

Drawing by Susan Coward

**RELIGIOUS UNDERSTANDINGS OF A  
GOOD DEATH IN HOSPICE PALLIATIVE CARE**

» *A Guide for Health  
Care Practitioners*

A joint project of the Centre for Studies in Religion and Society  
and the Centre on Aging at the University of Victoria



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## INTRODUCTION:

# Bridging the “Religion Gap” in Hospice Palliative Care

In a study done in the U.S. in 2001, up to 77 percent of patients interviewed said they would like spiritual issues to be considered as part of their medical care. Decades earlier, when Dame Cicely Saunders, founder of the present-day hospice movement, was asked which was more important in the care of the dying – the spiritual or the medical – she replied that the two are in fact inextricably mingled.

Saunders founded the modern hospice movement based on three principles: pain control, the importance of a family or community environment, and engagement with the dying person’s most deeply rooted religious beliefs. While the first two of Saunders’s principles have been well studied, the third, engagement with the dying person’s spirituality or religion, has not. It is this gap in knowledge that we set out to discover. We asked, “How is the notion of ‘good death’ in the context of hospice palliative care understood within the major religious traditions?”

Moreover, societies have changed a great deal since Dame Saunders’s time. As the principles of holistic palliative care become more widely adopted, they are being applied to ever-more diverse multiethnic and multifaith populations all over the world. In this context, we also wished to ask, “How well is awareness of the diversity of religious traditions and preferences at end of life being translated into clinical practice?”

Since no one person has all of this knowledge, we gathered an international team of scholars and practitioners to tackle these questions from a variety of angles.<sup>1</sup> Our work was hosted by the Centre for Studies in Religion and Society and the Centre on Aging at the University of Victoria, and funded by a three-year grant from the Canadian Institutes of Health Research.

The full results of our study are now available in the edited volume *Religious Understandings of a Good Death in Hospice Palliative Care*.<sup>2</sup> This small guide is intended as a preview of the larger book and as an incentive to encourage the further exploration of religions and their significance for those nearing the end of life. Drawing on case studies from real-life hospice encounters, the guide offers insights into world religions and suggestions to assist clinicians with helping patients and families to share their religious beliefs, hopes, and expectations as they prepare for death.

### **Accommodating religion in hospice palliative care: Practical challenges**

A common concern for hospice staff as they consider the idea of exploring religious beliefs with patients and family members is the fear of opening a Pandora’s Box of religious preferences that may be unworkable within the hospice environment. While rules and restrictions are

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religious traditions?*

real and necessary, we propose that increasing our knowledge of religious traditions can lead to greater flexibility on the part of staff, the institution, and family members in finding ways to accommodate religious rituals. The resulting clarity that emerges about what can and cannot be accommodated may also allow patients to make more informed decisions about where they want to die.

Of course, just as we try to avoid making assumptions about cultural values that are different from our own, we ought never to assume that “knowing” an individual’s religious affiliation translates into “knowing” what he or she believes about a good death. To know someone’s religious identity is simply the starting point in a conversation about the individual’s personal definition of what a good death means.

As such, the vignettes in the chapters that follow (which are adapted from examples in the larger study) provide a window on beliefs and rituals related to death within seven world traditions – Hinduism, Buddhism, Islam, Judaism, Christianity, Chinese religion, and Aboriginal spirituality. The stories provide a sense of the possibilities available for accommodating these perspectives within the hospice palliative setting. However, the stories are meant to be opportunities for learning only; they are not definitive accounts of any particular religion’s perspective on any particular aspect of the dying process.

In the course of our study, we became aware of a whole other dimension of care that our limited resources did not permit time for addressing. This concerns the end-of-life experiences of those who hold atheistic or agnostic understandings of death, or whose spiritual beliefs fall outside the realm of traditional religion. We observed that the numbers of those who embrace non-traditional spiritual beliefs or who reject religion altogether are rapidly increasing. To address the special issues and needs of this growing population, we launched a second study, which resulted in a companion volume to the first one entitled *Spirituality in Hospice Palliative Care*.<sup>3</sup>

In the end, whatever a person’s religious or non-religious orientation, we who provide care are ethically bound to respect, protect, and, to the fullest degree possible, support the personhood of every individual we encounter. As one rabbi wrote in a credo to be followed as he was dying, “I am ill, but I am still a person and I want my humanity respected”. To be effective in this context involves understanding the relevance of an individual’s beliefs to his or her quality of life as well as to the quality of their death.

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1 See the full list of research team members at the end of this book.

2 Harold Coward and Kelli I. Stajduhar, eds. *Religious Understandings of a Good Death in Hospice Palliative Care*. Albany, NY: SUNY Press, 2012. An order form for this volume is available on p.21 of this booklet.

3 Paul Bramadat, Harold Coward, and Kelli I. Stajduhar, eds. *Spirituality in Hospice Palliative Care*. Albany, NY: SUNY Press, 2013.

**Knowledge into practice:  
A hands-on approach**

The overarching goal of this guide is to provide caregivers with practical “hands-on” suggestions for beginning to recognize and attend to the religious concerns of people in palliative care. Few of us will ever have the time or the ability to become experts in world religions; yet we are privileged in our role as caregivers with the opportunity to expand, through direct experience, our knowledge of sacred rituals, texts, and beliefs, and their meaning for those at the end of life. In the words of the Christian saint Teresa of Avila, “God has no feet or hands but ours.”

We dedicate this guide, and the larger study it represents, to all those who provide care to the dying in palliative care settings. We hope it will go some way toward bridging the gap in our knowledge of the role of religion in life and in death, and to the translation of this knowledge into more informed and skillful standards of hospice palliative care.



## HINDUISM:

# “Like a Ripe Fruit Separating Effortlessly from Its Vine”

**A STORY:** A Hindu woman was dying, and the family and doctors knew she was dying. But when the doctors switched off the life-support machine, they would not let the family give the woman Ganges water or perform the last rites, fearing that the family intended to pour a large quantity of water down her throat that would choke her and cause her to have a “bad death.” As a result of the doctors’ lack of understanding of this ritual, which involves putting tiny drops of water on the dying person’s lips, family members were unable to fulfill a necessary religious obligation and remained distressed by the belief that future generations would be adversely affected by this omission.

### What we can learn from this story

Lack of knowledge and resistance to learning can become significant barriers to the very goal those who provide care to the dying are seeking to achieve: a “good” death. As this story illustrates, a good death is not just a medical phenomenon, nor can it be achieved outside the context of the dying person’s life and everything she values and

holds dear, including her cultural traditions and beliefs. Family members, burdened by grief and stress in the midst of caring for a loved one who is dying, may feel profoundly distressed when medical decisions are taken out of their hands, but may lack the language and confidence, much less the energy, to “fight the system.” Having a knowledgeable advocate on the health care team at such a time can make a profound difference in the outcome of a story such as this one. There are no “do-over’s” where dying is concerned, and family members must live with the death – whether “good” or “bad” from their perspective – for the rest of their lives.

### The beginnings of what you need to know

Hinduism is a highly diverse religious tradition based upon an array of sacred texts, oral traditions, rituals, and practices. Common ground is found in the belief that death is a normal and universal feature of existence and therefore not to be seen as an aberration in the stream of life. In

*Whatever state of being  
one remembers upon  
giving up the body at the  
end of life, to that very  
state one always goes  
(Bhagavad-Gita 8:6)*

addition to being an individual and family event, death is also a social event.

A good death in Hinduism is characterized by the dying person being able to turn her attention away from the finite and fix her heart and mind on God in order to attain a peaceful exit from “the vehicle that is the physical body.” In the context of palliative care, there are a number of rituals that are possible within the hospice setting that can help facilitate this liberation.

The creation of sacred space is one such practice. This may involve the family placing an icon (*murli*) somewhere visible to the dying person so that she may be comforted by both seeing and being seen by her favourite God-form. Another important practice may be the repeated recitation of the names of deities or of Hindu scriptures. In the absence of family members or friends to perform this ritual, appropriate recordings of sacred chants may be acceptable. The ritual referred to in the story above involves administering a few drops of sacred Ganges water and placing a basil leaf on the dying person’s lips. This ritual may be carried out by a priest or a family member. Hindus view the body as a temple of God, and so it follows that their perceptions of a good death are informed by norms of purity, cleanliness, and modesty. This may be reflected in the preference for caregivers of the same sex as the one who is dying.

### **A question to consider**

What specific religious traditions are followed by the patient, and what is his or her chosen God-form?



## **BUDDHISM:**

# “Welcoming an Old Friend”

**A STORY:** An elderly woman who was a devout Buddhist came onto the palliative care unit to die. Her daughters accompanied her, and although they did not share her religious beliefs, they nevertheless fulfilled her wish to be visited by two Buddhist monks, who gave a discourse on the teachings of the Buddha and chanted Buddhist sutras, supporting the woman to keep a calm and peaceful mind as she prepared for death. The monks also asked the woman’s daughters to reflect on the good deeds their mother had done, as a way of strengthening her confidence that those deeds would lead to a favourable rebirth and support in the next life. While this was going on, the nurses on the unit provided privacy, posting a “Do not disturb” sign on the door. This allowed for the temporary transformation of the hospice area into a sacred space for the practice of Buddhist rituals.

### **What we can learn from this story**

It is not uncommon for the role of hospice staff in supporting religious traditions to be nothing more than providing the space and privacy needed for a ritual to take place. In this story, the nurses were not asked to participate or even witness the monks’ activities, but were asked not to intrude and to delay administering medications or other medical procedures until the rituals had been completed. Creating this kind of space can be easy in a single room, but more challenging in a multi-bed ward. However, when there is open communication between staff and families about what is most important in a religious practice, then accommodation – such as allowing the use of a common lounge area, temporarily moving a roommate, or suggesting a visit at night when there might be a place that could be made sacred for awhile – becomes possible instead of impossible.

### **The beginnings of what you need to know**

Buddhism includes a number of doctrines, ideologies, and practices that are distinct within different regions of the world. Buddhism does not posit an ultimate being or divine source, and although it does adhere to a certain understanding of reincarnation, what happens after death is interpreted differently by the different Buddhist traditions. A common belief

*A good death in Buddhism involves having a clear and virtuous mind at the time of death, as this will influence the transition from death to rebirth.*

shared by most Buddhists is the importance of embracing death as natural and inevitable and as an opportunity for spiritual practice and liberation. Illness of any kind is considered a wake-up call and a reminder to use one's precious life wisely. The practice of meditating at end of life is linked to the process of "welcoming death like an old friend" and of being aware of how dreamlike and impermanent the world really is.

A key element of a good death in Buddhism involves having a clear and virtuous mind at the time of death, as this is believed to have a profound influence on the transition from death to rebirth. The final moments of life are ideally supported by an atmosphere that is calm, peaceful, and free of loud noises and distractions. Family members or monastics may recite prayers as the patient is dying as a way of alleviating fears and to help the person generate a serene and still mind. They may also wish to set up a small altar with an image of the Buddha or of the patient's spiritual teacher at eye level to invoke ease and comfort.

Two other important elements of a good death are pain management that allows the patient to remain attentive to the experience of dying, and the opportunity to be surrounded by family and spiritual friends. After death, if the body must be moved or touched, staff may be asked to first touch the body at the crown of the head to allow the consciousness to leave from the crown, fostering a good rebirth.

### **A question to consider**

Since deathbed and post-mortem practices are diverse in Buddhism, what rituals are important to this individual?



## ISLAM:

# “Preparing to Encounter God”

**A STORY:** When an elderly widowed man was admitted to a hospice unit with severe pain related to advanced prostate cancer, his family, who lived in another city, were not immediately available for consultation. Orders were quickly obtained by the nurse for an opioid for the patient’s pain, and she prepared to administer the first dose. However, to her surprise and confusion, the gentleman refused the medication, even though his suffering was clearly evident, as was the fact that his prognosis was short. Frustrated and upset, the nurse charted that the patient was “non-compliant” and suggested a physician visit the following day to try to “talk some sense into him.” The patient died that night, however, and in the subsequent debriefing by staff was described as having had a “bad death,” primarily because the staff felt they had not been allowed to offer the comfort they knew would have been possible.

### What we can learn from this story

The crux of this story is the assumption that the experience of pain is universally unacceptable, especially in the context of palliative care. However, while this may be a widely accepted “medical” truth, when we factor religious belief into our perspective on pain, a very different story may emerge. According to this gentleman’s

Muslim beliefs, his physical pain was directly related to his relationship to God and served the purpose of offering him an opportunity for atonement. The gentleman may have ultimately accepted the opioid, but perhaps only after having had the chance to learn more about how the medication would affect his consciousness and to explore the meaning of his pain in light of his impending death.

When medical care is guided by assumptions rather than by an informed understanding of religious beliefs and traditions, the definition of a good death can become narrow and prescriptive. This may cause health care providers to miss out on one of the basic goals of palliative care – to provide compassionate, holistic care that recognizes the physical, psychosocial, cultural, and *religious* dimensions of human experience.

*Even when a patient is  
bedridden and near death,  
he may still wish to  
observe the ritual of daily  
prayer to the best of  
his ability.*

## **The beginnings of what you need to know**

Islamic tradition is diverse, multilayered, and strongly influenced by cultural and regional customs. However, there is a common belief that each individual's relationship to God is personal and that the afterlife is more important than this life in terms of one's eternal destiny because each person will be judged and rewarded there according to one's deeds in life. Illness in this context may be viewed as a "test" and an opportunity to deepen one's knowledge of God. End of life is an occasion for looking back on one's life to be sure there are no unresolved issues with family and friends. It is also a time to clarify one's wishes regarding the disposition of one's estate and one's body after death, activities that are taken very seriously as part of the "labour" of dying.

Muslim rituals are essential for living a Muslim life, and so it follows that religious acts are also of the highest concern in achieving a good death. In the Islamic tradition, the most important daily ritual in life involves offering prayers five times a day at designated times. Even when a patient is bedridden and near death, he may still wish to observe this ritual to the best of his ability. At this time, family members may ask hospice staff to assist with a ritual washing of the patient's body in preparation for prayer, but such a request may ultimately depend upon the availability of a staff member of the same sex as the patient, as modesty is such an important aspect of Muslim values. During these rituals, privacy and a peaceful setting free of interruptions are very important. Following the death, it is customary for the deceased's body to again be bathed and for the burial to take place as soon as possible.

## **A question to consider**

What is the meaning of illness and pain to the Muslim patient, and how might this affect his decisions regarding treatment and his choice of where he wants to die?

## JUDAISM:

# “A Living Tradition”

**A STORY:** A young Jewish woman with multiple health challenges was admitted to hospital with inflammation of the brain caused by an unidentified virus. The staff knew very little about her except that at some point a note had been put on her chart indicating that she had not had any ties to family or to her religious tradition for many years. Given that information, staff were somewhat surprised when several family members arrived just days before her death and, in consultation with the physician, made decisions that reflected their understanding of the woman’s Jewish belief that she should not suffer pain and that nothing should be done to either hasten death or prolong life. A relative maintained a vigil at the young woman’s bedside until she died a few days later. Following the woman’s death, an autopsy was offered to diagnose the virus that had attacked her brain. However, as this would have prevented her from being buried within the twenty-four-hour period stipulated by Jewish tradition, it was declined.

### What we can learn from this story

This story illustrates, among other things, what can happen when a single note about a patient’s relationship (or lack of relationship) to her family or religious background is taken as the “final word.” While it is standard practice for staff to provide frequent monitoring and updating of a patient’s physical condition at the end of life, it is interesting to note how often opportunities are missed to explore the person’s psychosocial and spiritual condition, which may also be evolving and changing. In this case, there appears to have been an assumption that because this young woman had had minimal contact with her family, her family members would not know of her wishes concerning death, and that since she was separated from her (known) religious tradition, it would no longer be important to her.

Misunderstandings can happen when labels are applied to people that are never questioned, even as their situation changes. They can also occur when we forget that family and religious

connections are often complex and may be difficult for patients to articulate in a single structured conversation with someone they may not know well. In contrast, in an interdisciplinary care setting where patients are offered many opportunities to share and explore their religious values related to end of life, assumptions and labels begin to lose their power.

*A common custom is for the dying person to hear the opening words of the Shema, a central prayer of the Jewish faith: “Hear Israel, the Lord is Our God, the Lord is One.”*

## The beginnings of what you need to know

In Judaism, ideas about the end of life are framed by the laws of the Torah, the associated commentary contained in the Talmud, and the ongoing deliberations of rabbinic courts. The result is a rich tapestry of ancient tradition woven together with continually evolving contemporary ideas concerning end-of-life decisions. However, although there are many divergent outlooks within Judaism, there are also common beliefs and values that are more universally shared. For example, a prohibition against active euthanasia exists beside a belief that any impediments to the natural progress of death should also be removed. Likewise, the importance of family presence and intimacy at the time of death, and the practice of collectively attending to and reflecting upon the person's "life's work," are shared ideals that exist across the spectrum of Jewish denominations.

This emphasis on the dying process itself, rather than on the afterlife or the ultimate meaning of death, is characteristic of the Jewish world view. A custom practised in many Jewish denominations at the time of passing is for the dying person to hear the opening words of the *Shema*, a central prayer of the Jewish faith: "Hear Israel, the Lord is Our God, the Lord is One." Some Orthodox Jews may also wish to hear the words of the *vidui*, a final confessional prayer that acknowledges God's will and requests atonement for sins.

## A question to consider

What do the patient and family need to know in order to make informed decisions about the patient's prognosis and the effect of interventions that could hasten death or prolong life?



## CHRISTIANITY:

# “The Good News”

**A STORY:** A Catholic monk in his seventies had a minor stroke and was transported to a hospital near the monastery where he lived. Family members were notified, and one brother and sister-in-law set out on a cross-country drive to visit him. Although they had been told the monk was likely to recover, the sister-in-law had an uneasy feeling that prompted their hurried departure. Indeed, while en route they received word that his condition was failing, and by the time they arrived, he was in an irreversible coma, unable to communicate and very close to death. The two spent the night praying for their loved one to last until the next day, which happened to be the sister-in-law's birthday; as if in answer to their prayers, he passed away the following day. In looking back on the experience, the woman shared her belief that her brother-in-law had died a good death guided by a “guardian angel,” who had allowed him time to be with his family and to die on an important day within the family circle.

### What we can learn from this story

It is not uncommon for the definition of a “good death” to be solely based on the patient's experience of things like good pain control,

*In palliative care, we are called upon to care for, support, inform, and be informed by family members for a reason: because they matter, and because a good death does not concern only the one who is dying.*

a sense of spiritual peace, and the presence of loved ones. However, this story reminds us that family members' perspectives on a good death are equally important. The experience of the monk and his family illustrates how people make meaning out of the death of a loved one based both on their knowledge of the person as well as on their religious and spiritual beliefs and understandings. While, in some families, a death coinciding with a birthday or other special event might be seen as unfortunate, in this story it was seen as a treasured gift, an answer given to heartfelt prayers by an emissary from God. In palliative care, we are called upon to care for, support, inform, and be informed by family members for a reason: because they matter, and because a good death does not concern only the one who is dying. Holistic care is more than “whole-person” care; it often involves care of the whole family as well.

## **The beginnings of what you need to know**

The Christian religion has from the outset been characterized by diversity, yet here again we find unity in shared core tenets including belief in the sanctity of the life, death, and resurrection of Jesus of Nazareth; the existence of a compassionate God; and the importance of maintaining hope and acceptance in the face of adversity. Most Christians believe in the promise of an everlasting life through baptism and view death as part of the continuity of life, although there may be differences in how individual Christians envision what happens after death.

There are no universal or obligatory rituals to be observed in the death of a Christian believer. However, a good death is usually understood to be one in which the person is physically comfortable and at peace with God, family, and friends. An individual may also want to observe rituals and practices such as lighting candles, taking Communion, or reading scripture, devotions, or familiar prayers.

Because life after death is promised, and God's will is seen to be "for the best" even when the reasons for things that happen are not completely clear, Christians' calmness toward death may be perceived as "giving up" by caregivers who believe the dying should fight to the last breath, especially when leaving grieving family behind. Yet, this commitment to acceptance and to the value of healing, forgiveness, redemption, the sacredness of life, and the value of each individual in the eyes of God are beliefs that sustain the Christian believer in both life and death.

## **A question to consider**

What practices and rituals, and which representatives from the church, might help to bring about peace and closure to the person who is dying and her or his family?

## CHINESE RELIGIONS:

# “Becoming One”

**A STORY:** An elderly Chinese gentleman (Mr. P) had been at his wife’s bedside in hospice for two full days. He was very reluctant to leave his wife until his two sons arrived from Hong Kong, even though he was clearly becoming exhausted from lack of sleep. Because the patient had a diagnosis of long-standing COPD,\* it was difficult for the physician to predict for certain how long she had to live, but medically it appeared she probably would live for at least two more weeks. Given that prognosis, the staff strongly encouraged Mr. P to go home, assuring him that his sons would arrive in plenty of time and that they would check on his wife frequently and call if it was necessary. However, Mr. P resisted the pressure to leave, even refusing to accept a medical caution that he was putting his own health at risk. As a result, the staff charted that he was “non-compliant” and “difficult.” As it turned out, Mrs. P died an unexpected death that night. Had Mr. P gone home to sleep, his wife would have died without any family members present.

### What we can learn from this story

As more and more elderly people die of chronic life-limiting diseases, it has actually become harder for health professionals to accurately predict death, with the length of time a patient has to live likely to be overestimated rather than underestimated. This creates difficulty for family members of any culture or religion, but for Chinese families, it can make the difference between a good death and a bad death. This story highlights common attitudes and practices in hospice care settings that could be particularly challenging for Chinese families. First is the tendency among health providers to delay giving information to families until there is something “definite” to report. If ambiguous deaths are here to stay, perhaps it is time we became more skillful at sharing what we “don’t know for sure” in order to allow family members to make the crucial decisions necessary for ensuring a good

death. Second is the use of negative labels. By defining Mr. P as non-compliant, the staff lost an opportunity to discover the underlying reasons for his distress and to find creative ways of supporting him.

*At the family’s request, the physician may agree to withhold bad news from the patient instead of disclosing the truth.... Such a request would be made out of respect for the patient.*

.....  
\* Chronic obstructive pulmonary disease

The story also underscores again the value of religious knowledge for health care providers. With greater awareness of Chinese understandings of death, the staff in this story would have realized the importance of bedside company for the dying patient. Mr P. believed that his presence was mandatory, not just his “choice,” and that a good death for his wife required the presence of their sons, and the eldest one especially.

### **The beginnings of what you need to know**

Confucianism, Buddhism, and Daoism are three important traditions that blend together within the Chinese culture. For example, Daoist rituals are more important earlier in life, while Buddhist rituals are more common at death. From Confucianism comes the notion of “familism,” or filial piety, which emphasizes the importance of duty and respect toward one’s parents. Given this vast and complex heritage, there are significant variations in Chinese religious views concerning life and death. Nonetheless, common threads of belief are found in the recognition of the inherent interrelatedness of all things, the importance of family, and the value placed on the pursuit of a just, peaceful, and harmonious life.

Chinese children are expected to care for their parents and parents may expect to depend on their children, however it is also common for patients to become concerned that their illness will cause trouble or inconvenience for the family. Often, this concern may override the patient’s own needs. This mutual concern for one another is a manifestation of the central belief that social relationships and obligations take precedence over individual rights. Even young Chinese who have been exposed to Western rights-based society will still tend to return to tradition when faced with major life events such as the death of a loved one.

Physicians generally occupy a high status in Chinese culture, to the extent that doctors are expected to look after patients as if they were parents looking after their own children. The Chinese physician recognizes and respects the central role of family and may often involve the whole family in decision-making, with or without the patient’s consent. At the family’s request, the physician may agree to withhold bad news from the patient instead of disclosing the truth step by step. Such a request would be made not out of a wish to “control,” but out of respect for the patient and a belief that bad news might accelerate her or his decline.

### **Some questions to consider**

Whom should we talk to about your treatments and potential outcomes? Whom do you want to know about your condition? Whom do you want to make health care decisions for you?

## “GOING HOME”:

# Notes on Good Death in an Aboriginal Community

**A STORY:** An Aboriginal woman who was an elder in her community was sent directly from a walk-in clinic to a hospital for diagnostic tests, which revealed the likelihood of pancreatic cancer. An appointment was made for her to see an oncologist at the cancer agency, and during their first meeting, the oncologist realized the woman had only limited proficiency in English. An interpreter was located, and the oncologist began to explain the extent of the disease to the patient in some detail. Shortly into the conversation, the interpreter interrupted, explaining that the woman did not wish the interview to continue until such a time as it was possible for her family to accompany her to hear what the doctor had to say. The interpreter informed the oncologist that, according to traditional beliefs, “bad news” was supposed to be given indirectly, little by little, and only when family members were there to give support.

In subsequent appointments, the physician encouraged the family to participate, but addressed himself directly to the patient when asking what she understood about her illness and what she thought the health care team needed to know about her wishes for treatment and care. Although the woman avoided using the word “cancer,” she made it clear that she knew this was the end of her life journey. She informed the doctor that she wanted to die in her home community, with family present, where traditional ceremonies and rituals could be carried out. She also told the oncologist that she wanted him to be truthful with her about her prognosis so that she could make her own decisions about her care.

In the following weeks, health care teams from the cancer agency and the hospital worked collaboratively with traditional healers from the woman’s community to ensure her wish to be at home was carried out and that her family was well supported as they participated in providing personal care. When asked to sign an advance directive, the patient refused as she felt it would be incompatible with her traditional beliefs. She did indicate though that she would involve her family in end-of-life decisions when the time came and that they would convey her wishes.

One month after returning home, following a traditional ceremony that celebrated the connection between herself, her community, and the spirit world, the patient died peacefully and comfortably with her family at her side.

*The meaning of “home” encompasses much more than a particular location... it is the place of ceremonial traditions, kinship connections, and the sacred space in which life and death are experienced.*

### **What we can learn from this story**

Much of what happened in this story speaks to the essence of good end-of-life care. We note the availability of an interpreter, who was able to make the communication process between the oncologist and the patient both efficient and informative. The physician also demonstrated many exemplary qualities. First, he was willing to be a “respectful learner” when it came to understanding, via the interpreter, what the patient’s concerns were, based on her cultural background as well as her personal needs and beliefs. In delivering the diagnosis, the physician was attentive to how the woman was receiving the news and was willing to adapt his schedule and his style of communication to the family’s preferences. In contrast, it is easy for health care professionals to get caught up in their role as experts, especially when the meetings take place on their own turf. When this happens, the recognition that patients come with their own expertise about illness and death is lost. In this case, the patient and her caregivers were able to achieve holistic and mutually respectful relationships in which knowledge was given and received from both sides.

### **The beginnings of what you need to know**

The family in this story is representative of the spectrum of beliefs and affiliations that often coexist within Aboriginal communities. Members of the family included those who followed traditional values and customs as well as those who belonged to a particular Christian denomination. In such a situation, the health care provider’s ability to mediate respectfully among the family members’ different religious commitments is crucial. The woman’s wish to die at home reflects the cultural value placed on non-interference with the natural process of dying. It was also the preferable choice for accommodating rituals such as the burning of sweet grass, the sharing of traditional foods, and ceremonies involving large gatherings of the extended family, which would probably not have been permitted in an institutional setting. In an Aboriginal community, the meaning of “home” encompasses much more than a particular physical location. Home is understood as the place of ceremonial traditions, kinship connections, and the sacred space in which both life and death are experienced.

### **A question to consider**

What initial steps might you take to accommodate Aboriginal rituals and ceremonies in the hospice setting?

# In the End

Religious beliefs and traditions create an important context not only for how people live their lives but also for how they approach their death. Understanding this context allows health care practitioners in palliative care to expand their definition of what it means to care for the “whole person.” The stories presented in this booklet are only a preview of the much more detailed accounts of religious rituals and traditions found in *Religious Understandings of a Good Death in Hospice Palliative Care*. We have used them here to illustrate the opportunities available for engaging with patients and families around the topic of religion and exploring possibilities for accommodating a good death.

We hope that this knowledge, embraced with an open mind and in a spirit of respectful inquiry, will enable clinicians from all backgrounds to feel more comfortable initiating conversations about religion with the people they care for. In this way, they will fulfill Cicely Saunders’s third principle of seeking to appropriately engage with the dying person’s most deeply held values and beliefs.

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# Ordering Information

Religious Understandings of a Good Death  
in Hospice Palliative Care

Harold Coward and Kelli I. Stajduhar – Editors

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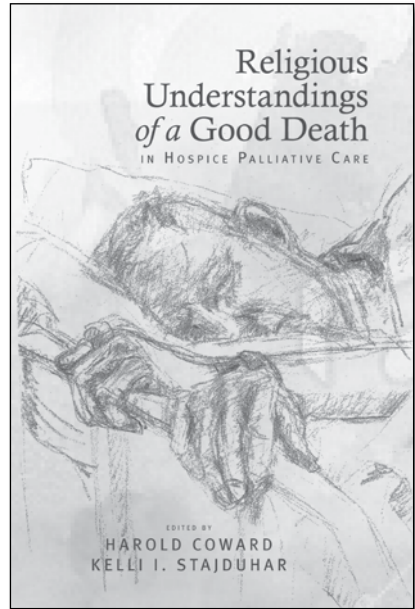
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*Religious Understandings of a Good Death in Hospice Palliative Care* is the first volume of its kind to critically explore how religious understandings of death are manifested and experienced in palliative care settings.

Contributors discuss how a “good death” is conceived within the major religious traditions of Christianity, Islam, Hinduism, Judaism, Buddhism, Chinese religion, and Aboriginal spirituality. A variety of real-world examples are presented in case studies of a Buddhist hospice center in Thailand, Ugandan approaches to dying with HIV/AIDS, Punjabi extended-family hospice care, and pediatric palliative care. The work sheds new light on the significance of religious belief and practice at the end of life and the spiritual pain that so often accompanies the physical pain of the dying person.

**Harold Coward** is Professor Emeritus of History and Founding Director of the Centre for Studies in Religion and Society at the University of Victoria. He is the author and editor of several books, including *The Perfectibility of Human Nature in Eastern and Western Thought*, also published by SUNY Press. **Kelli I. Stajduhar** is a palliative care nurse and Associate Professor at the School of Nursing and Centre on Aging at the University of Victoria.

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