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American society has become increasingly diverse. Critical to respecting this multicultural diversity and fostering acceptance among persons of diverse ethnicity, races, and cultures are increased education and awareness, especially on end-of-life and after-death rituals. Although an expansive body of literature has been created to explore the significance of religiosity and spirituality on the issue of death and dying, there is inadequate research on clinical practices provided for the deceased with different religions. Moreover, there is an expanded atheist population in the United States, which requires healthcare professionals to have a basic respect and acceptance for atheists' preferences and wishes toward death and dying. This study concentrates on the cultural and clinical rituals for end-of-life and after-death care for individuals affiliated with Christianity, Judaism, Islam, Buddhism, Hinduism, and atheism. A series of systematic interviews were conducted with an atheist president and eight religious leaders representing each religion. Additionally, a survey was distributed to staff from one Continuing Care Retirement Community (CCRC) in the greater Piedmont community to obtain their existing knowledge about end-of-life issue, especially after-death care. Specific end-of-life and after death customs, opinions on suicide, organ donation, euthanasia, and corresponding suggestions for healthcare providers will be discussed for each religion and atheism. The goal of this research is to provide accessible and

understandable information on end-of-life and after-death customs for healthcare professionals in a variety of healthcare settings.

MULTICULTURALISM: INCREASING SENSITIVITY AT END OF LIFE AND AFTER DEATH CARE

by

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APPROVAL PAGE

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A NOTE ON THE RESEARCHER

The researcher for this thesis lived in China until she was 24. Being raised in the Peoples Republic of China during a time of increasing economic growth permitted her advantages for education; however, as with the great majority of citizens, religion had been removed from her life and history. Because she was raised absent from any religious influences, no spiritual bias on both the attitudes and conclusions in this study would be expected. In addition, she has a clinical background as a Registered Nurse in China, which provided her with extraordinary insights into the clinical end-of-life and after-death practices crucial for maintaining individuals' dignity, fulfilling their final wishes, and providing comfort for family members. These insights were a driving interest in this study when the researcher came to study in America.

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CHAPTER I

INTRODUCTION

American society has become increasingly diverse. Education and awareness about the varied expectations and rituals for the end-of-life and after-death care are vitally important to truly respect the diversity of multicultural individuals who live in the United States. According to Putnam and Campbell (2012), 83% of people in the United States stated a religious affiliation, 40% reported attending church services at least once a week, and 58% said they prayed on a weekly basis. Christianity, which has the most followers in America, accounts for approximately 78.4% of the total American population (Putnam & Campbell, 2012). Jewish people comprise 1.7% of the American population, while Buddhists, Muslims, and Hindus represent 0.7%, 0.6%, and 0.4% of the United States population respectively (Putnam, & Campbell, 2012). Besides people with different religious affiliations, atheists account for approximately 12% of the American population (Putnam, & Campbell, 2012). With this increase in the diversity in America, there is an expanding demand for healthcare professionals who understand and can provide holistic end-of-life and after-death care that brings hope for the frail individuals and families, regardless of their religious and spiritual beliefs.

Death is a natural and inevitable process that raises ethnic, cultural, and religious considerations. While none of humanity may escape death, individuals with different

religious and cultural backgrounds perceive death differently. Cultural, religious, and spiritual aspects strongly influence end-of-life and after-death decisions (Ford, 2012; Broeckaert, Glelen, Iersel, & Branden, 2009). When approaching death, many people hope to find meanings from both religious beliefs and spirituality that can help them understand the purpose and meaning of their own lives (Sulmasy, 2009). For some, immediately after death, a religiously-appropriate manner in handling the body assists the deceased with achieving a smooth transition, receiving appropriate and beneficial comfort and assurance, and decreasing unnecessary conflicts to the afterlife. The influence of religiosity and spirituality cannot be neglected in the end-of-life process (Amoah, 2011). Patients possessing a strong religious belief often obtain relief from suffering and find hope for the next life, while people without religious beliefs may concentrate on spiritual perspectives, which can assist them with understanding the meaning of their lives. Both of these two viewpoints are to be respected and supported by staff members, who provide end-of-life care.

The rich diversity of the United States poses considerable pressure for medical staff in institutional settings, as it can often be difficult, or even impossible, for staff to have complete knowledge of all practices and beliefs of every cultural, religious and spiritual group in the United States. Nevertheless, cultural and religious beliefs strongly influence healthcare decisions an individual makes, especially with regard to the end-of-life and after-death decisions (Ramirez, 2009; Nolan & Mock, 2004). Caring for the deceased and their family members can be demanding and complex; therefore, it is

crucial for staff to pay attention to these rituals and arrange relevant services when required (Hills, & Albarran, 2010). In addition to these death ritual differences, attitudes about suicide, organ donation, and euthanasia are also profoundly influenced by cultural and religious differences.

Although an expansive body of literature exists exploring the significance of religiosity and spirituality on death and dying, there is inadequate research on clinical practices for end-of-life care and after-death care for one's body in institutional settings such as CCRCs, nursing homes, and assisted-living facilities. With an increasing number of older adults choosing to live out their retirement years in institutional settings, together with the increasing diversity, it is more important than ever for staff to be culturally sensitive. Thus, this study concentrates on six predominant spiritual beliefs, including Christianity, Judaism, Islam, Buddhism, Hinduism, and atheism. For this study, a series of qualitative interviews and survey questions were designed in order to explore specific end-of-life and after-death rituals. A number of interviews were conducted with an atheist and eight religious leaders representing different religions to gather educational and practical information relevant to the end-of-life and after-death care. A total number of 30 surveys were distributed to staff members in one CCRC in the greater Piedmont community of North Carolina to measure attitudes and knowledge on religions. Opinions on suicide, organ donation, and euthanasia regarding religious and cultural differences are also provided. Finally, based on the results, suggestions for

promoting care, decreasing conflict, and facilitating a peaceful death are offered for direct healthcare providers.

The Role of Religiosity and Spirituality on Old Age and End of Life

Religiosity and spirituality have long played an important role in the daily lives of Americans. These two are intertwined concepts that convey unique messages. Religiosity refers to an individual's attitudes and beliefs associated with specific religious traditions and rituals (Chun, 2012). Spirituality is defined as awareness of a transcendent dimension in which a person is concerned with ultimate values and interests (Vachon, Fillion, & Achille, 2009). It is proposed that spirituality is distinct and broader than the concept of religiosity (Lundberg & Kerdonfag, 2010). Koenig, George, and Titus (2004) proposed three main dimensions exist within religiosity: organizational religious activity (ORA), nonorganizational religious activity (NORA), and subjective or intrinsic religiosity (IR). Specifically, ORA refers to church services or participating in religious study groups. NORA includes private religious behaviors, such as prayer or meditation. IR indicates the significance of religion in the daily life, especially with regard to end-of-life and after death experiences.

People engage in religious and spiritual experiences throughout their lives; however, the importance of religiosity and spirituality may fluctuate in different life stages. Religious practices and spirituality are often more crucial for the older adults as they appear to provide hope, purpose, and meaning for their lives; decrease fear; navigate the dying process; and provide comfort when approaching death. Conner (2000)

indicated that for modern America, dying is a period of completion and reflection, especially for any religious or spiritual concerns. For a dying person, who possesses a religious belief in an afterlife, the dying process can be a joyful transition to a better place. In contrast, a lack of belief in an afterlife could cause the dying person to be fearful and distressed unless the family and professional caregivers are able to provide comfort.

Compared to religiosity, spirituality is an understanding of life's ultimate concerns, meaning, and purposes of living. When a person is at or near the end of life, spirituality provides coping skills for illness, a sense of peace, and comfort from successful life experiences. The spiritual understanding of death tends to be supported by an individual's religious beliefs and practices. Stepnick and Perry (1992) proposed an effective model of transitional phases of the dying experience. While the dying process is unique to each individual, some universal needs are shared and identified by most individuals, such as the need to alleviate depression, provide comfort, and obtain support during the dying experience. Three major spiritual demands of the dying patients were proposed by Doka (2010), including identifying the meaning of life, experiencing an appropriate and dignified dying process, and finding hope beyond death. Other spiritual needs may include the need for forgiveness and love, being surrounded by family and close friends, and maintaining a positive relationship with God.

In modern American society, people with terminal illness find themselves vulnerable due to the society's death-denying culture. In reality a vision of death should

not be separated from life, but should exist to embrace the dignity of the individual. Spiritual support provided by healthcare professionals would concentrate on listening and assisting the dying person with prayer services, opening communications, and assessing the dying person's preparedness on what to expect for their future life (Amoah, 2011). O'Brien (2007) indicated that if an individual did not discover purpose and meaning during the lifetime, a sense of guilt would remain as perceived from unfulfilled duties and responsibilities.

A number of studies explored the significance of religiosity and spirituality in the end-of-life and after-death perspectives and experiences for individuals from a variety of cultural backgrounds (Steinberg, 2011; Seale, 2010; Narayanasamy & Owens, 2001; McSherry, 2000). Providing religiously- and spiritually-appropriate care is critical for facilitating a peaceful death, fulfilling patients' religious wishes, and comforting their relatives and friends (Lundberg & Kerdonfag, 2010). Religious beliefs and spirituality provide patients, regardless of their beliefs, with hope, forgiveness, and faith in an afterlife. Sacred texts for each religion can provide guidance and assurance for people with terminal illnesses in the management of suffering, optimism for remission, and anticipation of an afterlife.

Despite numerous studies identifying the significance of religiosity and spirituality on death and dying experiences, studies indicated that it is often difficult for healthcare professionals to accept other religious and spiritual practices if they have serious divergence of beliefs about the end-of-life and after-death care (Khanna, &

Greyson, 2013; Balboni, et. al., 2010). Healthcare professionals' personal religious and spiritual beliefs constantly influence the choice of interventions (Ellershaw & Wilkinson, 2011). For a dying patient, religious practices can provide a crucial dimension of spiritual support and comfort (Khanna, & Greyson, 2013); professional caregivers must understand and encourage the spiritual support, regardless of their personal beliefs. Those with non-traditional religions compared to Western culture, often hope to practice traditional religious customs when death is near. In addition, researchers (Gore, 2013; Meredith, et. al., 2012) suggested that if healthcare professionals can assess and meet the spiritual needs of a dying patient, they could benefit from becoming involved in the spiritual journey as well. Despite these positive outcomes of supporting patients' spiritual end-of-life journeys, it may be difficult for healthcare providers to undertake and promote spiritual support without basic understanding and respect for patients' religious beliefs and spiritual demands.

Statement of Problem

With the recent increased immigration of individuals to the United States and the rapid aging of Baby Boomers, there is an increased need for healthcare professionals to be more culturally competent in providing direct care for the increasing diversity of aging older adults at end of life and immediately after death. As a result, it is particularly crucial that physicians, nurses, and staff understand diverse religious attitudes and beliefs. This is especially critical in regards to palliative care and treatment of the body after death, as people of the Eastern and Western hemispheres have such distinct

attitudes and customs. While previous studies (Epner, & Baile, 2012; California Healthcare Foundation, 2006; Teno, Clarridge, & Casey, 2004) have repeatedly shown the majority of individuals wish to die at home, only 20 to 30 percent do so. Thus most people die in a hospital, CCRC, or hospice center, where staff may not be familiar with end-of-life and after-death rituals of non-Western religion.

Unfortunately, in contemporary Western cultures, people often feel less comfortable when required to take care of the deceased. A number of studies indicated there are inequalities in access to palliative care for patients with non-traditional religions to Western culture, not to mention the lack of the availability of culturally sensitivity care (Essink-Bot, Lamkaddem, Jellema, Nielsen, & Stronks, 2012; Bosma, Apland, & Kazanjian, 2010; Nazroo, Falaschetti, Pierce, & Primatesta, 2009). Many clinicians feel uncomfortable discussing the religious and spiritual issues that are related to the end-of-life and after-death care. However, researchers (Sinclair, 2011; Siriwardena & Clark, 2004) found that when such religious and spiritual needs were met, the morale and satisfaction levels of family members significantly improved.

The significance of cultural and religious values in healthcare decisions, especially on palliative and after-death care continues to be explored (Ramirez, 2009; Johnson, 2006). As healthcare professionals may come from different cultural and religious backgrounds, it is understandable that they might not possess the necessary knowledge and understanding on the specific values and practices of an individual (Clarfied, et al., 2003). Nevertheless, reports indicate that knowledgeable professional caregivers are

better able to provide religiously-appropriate and holistic care to their patients (Johnson, 2006). Additionally, studies have reported the critical importance of understanding and respecting wishes of those patients who do not claim a religious affiliation (Vail, Arndt, & Abdollahi, 2012; Dunn, 2011). Healthcare professionals with different religious and spiritual backgrounds can easily impose their own personal beliefs and practices onto the patient, such as arranging a prayer service when it is not requested. Through an increased and more holistic education, such implications can be avoided (Bjarnason, 2012).

According to the latest report from Healthcare Commission (2009), over 8,000 complaints from acute healthcare environments focused on the end-of-life and after-death care. Possible reasons that lead to barriers to high-quality palliative and after-death care for ethnic minority patients might include a lack of educational training materials in providing care related to socio-cultural values, a failure to appreciate the complexities of various beliefs and values patients hold, and the often inefficient communication among healthcare professionals, patients, and family members regarding religious or spiritual beliefs for end-of-life and after-death care. Lack of cultural sensitivity should be addressed to facilitate a better situation for all involved. In addition, healthcare professionals may pose a bias towards their patients who diverge significantly from the professionals' religious and spiritual beliefs. Those professionals may not understand patients' fear, anxiety, and desire to fulfill their religious wishes as death approaches. Increased cultural competence is needed for healthcare providers to

ensure an understanding and respect of the religious and socio-cultural differences, the religiously-appropriate handling of the body immediately after death, and the inclusion of cultural concerns on organ donation, euthanasia, and suicidal issues.

Objectives

Abundant studies exist suggesting that there is an increasing need to educate healthcare professionals with regard to end-of-life and after-death issues for patients affiliated with different religious beliefs and atheists as well. Patients with different religious and spiritual backgrounds may prefer to follow their traditional customs and rituals as death approaches; however, healthcare professionals might find it difficult to understand and respect specific religious and spiritual demands from persons with religious and spiritual beliefs so different to Western culture. Currently there are no studies that focus on clinical practices provided for end-of-life care to accommodate a variety of spiritual beliefs. This thesis focuses on four non-Western religions, atheism, and Christianity, comparing end-of-life care for the dying and after-death care for the deceased. This study is the first study designed to provide guidance and suggestions on how to perform the end-of-life and after-death care for patients with different religious beliefs. It can also encourage those who work with and serve older adults to consider further the ritualized behaviors they regularly encounter among elders.

CHAPTER II

END OF LIFE AND AFTER DEATH CARE FROM RELIGIOUS AND ATHEISTIC REVIEWS

With the growth of diversity in America, there needs to be an increase in the number of healthcare professionals who are culturally sensitive and competent. As previously noted, Christianity is the most popular religion in America, followed by Judaism, Buddhists, Muslims, and Hindus for less than 2% of the U.S. population. In addition, atheists account for approximately 12% of the population. The majority of older adults spend their final days in an institutional setting, where healthcare professionals play a crucial role in the end-of-life and post-death care. However, depending on the individual, religious and spiritual differences can vary significantly, so it is important for the care-giving staff to recognize and respect these differences when caring for their patients.

Caring for patients at end of life and families who are grieving is considered the final stage in clinical care for an individual. Pattison (2008) demonstrated the steps involved in preparing the individual before and after death, including hygiene care, general religious considerations (e.g., religious leaders), and bereavement care for family members. Standard hygiene procedure normally includes respecting the person's requirements, wearing disposable gloves, and avoiding infectious diseases. Healthcare providers are to consider hygiene care sequences, respect patients' autonomy, and

follow basic religious requests. In addition, guidance is needed on providing general care for grieving families - for example, providing private time and space for the family members, explicitly explaining after-death procedures, and providing family members with a high degree of sensitivity and support. Appropriate end-of-life and after-death care is of paramount importance in maintaining the patients' dignity, fulfilling individuals' religious wishes, and comforting grieving family members.

Atheism

Atheism is characterized as the absence of belief in the existence of god. It favors humanity as the absolute source of ethics and values. Though not possessing any religious belief, atheists require equal spiritual attention and support from healthcare professionals when dealing with death. Spirituality plays a critical role in maintaining hope, decreasing fear, and providing comfort for the atheistic individual. Vali, Arndt, & Abdollahi (2012) conducted three separate experiments to test the influential power of spirituality for atheists. In these studies, a total of 28 participants were recruited through pre-screening tests where they measured the influence of spirituality in their lives. A series of interview questions were provided for these participants including “please briefly describe the emotions that the thought of your own death arouses in you” (Vail, Arndt, & Abdollahi, 2012, p. 20). The researcher then adopted "loneliness and isolation" for further interventions. Additionally, statistical analysis with a one-way ANOVA test found that all participants significantly reported an increased willingness to consider spiritual perspectives and belief in a higher power.

Clinical ritual practices were further examined by Swell (2002) and reported the significance of understanding, respecting, and accepting atheistic individuals' preferences as doing so can decrease the potential likelihood of unnecessary conflicts among healthcare providers, patients, and family members. Immediately after death, direct-care providers are encouraged to take an advocacy role for patients, since they have the most relevant information. The critical importance of family members and friends should be acknowledged, and consulting with close relatives in the care of the deceased's body is crucial, especially for the spiritual and cultural perspectives. Detailed guidance on the interventions implemented for the deceased were elaborated, such as using a pillow instead of the bandage to protect the deceased's head, closing the bedside curtain for privacy, and conducting general washing procedures to maintain the patient's dignity. Healthcare professionals must understand and respect these rituals and practices to provide comfort and hope for both the patient and families.

Christianity

Christianity, which is the major religion in the United States, began approximately 2,000 years ago. Its major beliefs focus on the teaching of Jesus Christ. Christianity consists of three primary denominations: Roman Catholic, Eastern Orthodox, and Protestants. Practices observed within Christianity vary by denominations. For instance, Catholics request last rites at the end of life to ask for forgiveness from God before death. Eastern Orthodox adherents often practice prayer services, while Protestant believers practice final visitation after death.

There is inadequate literature focused solely on the Christian's perspectives of death and dying even though Christianity is the largest religion in the United States. Kemp & Bhungalia (2002) studied end-of-life and after-death practices for a number of world religions, including Christianity. For most Christians the presence of religious leaders, sacred prayer services, and deathbed confessions were crucial for both individuals and family members. In addition, this study also elaborated on the significance of autonomy for most Christians, so healthcare professionals were suggested to consult and respect the decisions of patients and their family members.

A qualitative study by Sulmasy (2009) on the importance of spirituality and religiosity found that connection between spirituality and after-death care among Christian patients has evolved and developed for a long period of time. With a strong belief in an afterlife, most Christian elderly patients focus on religious practices, pursue spiritual meanings, and maintain a positive relationship with God. Critical work for some Christians is the presence of a respected priest who can conduct special sacraments (e.g., Anointing of the Sick) in order to help the dying and the deceased with a smooth transition, fulfill the spiritual demands, and bless the living individuals. The dignity of the deceased can be maintained only after religiously- and spiritually- appropriate care is provided by the caregivers.

Different practices and customs exist within Christianity. In a recent qualitative research study, Brooksbank et al. (2010) described a number of practices. For Eastern Orthodox individuals, immediately after death, the priest performs sacred prayer

services for the deceased and family members to offer hope and comfort. A candle is often lit by a family to ask God for forgiveness on behalf of the deceased. Funeral services are usually held by a respected priest, and an additional prayer service will be held to bless the family members.

Previous studies show disputes exist regarding traditional practices within Catholicism. Haas (2011) indicated that when a Catholic is approaching death, last rites are often performed - including Anointing of the Sick, Penance, and Eucharist - to make the deceased appear pure and sinless to God. On the other hand, Mazanec & Tyler (2003) stated that the Anointing of the Sick should not be considered as a component of last rites. They argue that this practice is performed to ask for blessing and healing for those at the end of life. Healthcare professionals need an awareness of the cultural and religious demands when performing end-of-life and after-death care for Christian individuals; but most of all, healthcare professionals need to communicate with both the patients and the family.

Judaism

As a monotheistic religion, Judaism is one of the oldest religions, accounting for less than 2% of the Americans. Jewish traditions state that God revealed the Ten Commandments to Moses. For the Jewish people the Torah comprises their religious and ethical rules. These guidelines from both the Ten Commandments and the Torah emphasize the ritual purity and the significance of remaining uninfluenced by the

surrounding polytheistic cultures. Regular religious observance is performed by those observant Jewish people, including Orthodox Jews, Reform Jews, and Conservative Jews.

Loike et al. (2010), while researching the ritual death and dying practices of the Orthodox Jewish people, found a diversity of perspectives regarding the end-of-life and after-death care among Jewish people. What distinguishes the Orthodox Jews from others is their strict adherence to Halakha. While for most Jewish people, it is crucial to consider and understand the utmost value of life and the inevitability of death, the Halakhic literature refers to a person who is approaching death as *goses*, to whom no medical treatment should be applied to shorten or hasten this preordained life span (Prosser, Korman, & Feinstein, 2012; Kinzbrunner, 2004). Although the presence of close family members and friends is encouraged by a Rabbi, physical touch is to be minimized during this period (Weiss, 2007; Kinzbrunner, 2004). Prayer is another important aspect to comfort the patient and to ensure a better reincarnation in the upcoming life; however, Halakha prohibits the act of prayer in the presence of filth (e.g., bodily fluids and waste). Often the Rabbi encourages caregivers to cleanse the waste, to allow time for prayers before death occurs (Prosser, Korman, & Feinstein, 2012; Kinzbrunner, 2004). Halakha mandates that immediately following death, the body be watched by *Shomrim* until the burial. *Chevra Kadisha,* a special volunteer group in the Jewish community, often are called to respectfully remove the medical tubes, wash, and prepare the body for burial. Cremation is prohibited in Halakha, even if it is a family member's decision or

wish (Wahlhaus, 2005). The casket is usually made of wood to assist the return of the body to the earth as quickly as possible (Star of David, 2012).

Brenna (2013) introduced a holistic palliative approach for a variety of religious beliefs and spiritual attitudes, including Judaism. This palliative care model emphasized the consideration of the physical, emotional, and spiritual aspects of the care for both the deceased and the family members. Cultural and religious concerns strongly influence people's decisions to after-death care. Consulting with a respectful Rabbi is strongly recommended prior to making critical medical decisions. Similarly, Prosser, Korman, & Feinstein (2012) conducted a qualitative study to offer insights into the Jewish law, ethics, and cultural perspectives on the end-of-life and after-death care for Jewish patients. They found that culturally- and religiously- appropriate care is crucial in the institutional settings in order to respect Jewish patients' wishes to follow religious beliefs and practices as death approaches. Thus, the acknowledgment and application of spiritual and cultural practices by healthcare providers will allow them the opportunity to provide a holistic and professional approach to the overall care of the patient and family members.

Islam

Muslims consider life as impermanent and sacred to Allah. An increased number of Muslim immigrants residing in the United States has made it crucial for direct-care providers to become familiar with beliefs and attitudes among Muslims. Based on Sarhill, LeGrand, Islambouli, Davis, & Walsh's research (2001), Muslims believe in Allah and his

Semitic prophets, from Adam to Mohammed. Muslims perform five pillars during the life, including *Shahaadah* (declaration), *Salat* (prayer), *Siam* (fasting), *Hajj* (the pilgrimage to Mecca), and *Zakat* (charity). These practices are guided from the holy book of Qur'an and the final prophet, Mohammed. Muslims' beliefs regarding death and dying concentrate on the concept that every creature will die eventually, and death is only a transition from this life to the next.

Sarhill et al. (2001) described general end-of-life and after-death care regarding Muslim perspectives, with a specific emphasis on the requirement for all patient care needs to be done by a professional of the same gender as that of the deceased. Immediately after death, the deceased's head must be turned toward Mecca, which is the northeast of America. The mouth and eyes are to be closed and the body is to be covered with a white sheet. The body is to be ritually washed prior to the funeral. This ritual was known as *Wazu*. Additionally, the body is to be placed in the grave facing Mecca, covered with stones and sand. Most Muslims prefer not to use a casket or coffin for burial. American laws may require caskets, so some families may take the deceased back to their homelands for burial. Staff should be made aware of this tradition so that they can advocate for the families. The initial bereavement normally lasts for three days, during which mourning is allowed; however, loud wailing is not encouraged. Loud wailing is viewed as a sense of mistrust toward Allah.

Queensland (2010) offers further clinical guidance on caring for Muslim patients. Death to Muslim patients is an inevitable part of human experience; hence, no life

support treatment should be applied to prolong life. When a Muslim passes, the healthcare professionals should consult with relatives and the Imam on each case and handle the body as little as possible. Religious icons are to be removed as Muslims believe that life is sacred to God and material attachment to worldly items should not be encouraged. An autopsy is not preferred as Islam forbids the disfigurement of the body. Gulam (2003) conducted a qualitative study to assist non-Muslim healthcare providers to obtain a better understand of Muslim traditions to provide religiously and culturally appropriate care to their Muslim patients. A basic outline of Islamic history, aspects of general care for Muslim patients, and death and dying issues were exclusively illustrated. Death is perceived as predestined by Allah, so Muslim patients consider death as only the beginning of eternal life. Healthcare professionals are encouraged to consider each person's religious and spiritual beliefs to provide competent and sensitive care for Muslims.

Buddhism

Buddhism, the fourth largest religion, was founded by Siddhartha Gautama in the sixth century BC; Buddhism focuses on the Law of Karma and the Four Noble Truths. For most Buddhists, the Law of Karma is a law of cause and effect, meaning that one's deed (actions) will have an influential impact on the afterlife (Lundberg & Rattanasuwan, 2007). Good thoughts and behaviors produce desired effects in both present and future life, while doing harm to others leads to harmful outcomes for the individual. The Four Noble Truths are basic teachings from Buddha, which emphasize the existence of life,

origin, cessation of Dukkha (suffering), and eightfold path leading to the cessation of suffering. Those teachings allow Buddhists to understand and apprehend the meaning of life and the path to cessation of suffering, which is the ultimate goal for all the Buddhists.

As a result of their beliefs in the Law of Karma and the Four Noble Truths, Buddhists treat death as a transition from the present life to the next. As death nears, patients are encouraged to focus their thoughts on God and avoid negative talking from others. Braun & Nichols (2010) conducted a qualitative study on religious and cultural values of the Asian and Pacific Islander (API) American groups, whose main religious affiliation was Buddhism. Specifically, informants and focus groups from four different countries (i.e., China, Japan, Vietnam, and the Philippines) were interviewed on their opinions regarding the death and dying process, suicide, organ donation, euthanasia, and burial procedures. They found that significant differences were observed regarding these issues among different denominations within Buddhism. For instance, most Chinese Buddhists view death as a taboo and feel reluctant to mention it. Families are often encouraged to burn symbolic paper money to ensure a wealthy and healthy rebirth for the deceased (Gu & Cheng, 2012). Immediately after the death of a Japanese Buddhist, Makuragyo (Saito, 2013) is required to be performed at the bedside of the deceased. Makuragyo, is also known as pillow sutra. Sutra is often chanted at the pillow where the deceased's head rests. This ritual is often performed to comfort family members and provide them assurance that the deceased will have a better rebirth and future life. When Vietnamese Buddhists approach death, they prefer to have a monk

present chanting sacred songs so that they can focus their minds on God (Le & Nguyen, 2013). For Buddhists who come from the Philippines, a nine-day Novena is often held after an individual passes. Novena refers to an institutional act of religious pious devotion associated with public or private prayers (Putre, 2012). On the ninth night an atang, a traditional food offering to ward off evil spirits, is held when the deceased return to their houses and bid farewell to family members.

A study explored how Buddhist traditions were incorporated into caring for older adults within institutions (Wilkins, Mailoo, & Kularatne, 2010). This study first provided general healthcare guidelines, including keeping privacy for the patients, maintaining their dignity, and respecting their attitudes on health and illness. Then, it offered recommendations on palliative care for Buddhist patients, especially the process of incorporating religious beliefs and practices when delivering care to them. For example, Buddhists believe that at the time of death, the state of mind is crucial and can influence the level of rebirth; therefore, healthcare professionals need to create and maintain a peaceful environment by reciting sacred texts. Professional providers should encourage family members not to express their emotions outwardly, as doing so can make the departed soul reluctant to leave. Buddhist teachings concentrate on the impermanence of life and the inevitability of death; therefore, healthcare professionals must fully acknowledge and appreciate these rituals and customs in order to provide holistic and appropriate care for their patients.

Hinduism

Unlike other religions, Hinduism does not have any particular founder or any detailed declaration of faith or creed. The adherents of Hinduism are referred to as Hindus. Previous studies (Johnsen, 2001; Bowker, 2000; Smith, 1991) indicated that Hinduism is the product of religious development in India that has survived almost 5,000 years, making it the oldest existing religion in the world.

Gupta (2011) conducted a qualitative study on Hindus' view about the death and dying practices and collected information regarding the end-of-life and after-death care for Asian-Indian Americans. It is found that Hindus believe in the transmigration of the soul and reincarnation. Karma will play a crucial role in the determination for the level of rebirth. Like other religions (e.g., Buddhism), death is an inevitable part of life, so respectful and dedicated care should be provided to the deceased. Based on Ramayana and the Bhagavad Gita (Ghimire, 2013), the two most sacred religious texts in India, the dying individuals are to concentrate their minds on God since the nature of one's mind and thoughts at the time of death strongly influence the departing soul's destination and the level for rebirth (Gupta, 2011; Doorenbos, 2003). When death is imminent, drops of Ganges holy water are to be sprinkled into the dying person's mouth. For most Hindus traditional cremation remains preferred, occurring after the sacred washing.

Puchalski & O'Donnell (2005) further elaborated on traditional rituals and customs for Hindu patients. Three major attitudes were listed. They were the infinity of life, the significance of karma, and a strong belief in a higher power. Karma is of critical

importance for Hindus. Individuals tend to accept their current situations as the result of past karma. Spiritual support is mandated in Hindu practices, which can bring hope and liberation for a dying patient. Immediately after death, the presence of both Brahmin priest, the religious leader in Hinduism, and family with a religious beliefs are recommended. The belief in reincarnation strongly influences Hindus' end-of-life and after-death decisions.

Hindus' perspectives on after-death and mourning traditions were further explored by Bhuvaneswar & Stern (2012). Cultural differences profoundly influence Hindus' preferences on end-of-life and after-death care and often complicate the process. This article concentrates on four areas relevant to the end-of-life care, including physical environment, conditions at the end of life, autopsy and handling of the body, and mourning procedures. Results showed that culturally and religiously appropriate care can alleviate suffering, provide comfort, and decease conflicts for Hindu patients and their family members.

Opinions on Suicide, Organ Donation, and Euthanasia

Views from Atheists

Assessing and determining the attitudes toward suicide from an atheist are often difficult (Gearing & Lizardi, 2009). A qualitative study by Gearing & Lizardi (2009) explored atheists' opinions on suicide and provided recommendations for direct-care providers. The databases PsycINFO and MEDLINE were used to search peer-reviewed articles on the relationship between atheism and suicide. Findings indicated that most

atheists had a strong preference for physician-assisted suicide (PAS), which is a crucial consideration in the palliative care. Additionally, results showed that atheistic professionals were more likely to choose PAS or euthanasia than those with religious beliefs.

Attitudes on organ donation varied from individual to individual (Lee, Midodizi, Gourishankar, 2010). Approximately 1,000 atheists were surveyed regarding knowledge and attitudes about organ donation. Results showed that less than half of the participants favored in organ donation. It was found that those who did not approve of organ donation were misinformed in some critical areas of knowledge that might have strongly influenced the decision(e.g., the consent process and disfigurement). An increased education should be provided for atheistic people with regard to organ donation decisions.

Broeckaert, Gielen, Iersel, and Branden (2009) researched ideological perspectives of healthcare professionals and patients toward euthanasia. Approximately 147 physicians, regardless of spiritual beliefs, were interviewed. Results indicated that compared to those with religious beliefs, both healthcare professionals and patients proclaiming no religious beliefs were more likely to favor euthanasia.

Viewpoints from Christians

In a cross-national analysis study, Stack & Kposowa (2011) examined the correlation between religious beliefs and suicide acceptability. Through using the database Values/European Values Surveys for 2000, Stack & Kposowa (2011) found that

participants who were affiliated with Christianity, attended religious activities, and were religiously committed were associated with lower suicidal acceptability. Christian perspectives on organ donation was examined by Henshaw (2012), through a series of interviews and case studies for 120 participants. He found that most Christians, regardless of denominations, agreed that organ donation should be a personal choice. It was also considered an act of selflessness that will benefit others. Gielen, Van, Van Iersel, & Broeckaert (2011) reported perspectives on euthanasia from individuals with a variety of religious backgrounds. This research found that for most Christians, active euthanasia was not acceptable. On the other hand, passive euthanasia would be considered if the person was suffering and death is inevitable.

Views from Jews

Gearing & Lizardi (2009) analyzed PsychINFO and MEDLINE databases to examine relationships formulating religious perspectives on suicide. Findings indicated that for the Jewish tradition suicide is forbidden and those who commit suicide may not receive the same funeral ceremony as others. Most Jews were reluctant to think about or accept deceased organ donation (Oliver, Woywodt, Ahmed, & Saif, 2011). Three main reasons might account for this reluctance, including desecrating a body, delaying burial for the deceased, and receiving benefits from a cadaver. It is recommended that for Jewish clients consulting with a Rabbi can be beneficial for both healthcare providers and patients. Attitudes toward euthanasia were explored by Baeke, Wils, & Broeckaert (2011). Results showed that active euthanasia is strictly forbidden as it equates to

murder. However, passive euthanasia might be permissible, based on the situation and preferences of the individual and family.

Perspectives from Muslims

Bulow et al. (2008) discussed Muslims' attitudes on suicide and brain death. Muslims basically premise that everything possible should be done to prevent premature death. Suicide is not acceptable. Based on the Islamic principle 'la darar wa la dirar' (Bulow et al., 2008), which means no harm and no harassment, there should be no intention to hasten death as well.

Oliver, Woywodt, Ahmed, & Saif (2010) studied Islamic opinions about organ donation. Islamic law concentrates on saving life, so organ transplantation might be considered appropriate if written consent is obtained from the donor. However, there is some dispute among Arab countries and the Indian subcontinent. Muslims from Arab countries generally give permission for organ donation, while those from the India subcontinent insist that the body is sacred and belongs to Allah; thus organ donation is forbidden (Adnan, 2012).

Islamic law does not permit passive or active euthanasia simply because Muslims believe that life is sacred and man has no right to interfere with the life given (Shuriye, 2011). Whenever these sensitive issues occur, Muslims prefer to consult their local Imam for guidance. Thus, healthcare professionals should understand these uncertainties, provide relevant education and references, and when necessary, seek the advice of a local Imam.

Viewpoints from Buddhists

Many different Buddhist traditions on body care and memorial services exist concurrently; however, opinions on suicide, organ donation, and euthanasia appear to be consistent. Specifically, suicide is not acceptable (Boyd, & Chung, 2012). Concerns on organ donation vary from individual to individual. Although saving life is beneficial for achieving a peaceful and assured rebirth in the next life, traditional views are that bodies should not be defiled; maintaining the whole body in this life is the only guarantee to be reborn with all parts of the body. On the other hand, Oliver, Woywodt, Ahmed, & Saif (2010) argued that compared to preserving the physical integrity, the dying process and the quality of care provided might be more crucial to most Buddhists.

Passive euthanasia might be considered in some extreme conditions (e.g., persistent vegetative state); however, active euthanasia is forbidden for all sects of Buddhists (Priscilla, 2012). Therefore, as with a religion, understanding and respecting traditions allow healthcare professionals to provide efficient and appropriate care for the Buddhist patient as well as to comfort family members.

Perspectives from Hindus

A qualitative research study conducted on opinions about suicide and euthanasia for Hindu patients (Boyd & Chung, 2012) found suicide and euthanasia forbidden in Hindu society because life is sacred and predestined. In addition, Sisask et al. (2010) conducted a cross-cultural study to investigate whether religiosity might serve as a protective effect against suicide. A total number of 5,484 participants, regardless of their

religious beliefs, were enrolled in the study. Through statistical analysis, results indicated that Hindus were less likely to act on suicide because of their belief in karma which can strongly influence the level of rebirth in their next life.

Hindus' opinions towards organ donation are similar to those of Buddhists. Hindus usually have the dilemma between saving life and physical integrity (Rao, 2011). Sinha, Basu, and Sarkhel (2012) examined Hindus' opinions on euthanasia Findings showed most Hindus do not approve of active euthanasia, which equates to murder in this religion. However, physician-assisted suicide might be permitted depending on the wishes of the dying patient and family members.

In sum, both similarities and differences exist on the opinions of suicide, organ donation, and euthanasia. Suicide is forbidden in all of the religious groups. One exception is that Buddhist military personnel can choose suicide when forced to surrender to their enemies. Muslims find neither passive nor active euthanasia acceptable, while individuals from other five spiritual backgrounds would permit passive euthanasia if the individual is near death. Opinions on organ donation vary among different religious groups, so consulting with religious leaders and family is necessary and recommended.

Comparison and Contrast of Care Review

This literature review discusses current research studies on end-of-life and post-death rituals of atheism and five religious disciplines. All studies were qualitative in design. Qualitative design is the method of inquiry used in a variety of academic

disciplines, where researchers aim to collect in-depth information on human behavior and the underlying reasons for that behavior. For instance, Vail, Arndt, & Abdollahi (2012) used a pre-screening test and a series of qualitative interview questions to collect relevant information on the significance of spirituality and religiosity for Christians. Similarly, Braun & Nichols (2010) conducted a qualitative study on religious and cultural values of the Asian and Pacific Islander (API) American groups and interviewed four Buddhist religious leaders with regard to their opinions on the death and dying process, suicide, organ donation, euthanasia, and burial procedures.

For all the religious adherents, it was found that patients with different religious backgrounds share some common practices and customs regarding death and dying issues. First, for each religion, the religious leader is highly important to the dying patient and can perform sacred prayer services that can be helpful for the dying soul to transit smoothly into the next life (Hass, 2011; Loike et al., 2010; Sarhill et al.,2001; Braun & Nichols, 2010; & Gupta, 2011). Secondly, people affiliated with different religions all believe in an afterlife, which gives patients hope for positive connection with god, alleviates suffering, and provides assurance for a smooth rebirth process. Thirdly, religions that originate from similar backgrounds tend to share more common practices. For instance, both Buddhist and Hindu practices encourage patients to concentrate their mind on God to ensure a better rebirth in the next life.

Nevertheless, different death traditions and customs exist in each religion and atheism. Specifically, immediately after the death of a Christian, special sacraments (e.g.,

Holy Communion) are held to bless both the deceased and family members (Kemp & Bhungalia, 2002; Brooksbank, et. al., 2010). Jewish tradition requires that the body not be left unattended, so *shomrim* and *chevra kadisha* should be arranged (Loike et al., 2010; Brenna, 2013). Two requirements for caring for deceased Muslims are that their heads should always point towards Mecca after their death and that they should receive care by a medical professional of the same gender both before and after their death (Sarhill et al., 2001; Queensland, 2010). When a Buddhist dies, only minimal physical touch immediately after death is allowed to prevent hindering the dying soul from searching for a better rebirth (Braun & Nichols, 2010; Gu & Cheng, 2012). For most Hindus, any mirror on the wall should be covered to prevent a devil from crawling out of it to seize the soul (Gupta, 2011; Puchalski & O'Donnell, 2005). When an atheist passes in institutions, healthcare professionals must perform last offices that comply with institutional policies in order to show respect and maintain dignity for the deceased.

Despite the need for information on religious beliefs and spirituality at end-of-life and after-death practices, there are an inadequate number of studies providing guidance for healthcare professionals. This study aims to promote the knowledge and respect by healthcare professionals in CCRCs toward residents of faiths other than their own and to improve the overall care that the residents and their family members receive. While many of the studies utilized in this paper included information on religions, this will be the first qualitative study to combine the end-of-life and post-death perspectives of individuals in the six predominant spiritual beliefs in the greater

Piedmont community of North Carolina (Christianity, Judaism, Islam, Buddhism, Hinduism, and Atheism).

CHAPTER III

RESEARCH METHOD, DESIGN, AND STATISTICAL ANALYSIS

Methodology

The main objective of this study is to provide practical and informative educational materials for those who provide end-of-life and after-death care especially for those with non-Western spiritual beliefs. A proof-of-concept study is adopted, which is a demonstration with a purpose of verifying that the concept or theory has the potential of being used. It saves time and resources before adopting a larger sample and generalizing a study to a larger population. More importantly, it verifies the potential possibility of applying the study findings into the clinical practice (Wei, 2010).

To my knowledge, this is the first study to combine end-of-life and after-death perspectives of atheism, Christianity, Judaism, Islam, Buddhism, and Hinduism for institutional settings. After death, those with different religious and spiritual beliefs prefer their bodies to be cared for based on their traditions. Healthcare professionals with their own beliefs may not be aware of the necessity to understand other cultural rituals. Professionals having a better understanding of different rituals and customs can assist patients with a smooth transition into the next life, comfort family members, and promote the quality of care delivered.

Research Questions

. What would a religious leader want institutions to know about patients' needs at end-of-life and after-death care specific to their spiritual and religious traditions?

. How aware are healthcare professionals of non-traditional end-of-life and after-death rituals?

. How will a healthcare professional accommodate these diverse rituals and practices?

To evaluate these research questions, a multiple-methods approach was used that included a series of interviews with a number of religious leaders and a series of surveys with staff at a local CCRC.

In-depth qualitative interviews were conducted with eight religious leaders and the President of the Greensboro Atheist Organization. These interview questionnaires were focused on religious-based end-of-life and after-death rituals, opinions on critical medical decisions (e.g., suicide, organ donation, and euthanasia), and suggestions for healthcare professionals in institutions. Staff members in one CCRC in the greater Piedmont community were surveyed (N=30). These questionnaires focused on measuring the existing knowledge of staff members in CCRC on practices at the end of life. These survey questions were designed to measure participants' attitudes and experience relevant to staff working in CCRCs across North Carolina. Both the interview and survey questions for all of the participants may be found in the appendixes B to G.

Ethical Considerations

This study was approved by the UNCG Institutional Review Board (IRB). A detailed description of the study, including the possible risks, benefits, and the assurance of the information's confidentiality were described prior to each interview and survey. The IRB granted permission to audio record all interviews. The objective of the study is to raise awareness of healthcare providers in the CCRCs in terms of delivering care to a diverse population. No monetary payment or reimbursement was offered for participating in this study.

An Informed consent form for all the staff members was provided. The interviewer made certain that the participants in the study fully understood the informed consent and they might leave the study at any time. Interviews and surveys were conducted in their workplaces in a private location provided by the employer and at a time convenient to the participant. Data was collected by the researcher and reported anonymously; all the identified data and consent forms will be shredded after three years. Detailed information in regard to the potential risks and benefits can be found in Appendix A.

Participants and Recruitment

Religious Leaders. A purposive sampling method was used to recruit both religious and atheistic leaders for the six prevalent spiritual beliefs: Christianity, Judaism, Islam, Buddhism, Hinduism, and atheism. The Islamic Imam and the Hindu Brahmin priest were recommended by Dr. Raleigh Bailey, the Director of the Center for New

North Carolinians, and by Ms. Lia Millar, the Executive Director of the Creative Aging Network. The researcher went to both the Islamic mosque and the Hindu temple to meet both religious leaders to schedule interviews. The Christian clergy, Jewish Rabbi, Buddhist Monk, and Director of Greensboro Atheist Organization were initially contacted by telephone to arrange an in-person interview. However, both the Jewish Rabbi and the Islamic Imam became unavailable, and the researcher personally went to both the synagogue and the mosque several times attempting to reschedule. Finally an appropriate time to conduct the interviews was made.

All the spiritual leaders resided in the greater Piedmont community of North Carolina, and all agreed to sign an informed consent form prior to each interview. These participants were selected for their roles as community spiritual leaders and their knowledge of their community's practices. Qualifications for all the interviewees include that they must be a recognized leader of the appropriate religious and spiritual belief (i.e. Christianity, Judaism, Islam, Buddhism, Hinduism, and atheism), appropriately educated, bilingual (English and their native tongue), and at least 20 years old or older at the time of the study.

Staff Members in the CCRC. Thirty staff members in the CCRC were selected to conduct a survey to examine their current knowledge and understanding on end-of-life and after-death care in regard to different religious and spiritual beliefs. The selected CCRC was a neighborhood community specifically designed to offer a complete package of services and amenities to provide appropriate and dedicated care for people aged 60

and over. Four different levels of care were provided: independent apartments, assisted living facilities, skilled nursing facilities, and memory care center. This CCRC was selected because it serves a diversity of older adults from multiple cultural backgrounds. Prior to the survey, the researcher went to the CCRC and explained the purpose and significance of this study to the supervisor. The supervisor showed great interest in this study and was willing to help with the arrangement of this study. A recruitment flyer was posted before survey started in the CCRC, indicating the purpose of the study and the required qualifications to participate. All staff members were invited to participate in the study, including RNs, LPNs, CNAs, and other healthcare professionals (ie, healthcare coordinator, social worker, and physical therapist) in the CCRC.

Requirements for participants from the CCRC staff were that they must be employed part-time or full-time by the CCRC for at least one year, appropriately educated, 20 years old or older at the time of the study, and able to read English. The potential reason for setting these qualifications was to obtain reliable information from participants' responses on end-of-life and after-death care. By providing participants with accurate and relevant information about religious customs on death care, the proposed intervention is hypothesized to enhance participants' knowledge and understanding on cultural sensitivity care for patients and their families near the end-of-life, thus providing families comfort that their loved one's wishes will be honored.

Data Collection

This proof-of-concept study was developed to provide healthcare providers with relevant and educational information on the end-of-life and after-death care. Generally, to collect useful and relevant data, a variety of qualitative methods can be used, such as storytelling, shadowing, interviews, and group discussions. As indicated by Braun & Nichols (2010) and Rubin & Rubin (1995), qualitative interview methods refer to advanced interview skills of learning about the rituals and customs in different countries and their differing cultural values and practices. The process aims to discover the emotions and values of individuals and how they differ.

In this proof-of-concept study, a series of interview and survey information were collected and analyzed from participants to provide guidance for staff members in the CCRCs on the best care practices of residents during the end of life and immediately after death in regard to their spiritual beliefs. This study uses the natural strength of a proof-of-concept study to encourage participants to respond with more detailed information to expand the results.

For this study, a series of thirteen in-depth qualitative interview questions were asked of eight religious leaders and the Director of the Greensboro Atheist Organization. The interview questions were developed for the review of current literature of traditional rituals and customs of multiple religions. Interview questions for each religion and atheism concentrated on the traditional rituals and customs performed immediately after an individual passes and opinions on suicide, organ donation, and euthanasia. In

addition, for non-traditional religions (i.e., Judaism, Islam, Buddhism, and Hinduism), a specific question “How can these traditional customs be integrated into modern American society?” was asked of each religious leader. Moreover, in an attempt to provide appropriate and necessary educational information for CCRC and institutional staff, each religious and the atheistic leader was asked “What particular traditional customs would you like the healthcare providers to know?” For all religious and atheist leaders, a series of open-ended and probe questions were designed to initiate a discussion on clinical practices of diverse spiritual beliefs in regard to end-of-life and post-death care.

A series of twelve qualitative survey questions were completed by thirty CCRC staff members, developed through an examination of literature. For each participant in the CCRC, a specific survey question “How important is religion in your life?” was asked to measure the significance of spiritual belief.

The complete survey may be found in appendix G. The survey questions included

- Respondent's role
- Respondent's age
- Active performance of end-of-life and after death care
- The availability of spiritual leaders
- The acceptability of leaving a body untouched for at least eight hours
- The acceptability of speaking to the dying souls

- The acceptability of covering mirrors and pictures in the resident's room
- The availability of providing a copy of Torah/ Quran/ Dhammapada/ Bhagavad Gita
- The availability of *Chevra Kadisha*
- The availability of a same sex professional to perform care
- The availability of *Shomerim*
- The significance of religion

Data Analysis

All interviews from the religious and atheist leaders were recorded and transcribed. The transcripts were analyzed using the qualitative analytical techniques (Adam, Fabrik, & Kizek, 2010). Specifically, a number of variables were created, including Christian practices, Judaic practices, Muslim practices, Buddhist practices, Hindu practices, and atheistic practices. These different variables, a comparison of the emerging themes on both similarities and differences towards end-of-life and after-death care for each religion and atheists, and the results are summarized in Table 1. Table 2 shows the most critical guidance and suggestions for healthcare professionals when performing palliative and post-death care provided by religious leaders.

In addition, to analyze the data collected from the survey, the Statistical Product and Service Solutions (SPSS) software was initially used for a descriptive analysis and a series of chi-square tests to analyze different variables. In total, two different categories of variables were created, including variables for basic characteristics of participants (e.g., Profession, Age, Active performance of end-of-life care, Significance of religion),

and responses from participants' perspectives on different religious beliefs and practices (e.g., *Chevra Kadisha, Shomrim*, Minimal physical touch, Speaking to the dying soul, Providing care by the same-sex professional, Turning the religious pictures and covering the mirrors, Spiritual leader, and Sacred text). Different values were set for each variable, representing different responses from participants.

Due to the small sample size and the number of zeros in many cells, three variables - Age, Active performance of end-of-life care, and Significance of religion - were recoded. A series of chi-square tests were then conducted, using SPSS to examine the correlation among these four variables. Again, the small sample size continued to produce too many cells containing zeros for normal Chi-square methods analyzed. Thus, the Fisher's Exact test was selected. Since SPSS does not provide the Fisher's Exact Test for nominal data greater than 2 * 2 tables, the Statistical Analysis System (SAS) was used for the analysis. The Fisher's Exact Test is a statistical significance test used when one has nominal variables and small samples that result in multiple cells with zeros - in this case, a sample of N=30. For the Fisher's Exact test, the p-value is reported.

CHAPTER IV

REVIEW OF SPIRITUAL LEADERS' INTERVIEWS

A systematic review of interviews with spiritual leaders follows. The purpose of this study is twofold: to make staff more culturally competent with the religious beliefs of residents and to help staff become more sensitive about end-of-life and after-death rituals. This outcome is reached in three different ways. First, specific end-of-life and post-death rituals regarding different spiritual beliefs are summarized from a number of qualitative interviews with each spiritual leader. Secondly, opinions on suicide, organ donation, and euthanasia are explored to provide healthcare professionals necessary and critical information. Thirdly, crucial implications are presented for each religion to provide professionals guidelines for caring for patients with different spiritual beliefs, especially non-Western religions and atheism.

Perspectives from Atheists

Overview

During the past few decades, there has been an increase in the number of atheists in the United States, accounting for approximately 16.1% of the total population (Putnum, 2010). Healthcare professionals need to respect a patient's choice to have no religious affiliations. An appropriate way of handling the body is to show respect to and preserve the dignity of the deceased, regardless of one's spiritual beliefs. Healthcare

providers with a good understanding of necessary procedures can provide professional and individualized care that meet both patients' and family members' demands.

Death Rituals and Practices

An interview was conducted with the atheist president of the Greensboro Atheist Organization, the largest atheist organization in the greater Piedmont community of North Carolina. The researcher first contacted the atheist president via telephone, explained the purpose and significance of the study, and scheduled an interview. The researcher then personally went to the organization where she was enthusiastically welcomed by the atheist president. The interview was conducted in a private conference room inside the building. The atheist president stated this organization served approximately 80 families in the greater Piedmont community with the majority of the residents not having a preference for the place of death, thus increasing the demand for cultural trainings in the institutional settings.

The atheist president was asked to illustrate several end-of-life and after-death care procedures for atheists to ensure that staff delivers top quality of care. Consistent with the literature, the atheist president emphasized the significance of spirituality and family connections to patients. Though not possessing religious beliefs, atheistic patients still require spiritual care from health professionals to provide relief, comfort, and peace. Additionally, when an atheist approaches death, healthcare professionals should be aware of the patients' needs for friends and families, which they believe can significantly decrease fear and provide relief for the dying patient. The atheist president strongly

recommended healthcare providers consult with family members about procedures regarding the body's disposal to ensure that interventions provided by healthcare professionals are acceptable and decrease potential conflicts.

Clinical end-of-life and after-death care is summarized from the interview with the atheist president. Specifically, the president advised that it is essential for healthcare providers to put on plastic gloves before performing last offices to reduce infection and cross-contamination to patients through body fluids. Following institutional policies, healthcare professionals should gently close the deceased's eyes and jaw, use a pillow around the head and neck to prevent potential harm, and cover the body with a white cloth. If the patient is an awkward position, providers are encouraged to straighten his or her arms and legs.

Throughout the interview, the atheist president emphasized that healthcare providers should perform a thorough oral care and a general washing and dressing procedure that complies with the regular institutional policies. Before transferring the body to the mortuary, providers should wrap the body tightly in a clean sheet to avoid potential damage and attach an institutional identity band to the patient's wrist for identification and documentation purposes. All personal items should be documented, organized in front of family members or another staff member, and returned to the executor of the will.

In sum, due to the lack of belief in god or the afterlife, atheists tend to seek spiritual support from families and friends. Instead of providing chaplain services to

those atheists patients, healthcare professionals are encouraged to perform regular palliative and after-death care to offer comfort and reassurance for both the deceased and families.

Opinions on Suicide, Organ Donation, and Euthanasia

The atheist president reported that attitudes on suicide, euthanasia, and organ donation vary from person to person. For most atheists, committing suicide is not encouraged; however, physician-assisted suicide is often acceptable. Differ from those with religious beliefs, atheists believe that both active and passive euthanasia might be permitted if the person is near death. Opinions on organ donation often depend on the individual. Increased education and awareness should be provided for atheists in regard to individual decisions.

Perspectives from Christians

Overview

Christianity, which originated around 2,000 years ago, concentrates on the doctrine of the Trinity, which refers to God as the Father, Son, and Holy Spirit. Christianity consists of three major denominations, including Roman Catholic, Eastern Orthodox, and Protestant. Diverse beliefs and practices exist among different denominations within Christianity.

Death Rituals and Practices

To obtain detailed information on a diversity of rituals and practices within Christianity, clergy from three Christian churches were interviewed: a Catholic priest, an Eastern Orthodox priest, and a Baptist pastor. The researcher first contacted each

interviewee via telephone, scheduled a convenient time for each interview, and met the religious leaders. The researcher was enthusiastically welcomed by the clergy. All the interviews were arranged in separate rooms to ensure that the conversations were uninterrupted.

Based on the information collected from all the interviews, Christians account for approximately 79% of the North Carolina population. The Catholic priest reported that this local Catholic church served approximately 150 families, and approximately 70% of the residents in this community dies while in an institution. The Eastern Orthodox priest stated that the Eastern Orthodox Church in this study served approximately 110 families, and approximately 60% dies in an institutional setting. The Baptist pastor stated that the Baptist church in this study served around 160 families, and approximately 75% dies within institutions.

All the Christian religious leaders stated that death is not a devastating event for most Christians because Jesus taught and promised an eternal life for all believers. Consistent with the literature, the interviewees emphasized the significance of religious leaders' presence at end of life to recite prayers and sing hymns to lead the dying soul smoothly to the next life. Immediately after death, healthcare professionals should close the deceased's eyes and cover the body with a white clean cloth. Interestingly, as it was not mentioned in the literature, the Catholic priest stated the significance of ablution, or the sacred washing for the purpose of purification or dedication in Christianity. Performed by family members or friends of the deceased, ablution is a crucial aspect of

charitable care for the departed soul and a distinctive ordinance of Christian society based on the belief that it is required for the departed soul to enter into the Kingdom of God. After the ritual washing, professional providers should assist the priest or the pastor to dress the body with clothes that are equivalent to his or her social status. Most people who die in an institutional setting in the United States are of some Christian faith. Therefore, healthcare providers may find it easier to understand and acknowledge end-of-life and after-death rituals for Christian patients; however, diverse practices remain for different denominations within Christianity.

The interview with Catholic priest indicated that similar to other denominations, when a Catholic individual dies, it is crucial for healthcare professionals to acknowledge that both prayers and blessings from a priest are essential to both the patient and families. Previous studies (Ford, 2012; Meyendorff, 2009) have questioned whether or not Anointing of the Sick is one of the last rites in Catholicism. The Catholic priest in this study reported while the express purpose of this sacrament is for healing and is often offered to those who are physically, mentally, or spiritually sick, in modern American society it is also performed at the deathbed, offering forgiveness as final preparation for heaven. Anointing of the Sick is performed by a Catholic priest who uses olive oil or other plant oil to anoint the patient's forehead and other parts of the body while reciting prayers to provide comfort, peace, and encouragement for the dying.

The priest indicated that two other sacraments were also performed as the Catholic approaches death, the Sacrament of Penance and the Eucharist. Specifically, the

sacrament of Penance or Reconciliation is performed to obtain divine mercy through faith for the mortal sins committed during the lifetime and ask forgiveness from God. In this sacrament, the priest pronounces absolution, the remission of sin. The Eucharist, also known as Holy Communion, is a holy sacrament in which Catholic believers experience God's grace in a special way through praying and tasting the physical elements (bread and wine) made by God. Catholics believe this act blesses them by producing energy and trust into the next life. Therefore, if requested by family members, healthcare professionals should notify the priest and arrange for the Holy Communion in advance.

Catholicism requires that the body must not be left unattended before the funeral, so a Vigil (Wake) is often held by a respectful priest prior to the public worship. In modern American society, the Wake is frequently conducted at a funeral home, where family members are encouraged to speak in remembrance of the deceased. The priest especially emphasized the significance of the Funeral Mass, usually held in the church where the mourners can keep company with the deceased, pray for the person, and receive blessings from the priest. Additionally, there is a traditional offering for the deceased's family, where visitors offer money or other valuables in the hope of benefiting the departed soul. A basic understanding and respect for these Catholic rituals can assist healthcare provider with providing effective and holistic care for the patient.

According to the Eastern Orthodox priest, the Eastern Orthodox view death as a consequence of judgment from Jesus Christ. When the person dies, he or she will enter into a condition known as Partial Judgment, referring to a foretaste of one's future in eternity. For most Eastern Orthodox patients, physical death is not as fearsome as spiritual death. Preferably a priest is asked to perform prayer services for the dying patient to assist with a smooth transition for the dying soul.

Immediately after the death of an Eastern Orthodox patient, the priest often performs another prayer service for the family members to comfort those left living. The deceased is then taken to a local church where a priest will hold a sacred service to remember and celebrate the deceased's life. Specifically, the priest offers opening remarks and prayers. The congregation sings sacred hymns to bless the deceased. Family members are not encouraged to show outward expression since as it is believed to interfere with the soul's transition to the Partial Judgment. A sacred scripture, Psalm 23, is recited to bless the deceased, comfort the living, and provide positive connection with God. The priest then asks family members and visitors to reflect on death and demonstrate their trust in God in spite of death. This is followed by a final prayer to conclude the service.

During the interview with the Baptist pastor, he said that prayer services performed by a pastor are of paramount importance to lead the dying soul smoothly to the next life. Relatives and friends of the deceased are encouraged to pay their final visit to the body. In modern practices, the visitation is often held the same day as the funeral.

The pastor reported that most Protestant services include prayers, eulogies, sermons, and scripture readings from Bible. Similar to Eastern Orthodox practice, music and hymns are interspersed throughout the service. The pastor often hosts a final gathering either at a church or in the deceased's home, which occurs directly after the funeral service. Most Christians, regardless of denominations, prefer burial services. However, cremation is permitted due to the increasing expense of burials.

Opinions on Suicide, Organ Donation, and Euthanasia

Although a variety of perspectives were observed among different denominations within Christianity, all three interviewees' opinions on suicide, organ donation, and euthanasia were similar. For most Christians, suicide is a serious sin - simply stated that life is sacred to God and destroying it is to wrongly assert dominion over God's will. Thus, if a person commits suicide, the priest and close family members are encouraged to pray for the departed soul to bring love and healing power from God and comfort those torn by the impact of suicide. Passive euthanasia might be permissible if the patient is in an irreversible condition and a consent form has been obtained from family members. However, active euthanasia is strictly forbidden in that it is equates to murder. Christians significantly differ between the behavior of taking a life and allowing a terminally ill patient to die. Opinions on organ donation vary from individual to individual; therefore, healthcare professionals are encouraged to consult with the priest or the pastor, patients, and their family members on organ donation as it appears to be left to individual choice.

Perspectives from Jews

Overview

Considered the oldest of the three great monotheistic religions which originated from the Middle East, Judaism has a remarkable history dating back to 2,000 BC. Though diverse perspectives exist within Judaism, observant Jewish people believe in one all-powerful and all-knowing God, pray regularly, and worship at a synagogue. In Jewish traditions, the study of the Torah and the Talmud is virtuous and laudable, especially for those who are approaching the end of life. Based on Jewish beliefs, everyone belongs to God, so death is not a tragedy even if it occurs in early life or through unfortunate accidents. Jewish people firmly believe in an afterlife, where those who have lived a worthy life will be rewarded and will be set free from suffering.

Death Rituals and Practices

Both religious leaders and healthcare professionals play a critical role in caring for a deceased Jew. The Jewish synagogue in this study consisted of vibrant and caring Reform Jewish people. The researcher first contacted the Jewish Rabbi by telephone and scheduled an appropriate time and place for the interview; unfortunately, the Rabbi became unavailable at the time of interview. The researcher returned to the synagogue a number of times and finally successfully scheduled a time convenient for the Rabbi. The interview was conducted in the synagogue. During the interview the Rabbi indicated that Reform Jews are now the largest denomination of American Jews. What distinguishes the Reform Jews from others is their belief in modernization and

compatibility when following Jewish traditions in a surrounding culture. However, Reform Jews prefer traditional customs when relating to end-of-life and after-death care. In the interview the Rabbi indicated that the Jewish population has increased dramatically over the last few decades, accounting for approximately 0.3% of the total population in North Carolina. The synagogue in this study served nearly 110 families, among whom, approximately 67% would prefer to die in an institutional setting.

Consistent with the previous literature, the Rabbi stated the importance of the existence and responsibilities of both *Chevra Kadisha* and *Shomrim* for the institutions. Family members or relatives must remain with the deceased until the funeral so that the body is not left defenseless. If there are no close relatives, a *Shomrim*, who guards the body during the night, may be requested (Ramirez, 2009). In addition, the Rabbi emphasized the importance of a special group of volunteers, *Chevra Kadisha*, whose main responsibility is to take care of the body after death (Goodman, Goodman, Hofman, 2011). These volunteers take full responsibility for washing and preparing the body for the burial ceremony that complies with the Jewish traditions and rituals. The Rabbi reported that if requested, the synagogue would provide *Chevra Kadisha* to assist with after-death care in institutions. However, if no such service is available from the synagogue at the time of death, healthcare professionals are encouraged to contact the National Association of *Chevra Kadisha* (NASCK, 2013) and request assistance from them. Specifically, in North Carolina, two organizations, the Western North Carolina Jewish

Burial Society and the Raleigh/ Cary Community *Chevra Kadisha* can arrange for adept personnel to provide assistance to families and the deceased.

Jewish people do not usually have a preference for the place of death, but approximately 67% indicated a desire to die in institutions. Significant spiritual support, such as the Rabbi, is crucial for the dying individual. Thus, it is essential for healthcare providers to understand and respect patients' wishes and notify a Rabbi as soon as possible. Sacred texts, such as the Torah or the Psalms, are usually recited by a Rabbi to provide hope and comfort for the dying individual. A personal confession or the deathbed prayer, Viddui, is often provided to the patient so that he or she may be seen as sinless and pure to God. Additionally, the Rabbi also reported that healthcare professionals should be encouraged to cover the mirrors in the dying patient's room to avoid personal vanity and any concern with appearance.

Immediately after death, although it is recommended to minimize physical contact with the deceased, it is permissible for healthcare providers to close the deceased's eyes and straighten the body if it is in awkward position; however, repositioning the body is discouraged unless requested by a family member. Providers can prepare some artificial candles in advance to bless both the deceased and the family members. Jewish people believe that being near a dead body is ritually unclean. Thus, healthcare professionals need to remind people to wash their hands before entering the deceased's room in a clinical environment. If a death occurs on Sabbath, healthcare professionals should be aware that no funeral services are performed and only minimal

arrangements are allowed. Eating and drinking are not permitted near the body as such activities are a mockery to the deceased who is no longer capable of doing so.

Although most healthcare professionals are not likely to be actively involved in the funeral services, an understanding of these traditional rituals can assist those professional caregivers in delivering dedicated and appropriate care for their patients and family members. Specifically, the sacred washing procedure, *Tahara*, is often performed by a respected Rabbi before funeral. The body is first thoroughly cleansed of dirt, body fluids, and solids; then it is ritually purified by a continuous flow of water from the head over the entire body. After the sacred washing procedure, the body is often anointed with spices and wrapped in special shrouds that are called *takhrikhim*, which are hand-sewn white cotton garments without buttons, zippers, or fasteners. The Rabbi then performs a final prayer before the funeral to ask for forgiveness of the deceased from relatives and friends. *Kriah*, the act of tearing one's clothes or cutting a black ribbon that is attached to one's sleeves, is conducted while standing to show strength at a time of grief. The cut is made on the left side of the clothing for close family members and on the right side for all other relatives. Jews want their loved ones to be buried within 24 hours after death; therefore, physicians and nurses should handle the death certificate as quickly as possible and avoid undesired conflicts due to a lack of knowledge of these traditions.

During the interview, the Rabbi stated that he also provided guidance on special mourning procedures for family members and friends. The first seven days after the

burial are referred to as the Shivah (Allen, 2011), during which time mourners must obey particular rules, such as not to wear jewelry, use hot water or sit on high stools, to pay respect to the deceased. While mourners may have fewer restrictions after the first seven days, they are still prohibited from attending entertainment. On the first anniversary of the death, a modern memorial ceremony is held by the Rabbi to place the name of the deceased in the synagogue, where mourners unveil a gravestone and say *Kaddish* at the graveside. A variety of texts of *Kaddish* can be adopted, depending on the wishes of deceased and their family members. *Kaddish* texts (e.g., Yitgaddal veyitaqaddash shmeh rabba) are usually chanted by a respected Rabbi to show that despite the loss of a loved one they still praise God. It is also customary to recite the mourner's *Kaddish* in front of a congregation daily for thirty days and then at every anniversary of the death. Although healthcare professionals might not be actively involved in these burial and mourning procedures, these traditional customs are interesting to understand and create bonds between unique cultures.

Opinions on Suicide, Organ Donation, and Euthanasia

When referring to the attitudes on suicide, organ donation, and euthanasia, the Rabbi reported that suicide is generally forbidden by the Jewish law. The exception is in a commission of particular cardinal sins, one must perform self-sacrifice to maintain dignity. People who commit suicide are to be buried in a separate area of the Jewish cemetery, where special mourning rituals are not performed. In the Jewish law there are intense disputes about the balance of Jews' responsibilities of preserving one's own life

and saving others. Healthcare providers need to be aware of this dilemma and always recommend that family members consult with a Rabbi prior to making a decision for organ donation. Judaism considers the preservation of human life as one of its supreme moral ethics and prohibits any intentions that might shorten one's life. Active euthanasia is absolutely forbidden and is regarded equal to murder. However, if a person is certain to die and only a ventilator impedes the natural process of death, then it is permissible for the physicians to switch off the ventilator.

Perspectives from Muslims

Overview

Islam is a monotheistic religion guided by the Qur'an, a sacred text taken by its adherents as the last prophecy of God. Muslims are primarily composed of two different schools of thoughts, the Sunni and the Shia. Approximately 75% of Muslims belong to Sunni (Sarhill, LeGrand, Islambouli, Davis, Walsh, 2001); however, no significant differences were observable between adherents of the Sunni and the Shia when referring to traditional customs.

Death Rituals and Practices

The recommendation for the contact with the Islamic Imam came from Dr. Raleigh Bailey, the Director of New North Carolinians. Since the mosque had no phone, the researcher personally went to the mosque and scheduled an interview with the Imam. The Imam was occupied at the time of interview, so the researcher returned to the mosque a number of times and finally was able to reschedule the interview. The

interview took place in the Imam's private office. The Imam indicated that approximately 8 million Muslim immigrants now reside in the United States, and many of them have assimilated into the modern American society. However, when death approaches, Muslims prefer to practice death rituals and customs based on their original faith. The mosque in this study served approximately 120 families in the great Piedmont community. Most Muslims prefer to die at home, and only about 8% of the Muslim population in this community dies in institutions. In spite of that low percentage, the Imam felt that comprehensive knowledge of Muslim traditions can still be beneficial for professional healthcare providers.

As noted in the literature, the Imam also stated that it is crucial for healthcare professionals to be aware of the importance of family connections for Muslims. When death is imminent, both the religious leader and families should be notified because they provide hope and comfort for the dying patient. Immediately after death, the deceased must be placed toward Mecca, which is the holiest city in Islamic traditions. In addition, it is of critical importance for healthcare professionals to understand that the deceased must be taken care of by a professional of the same gender.

The Imam further indicated a series of procedures that must be performed immediately after the death of a Muslim. Specifically the elbows, shoulders, knees and hips must be flexed before the body is straightened. The head is turned toward the right shoulder, toes are tied with a thin thread, and the body covered with a long plain sheet before the Imam is able to practice the religious rituals and customs. Meanwhile, two

copies of Qur'an must be prepared in the ward: one is placed on the chest of the deceased, and the other one is used by healthcare professionals to recite verses to alleviate families' anxiety, reduce their sadness, and promote a smooth transition for the departed soul. If death falls during the night, a candle is to be lit at the head of the body. The burial procedure must take place within 24 hours, so healthcare providers must facilitate the death certificate as soon as possible. In an attempt to prevent body-fluid leakage, body orifices are closed and stuffed with cotton.

Previous literature has indicated the significance of *Wazu*. The Imam in this study illustrated the procedure of *Wazu*, which means in Islam the sacred washing. It is often performed by the Imam before the funeral service. Usually the body is washed three times, with water and lotion respectively. If a healthcare provider performs the *Wazu*, the provider must always wear a pair of disposable gloves and use sponges to wash the body. The body is first turned to the left side, letting warm water sprinkle over the right side, and then the procedure is reversed. This is repeated three times. After the washing procedure, the body must be covered with perfume to show respect for the deceased. The deceased is then wrapped in a special cotton shroud, which is comprised of three or five pieces of white cloth which has been saved by the deceased during his or her entire life.

A series of special prayer services were further described by the Imam. Upon the death of a Muslim, other Muslim people are obligated to pray for the deceased. The body must be placed in front of the Imam. The Imam will guide all the individuals to

stand with their chests facing Mecca and will lead the prayer services by saying “I intend to pray the Funeral prayer for this dead Muslim.” All those praying are required to recite "Allahu Akbar" after that and then recite the "Fatihah" softly. Later, the Imam and those who pray will turn their head to the right while saying “as-salamu ^ alaykum wa ralmatullah.” The prayer is repeated when people turn their head to the left. Though healthcare professionals are not likely to attend these prayer services held in a mosque or funeral home, a grasp of these traditions can still be valuable for understanding the Muslim culture. Additional educational information valuable to healthcare professionals focuses on special Islamic consoling procedures. On consoling a Muslim on the death of a loved one, healthcare professionals need to say “May Allah reward you greatly, give you good patience, and forgive your deceased loved one.” While consoling a Muslim concerning the death of a non-Muslim relative, professionals should say “May Allah reward you greatly and give you patience.”

Muslims are always buried, and all Islamic adherents are encouraged to attend funeral services. This is a meritorious performance, no matter if the adherent knows the deceased or not. Previous studies have indicated that most Muslims prefer not to use a casket for burial so as to return back to the earth as soon as possible. However, the Imam stated that in the United States, some states (e.g., North Carolina) require that the body be placed inside a coffin prior to burial, in which case a wooden coffin will be used to accelerate the decomposition process. The grave is usually 7 feet long by 3 or 4 feet wide by 4 feet deep, depending on the height and weight of the deceased. Differing

from previous studies, the Imam in this study indicated that once the coffin is lowering into the grave, a layer of wood will be put on top of the coffin as a natural protection and as an enhancement for the rebirth, followed by a layer of dust or sand on top of the wood.

Basic knowledge about bereavement procedures can assist direct-care givers to provide support for bereaved families. The initial bereavement often lasts three days. Those praying are invited back home to recite sacred texts to bless the deceased. The Imam reported that it is forbidden for mourners to excessively wail or scream since an exaggeration of the mourning process shows a mistrust of Allah's love and mercy. No requirements were stated for the color of clothes that mourners wear; however, it was recommended that women not wear any makeup or jewelry during the mourning period. The Imam also reported that traditionally a widow must stay at home for four months and 10 days unless it is necessary for her to step outside (e.g., see the doctor). This tradition is required because this period (i.e. four months and ten days) serves to identify whether the woman was pregnant. Therefore, women must remain at their houses and avoid socialization and entertainments.

Opinions on Suicide, Organ Donation, and Euthanasia

When referring to opinions on suicide, organ donation, and euthanasia, the Imam reported that based on the concept that God is the creator of all human beings, suicide is strictly forbidden by the Islamic law. A person neither owns his or her life, nor does the person have the right to end it. Muslims believe that death is the transition

between the current life force and the afterlife; therefore, any measures that attempt to prolong life by supportive machines are not acceptable. Healthcare providers are encouraged to refer family caregivers to an Imam when euthanasia decisions need to be made. As illustrated in the holy book Qur'an (Chapter 5:32), "Whosoever saves the life of one person it would be as if he saved the life of all mankind," it is a shared fundamental principle that saving life is placed highly in the Muslim culture. The Imam stated that though most Islamic scholars agree with organ donation, individual Muslims still are reluctant to it. Due to these ongoing conflicts, Muslims prefer to consult their local Imam for help with such decisions.

Perspectives from Buddhists

Overview

Buddhism is a major global religion encompassing a variety of traditions, beliefs, and practices, all of which were founded by Siddhartha Gautama, commonly known as the Buddha. Most Buddhists believe that both Karma and the final thoughts at the time of death play an essential role in the level of rebirth for the upcoming life. Most Buddhists prefer rigorous religious practices; therefore, it is crucial for healthcare providers try to meet the religious demands of both the dying patient and the family members.

Death Rituals and Practices

In an attempt to obtain appropriate and practicable Buddhist traditions and customs, the researcher arranged a qualitative interview with a respected monk in a

Vietnamese temple in the greater Piedmont community. The researcher first contacted the monk by telephone, scheduled an appropriate time for the interview, and then personally went to the temple to conduct the interview with the monk, who arranged a private room for this meeting. In the interview, the monk stated that this Vietnamese temple served approximately 120 families in the greater Piedmont community. The fact that a Vietnamese temple was scheduled for this study limited the results to the perspectives of Vietnamese Buddhists; however, relevant questions regarding to other branches within Buddhism were also explored. According to the monk, most Vietnamese Buddhists prefer to die at home; only about 10% of them tend to spend their end of life in an institutional setting. However, the monk indicated that the increase in both the development of medical technology and the number of institutions in North Carolina could lead to an increase in the number of Buddhists who choose institutionalization. Therefore, a better understanding of traditional customs can be beneficial for healthcare providers in order to decrease conflict and encourage a peaceful end-of-life experience.

Consistent with the literature review, the monk indicated that both karma and the final thoughts at the time of death are of critical importance for most Buddhists. In addition, he strongly recommended that both the monk and family members be notified immediately after a person dies. During the interview, the monk further described a number of essential procedures that direct-care providers should know. Specifically, there is a prevalent belief among Vietnamese Buddhists that everyone is impermanent and will eventually die. Some Buddhists prefer to die at home as they believe this will

prevent the soul from wandering for all eternity; others insist on dying in an institution because of the advanced equipment and medical resources. When one is approaching death, the *Bardo Thodol* (the Holy Buddhism textbook) is to be recited by a monk to orient the dying soul for a smooth transition. Immediately following death, if there is a Buddha image on the wall or in the room, healthcare professionals are to place the deceased toward the Buddha image. This is done so that when the deceased enters *bardo realm*, Buddha would welcome them into the next life. Incense is provided as a symbol of respect to the deceased as well as to cover up the odor of the body's decomposition. The lingering incense is also distributed outside the room to encourage the spirit to leave the body.

In addition, the monk described that it is crucial for healthcare providers to understand that most Asian cultures discourage much physical touch with the body for a specific period of time after death. Buddhists believe that the departed soul rises into an intermediate state (*Bardo*), where the soul can move through solid objects, such as the body, and search for a suitable place for rebirth. In modern America, this can become an issue due to limited spaces and the fast turnover that is considered normal in healthcare settings. By educating staff, this issue can be easily avoidable. A separate room can be prepared in advance for Buddhist patients into which healthcare providers can transfer the body after death and allow it to remain undisturbed until the monk arrives. Minimal physical contact by healthcare providers -- such as closing the deceased's eyes and covering the body with a clean white cloth -- is performed. Outward expression by family

members is discouraged because it is believed that public demonstrations of grief could delay the rebirth process, making the spirit regret dying and become more attached to the life force. This does not necessarily mean that mourners are to be completely silent; however, it is believed that it is always better to keep the atmosphere as undisturbed as possible.

The preferable date and time for burial is determined after consultating with a monk. In Vietnamese tradition, the eldest son usually takes full responsibility for the funeral arrangements. Throughout the interview, the monk stated that third- or fourth-generation Buddhists may be too Westernized and not aware of these traditions and customs; thus a basic knowledge of Buddhists' practices would allow healthcare professionals to assist with caring for the body and arranging services. Traditionally it is common for the deceased to be buried; however, in modern American society, cremation has become more acceptable, after which, the mourner can place the ashes in an urn and either place it in the temple or take it home. Before the funeral ceremony, the monk guides the family members to place a tiny piece of gold and a piece of raw rice in the deceased's mouth to encourage a wealthy and peaceful rebirth. In addition, coffee and tea are usually placed inside the casket to keep away the odor of the body. Lighted candles are put on the four corners of the casket to protect the deceased from the attack of ghosts. Prayer ceremonies are held by a monk before burial or cremation. Memorial services are held every 7 days for 7 weeks, then again after 100 days.

Mourning may last up to 3 years. Mourners are encouraged not to beautify themselves or attend entertainment to show respect for the deceased.

In the interview, the monk reported that diverse traditions were observed between different denominations within Buddhism. For instance, for most Chinese Buddhists, death is a taboo. Most Chinese people prefer not to discuss it, and mourners are often encouraged to wear black or white clothes to show respect to the deceased. Consistent with the previous literature, the monk stated that when a Japanese Buddhist dies, the Japanese monk often carries out a special performance called *Makuragyo,* or pillow sutra. The monk is encouraged to chant sacred sutra at the pillow where the deceased's head lies. A better understanding and respect for these different rituals and customs can provide comfort and hope for the patients' families.

Opinions on Suicide, Organ Donation, and Euthanasia

Based on the Law of Karma, suicide is generally not acceptable to Vietnamese Buddhists. However, the monk stated that in certain circumstances, such as if a military man committed suicide instead of surrendering to the enemy, he might reach a higher level in his future life. The monk mentioned that the decision on euthanasia is similar to Judaism's perception. Active euthanasia is strongly prohibited, while the decision on passive euthanasia depends on the individual and the family members. Organ donation is mostly discouraged from a Vietnamese Buddhist's view because life is sacred to God and no one would like to be born without a certain organ in his or her next life. Buddhism concentrates on the impermanence of life and the inevitability of death;

therefore, it is vital for healthcare professionals to understand and respect their patients' decisions and provide appropriate and dedicated care for them.

Perspectives from Hindus

Overview

Considered as a minor religion in the United States, Hindu has over 1.1 million Hinduism adherents now residing in America (Gupta, 2011). Unlike other religions, Hinduism does not have a specific originator or a detailed declaration of faith or creed. A number of researchers (Kamble, Watson, Marigoudar, & Chen, 2013) have indicated that Hinduism is not only a religion but also a way of life. Hindus who have adopted a modern American lifestyle still prefer to practice traditional rituals and customs during the end of life.

Death Ritual and Practices

The recommendation for the Hindu Brahmin priest came from both Dr. Raleigh Bailey, the Director of the Center for New North Carolinians, and from Ms. Lia Miller, the Director of Creative Aging Network. Due to the lack of telephone services, the researcher personally went to the temple to schedule an interview with the Brahmin priest. He kindly provided a separate room to keep the conversation uninterrupted. During the interview, the Brahmin priest indicated that the Hindu temple in this research study is a local temple serving approximately 130 families in the greater Piedmont community. He also stated that there are approximately 1.18 million Hindu people in the United States. North Carolina has seen a dramatic increase in Hindu population during

the past few decades. It is estimated that around 0.4% of the North Carolina population is Hindu. Most Hindus prefer to die at home; some of whom may even wish to return to the sacred city of Varanasi in India. Only around 8% in this community choose to die in an institutional setting; however, increased education and awareness of Hindu customs are still crucial to ensure that healthcare providers meet the wishes and rituals of Hindu patients.

When referring to previous studies, the Brahmin priest argued that when death is imminent, it is crucial for the dying patient to be surrounded by family members and relatives. Dying with love and acceptance leads to higher level of reincarnation than dying with regret and fear. Drops of holy water from the Ganges River are sprinkled into the patient's mouth to purify the dying patient’s sin and contribute to a smooth transition for rebirth. During the interview, the Brahmin priest priest further indicated that most Hindu patients wish to return to the sacred city of Varanasi, where access to the holy water of the Ganges River is easier; but when such care is not possible, Hindus will order the holy water through the Internet and have it delivered to the United States before the death occurs. If that is not possible, they will skip that expensive process and use plain tap water.

Regarding the end-of-life and after-death care, the Brahmin priest priest stated that most Hindus believe that death of an "oldest old" patient (usually over age 80) is not viewed as a tragedy. Family members are not encouraged to express any outward emotion because an oldest old has completed all the duties and responsibilities in this

life, and any discernible sadness would interfere with the transition into the next life. Having this information can help direct-care providers comfort the families after the death of an oldest-old individual. The Brahmin priest priest further described that similar to other religions non-traditional to Western culture (e.g., Buddhism), the dying individual is encouraged to focus his or her thoughts and attention to God. These thoughts have a crucial effect on the level of rebirth; therefore, healthcare professionals should work to create a calm atmosphere for the recitation of mantra so that the dying patient can earn as much merit as possible.

A respected Brahmin priest should be notified, if one is available in the community when a Hindu individual is dying, to assist with the holy rituals and practices. Through the interview, the Brahmin priest recommended that when death is imminent, a lamp should be lit near the dying patient's head and a thread be tied around the wrist or neck. Immediately after death, healthcare professionals should place the deceased's head toward south. Tulsi (a basil leaf), ghee (clarified butter), and a piece of gold are put into the mouth of the deceased so that the person will have a healthy and wealthy rebirth. Holy ash or sandal paste is applied to the deceased's forehead and certain religious objects (e.g., sacred threads, jewelry) are to stay with the body. Interestingly, the Brahmin priest reported that any religious pictures or mirrors in the deceased's room must be turned against the wall and mirrors must be covered so that devils cannot crawl out and capture the spirit of the individual. The Brahmin priest guides the family members to softly chant a mantra, such as the "Aum Namo Narayana" or "Aum Nama

Sivaya” in the person's right ear unless a specific mantra is used (Kemp & Bhungalia, 2002).

Hindus usually discourage non-Hindus from touching the body, so if a non-Hindu nurse has to handle the deceased, a pair of disposable gloves must be worn. The body is to be wrapped in a clean plain sheet, and only family members perform the ritual washing procedure before the funeral ceremony. After the body is cleaned, a cloth is to be tied under the chin, and the top of the head must be fully covered. A red cloth must be prepared before the person becomes terminally ill and should be used to wrap the dead body after the cleansing.

Similar to Islamic practices, the burial procedure must take place within 24 hours after a Hindu dies, so healthcare professionals must obtain the death certificate as soon as possible. Traditionally the soul is believed to wander through the home for 12 days after the death has occurred, so the family will chant mantras and pray sincerely and continuously. The Brahmin priest advised that it is also crucial for healthcare professionals to understand that family members are not permitted to cook during this period of time. On the twelfth day, the soul is considered to be reincarnated and family members or relatives are encouraged to donate money, clothing, and food to the Brahman to obtain “punya karma” (a good deed) for the individual (Gupta, 2011). The next day, “pind dan” is held by the bereaved family to make rice balls, cooked in milk and fed to the birds (Pathak, 2003). If the birds do not eat the cooked rice balls, it will cause

anxiety and fear for the bereaved family about the state of the soul of the deceased relative.

Opinions on Suicide, Organ Donation, and Euthanasia

The Brahmin priest mentioned that in Hinduism, committing suicide is regarded a violation of ahimsa (non-violence) and equal to murdering others. Hindus believe that when a person commits suicide, the deceased will become a ghost and wander on the planet until someone else dies. However, Hindus accept the non-violent practice of fasting to death, which is referred to as Prayopavesa (Nimbalkar, 2007). As to organ donation, the Brahmin priest indicated that Hindus are not prohibited from organ donation. Some Hindus insist that by helping to prolong the life of another though organ donation, a Hindu is accumulating a good deed and fulfilling ritual obligations. Therefore, direct care-providers are encouraged to consult with the Brahmin priest and family members on such a decision. Most Hindus do not approve of either passive euthanasia or active euthanasia. It will breach the teaching of ahimsa (doing no harm) and will damage the karma of both the doctor and the patient. Healthcare providers are also encouraged to contact the Brahmin priest in order to better assist with the dying process.

Summary of Crucial Information for Healthcare Professionals

During the interview, all the religious leaders and the atheist president were asked to provide some crucial implications for healthcare professionals in regard to end-of-life and after-death care. These essential information is summarized as follows.

Essential Implications from the Atheist President

With the increased number of atheists in the United States, there has been an expanding demand for healthcare professionals to understand and respect atheists' requirements and wishes. Throughout the interview, the atheistic leader indicated three essential implications that healthcare providers must know in order to provide appropriate and dedicated care for their atheistic patients. First, healthcare professionals must not impose their own beliefs onto their atheistic patients; for instance, do not arrange a clergy visit if it is not requested. Secondly, those who provide direct care must acknowledge the significance of spirituality to those atheistic patients because it can provide them with hope and comfort when approaching death. Thirdly, professional providers must also understand the significance and necessity showing respect to and maintain dignity for their patients.

Table 1. Summary of Crucial Information for Healthcare Professionals

Spiritual beliefs	Crucial implication for healthcare professionals
Christianity	・The significance of a priest or pastor present ・The significance of sacred prayer services provided for dying patients and their families ・Acknowledgment of different practices performed by different branches within Christianity

Judaism	・Understanding the existence and responsibilities of *Chevra Kadisha* and *Shomrim* ・The importance of handling death certificate in a time-efficient way ・The significance of a Rabbi present
Islam	・Understanding and respecting that the deceased's head must be turned toward Mecca ・Awareness that all end-of-life and after-death care must be performed by a same-sex professional ・The importance of handling death certificate efficiently
Buddhism	・Awareness that only minimal physical touch is allowed immediately after death and the necessity of adapting to institutional policies ・Respect that dying patients are required to concentrate their last thoughts on God ・Understanding the significance of a monk present
Hinduism	・Awareness that all religious pictures must be turned against the wall and mirrors must be covered ・Awareness of the significance of family connections ・The importance of handling death certificate efficiently
Atheism	・No imposition of one's own beliefs onto the patient ・Acknowledgment of the significance of spirituality to those who do not have any religious beliefs ・Understanding the necessity to perform dedicated last offices

Fundamental Recommendations from Christian Clergy

Christians have a strong belief in an afterlife, so death is only a transition into the next life. It is crucial for healthcare professionals to understand that the priest or the pastor must be notified before death so that a prayer service can be arranged for the dying patient. The interviewees also stated that sacred prayer services and other sacrament services that are held by the priest or the pastor are of critical importance for both the dying patient and the family members. In addition, patients affiliated with

different denominations within Christianity have different end-of-life and after-death rituals and practices. For instance, Catholic patients might wish to have Reconciliation to ask forgiveness from God and purify their soul when transitioning into the next life. Individuals affiliated with Eastern Orthodox sects might prefer to hold a prayer service before and immediately after death. An in-depth knowledge of a variety of Christian traditions and customs can decrease conflict and provide comfort for the families. In sum, although Christianity is a major religion in the United States, traditional practices differ among different denominations. Healthcare professionals must cater their care plan to the individual's needs and wishes.

Critical Understanding from Jewish Rabbi

The Rabbi stated that Jewish traditions are fairly easy to assimilate into modern American society. Healthcare professionals should understand and respect special Jewish traditional practices (e.g., the arrangement of *Chevra Kadisha*). An in-depth knowledge of these ritual and customs can help healthcare professionals provide professional and appropriate care for the deceased as well as the family members.

In an attempt to provide more accurate and helpful information for healthcare professionals, the Rabbi was asked what particular traditional customs he would prefer to let healthcare professionals know. First, immediately after death, the Rabbi is to be notified as soon as possible. Secondly, Jewish tradition requires that the body should be buried within 24 hours after death; therefore, healthcare professionals must handle the death certificate in an efficient way. Thirdly, the Rabbi reported that it is crucial for

healthcare providers to become familiar with the responsibilities of *Chevra Kadisha* and *Shormim i*n the Jewish community. It is crucial for Jewish people to obey specific traditional rituals and customs when death approaches; therefore, profound knowledge of these traditions and practices can make nurses become more proficient in providing end-of-life and after-death care for patients and their family members.

Primary Perspectives from Islamic Imam

The Imam stated that nowadays, young Islamic generations find it easier to assimilate into American culture; therefore, some traditional rituals might not be known or understood by these young adult Muslims. In these circumstances, healthcare professionals possessing knowledge of these traditions can better educate these younger generations and provide appropriate care for the deceased as well as the family members.

In the interview, the Imam indicated that an understanding of traditional Islamic customs can better assist healthcare professionals performing palliative and after-death care. First, it is crucial for healthcare professionals to know that immediately after death, the deceased individual's head must be turned toward Mecca. Secondly, similar to Jewish tradition, Muslims are required to perform the burial ceremony within 24 hours after the patient dies; therefore, healthcare professionals must facilitate the process of death certification. Thirdly, it is also required that both the palliative and after death care should be provided by a professional of the same gender of the deceased. Terminally ill patients prefer to practice the traditional ritual requirements that may

cause conflicts between patients and healthcare professionals. Those who provide end-of-life and after-death care should possess an in-depth understanding of Islam religious beliefs in order to provide culturally sensitive care, facilitate a peaceful death, and comfort bereaved families and relatives.

Vital Suggestions from Buddhist Monk

Similar to the Islamic society, the monk also indicated that young Buddhist generations often find it easier to follow a more modern lifestyle in the United States. These young adults might not fully know or understand those traditional practices, which might be preferred when their parents or grandparents approach death. Healthcare professionals with basic understanding and knowledge of these customs can better educate these younger generations and provide appropriate care for the deceased and their loved ones.

During the interview, the monk illustrated three key traditional customs that healthcare professionals should know. First, despite the limited resources of institutional settings, Buddhists mandate that only minimum physical contact is allowed immediately after death. Professional providers need to be aware of this mandate and prepare a vacant room in order to honor this custom. Secondly, Buddhists believe that an individual's mind at the end-of-life is crucial for reincarnation. Therefore, healthcare providers are to maintain a calm atmosphere for the dying patient and family members and arrange for a local monk ahead of time so that he can chant sacred songs or recite sacred texts for the dying patient. It is believed that the purer the final thoughts a person

possess, the better level of rebirth he or she will obtain. Finally, healthcare professionals are encouraged to know that different rituals and customs are practiced within Buddhism. When a Buddhist dies, providers should consult with family members and arrange for an appropriate monk to perform the sacred rituals for the deceased and their families.

Considered as the fourth largest religion in United States, Buddhism requires special religious rituals to be practiced when death occurs. Direct-care providers are encouraged to understand and respect these rituals in order to provide religiously and culturally suitable care for patients and their family members.

Critical Recommendations from Hindu Brahmin Priest

With the increase of Hindus who die in institutional settings, it is crucial for healthcare providers to have abundant knowledge on Hindu death rituals. The Brahmin priest illustrated four major rituals that providers should know. First, similar to Islamic tradition, when a Hindu patient is approaching death, family members and close relatives must be informed. Secondly, it is especially crucial for healthcare professionals to understand that religious pictures must be turned against the wall and mirrors must be covered because Hindus believe that the devils come out of the mirror and get the soul of the deceased. Thirdly, healthcare professionals must handle the death certificate in an efficient way when a Hindu patient dies in the institutional setting in order to uphold the practice of burial within 24 hours after death. Hinduism primarily concentrates on the consequences of karma; in order to ease the dying, healthcare

professionals should be capable of identifying factors that contribute to patients' substantial distress and fears at end of life.

Similarities and Differences from Interview Results

Results from religious leaders' interview responses to end-of-life and after-death customs revealed similarities. For the departed, regardless of religions, an important similarity was their strong belief in an afterlife, which offered them hope, decreased their fear in death, and provided them with assurance for a smooth transition to the next stage – whatever form that might take. Another key similarity revealed was the religious leaders' recommendations for healthcare professionals. Regardless of personal beliefs, healthcare professionals must respect the deceased and their family members' beliefs, follow their culture's tradition in handling the body, and provide comfort for the family members. For patients with religious affiliations, the significance of a religious leader and the preparation of sacred texts cannot be neglected. An appropriate religious leader representing each religion can help patients maintain a positive relationship with God and assist them with a smooth transition into the next life. For those who do not claim a religious belief, the significance of spirituality cannot be neglected because it can provide hope and meaning in their lives. Finally, all spiritual leaders believed that this study is an important first step in increasing awareness and cultural sensitivity for healthcare providers in institutional settings.

Table 2. Similarities and Differences from Interview Results

Items	Similarities and Differences	Christianity	Judaism	Islam	Buddhism	Hinduism	Atheism
	Similarities	・Critical importance of maintaining patients' dignity, obtaining assurance, and fulfilling last wishes ・Recognizing the significance of family connections ・For those with religious beliefs, acknowledging the significance of a respected religious leader being present					
	Differences						
Icons		No requirements observed	No requirements observed	No attachment to worldly materials	Keep the religious icons with the deceased	No requirements observed	No requirements observed
Religious pictures and mirrors		No require-ments observed	Mirrors covered	No requirements observed	Place the deceased toward Buddha image	Turn the religious pictures and mirrors against wall	No requirements observed
Touch		Eyes are closed gently	Minimal physical touch is recommended	The elbows, shoulders, knees and hips must be flexed	Minimal physical touch immediately after death	Eyes are closed gently	Gently close eyes and jaws
Mourning		Funeral Mass; Prayer services	Shiva	Widow is sequestered; no jewelry; no entertainment	Extended mourning period	"*Pind dan*"	Regular mourning procedure

Body washing		Absolution	*Tahara*	*Wazu*	Sacred washing	Sacred washing	General washing
Death certificate		No requirements observed	Handle as quickly as possible	Handle as quickly as possible	No requirements observed	Handle as quickly as possible	Handle as quickly as possible
Other Important rituals		Last rites; Vigil; Final viistation	*Chevra Kadisha; Shomrim; Viddui*;	Mecca; Same-sex professional	Last thoughts on God	Drops from Ganges River; Tulsi, ghee, and a piece of gold;	Comply with institutional policies; Spiritual support
Suicide		No	No	No	No	No	No
Organ donation		Individual choice	Individual choice	Consult Imam	Individual choice	Consult Brahmin priest	Individual choice
Euthanasia		Active: No; Passive: Might be	Active: No; Passive: Might be	Both active and passive unacceptable	Active: No; Passive: Might be	Active: No; Passive: Might be	Active: No; Passive: Might be

Findings from this study also reveal that traditional practices may be more similar than one realizes when two religions share similar history. For instance, both Catholic priest and the Jewish Rabbi indicated that in many Christian faiths - and required for the Jewish faith of the deceased - someone must stay with the body until the funeral. During the interview, both Buddhist monk and Hindu Brahmin priest suggested that when a Buddhist or Hindu is dying, the person is often encouraged to concentrate the mind on God to obtain a better rebirth. The differences among patients with different religions were also apparent. Special rituals are practiced for patients with different religious affiliations. For instance, a dying Catholic might request Holy Communion to pursue God's mercy. The Rabbi stated that the Jewish community often arranges a special volunteer group, *Chevra Kadisha,* to assist with handling the deceased body, whereas no such group is mentioned in other religions. In the Islamic tradition, the deceased must be placed toward Mecca immediately after death. The Monk stressed that Buddhist tradition requires that only minimal physical contact is allowed immediately after a Buddhist dies. In Hinduism, if there is a mirror on the wall, it must be covered to prevent a devil from crawling out to get the dying soul. For those who do not state any religious beliefs, it is crucial to pay respect and maintain dignity for the deceased. Healthcare professionals are encouraged to become familiar with different traditional customs and practices in order to provide holistic and dedicated care for their patients.

On the issues of suicide, organ donation, and euthanasia, several similarities and differences exist among the top six spiritual beliefs of individuals in the United States. Suicide is forbidden in all of the religious groups except for Buddhist military personnel, who may chose suicide only when forced to surrender to their enemies. Both Muslims and Hindus find passive and active euthanasia unacceptable; Christianity, Buddhism, and Judaism occasionally permit passive euthanasia if the individual is certain to die. Opinions on organ donation vary among different religious groups, so consulting with both a religious leader and family members is both necessary and recommended.

CHAPTER V

SURVEY RESULTS

In total, thirty surveys were distributed to staff in one CCRC in the greater Piedmont area of North Carolina. Results are summarized in the following tables. Detailed survey questions are in Appendix G.

Table 3 provides results for a descriptive analysis for the independent variables: the respondents' profession, age, active involvement in end-of-life care, and the significance of religion in their lives. In this sample of respondents at this CCRC, the majority were CNAs (46.7%), aged 31 to 50 (60%), have performed end-of-life and after death care three or more times (46.7%), and most said religion was an integral part of their lives (63.3%). It is worth noting that no respondents reported having performed end-of-life care only twice; thus for additional analysis of age, end-of-life care, and significance of religion, variables were recoded to incorporate new values for each variable.

Table 3. Descriptive Analysis

		Frequencies	Percentage
Profession	RN	5	16.7
	LPN	4	13.3
	CNA	14	46.7
	Other professionals	7	23.3
Age	20 - 30	6	20
	31- 40	9	30
	41 - 50	9	30
	51- 65	6	20
End-of-life care	Never	13	43.3
	Once	3	10
	Twice	0	0
	3*times	14	46.7
Significance of religion	Very important	19	63.3
	Somewhat important	6	20
	Not too important	4	13.3
	Not important at all	1	3.3

N=30

Table 4 shows respondents' ages and the likelihood of their actively performing end-of-life care. It might be presumed that those who are older might have had more experience with end-of-life care in an institutional setting. When examining the respondents' ages and the likelihood of providing end-of-life care, the data support the assumption that those aged 21 to 30 (66.7%) are less likely to have had an end-of-life care experience, while most respondents aged 31 to 65 (56.7%) have provided end-of-life care for multiple patients; however, there was not statistical significance found, with p value greater than 0.05.

Table 4. Respondents' Ages
on the Likelihood of Performing End-of-life Care

Frequencies (Percentage)		End-of-life care	
		Never	More than once
Age	21-30	4 (66.7%)	2 (33.3%)
	31-65	9 (37.5%)	15 (62.5%)
N=30			
Total		13 (43.3%)	17 (56.7%)
Chi-square	1.663		

Table 5 shows that respondents' ages have significantly influenced the importance of religion in their lives, with p value less than 0.1. When looking at respondents' ages relative to the significance of religion in their lives, results showed that most respondents aged 21 to 30 (66.7%) stated that religion is not important, while 70.8% of all respondents aged 31 to 65 reported that religion is crucial for them.

Table 5. Respondents' Ages
Relative to the Significance of Religion of Respondents

Frequency(Percentage)		Significance of religion	
		Very important	Not important
Age	21 -30	2 (33.3%)	4 (66.7%)
	31- 65	17 (70.8%)	7 (29.2%)
N=30			
Total		19 (63.3%)	11 (36.7%)
Chi-square: 2.907			

Table 6 shows that the professional role is significant to the likelihood of involvement in active end-of-life care, with p value less than 0.05. While both RNs and

LPNs have been involved in end-of-life care, the majority of end-of-life care falls to the CNA. Those who categorized as other professionals are mainly healthcare coordinators, social workers, and physical therapists who might have little access to actively perform such care; thus it is not surprising that the majority in this category have never performed clinical end-of-life care.

Table 6. Respondents' Professions on the Likelihood of Performing End-of-life Care

Frequencies (Percentage)		End-of-life care	
		Never	More than once
Profession	RN	2 (15.4%)	3 (17.6%)
	LPN	2 (15.4%)	2 (11.8%)
	CNA	3 (23.1%)	11 (64.7%)
N=30	Other professionals	6 (46.2%)	1 (5.9%)
Total		13 (43.3%)	17 (56.7%)

Chi-square: 7.951

Table 7 shows respondents' professions and the relative to the significance of religion in their lives. While considering the respondents' profession in the significance of religion in their lives, results show that the majority of respondents (43.3%) claimed that religion is important to them; however, the results were not statistically significant, with p value greater than 0.05.

Table 7. Respondents' Professions
Relative to Significance of Religion of Respondents

Frequencies (Percentage)		Significance of religion	
		Very important	Not important
Profession	RN	3 (60%)	2 (40%)
	LPN	3 (75%)	1 (25%)
	CNA	9 (64.3%)	5 (35.7%)
	Other professionals	4 (57.1%)	3 (42.9%)
N=30			
Total		19 (43.3%)	11 (36.7%)
Chi-square: 0.379			

Surprisingly, the majority of respondents, regardless of age, were not familiar with the existence of *Chevra Kadisha*. See Table 8. All respondents aged 20 to 30 reported that they were not aware of *Chevra Kadisha*. Only the one respondent indicated that the *Chevra Kadisha* was accessible when requested; however, results showed that respondents' ages do not significantly influence their opinions on *Chevra Kadisha*, with p value greater than 0.05.

Table 8. Knowledge of *Chevra Kadisha* by Respondents' Ages

Frequency (Percentage)		*Chevra Kadisha*		
		Yes	No	Don't know
Age	20 - 30	0 (0%)	0 (0%)	6 (100%)
	31 - 65	1 (4.17%)	7 (29.17%)	16 (66.67%)
N=30				
Fisher's Exact test	p=0.4308			

One might assume that staff members with higher education levels would be more aware of unfamiliar Jewish traditions. Contrary to assumptions, no RNs, LPNs, healthcare coordinators, social workers, or physical therapists indicated they were familiar with the accessibility of *Chevra Kadisha*. See Table 9. Only a single CNA reported the existence and responsibility of *Chevra Kadisha* in the CCRC when a Jewish patient dies. Referring to table 6, it is highly possible that this CNA is the one aged 31 to 65.

Table 9. Knowledge of *Chevra Kadisha* by Respondents' Professions

Frequency (Percentage)		*Chevra Kadisha*		
		Yes	No	Don't know
Profession	RN	0 (0%)	2 (40%)	3 (60%)
	LPN	0 (0%)	2 (50%)	2 (50%)
	CNA	1 (7.14%)	2 (14.29%)	11(78.57%)
	Other healthcare professionals	0 (0%)	1 (14.29%)	6 (85.71%)
N=30				
Fisher's Exact	p=0.6228			

Table 10 provided results for knowledge of *Chevra Kadisha* by respondents' active performance of end-of-life care. Staff members who have performed post-death care multiple times are more knowledgeable on Jewish rituals than those who have not. Respondents never performing end-of-life care were not aware of the existence of *Chevra Kadisha*. Even those who had performed end-of-life care multiple times were not familiar with *Chevra Kadisha.* A single respondent who has performed end-of-life care

for multiple patients stated the availability of *Chevra Kadisha* in this CCRC. When referring to Tables 8 and 9, it is also highly possible that this is the respondent who is a CNA, aged 31 to 65.

Table 10. Knowledge of *Chevra Kadisha* Relative to End-of-life Care Performed

Frequency (Percentage)		*Chevra Kadisha*		
		Yes	No	Don't know
End-of-life care	Never	0 (0%)	2 (15.38%)	11(84.62%)
	More than once	1 (5.88%)	5 (29.41%)	11(64.71%)
N=30				
Fisher's Exact test	p=0.5203			

As with the lack of knowledge of *Chevra Kadisha*, all respondents - regardless of age - reported that they were not aware of the existence and availability of *Shomrim*. Only one participant knew that S*homrim* were accessible when requested. Referring to Table 8, it is highly possible that this participant also acknowledged the accessibility of *Chevra Kadisha*. See Table 11. Results show that respondents' knowledge of *Shomrim* is not significantly influenced by their ages.

Table 11. Knowledge of *Shomrim* by Respondents' Ages

Frequency (Percentage)		*Shomrim*		
		Yes	No	Don't know
Age	20 - 30	0 (0%)	0 (0%)	6 (100%)
	31 - 65	1 (4.17%)	5 (20.83%)	18 (75%)
N=30				
Fisher's Exact test		p=0.6421		

Although not significant, the results from Table 12 are interesting. Similar to responses on *Chevra Kadisha*, no RNs, LPNs, healthcare coordinators, social workers, and physical therapists were familiar with the availability and responsibilities of *Shomrim*. Only one single CNA was aware of the accessibility of *Shomrim* in the CCRC when a Jewish patient dies. When referring to Table 9, this single CNA is likely familiar with the existence and responsibilities with *Chevra Kadisha.*

Table 12. Knowledge of *Shomrim* by Respondents' Professions

Frequency (Percentage)		*Shomrim*		
		Yes	No	Don't know
Profession	RN	0 (0%)	2 (40%)	3 (60%)
	LPN	0 (0%)	1 (50%)	3 (75%)
	CNA	1 (7.14%)	1 (7.14%)	12(85.71%)
	Other healthcare professionals	0 (0%)	1 (14.29%)	6 (85.71%)
N=30				
Fisher's Exact test	p=0.6596			

As with the responses on *Chevra Kadisha,* staff members who have performed post-death care multiple times are not more knowledgeable of Jewish rituals than those who have not. See Table 13. Only one participant who had performed end-of-life care for multiple patients stated the awareness of *Shomrim* in this CCRC. Referring to Table 10, one could assume the same respondent acknowledged the existence of *Chevra Kadisha*. Results show that the frequency of performing end-of-life care does not significantly affect respondents' knowledge of *Shomrim*.

Table 13. Knowledge of *Shomrim* by End-of-life Care Performed

Frequency (Percentage)		*Shomrim*		
		Yes	No	Don't know
End-of-life care	Never	0 (0%)	2 (15.38%)	11(84.62%)
	More than once	1 (5.88%)	3 (17.65%)	13(76.47%)
N=30				
Fisher's Exact test	p=1.00			

Table 14 shows respondents' age and the likelihood of their knowing the importance of arranging for a same-sex professional to care for the deceased of the Muslim faith. Four respondents aged 20 to 30 were aware of the Muslim tradition, and 14 respondents aged 31 to 65 also found it acceptable for the dying patient to request a same-sex professional to care for them. However, the results were not statistically significant.

Table 14. Importance of Providing Care to Those of Muslim Faith by Individuals of Same Gender by Respondents' Ages

Frequency (Percentage)		Providing care to those of Muslim faith by individuals of same gender	
		Yes	Don't know
Age	20 - 30	4 (66.67%)	2 (33.33%)
	31 - 65	14 (58.33%)	10 (41.67%)
N=30			
Fisher's Exact test	p=1.00		

Table 15 shows that respondents' professions significantly influenced the knowledge of the importance to arrange for a same-sex professional to care for those of the Muslim faith, with p value less than 0.1. It is surprising to see that all RNs in this study reported that Muslim traditions are acceptable in this CCRC, while only 28.57% of those who are categorized as other professionals reported the availability of such care in this CCRC. Those categorized as other professionals are mainly healthcare coordinators, social workers, and physical therapists who might have little access to clinical practice, and many were not familiar with this Muslim tradition.

Table 15. Importance of Providing Care to Those of Muslim Faith by Individuals of Same Gender by Respondents' Professions

Frequency (Percentage)		Providing care to those of Muslim faith by individuals of same gender	
		Yes	Don't know
Profession	RN	5 (100%)	0 (0%)
	LPN	2 (50%)	2 (50%)
	CNA	9 (64.29%)	5 (35.71%)
	Other professionals	2 (28.57%)	5 (71.43%)
N=30			
Fisher's Exact test	p=0.0853		

Table 16 shows the frequency of active involvement in end-of-life care relative to the likelihood of knowing the importance to arrange for a same-sex professional to care for the deceased of the Muslim faith. Approximately 64.71% of respondents who have performed end-of-life for multiple patients reported as acceptable the availability of a same-sex professional to care for a Muslim patient if requested. Comparatively, approximately 53.85% of those respondents who had never performed end-of-life care agreed that such demand is to be met if one requests. However, the results were still not statistically significant.

Table 16. Importance of Providing Care to Those of Muslim Faith by Individuals of Same Gender Relative to End-of-life Care Performed

Frequency (Percentage)		Muslim tradition	
		Yes	Don't know
End-of-life care	Never	7 (53.85%)	6 (46.15%)
	More than once	11 (64.71%)	6 (35.29%)
N=30			
Fisher's Exact test	p=0.7106		

To explore respondents' knowledge on traditional Hindu customs, two primarily questions were asked, including the importance of turning the religious picture against the wall and covering the mirror in the room. Surprisingly, approximately 83.33% of respondents aged 20 to 30 reported the acceptability of these Hindu traditions in the CCRC. See Table 17. Meanwhile, approximately 75% of respondents aged 31 to 65 found the Hindu traditions acceptable. Interestingly, several individuals were not able to determine acceptability and answered "Don't know." However, results show that respondents' ages do not significantly influence their perspectives on Hindu traditions.

Table 17. Knowledge of Turning Religious Pictures and Covering Mirrors by Respondents' Ages

Frequency (Percentage)		Hindu traditions		
		Acceptable	Unacceptable	Don't know
Age	20 - 30	5 (83.33%)	0 (0%)	1 (16.67%)
	31 - 65	18 (75%)	1 (4.17%)	5 (20.83%)
N=30				
Fisher's Exact test		p=1.00		

One might assume that RNs would find Hindu traditions more acceptable than would other professions. Surprisingly, the majority of respondents, regardless of their professions, reported the acceptability of Hindu traditions in the CCRC. See Table 18. It is worth noting that all RNs (100%) stated that when a Hindu patient dies in the CCRC, it is acceptable for the mirrors to be covered and religious pictures to be turned toward the wall. Only one single CNA felt these traditional Hindu customs were unacceptable in this CCRC, and perhaps the lack of education on these traditions and rituals may offer the answer. However, the results were not statistically significant.

Table 18. Knowledge of Turning Religious Pictures and Covering Mirrors by Respondents' Professions

Frequency (Percentage)		Hindu traditions		
		Acceptable	Unacceptable	Don't know
Profession	RN	5 (100%)	0 (0%)	0 (0%)
	LPN	3 (75%)	0 (0%)	1 (25%)
	CNA	9 (64.29%)	1 (7.14%)	4 (28.57%)
	Other healthcare professionals	6 (85.71%)	0 (0%)	1 (14.29%)
N=30				
Fisher's Exact test	p=0.8079			

The majority of respondents, regardless of the frequency of performing end-of-life care, find it easy to accept these Hindu traditions. One might assume that those who have performed end-of-life care multiple times would be more familiar with other

traditions. Surprisingly, one single respondent who performed end-of-life care multiple times found these traditions unacceptable. However, the results were not statistically significant.

Table 19. Knowledge of Turning Religious Pictures and Covering Mirrors by End-of-life Care Performed

Frequency(Percentage)		Hindu traditions		
		Acceptable	Unacceptable	Don't know
End-of-life care	Never	11 (84.62%)	0 (0%)	2 (15.38%)
	More than once	12 (70.59%)	1 (5.88%)	4 (23.53%)
N=30				
Fisher's Exact test	p=0.8089			

Table 20 provides results on the importance of religion in respondents' lives and the acceptance of Hindu traditions, with p value less than 0.05. Specifically, for those who have a strong religious affiliation, approximately 68.42% reported the acceptability of these traditional Hindu customs while 31.58% were not aware of such traditions. It is worth noting that no participants possessing a strong religious belief stated the unacceptability of such customs. Comparatively, approximately 90.91% of respondents who stated the insignificance of religion reported the acceptability and availability of these Hindu customs, with a single respondent claiming unacceptability. It is also worth mentioning that no participant in this group stated the unawareness of such issues.

Table 20. Knowledge of Hindu Traditions by Significance of Religion of Respondents

Frequency (Percentage)		Hindu traditions		
		Acceptable	Unacceptable	Don't know
Significance of religion	Very important	13 (68.42%)	0 (0%)	6 (31.58%)
	Not important	10 (90.91%)	1 (9.09%)	0 (0%)
N=30				
Fisher's Exact test		p=0.0365		

Table 21 shows respondents' ages and the likelihood of their knowledge of the importance of allowing only minimal physical touch immediately after a Buddhist dies. The majority of respondents aged 20 to 30 (66.67%) reported that healthcare professionals should minimize physical touch, while approximately 50% of respondents aged 31 to 65 reported unawareness of these Buddhist traditions. It is worth noting that no respondents aged 20 to 30 reported that such traditions were not acceptable in the CCRC. Results showed no significant difference between respondents' ages and their knowledge of Buddhist practices, with p value greater than 0.05.

Table 21. Acceptance of Minimal Physical Touch by Respondents' Ages

Frequency (Percentage)		Minimal physical touch		
		Yes	No	Don't know
Age	20 - 30	4 (66.67%)	0 (0%)	2 (33.33%)
	31 - 65	8 (33.33%)	4 (16.67%)	12(50%)
N=30				
Fisher's Exact test		p=0.3762		

One might also presume that healthcare professionals with higher education levels are more aware of these customs non-traditional to American culture. Results from Table 22 indicated that comparatively RNs found these Buddhist practices more acceptable (60%) and were more willing to understand and respect them. However, no significance was found between respondents' professions and their opinions on these Buddhist traditions, with p value greater than 0.05.

Table 22. Acceptance of Minimal Physical Touch by Respondents' Professions

Frequency (Percentage)		Minimal physical touch		
		Yes	No	Don't know
Profession	RN	3 (60%)	1 (20%)	1 (20%)
	LPN	1 (25%)	2 (50%)	1 (25%)
	CNA	6 (42.86%)	1 (7.14%)	7(50%)
	Other healthcare professionals	2 (28.57%)	0 (0%)	5(71.43%)
N=30				
Fisher's Exact test		p=0.2663		

Table 23 shows the frequency of performing end-of-life care and the likelihood of knowing the importance of allowing only minimal physical touch immediately after a Buddhist dies. Surprisingly, approximately 58.82% of those who have performed the end-of-life care for multiple patients reported that they were not aware of this Buddhist tradition when performing clinical care, with approximately 53.85% of those who have

never performed the end-of-life care acknowledging such traditional customs. However, the result was not statistically significant.

Table 23. Acceptance of Minimal Physical Touch by End-of-life Care Performed

Frequency(Percentage)		Minimal physical touch		
		Yes	No	Don't know
End-of-life care	Never	7 (53.85%)	2 (15.38%)	4 (30.77%)
	More than once	5 (29.41%)	2 (11.76%)	10 (58.82%)
N=30				
Fisher's Exact test	p=0.3144			

Table 24 provides the results for the significance of religion relative to knowledge of allowing only minimal physical touch immediately after a Buddhist dies. Interestingly, although the majority of respondents claimed that religion was important in their lives, approximately 47.37% of them were unaware of the importance of minimizing physical touch immediately after a Buddhist passes. Results show that the importance of religion in respondents' lives does not significantly influence their attitudes on Buddhist tradition.

Table 24. Acceptance of Minimal Physical Touch by Significance of Religion of Respondents

Frequency (Percentage)		Minimal physical touch		
		Yes	No	Don't know
Significance of religion	Very important	7 (36.84%)	3 (15.79%)	9(47.37%)
	Not important	5 (45.45%)	1 (9.09%)	5 (45.45%)
N=30				
Fisher's Exact test	p=1.00			

Table 25 shows the respondents' ages and the likelihood of their acceptance of speaking to the soul immediately after a Buddhist individual dies. As with the responses to the minimal physical touch, those ages 20 to 30 (66.67%) stated the acceptability of allowing families to speak to a dying soul, while approximately 50% of respondents aged 31 to 65 reported the unawareness of these Buddhist traditions. However, no statistical significance was found.

Table 25. Acceptance of Speaking to the Soul by Respondents' Ages

Frequency (Percentage)		Speaking to the soul		
		Yes	No	Don't know
Age	20 - 30	4 (66.67%)	1 (16.67%)	1 (16.67%)
	31 - 65	8 (33.33%)	4 (16.67%)	12 (50%)
N=30				
Fisher's Exact test		p= 0.2293		

Table 26 shows the respondents' professions relative to the likelihood of their acceptance of speaking to the soul immediately after a Buddhist individual dies. One might also assume healthcare professionals with higher education levels would be more aware or more accepting of Buddhist rituals and customs. Results indicated that comparatively, RNs found these Buddhist practices more acceptable (60%) and were more willing to understand and respect them. However, no statistical significance was found between respondents' professions and their opinions on these Buddhist traditions, with p value greater than 0.05.

Table 26. Acceptance of Speaking to the Soul by Respondents' Professions

Frequency (Percentage)		Speaking to the soul		
		Yes	No	Don't know
Profession	RN	3 (60%)	0 (0%)	2 (40%)
	LPN	0 (0%)	1 (25%)	3 (75%)
	CNA	6 (42.86%)	3 (21.43%)	5 (35.71%)
	Other healthcare professionals	3 (42.86%)	1 (14.29%)	3 (42.86%)
N=30				
Fisher's Exact test	p=0.6436			

Table 27 shows the acceptance of speaking to the soul and the likelihood of the frequency of performing end-of-life care. Those who have performed end-of-life care multiple times reported it is easier to accept this traditional Buddhist practice. Specifically, approximately 41.18% of those who have performed end-of-life care multiple times stated that it is suitable to speak to the dying soul, while only 38.46% of those who have never performed such care find it acceptable. However, the results are not statistically significant.

Table 27. Acceptance of Speaking to the Soul by End-of-life Care Performed

Frequency(Percentage)		Speaking to the dying soul		
		Yes	No	Don't know
End-of-life care	Never	5 (38.46%)	2 (15.38%)	6 (46.15%)
	More than once	7 (41.18%)	3 (17.65%)	7 (41.18%)
N=30				
Fisher's Exact test	p=1.00			

Table 28 shows the acceptance of speaking to the soul by the significance of religion in participants' lives. Surprisingly, those who are affiliated with religious beliefs find it more difficult to understand family's need of speaking to the dying soul. Only approximately 36.84% of this group reported the acceptability of such rituals. On the other hand, approximately 45.45% of respondents who reported religion to be not important in their lives indicated that speaking to the dying soul was acceptable and understandable. However, the results were not statistically significant.

Table 28. Acceptance of Speaking to the Dying Soul by Significance of Religion of Respondents

Frequency(Percentage)		Speaking to the dying soul		
		Yes	No	Don't know
Significance of religion	Very important	7 (36.84%)	4 (21.05%)	8 (42.11%)
	Not important	5 (45.45%)	1 (9.09%)	5 (45.45%)
N=30				
Fisher's Exact test	p=0.7797			

CHAPTER VI

DISCUSSION

The recent increase in immigration to the United States and the rapid aging of population have created an expanded demand for healthcare professionals who provide direct care for patients prior to and immediately after death to be culturally competent. This is the first study to combine perspectives of the end-of-life and after-death care from a number of religious and spiritual backgrounds to provide clinical guidance and suggestions for professional providers in institutional settings. Through a series of qualitative interviews with spiritual leaders and surveys of staff in a CCRC, this study explored specific traditional end-of-life and after-death rituals from five different religions - Christianity, Judaism, Islam, Buddhism, Hinduism - and atheism. Opinions on suicide, organ donation, and euthanasia with regard to different religions and atheism were also addressed. Additionally, to provide more reliable and practicable guidance for those who provide direct care, a number of crucial implications were illustrated for each religion and atheism.

The survey results show the necessity of increased education and awareness for healthcare professional to become more culturally competent and sensitive. An understanding and respect of different religious and spiritual beliefs can decrease conflicts, fulfill patients' final wishes, and comfort their family members. Several

surprising findings were represented in this study. First, Judaism has been part of the American culture since before the American Revolution and assimilated into the modern society; thus it would be assumed that most healthcare professionals would be culturally sensitive to this group of patients. Surprisingly, the majority of participants in this study were not familiar with traditional Jewish rituals of Jews nearing, at or after death. *Chevra Kadisha,* the volunteer groups in the Jewish community whose responsibilities are to take care of the body immediately after death, are of critical importance to the Jewish community. Similarly, Jewish law mandates that the body should not be left unattended before a funeral; therefore, if no family members are present, *Shomrim*, who guard and watch the body, should be arranged immediately after a Jewish patient dies. Healthcare professionals need to understand and respect traditional Jewish customs; yet, survey results indicate these professional providers lack of knowledge of these traditions. Among all the 30 respondents, nearly all were unaware of the existence of *Chevra Kadisha* and 24 respondents were not familiar with *Shomrim*. Lack of mutual understanding of these rituals can interfere with the deceased's journey into the next life and bring stress to their families. Reasons for the lack of knowledge may be as simple as lack of exposure to the Jewish culture or the quiet assimilation of Jews into American culture in such a manner as to leave these customs closed to non-Jews.

On the contrary, it is interesting to find that more than half of the respondents reported the acceptance for Muslim and Hindu traditions. Those who have performed end-of-life and after-death care for multiple Muslim patients reported a higher tolerance

for acceptance of these Muslim traditions. As with any religion, custom, or culture, an understanding and respect of these traditional Muslim customs can significantly decrease complicated conflicts with family members. As one of the largest minority groups in the United States, Hindus are increasingly using modern institutional resources, especially during the end of life or even after death. A growing pressure is being imposed on healthcare providers to be more culturally competent and tolerant, especially toward religions that are non-traditional to Western culture. In this study, nearly 75% of providers felt it was important to follow these Hindu traditions, including covering the mirror and turning the religious pictures against the wall immediately after a Hindu patient dies in this CCRC.

Although approximately two-thirds of all participants have strong religious beliefs; less than half of the respondents were familiar with religious rituals that are non-traditional to Western culture. Results suggest that the importance of religion in the participants' lives significantly influenced their perspectives toward Hindu traditions. Perhaps traditional American culture has come to understand the gentleness of the Hindu traditions and found greater tolerance for those different from themselves.

Results from the interviews with religious leaders found both similarities and differences on traditional practices. Regardless of belief system, these leaders felt it is critical for professionals to maintain the patients' dignity, offer reassurance, and fulfill the patients' final wishes. In addition, all religious and spiritual leaders insisted healthcare professionals need to understand and acknowledge the significance of family

connection to all the dying patients, regardless of beliefs. Doing so would not only alleviate fear and stress but also could provide beneficial comfort and support to the individuals. When caring for those with religious beliefs, healthcare professionals must understand the significance of religious leaders and sacred prayer services for the dying patients. For those without religious beliefs, it is imperative for the healthcare professionals to show respect for the departed.

Increased cultural diversity has imposed considerable pressure on the professional caregivers. It might be impossible for professional healthcare providers to have a complete knowledge of a variety of traditional religious rituals when delivering care, and unknowingly one may breach a cultural norm without cultural training. However, acknowledging and distinguishing different practices that are performed by individuals with a variety of religious and spiritual beliefs can positively assist those professionals with delivering culturally appropriate care. For instance, the arrangement of *Chevra Kadisha* and *Shomrim* for a Jewish patient, or providing a same-sex professional healthcare attendant for a Muslim patient can avoid unnecessary conflicts, maintain the deceased's dignity, and offer comfort for the families. An extended education and awareness of these traditional rituals and customs can significantly improve those professionals' cultural competence when delivering care for those with a diversity of religious and spiritual beliefs.

Based on the shortage of existing literature on cultural differences in end-of-life and after death practices, this study begins to provide relevant information for

healthcare professionals working with an increasing number of patients from different religious backgrounds. Especially, educational resources toward Jewish end-of-life and after-death rituals must be offered for those care providers in order to fulfill patients' religious wishes and promote the quality of care delivered. The significance of this study lies in the fact that similarities and differences coexist among different religious groups and must be respected and acknowledged by healthcare professionals.

This study has several unique strengths: first, the researcher does not have any claimed religious belief and thus does not have any spiritual bias on the opinions and conclusions that have been reached in this study. In fact, one unique characteristic of this study is that until she was 24, she lived in China, absent from religious influences. Secondly, this is the first study that provides applicable and educational information on end-of-life and after-death care for the top six spiritual beliefs and atheism in the United States. Next, all of the research subjects in this study reported a willingness to learn and apply the ritual beliefs of the six major American religious beliefs and atheism. Finally, despite a lack of statistical significance in the most of the findings in this study, the respondents were enthusiastic about the diverse ritual and customs with regard to end-of-life and after-death care. In fact, After the survey was completed, all the staff members showed willingness to learn different traditional rituals and customs with regard to end-of-life and after-death care. Questions that were most frequently asked by the staff were "Who are *Chevra Kadisha*?" and "Who are *Shomrim*?" Although it is

surprising to observe respondents' little awareness of Jewish traditions, all showed the enthusiasm to learn these relatively new concepts from Jewish rituals.

CHAPTER VII

CONCLUSION

Although the majority of survey results showed no significance among different variables, results suggested that most respondents were willing to learn and respect these traditional customs. The reliability of this research study lies in the consistent responses from respondents in this proof-of-concept study. As America becomes increasingly diverse, a variety of unfamiliar religions in a historic Judeo-Christian Nation have emerged, requiring a greater understanding of a diversity of people. Such understanding includes respect for the traditional rituals and customs that come with religions non-traditional to Western culture.

Referring to the research questions, it is proposed that an increased awareness and education be provided for professional caregivers in a variety of institutions to promote quality of care delivered at end of life and after death. The first research question explored the crucial end-of-life and after-death information that religious leaders want institutions to understand and practice. After a series of qualitative interviews, the researcher found both similarities and differences in the palliative and after-death care. For example, professional caregivers must respect and maintain individuals' dignity, offer reassurance, and fulfill their final wishes, regardless of individuals' religious and spiritual beliefs. Differences exist among a variety of beliefs.

For instance, institutional professionals must place the deceased's head toward Mecca immediately after the death of a Muslim and must invite *Chevra Kadisha* when a Jewish patient dies. A full understanding of these special end-of-life and after-death rituals can assist professional caregivers with delivering appropriate and dedicated care for the individual.

The second research questions focused on professionals' knowledge of religious-related end-of-life and after-death customs. It was quite surprising to notice that although Judaism has been assimilated into American culture since the Revolution, the majority of respondents in this study were not aware of Jewish traditions in end-of-life and after-death care. A possible reason might be the quiet assimilation of Jews into modern American society, and the reminders of persecution in World War II that have kept the Jewish culture quiet about their traditions. Overall, healthcare professionals demonstrated a lack of basic knowledge of the traditions and customs in the end-of-life and after-death care for those non-Western religions.

The third research question focused on professionals' willingness to learn end-of-life and after-death rituals for different religions. It was especially interesting to observe the openness of CCRC staff to non-Western religions, such as Muslims and Hinduism, given the location of the study - North Carolina, a Southern state known as part of the Bible-belt. Perhaps the increased visibility of Muslims and other non-Western cultures on the media and in the news together with increased political correctness and other awareness have made individuals more welcoming to cultural sensitivity.

There are weaknesses in this study that must be carefully examined and discussed. First, a relatively small survey sample size was used, with a total number of 30 respondents in one CCRC in the greater Piedmont community. This survey size limits the discussion so that the results may only be generalized and applicable for a CCRC and the small sample size resulted in few significant P values. Secondly, the qualitative design in this study limited the methodology approach. Future research should use a quantitative approach to reach out to larger population to find out, for example, how more family members might want to design end-of-life and after-death care program options in advance to meet their needs. Additionally, specific end-of-life and after-death rituals for only six prominent spiritual beliefs were examined and discussed in this proof-of-concept study. Despite of all these recommendations provided for healthcare professionals, it is critical to understand that there is so much variation that is impossible to generalize to even one denomination within a larger religion.

It is highly possible that healthcare professionals will not be able to perform all these observed traditional rituals and customs in a clinical setting; therefore, a website toolkit needs to be developed to help healthcare providers to become more culturally sensitive by guiding them to ask the most relevant questions. Further study is needed to analyze existing knowledge of end-of-life and after-death care from a larger sample size in multiple institutions to generalize the findings to a larger population. End-of-life rituals from additional cultures (e.g., Native Americans, Jehovah's Witnesses) are to be further explored. Cultural sensitivity education and training materials with regard to

end-of-life and after-death care need to be provided to professionals to aid professionals in their quest to be more culturally competent. More research studies also need to provide policy guidance and accommodations for all healthcare institutional settings on end-of-life and after-death issues with regard to a variety of religious and spiritual backgrounds. Further research is of critical importance to provide extended knowledge on end-of-life and after-death practices from additional cultural and religious beliefs to honor the multiple cultures in which we live-and in which we die.

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APPENDIX A

POTENTIAL RISKS AND BIAS

Potential risks

This study meets the Federal standards of "minimal risks" to study participants. It is possible, however, that on rare occasion some participants may suffer mild or moderate distress while answering questions related to body care. It is unlikely that participation in this study will place any subject in harm's way. If participants in the study become distressed, the researcher will offer a referral to a professional staff coordinator for the CCRC. The staff coordinators have been contacted, and they indicated that it is a standard practice to provide psychological support to any staff in this CCRC without any charge.

Potential benefits

By providing participants with accurate and relevant information about religious customs on death care, the proposed intervention is hypothesized to enhance participants' knowledge and understanding of cultural sensitivity care for patients and their families near the end of life thus providing families comfort that their loved one's wishes will be honored.

Healthcare professionals will enhance their cultural sensitivity when performing end-of-life and death care to patients with specific religions. Results from this study will also raise the awareness of other healthcare environments (e.g., hospice, home care agency) in terms of performing body care.

APPENDIX B

INTERVIEW QUESTIONS FOR CHRISTIAN CLERGY

Good morning. My name is Jenny Jiang. I have an appointment with Priest or Pastor at 9am this morning. As we discussed in our earlier conversation, my interest is in rituals and customs related to end-of-life and death care. I am concerned about honoring the person who is going through the death process, their family members and making certain that their faith rituals as followed and honored also. This is extremely important in a multicultural world, and there has been a constant increase in pressure on healthcare professionals to be culturally competent. As I know, in North Carolina, more than 30 percent of all deaths of people age 60 and older occur in an institutional setting (e.g., CCRC, hospital, etc.). So I'm planning to provide related educational information for those healthcare professionals on end-of-life issues. What can you tell me that I need to know on rituals and customs related to end-of-life and death care? This will be an open ended question.
If they haven't answered what I have learned through my research, I will follow up with questions as following:

(1) In North Carolina, what percentage of the population do you think is Christianity/ Jewish/ Muslim/ Buddhist/ Hindu/ Atheist?
(2) Can you tell me the procedure that is commonly carried out when a person with Christianity/ Judaism/Islam/ Buddhism/ Hinduism dies?
(3) Are there different sects within your faith that have different end-of-life customs?
(4) How can these traditional customs be integrated into modern American society?
(5) How large is this religious community you are serving?
(6) What is the percentage of the population in your community dies in an institutional setting?
(7) What particular traditional customs would you prefer to let the healthcare providers know?
(8) How do you usually dress the body? If the body is to be dressed in a shroud, are there specific requirements for the shroud?
(9) It is known that certain purification needs to be performed after the family members return from the funeral. Would you mind telling me a little more about that?
(10) What can you tell me about the final graveside farewell? Is it performed significantly different within different sects of Christianity?
(11) Is there a specific washing procedure for the body?
(12) Are there any differences on end-of-life and after death care among persons with Catholic, Orthodox, and Protestant? Can you tell me a little more about that?

APPENDIX C

INTERVIEW QUESTIONS FOR JEWISH RABBI

Good morning. My name is Jenny Jiang. I have an appointment with Rabbi at 10am this morning. As we discussed in our earlier conversation, my interest is in rituals and customs related to end-of-life and death care. I am concerned about honoring the person who is going through the death process, their family members and making certain that their faith rituals as followed and honored also. This is extremely important in a multicultural world, and there has been a constant increase in pressure on healthcare professionals to be culturally competent. As I know, in North Carolina, more than 30 percent of all deaths of people age 60 and older occur in an institutional setting (e.g., CCRC, hospital, etc.). So I'm planning to provide related educational information for those healthcare professionals on end-of-life issues. What can you tell me that I need to know on rituals and customs related to end-of-life and death care? This will be an open ended question.
If they haven't answered what I have learned through my research, I will follow up with questions as following:

(1) In North Carolina, what percentage of the population do you think is Christianity/ Jewish/ Muslim/ Buddhist/ Hindu/ Atheist?
(2) Can you tell me the procedure that is commonly carried out when a person with Christianity/ Judaism/Islam/ Buddhism/ Hinduism dies?
(3) Are there different sects within your faith that have different end-of-life customs?
(4) How can these traditional customs be integrated into modern American society?
(5) How large is this religious community you are serving?
(6) What is the percentage of the population in your community dies in an institutional setting?
(7) What particular traditional customs would you prefer to let the healthcare providers know?
(8) What are the responsibilities for *Chevra Kadisha* in Jewish community?
(9) Does the synagogue provide volunteer resources for CCRCs to help with preparation of the body when requested?
(10) Are there any restrictions during shiva?
(11) Is there a specific washing procedure for Jewish people?
(12) Can you tell me a little more about Kaddish? Is there always a chosen Kaddish people will prefer to chant?
(13) Can you tell me a little more about Kriah, which is the tearing of clothes at the time of death? If there is a black ribbon provided, will Kriah still be provided? If it will, is there any difference in the procedure?

APPENDIX D

INTERVIEW QUESTIONS FOR ISLAMIC IMAM

Good morning. My name is Jenny Jiang. I have an appointment with Imam at 11am this morning. As we discussed in our earlier conversation, my interest is in rituals and customs related to end-of-life and death care. I am concerned about honoring the person who is going through the death process, their family members and making certain that their faith rituals as followed and honored also. This is extremely important in a multicultural world, and there has been a constant increase in pressure on healthcare professionals to be culturally competent. As I know, in North Carolina, more than 30 percent of all deaths of people age 60 and older occur in an institutional setting (e.g., CCRC, hospital, etc.). So I'm planning to provide related educational information for those healthcare professionals on end-of-life issues. What can you tell me that I need to know on rituals and customs related to end-of-life and death care? This will be an open ended question.
If they haven't answered what I have learned through my research, I will follow up with questions as following:

(1) In North Carolina, what percentage of the population do you think is Christianity/ Jewish/ Muslim/ Buddhist/ Hindu/ Atheist?
(2) Can you tell me the procedure that is commonly carried out when a person with Christianity/ Judaism/Islam/ Buddhism/ Hinduism dies?
(3) Are there different sects within your faith that have different end-of-life customs?
(4) How can these traditional customs be integrated into modern American society?
(5) How large is this religious community you are serving?
(6) What is the percentage of the population in your community dies in an institutional setting?
(7) What particular traditional customs would you prefer to let the healthcare providers know?
(8) What is the procedure for Wazu in Islamic community?
(9) Are there different fluids used during Wazu?
(10) What is the usual procedure for burial?
(11) I understand that prayers need to be said quite a few times while performing death care and funeral arrangements. Would you tell me a little more about that?
(12) Is it true that Imam need to say "Bismillah Wa A'la Milla Rasulallah" while placing the body into the grave?
(13) Is it recommended that religious items need to be removed while performing death care?

APPENDIX E

INTERVIEW QUESTIONS FOR BUDDHIST MONK

Good afternoon. My name is Jenny Jiang. I have an appointment with Monk at 1pm this afternoon. As we discussed in our earlier conversation, my interest is in rituals and customs related to end-of-life and death care. I am concerned about honoring the person who is going through the death process, their family members and making certain that their faith rituals as followed and honored also. This is extremely important in a multicultural world, and there has been a constant increase in pressure on healthcare professionals to be culturally competent. As I know, in North Carolina, more than 30 percent of all deaths of people age 60 and older occur in an institutional setting (e.g., CCRC, hospital, etc.). So I'm planning to provide related educational information for those healthcare professionals on end-of-life issues. What can you tell me that I need to know on rituals and customs related to end-of-life and death care? This will be an open ended question.
If they haven't answered what I have learned through my research, I will follow up with questions as following:

(1) In North Carolina, what percentage of the population do you think is Christianity/ Jewish/ Muslim/ Buddhist/ Hindu/ Atheist?
(2) Can you tell me the procedure that is commonly carried out when a person with Christianity/ Judaism/Islam/ Buddhism/ Hinduism dies?
(3) Are there different sects within your faith that have different end-of-life customs?
(4) How can these traditional customs be integrated into modern American society?
(5) How large is this religious community you are serving?
(6) What is the percentage of the population in your community dies in an institutional setting?
(7) What particular traditional customs would you prefer to let the healthcare providers know?
(8) Are there special requirements for the coin that is placed into the mouth of the deceased?
(9) Is there any requirement for the Buddha image placed in the deceased's room?
(10) Is it preferred that death occurs at home?
(11) Is it true that family members and relatives are not allowed or encouraged to express an outward emotion immediately after their loved ones die?
(12) Can you tell me a little more about Bardo? What responsibilities does the monk usually take during this period of time?
(13) What does the monk usually perform to help the dying patient to concentrate on God?

APPENDIX F

INTERVIEW QUESTIONS FOR HINDU BRAHMIN PRIEST

Good morning. My name is Jenny Jiang. I have an appointment with Brahmin priest at 3pm this afternoon. As we discussed in our earlier conversation, my interest is in rituals and customs related to end-of-life and death care. I am concerned about honoring the person who is going through the death process, their family members and making certain that their faith rituals as followed and honored also. This is extremely important in a multicultural world, and there has been a constant increase in pressure on healthcare professionals to be culturally competent. As I know, in North Carolina, more than 30 percent of all deaths of people age 60 and older occur in an institutional setting (e.g., CCRC, hospital, etc.). So I'm planning to provide related educational information for those healthcare professionals on end-of-life issues. What can you tell me that I need to know on rituals and customs related to end-of-life and death care? This will be an open ended question.
If they haven't answered what I have learned through my research, I will follow up with questions as following:

(1) In North Carolina, what percentage of the population do you think is Christianity/ Jewish/ Muslim/ Buddhist/ Hindu/ Atheist?
(2) Can you tell me the procedure that is commonly carried out when a person with Christianity/ Judaism/Islam/ Buddhism/ Hinduism dies?
(3) Are there different sects within your faith that have different end-of-life customs?
(4) How can these traditional customs be integrated into modern American society?
(5) How large is this religious community you are serving?
(6) What is the percentage of the population in your community dies in an institutional setting?
(7) What particular traditional customs would you prefer to let the healthcare providers know?
(8) Is there a special procedure performed when an oldest old Hindu passes away?
(9) Is there a special procedure performed to make certain that the deceased Hindu patient will have a satisfying rebirth?
(10) Is there any special washing procedure immediately after a Hindu passes away?
(11) How do you usually perform a cremation ceremony?
(12) Can you tell me a little more about arati, which is the religious ritual of worship in Hindu tradition?
(13) Is there always chosen mantra to be chanted after the Hindu patient dies?

APPENDIX G

SURVEY QUESTIONS FOR STAFF IN CCRCS

1. What is your role in the CCRC?
A. RN C. CNA
B. LPN D. Healthcare coordinator

2. How old are you?
A. 20 – 30 C. 41 – 50
B. 31 – 40 D. 51 – 65

3. How many times have you provided end-of-life and after death care to individuals with religions that are non-traditional to Western culture?
A. Never C. Twice
B. Once D. More than three times

4. Are there spiritual leaders available to staff when a resident whose religion is one that is non-traditional to Western Culture is approaching the end of life?
A. Yes C. Don't know
B. No D. Never thought about it

5. How acceptable is it for a body of a resident to stay untouched for at least eight hours if one's religion requires it?
A. Acceptable C. Don't know
B. Unacceptable D. Never thought about it

6. Is it acceptable to speak to souls of one's deceased relatives or ancestors to appeal for their aid?
A. Acceptable C. Don't know
B. Unacceptable D. Never thought about it

7. How acceptable is it to cover mirrors and pictures in the resident's room if family members request such measures near the time of death and afterwards?
A. Acceptable C. Don't know
B. Unacceptable D. Never thought about it

8. Do you keep a copy of Torah/ Quran/ Dhammapada/ Bhagavad Gita in the library in the CCRC?
A. Yes C. Don't know
B. No D. Never thought about it

9. Has the *chevra kadisha* been asked to help with the preparation of a body of a resident?

A. Yes C. Don't know

B. No D. Never thought about it

10. Do you think that residents with religions that are non-traditional to Western Culture would prefer to be taken care of by a healthcare professional with the same sex?

A. Yes C. Don't know

B. No D. Never thought about it

11. Is there any *shomrim* in the CCRC when a Jewish resident dies?

A. Yes C. Don't know

B. No D. Never thought about it

12. How important is religion in your life?

A. Very important C. Not too important

B. Somewhat important D. Not important at all