physician may wish to consult with another physician about treatment for a Muslim patient. The consulting physician must also be the same gender as the patient and this restriction may influence the choice of a consultant.
According to Tervalon, the training that health care professionals receive is also very important in reducing the impact of personal biases. When the instruction is effective and standardized, health care providers are more likely to be aware of their own biases and to recognize when certain health care resources are being denied to specific cultural or spiritual groups. Although this model does little to address the presence of implicit bias, it does offer training for medical professionals on how to deal with their own bias, explicit or otherwise.

When health care professionals have negative stereotypes about cultural groups, they may depart from the standard of care and exacerbate health care disparities. In order for health care professionals to prevent negative stereotyping, as students they must be taught inward reflection and self-assessment. In the model proposed by Tervalon, students must acknowledge their own cultural identity along with those of their peers and how their identity may conflict with others in the health care setting. Then, students must learn to identify the existence of bias, prejudice and discrimination and how to correct them through anti-bias training. Lastly, students must use the self-reflection tools that they have been taught for the entirety of their careers.

Emphasis on the community surrounding the academic medical center is also vital. In order to teach the future health care professionals about the lives of their patients, it is important for members of the community in which they live to explain how the community functions and what is important to them. Introducing community teachers who can educate health care professionals about the nature and culture of the people with whom they will come into contact can encourage the professionals to accept responsibility to care for the members of the community.
Finally, the third IOM consultant, Majorie Kagawa-Singer (2003), offered suggestions similar to those of Betancourt and Tervalon. The first step in implementing cultural competency into medical education, according to Kagawa-Singer, is for health care professionals to become aware of their own beliefs. Second, the health care professional should interview patients using open-ended questions that allow patients to convey their beliefs and practices. Through the interview, the health care professional can learn what is important to the patient and how it would be best to proceed with care. Finally, institutions must develop policies and strategies for overcoming cultural biases so that patient satisfaction and quality of care for individual patients are the top priority.

**Tool for Assessing Cultural Competence Training (TACCT)**

Using the information gathered from the three commissioned papers described above, the AAMC sought the best way to incorporate cultural competency into medical school training. The AAMC brought together a panel of experts in medicine, anthropology and other relevant fields to identify which areas of cultural competence were most important to incorporate into medical school education. The AAMC proposed the Tool for Assessing Cultural Competence Training to enable medical schools to identify inclusion of cultural competence training in their existing curriculum so that they will meet the LCME standard mentioned above (Lie et al., 2008)

In using the TACCT, medical schools evaluate their own curricula to find the areas where elements of cultural competency are taught. It also allows schools to find areas where there are gaps in teaching and areas where goals are not being met. The tool
falls short, though, in enabling schools to view *how* cultural competency is taught. Since there are various venues for cultural competence to be taught, the tool does not allow for all learning to be documented. For example, during clinical rotations, a student may come into contact with a patient from a different religious background. The student can use this encounter to gain cultural competency experience, but the student’s increased understanding is not able to be measured using the TACCT.

**A New Model for Cultural Competency Training**

The development of the TACCT was a large stride in ensuring that medical schools provide cultural competency training for their students. However, the system for evaluating places where elements of cultural competency training takes places does fall short. Although the tool is used to find areas where the institution educates the health care professionals in cultural competency, it does not actively show *how* the training happens. There are many ways to teach cultural competency, ranging from practice in the field to classroom lectures and workshops. But, as schools generally only use a small amount of curricular time discussing cultural competency in patient care, it is important to identify the best teaching methods. Most cultural competence training happens in the first two years of medical school and is not reinforced afterward. To be most effective, however, the training must be continual and easily applicable to the daily life of the health care professional (Kripalani, 2006).
The PRIME Cultural Competency Curriculum works within the schools’ existing curricula to find areas where cultural competency would best be taught. The system includes several different, but equally important, elements to be included in the curriculum throughout professional education. It also includes 27 “Core Competencies” or goals for basic understanding that students should gain by completion of the curriculum (Cultural Competency in Medical Education, 2004).

PRIME takes advantage of the Adult-Learning Theory developed in the 1980s, which states that adults learn best when the materials are connected to their own experience. The theory suggests that adults absorb information best when the teaching is self-directed, possesses a foundation of life experiences, is goal-oriented, is relevant and has clear practical application. Additionally, the role of instructors for adult learning is that they convey the relevance of what they are teaching to the student, teach through experience and problem-solving and provide practical application of the information (Knowles, 1984).

Using the Adult-Learning Theory, the PRIME curriculum combines knowledge and experience, enabling teachers to convey information and give students opportunities to apply it in the health care setting. For example, students may learn concepts of various cultural and religious practices in the classroom and how patients’ spiritual practices may affect the care that they receive. Students will then be able to apply this knowledge to the situations that they encounter in their clinical rotations.

The PRIME Cultural Competency Curriculum begins with student development of definitions for culture and cultural competency. These are foundational and working definitions so that students can apply them throughout the program. Using these
definitions, students will be able to see how language, worldview, spirituality and many other personal characteristics affect patient definitions of health and views of health care. The Core Competencies for this section are that students have a working definition of culture and the different elements that make up culture.

The second aspect of this cultural competency curriculum is developing working definitions of diversity and diverse populations and their relationship to culture. The students are taught that populations are not uniform and each person is unique. Students learn to avoid stereotyping and bias as well as strategies for ascertaining what care ought to be delivered to each individual patient. The main topics addressed in this section include, but are not limited to race and ethnicity, spirituality and religion, sexual orientation, socioeconomic status, family dynamics and modes of communication. The goals for the end of this section are for students to understand that there are both visible and invisible parts of culture, to recognize subcultures and individuality of people within a population and to recognize their own tendencies toward bias.

The third building block is pulling issues of diversity from the abstract to the concrete and making them directly applicable to health care. This part shows how culture affects health care and how the relationship between health care and culture has changed over time. It also examines the increasing diversity of the U.S. population and its influence on health care. By the end, students should understand the relationship between culture and health care with particular knowledge about how the relationship has developed in the past and where it looks to be headed for the future. Students should also understand the implications and importance of culturally competent health care.
The fourth part of the curriculum considers how spiritual practices affect health care and the individual patient’s view of health. Without this knowledge, there may be misinterpretation of symptoms by either the health care provider or the patients, and misunderstandings may lead to misdiagnoses. An example of the importance of understanding the patient’s context would be that a patient of one culture who is experiencing pain may attribute it to a kind of imbalance of the spirit or as punishment from God. If the health care professional does not have a basic understanding of the patient’s beliefs, he or she may not provide the care that the patient needs. In this example, the health care professional may opt to provide the patient with access to a spiritual leader for their religion who can offer guidance to the patient. If misunderstandings persist, they can affect the relationship between the physician and the patient as well as the quality of care that the patient receives. The Core Competencies for this section are to recognize how different cultures view health and illness and to become familiar with different religious beliefs about health care. In training the students to recognize how different religions and cultures view the causes of illness and treatment, health care professionals can more provide more adequate care for the patient.

Another part of the curriculum is introducing students to the importance of how the patient’s views can affect patient decision-making. This aspect dives deeper into areas of familial structures and relationships, how the patients views their own illness and the trustworthiness of the health care system as a whole for particular cultures. In completing this section, students learn about folk and faith healing and their roles in meeting patient health needs.
Also important for teaching students about culturally competent care is training them how to handle situations where their own views about health and treatments directly conflict with patient views. In this section of the curriculum, students review types of these conflicts, discuss how to address conflict and examine strategies for coming to a mutually agreeable decision that respects the patient while also meeting the needs of the care team.

Research commissioned by the AAMC found that interview skills are crucial for understanding and communicating with the patients. The next building block teaches physicians appropriate forms of communication and how to elicit the patient’s views of their situation to aid in delivering culturally competent care. Through effective interviewing, the physicians can learn necessary information for treatment, such as family dynamics, religious or spiritual views and cultural views on illness and disease. In establishing effective communication, the physician enables the team to be able to deliver appropriate care. By the end of this part of the training, students are be able to demonstrate that they are able to effectively understand the patient’s perspective, including his or her concerns and goals and are able to recover from any miscommunication in the past.

After learning the basics of interviewing, students learn how to utilize interpreters effectively. Students learn how interpreters can help to eliminate communication barriers between the health care team and the patient. The Core Competencies for this part are abilities to identify when an interpreter is necessary, to obtain an interpreter when needed and to utilize interpreters effectively.
The last part of the PRIME Cultural Competency curriculum is teaching students to take the patient’s cultural profile. The students are taught a framework to help them identify and assess elements of different cultures. Examples of this part would be learning how to identify how patients prefer to communicate and to identify family relations and dynamics. They also learn what the patient values about his or her culture. Core Competencies for this portion of the curriculum are an ability to identify the elements of a cultural profile and record those in the patient’s medical record (Cultural Competency in Medical Education, 2004).

**Barriers to Effective Cultural Competency Training**

One of the main barriers that prevents more extensive cultural competency training in medical schools is a lack of institutional support. Without the support of administrative team members, funding is not available, staff cannot be allocated appropriately and the overall success of the cultural competency programs will be diminished. In order for a successful change in curriculum to take place, the administration, students and faculty of the institution must be on board. The LCME requires that medical school faculty demonstrate an understanding of the diverse cultures and belief systems and the commitment of each group of stakeholders is needed to fulfill the LCME’s requirements for teaching this topic.

When shifting toward a cultural competency model of teaching in medical schools, there may be some backlash from faculty who do not understand the importance of cultural competence for their subject matter. Often, securing the commitment of
faculty members to introducing cultural competence in their courses can be difficult. As stated before, the goal should be for all faculty, staff and students to understand the negative outcomes that come from failing to educate students on how to provide culturally competent care. The PRIME model takes some of the pressure off of the faculty and allows them to seek aspects of cultural competency in their existing classes. Whereas another model may require employing separate or supplementary faculty, the PRIME curriculum allows teachers to use their experience in teaching their courses to find areas where cultural competence would be important. The administration would need to be diligent to ensure the necessary tools are being taught to students and help teachers incorporate the curriculum into their classes.

In other models, students are taught cultural competence in elective courses. Some students may sign up because of personal interest in the material, but when the cultural and diversity training classes are electives and there is no need or requirement for them to enroll in the classes, the classes may not have many students enroll. Additionally, when the courses are offered for first and second year students, second year students are uneasy about taking on extra coursework, especially when it is not required, before their board exams (Cultural Competency in Medical Education, 2004). By incorporating the PRIME curriculum, students will gain necessary knowledge in cultural competence in applicable ways through the classes that they would already be taking. It does not add pressure to students by requiring them to take on additional courses, and every student would learn how to provide culturally competent care, reducing the care gap and improving the relationship between health care providers and their patients.
Prior research studies had shown that there are many ways to teach cultural competency to students entering the medical field. It can be taught through lectures, role-playing exercises, workshops or clinical rotations. The disadvantage of these models, however, is that they often portray cultural competence training as something that a student has to learn after clinical training was over or, in cases of lectures and workshops, as something completely separate from clinical training. The models often pigeon-hole cultural competence instead of allowing the training to be used in everyday medicine. Recreating the existing curricula and revamping the views that professional schools and their students have about cultural competence enables students to learn how to deliver culturally competent care throughout their career (Cultural Competency in Medical Education, 2004).

Despite research supporting the PRIME model, there is not a consensus on how to incorporate cultural competency effectively into education for medical professionals (Kripalani, 2006). On the one hand, there is a need for the delivery of culturally competent health care. In fact, in a study conducted in 2005 involving more than 2,000 physicians in their final year of residency, 96 percent stated that having training in cultural issues was moderately or very important. On the other hand, the same study revealed that only 20 to 25 percent of the respondents felt prepared to provide specific components of cross-cultural care (Weissman et al., 2005).

The research has shown that cultural competency educational programs can improve the quality of care for patients and reduce or even eliminate cultural and racial health care discrepancies (Crossing the Quality Chasm, 2001). Without a consensus on
how best to provide the education, there is no uniformity, which can lead to variability in the quality of care that patients are provided.

Since its inception, the PRIME curriculum model has challenged educators to incorporate its various building blocks into their existing curricula. With its open-ended structure, it allows for medical schools to adjust courses within the curriculum instead of requiring them to do a full overhaul. The administration or other faculty members can employ the TACCT to find places where their cultural competency education may be lacking. Then, they will be able to find ways to develop and foster cultural competence in their students through existing classes. This approach may save time and money for the schools.

Other models for medical students offer cultural competence education for a total of one week (Kripalani, 2006). This small amount of time spent on this integral part of educating future medical professional is not likely to lead to a long term change in behavior and does not allow for the development of skills that can be used in the workforce. Additionally, because of the lack of standardization or curricula throughout the United States, little research has been done on the effectiveness of different cultural competency programs. The extreme heterogeneity of the medical school curricula makes it nearly impossible to determine the effectiveness of current curricula (Beach et al., 2005).

Because PRIME allows for the introduction and continuing education of cultural competency throughout the entirety of the program, it is best suited to provide students with the resources that they need to provide adequate care to diverse populations. Students are frequently evaluated on their ability to obtain information from patients to
help them to make health care decisions that are best for the patient. Incorporating the message of cultural competency should be a priority throughout medical education, not just in an isolated workshop or elective. Learning about providing care while doing rounds allows for a wholesome approach to health care for students and for understanding how culture and religion may affect patients’ experience of illness and their health care choices (Kripalani, 2006). The standardization of the curricula would also allow for studies to be performed to determine the most effective ways of incorporating cultural competence into medical education.

I believe that the PRIME model is an easier model to apply to the curriculum than a complete overhaul and, despite its flexibility, is the best model for standardization. Its design enables cultural competence to be taught throughout the program using the schools’ existing curricula, but ensures that all medical professionals will graduate with core knowledge to help them provide culturally competent care. Instead of spending time, money and other resources in extensively training faculty members in cultural competence, the PRIME curriculum allows teachers to assess where they believe that cultural competence should be incorporated into their existing classes. Students would benefit from the teachers’ experience in the field and learn how to apply it to daily situations in their professional lives.
PRIME, Spirituality, Religion and End-of-Life Care

The PRIME curriculum trains health care professionals in how to understand the patient’s needs while meeting the needs of the care team. The fourth and fifth aspects of PRIME as detailed above emphasize the importance of spirituality and religion on the patient’s views of health care and also on family dynamics. By having this educational background, the health care professional is able to understand more fully patients’ wishes at the end of life and how their treatment can affect their dying process.

Also emphasized throughout PRIME is the importance of listening to patients and learning about how they understand what is happening to them. In many cases, interviewing patients and listening to their needs, particularly as their time of death draws closer, can help to address exactly what patients wish their end of life to look like.

Sometimes, the patient’s views on the end of life may come into direct conflict with the beliefs of the health care professional. PRIME offers a portion of the curriculum to addressing that scenario, using real cases. The health care professional will be able to draw upon that experience and utilize it to come to a decision for how to proceed with care.

The PRIME curriculum offers medical students the necessary training to provide patients with culturally competent care at the end of life. In the fourth and fifth building blocks of the model, students explore how a patient’s spiritual life may affect medical decision-making at the end of life. Core Competencies are used to ensure that they have a working knowledge of various religions and cultures they may encounter and also how they can utilize hospital resources to give the patient access to what they may want or
need. After successful completion of the curriculum, health care professionals will be able to understand their patients better and offer them appropriate care.

The PRIME curriculum was developed as a part of a study begun by the AMA to address the issue of health care disparities among different races in the United States. In 2004, the Commission to End Health Care Disparities was established by the AMA and the National Medical Association. As a part of the Commission’s plan to help reduce health care disparities, it developed the PRIME curriculum for medical students so that they would be able to provide adequate care to a diverse population. The Commission officially ended in 2016 and literature about the study is being released (“Reducing Disparities in Health Care”). Other parts of the study examined how an increase in the number of racial minority physicians affected patient care as well as increasing public literacy about health (“Reducing Disparities in Health Care”).

A person’s spiritual well-being may have many effects on health care. In the following chapter, I will discuss the negative effects of spiritual suffering and the role of health care professionals in promoting spiritual well-being for patients.
Chapter 4

The Future of End-of-Life Care

In this thesis, I have argued that provision of appropriate care for a diverse and aging patient population requires medical professionals to understand how the spiritual lives of patients can influence end-of-life care. To achieve this educational goal, I have proposed that medical schools implement a model curriculum that trains medical students to provide culturally competent care to all patients, regardless of background. Despite efforts made by agencies such as the AAMC and LCME to implement cultural competency curricula in medical schools, little progress has been made toward standardizing what is being taught. Research conducted on current models reports that American medical schools are not meeting the LCME requirement that students to understand the significance of the patient’s background for their medical care. Some authors cite the lack of social and behavioral science training in undergraduate medical education for not preparing students adequately to provide culturally competent care (Rapp, 2006).

Little detailed information about cultural competency training in medical schools is available, because of the lack of standardized approach to this topic in the curriculum. Without standardization, each medical school is left to its own devices for meeting the requirements of the LCME, creating extreme variability in strategy. This variability makes it difficult to investigate which model is best. Furthermore, current models focus cultural competence training in the first two years of medical school, but do not hone these skills in the clinical training of the third and fourth year curricula. The lack of reinforcement and opportunity to apply their knowledge in a clinical setting poses a
major threat to cultural competency education. Without standard competencies and reinforcement of strategies in clinical situations, students may forget the strategies or misunderstand how to apply them in the clinical setting.

The PRIME curriculum offers guidance in how to teach cultural competency in ways that directly apply to what students will face in the clinical setting. Included in the curriculum is an exploration of how diversity affects medicine as a whole and how appropriate interactions with patients boost trust in the relationship. Appreciating the relationship of medicine and spirituality is essential for understanding how a patient sees his or her illness, and it enables the health care professional to provide more adequate care to the patient, alleviating suffering caused by questions that many patients confront in the dying process. Although it is impossible for health care professionals to be familiar with all religions and spiritual backgrounds, the PRIME model teaches interview skills for how to learn about the patient’s spirituality and how it can affect care. Learning the patient’s own preferred language can enable physicians to use that language to convey treatment information more effectively. These interviews can provide valuable guidance, enabling medical professionals to learn about what patients value and believe and how they practice their spirituality or religion.
Spirituality and the End of Life

Victor Frankl once wrote, “Man is not destroyed by suffering; he is destroyed by suffering without meaning” (Frankl, 1984). How patients understand their illness and deal with suffering is often tied to their spiritual life, and one of the challenges that healthcare professionals face is knowing how to help patients find that meaning at the end of their lives. For many people, religion and spirituality provide that meaning (Foglio, 1988). At the end of life, patients may wrestle with questions about what awaits them after death and, if there is a god, how he or she will care for them. These struggles can be deeply personal and may require support from the care team. The care team will be able to facilitate the interventions of other professionals, such as chaplains, or offer a listening ear to patients who need to talk.

Puchalski (2001) offers several cases describing how patient spirituality influenced the care she provided and how she as a physician was able to support her patients in their suffering. In one case, a patient was diagnosed with HIV. When the physician informed the patient of her illness, the patient interpreted the diagnosis as punishment from God for something that she had done previously in her life. Only after addressing her spiritual issues with a minister was she willing to seek treatment. Puchalski was able to facilitate the meeting with the minister and stand by her patient as she wrestled with this existential crisis. In another case, a patient at the end of her life used her spirituality to cope with her illness. The patient’s religious community was a very large part of her life and she benefited greatly from the support system her community offered. The physician’s role in this case was to be aware of her deep
spirituality and to encourage visits from members of her religious community in order to provide her with strength and hope.

Cases like these illustrate how teaching medical professionals to support their patients’ spiritual needs is necessary for providing patients with adequate care. The health care professional provides care for the patient’s mind, body and spirit. Offering holistic care is very important because, especially at the end of their lives, patients may turn to their spirituality to deal with their suffering. Having a physician who can support them in this time is important to enable spiritual healing to take place, even when physical healing is no longer possible.

The PRIME curriculum guides students in delivering care that enables patients from diverse backgrounds to experience spiritual healing at the end of their lives. Throughout the curriculum, students are encouraged to listen to their patients, interviewing them to gain insight into their spiritual lives and learn about what patients value so that they can best help their patients answer questions that they have at the end of life. The most important reason for addressing the spirituality of the patient is that the patient’s spiritual concerns affect the whole person. Taking the patient’s concerns about spirituality out of the relationship between the patient and the physician completely ignores a part of the patient’s well-being and discounts the role those questions play in his or her view of health. Ignoring these concerns can be especially damaging at the end of life when medicine is no longer focused on curing the patient. The suffering that patients feel may manifest in many ways. Sometimes spiritual suffering manifests by causing a person to be extremely emotional and lash out at caregivers, friends and family. It also may present itself as depression, causing the patient to withdraw from the care
team and others. It also can manifest as physical ailments, creating symptoms that had not been present previously.

In 1999, the AAMC published Report III of the Medical School Objectives Project (MSOP), which included the following description of spirituality in the clinical setting:

“Spirituality is recognized as a factor that contributes to health in many persons. The concept of spirituality is found in all cultures and societies. It is expressed in an individual’s search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All of these factors can influence how patients and health care professionals perceive health and illness and how they interact with one another” (AAMC Report III, 1991).

This definition of spirituality reinforces the importance of spirituality in the health care setting. Spirituality is not culture-specific and may have drastic influence on patient decisions and how they view health.

Religiosity is deeply personal and develops over the course of a person’s lifetime. No matter what religious affiliation people have or whether they have one at all, their beliefs based on personal experiences or relationships with the transcendent or nature can enable them to answer the question of why they are here. Because it is so personal, there cannot be a uniform way of handling spirituality at the end of life. The strategies that are taught in the PRIME curriculum offer guidance for initiating the conversations about the role of spirituality in the patient’s life and steps to take after the beliefs are made known.

A person’s spiritual well-being is linked to many aspects of health care. Studies have shown that when a patient’s spiritual life is tended to, they are less likely to experience loneliness and anxiety while also being more likely to handle difficult situations positively and have hope during times of despair (Hermann, 2007). In another study, researchers found that patients nearing the end of life rated spiritual well-being nearly as important to them as pain control (Steinhauser et al., 2000).
Numerous studies have been conducted on patient sentiments toward discussing spirituality with their health care providers. These studies show that between 65 and 95 percent of respondents wish that their health care provider would discuss issues of spirituality with them, but only around 10 percent of providers do so (Ehman et al., 1999; McNichol, 1996). The gap between the care that health care professionals provide and the care that patients desire is astounding. It is widely recognized that health care professionals have an obligation to relieve the suffering of their patients. In fulfilling this obligation, health care professionals should communicate with their patients about their spirituality and offer opportunities for allowing patients to practice their spirituality in the health care setting.

Also important to consider is the role of the family as their loved one dies. Ultimately, this time can be very distressing for all, and a negative experience with health care professionals who do not attend to the patient’s beliefs can cause serious problems with the family, too. Health care professionals must consider how much to involve the family in the care process and should speak to the patient, if possible, to inquire about the family’s involvement.
Conclusions

Recent developments in Western medicine have caused the need for a re-evaluation of the education that health care professionals regarding provision of culturally competent care. The focus of medicine has changed from “treating the disease” to “treating the patient.” Promoting quality of life by alleviating pain and suffering in the spiritual, emotional, social and physical realms is an important feature of this new focus.

The diversity of the aging U.S. population makes it crucial for health care professionals to learn to provide culturally competent care to patients regardless of religious background. Because the majority of people die in institutional settings, health care professionals are responsible for caring for patients at the end of their lives and for providing care that ameliorates their suffering. The end of life can be a time of vulnerability for patients, as they confront questions about the meaning of their life. They may question whether their life had value, who they are as a person, the quality of the relationships that they had during their lifetime and what it means to die a good death. Health care providers should be committed to helping their patients address these existential questions.

Education is the most valuable tool for ensuring that culturally competent care is delivered for each and every patient, regardless of religion. Current medical school curricula, however, do not adequately prepare students for this aspect of their work in the clinical setting. Although some professional schools teach generalizable information about leading religions, this information is insufficient and can lead to stereotyping. Other models may also pigeonhole cultural competency, giving students information that they are not able to readily apply to the clinical setting. The PRIME curriculum enables
medical schools to use their own existing curricula to teach students strategies for
delivering culturally competent care. The PRIME curriculum also offers core
competencies that can standardize medical education in this area. Standardization would
be a significant step toward the goal that all students have the skills to deliver culturally
competent care by the time they enter the clinical setting.

The need for culturally competent health care professionals is clear. The aging
U.S. population is more diverse than ever and will require access to care that offers to
heal the whole person, even in cases of incurable illness. Patients’ views about their own
spirituality and health must be respected and honored. Failure to do so may expose
patients to unnecessary suffering and deprive them of a good death. To address this need,
I have proposed in this thesis that medical schools implement a curriculum that can
enable physicians to recognize, understand and address the religious and spiritual beliefs
and practices of their patients.
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