“I Want a Chocolate Milkshake:”
Pharmacy, Spirituality, and Palliative Care

by
Alena N. Arounpradith

A THESIS
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Linda Richards

How can healthcare providers, particularly pharmacists, help palliative care patients cope with the inevitability of death? This thesis reviewed how spirituality and religious beliefs can be utilized as key coping strategies for many patients and their loved ones regarding various stressors associated with facing mortality in palliative care. In the healthcare field, many treatment options have usually overlooked patients’ spiritual needs, even in end-of-life care, patients are more likely to reiterate their beliefs in order to have a peaceful and meaningful death. For pharmacists, having a greater understanding and awareness of spirituality and religious beliefs is vital because spirituality has had an influence on a patient’s medication adherence. Therefore, this thesis goes over the definitions of ‘spirituality’ and ‘religion’, the end-of-life values of the five major world religions, and the relationship between religion, spirituality, and medicine adherence. To learn more about providing spiritual care, chaplains from Lumina Hospice & Palliative Care were also interviewed for this thesis. The use of psychedelics, spiritual assessment tools, and Buddhism philosophy were also explored as tools for addressing end-of-life anxiety and spiritual distress. In the future, it is essential that future pharmacists learn about the importance of spirituality and religion in patient care through the pharmacy school curriculum and training.

Key Words: palliative care, religion, spirituality, pharmacy, medicine adherence

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Introduction
*Memento Mori.* In Latin, this phrase means, ‘Remember, you must die’ (Effectiviology, n.d, para 1). It is a symbolic reminder of the inevitability of death that all beings have to face. However, unless there is terrible suffering, nobody wants to die. Chagdud Tulku Rinpoche, a Tibetan teacher of Vajrayana Tibetan Buddhism, stated the following about the concept of death:

“Death and dying is a subject that evokes such deep and disturbing emotions that we usually try to live in denial of death. Yet we could die tomorrow, completely unprepared and helpless. The time of death is uncertain, but the truth of death is not. All who are born will certainly die” (Masal, Schur, and Watze, 2012).

This leads to a question: after receiving a diagnosis of a life-threatening disease, like cancer, how does a patient cope with the inevitability of their death?

My first encounter with death occurred when my great-uncle died. He was 83 years old. His cause of death was not cancer, but for as long as I could remember, he was constantly bedridden and had numerous medical conditions, including high cholesterol, arthritis, cardiovascular disease, diabetes, and hypotension. In the days leading up to his death, it was difficult for me to see him. He had rapid, shallow breathing and his eyelids were unable to close, causing his brown eyes to be glazed over. When I held his hands, they were cold and clammy. When family members talked to him, he was unable to respond back to us; sometimes, it even seemed like he did not realize that we were in the room with him. He was dying in front of our eyes and all he could do was lay on his bed and wait for the pain and suffering to end.

However, in his last days, my great-uncle found solace in his Buddhist faith. On the night of his death, a Buddhist monk came to visit his bedside. The monk then chanted verses and read prayers to provide him comfort and peace in the face of his imminent death. In Buddhism, the
monk’s chants and prayers also help calm down the individual’s soul so that after it exits the body, it can properly travel to another for rebirth (Newman, n.d.). My family and I found value and purpose in our Buddhist faith. Therefore, by following these Buddhist practices, it provided us with comfort and reassurance that my great-uncle was going to have a good humane death. I cannot speak for him, but due to his unwavering faith in Buddhism, I believe that the Buddhist monk’s chants and prayers provided my great-uncle peace and comfort during end-of-life care.

In the face of their physical and spiritual transition to death, many people, like my great-uncle, desire not only prescription medication, but also spiritual support from their end-of-life care team. Therefore, this work seeks to explore how future pharmacists might provide a different kind of prescription for spiritual healing, which is just as important as addressing the patients’ physical comfort to alleviate their suffering. Therefore, can addressing a patient's spirituality, and learning about the values of the five major world religions help healthcare providers deliver culturally competent care?

**End-of-Life and the Role of Caregiving**

When a patient is given a cancer diagnosis, they are likely to undergo great physical and emotional distress, regardless of what type of cancer or stage they have (Conway, 2010). They may feel fear and anxiety about the treatment’s effectiveness and the financial and emotional impact their illness may have on their families. As a result, cancer treatments affect a patient’s physical, mental, and spiritual state (Conway, 2010). In a patient narrative, a Stage IV cancer patient stated that after undergoing cancer treatment, they felt themselves disappearing, and that their “mind and body were at war” (Murphy, 2017, para 18).

Westernized healthcare treatments in the 21st century usually focus on the physical aspects of care, while overlooking the patient’s spiritual and psychosocial needs, particularly
during end-of-life care (Choundry, Latif, and Wabuton, 2018). In addition, it is often near the end-of-life where patients may wish to reiterate their beliefs in order to have a peaceful and fulfilling death. According to a 1994 study that examined the relationship between religion, health, and patient care, 77% of inpatients believed that physicians should take in more consideration their spiritual needs as part of their medical care. However, the study’s results also reported that 68% of inpatients stated that their physicians never or rarely discussed their spiritual or religious beliefs with them (King and Bushwick, 1994).

Over twenty years later, a 2019 documentary short called Palliative explored end-of-life care conversations with caregivers, patients, and Dr. Nadia Tremonti, a pediatric palliative care specialist at Detroit’s Children’s Hospital in Michigan. The documentary aimed to draw more attention to the negative stigma around death and dying in palliative care. According to Dr. Tremonti, many healthcare providers are afraid to even tell patients and their loved ones that they are dying (Beder, 2019). Due to this, many health providers do not consult palliative care specialists until it is too late for the families. Dr. Tremonti stated that “if we wait until families finally become ready to talk to me [about their dying loved one], then we have woefully failed this family” (Beder, 2019). For healthcare providers, initiating dialogue about death, spirituality, and religious beliefs may induce fear due to a lack of knowledge or cultural understanding regarding these topics (Morgenweck, 2015). Some healthcare professionals may also be concerned about unintentionally projecting their own beliefs onto the patients (Koenig, 2018). However, in order to provide culturally competent end-of-life care, every healthcare professional, including pharmacists, need to develop an understanding of the spiritual beliefs and religious traditions that are observed by the communities they serve.
Before the 1960’s, pharmacists had limited patient interactions compared to other medical professions like physicians and nurses (Ahmed, 2008). However, the changing role of pharmacists has caused an increase of them to have expanding roles in clinical settings, where they have more exposure to direct patient care. Pharmacists who lack a greater understanding and awareness of cultural competence will be unable to properly serve and address their communities’ health needs. By having this kind of understanding, healthcare professionals can easily avoid disputes that may arise. Some of these disputes may include tensions between conflicting views of sociocultural beliefs and westernized medical practices, and more importantly, ensure that spiritual needs of their patients and loved ones are addressed (Choundry, Latif, and Wabuton 2018).

Although pharmacy schools have begun to implement courses focused on cultural awareness for minority communities and patient care treatment plans, it was not until 2008 that the first cultural awareness training book was published for pharmacy schools (O’Connell et al, 2013). In 2003, a study was conducted to discover how well the Spiritual Aspects of Patient Care (SAPC) was integrated into pharmacy schools’ curriculum; the results showed that out of all the participating schools, about 10% of them required students to take a course that involved SAPC, and only 21.4% actually taught students the aspects of SAPC (Cooper et al, 2003).

Due to the major advancements in modern medicine, science, public health, and technology, human life expectancy has drastically increased in modern Western societies. In the United States, the life expectancy at birth has nearly doubled from 47.3 to 78.7 years over the span of 110 years (CDC/NCHS, 2013). However, as modern healthcare professionals were trained to “manage the dying” in medical facilities, the further depersonalization of death caused avoidance and fear to be the dominant attitude towards death in Western culture (San Filippo,
Without a reminder of death, we tend to take life for granted, often becoming lost in endless pursuits of self-gratification. Therefore, for many, the awareness of their morality is not recognized until their own, or a loved one’s, diagnosis comes back with life-threatening disease or condition.

“From the moment of diagnosis, death becomes a bell that won't stop ringing. Like a dreaded phone call, we can try to avoid it, but the noise is always there. We can distract ourselves with medical information and frenetic activity. We can drink or take drugs to muffle the call, but at quiet moments, we can always hear its ring. Ultimately, usually reluctantly, we can find that only by answering the call can we hope to silence the shrill bell within.” (Halifax and Byock, 2008).

Interdisciplinary palliative care teams help patients answer that call. In the 1960s’, palliative care arose out of the modern hospice movement and has evolved significantly over the past 50 decades (Saunders, 2001). The World Health Organization (WHO) describes palliative care as an approach that improves the quality of life for terminally ill patients and their family members while minimizing their suffering (WHO, 2020, para 1). In addition, the National Consensus Project for Quality Palliative Care of the National Quality Forum reports palliative care as “patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering . . . throughout the continuum of illness . . . addressing the physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice” (American Society of Health-System Pharmacists, 2016).

Hospice care is a branch of palliative care offered to patients who have a prognosis of 6 months or less to live (American Cancer Society, 2019, para 3). The hospice care team works to ensure that in the last phase of terminal disease, the patient’s last days are as fulfilling and
comfortable as possible. Some patients also go into hospice care when their disease is not responding to medical attempts to cure it or slow it down. If a patient does choose to go into hospice care, they stop undergoing all the treatment that was aiming to cure their disease (American Cancer Society, 2019, para 4). However, if they wish to, a patient can leave hospice care anytime.

As a patient finally nears the end of their life, they are provided with medical care and support; this occurs in four main areas, physical comfort, mental and emotional needs, practical tasks, and spiritual nurturing (National Institute of Aging, 2017, para 5). When my great-uncle was dying, he could only lay in the bed; he could not move and was unable to perform practical tasks, like eating or attending to the bathroom, without the assistance of others. His physical pain and lack of agency may have understandably caused him to suffer emotional and spiritual distress. During those moments, my great-uncle may have failed to recognize his own spirituality, or his meaning of purpose in life; this may have caused him to lose his will to live on. Due to this, it is essential for members of end-life care teams, like pharmacists, to understand the importance of spiritual nurturing so that they can help patients find strength in their own spirituality so that when death finally comes, they will be able to find peace and comfort in death. The overall goal of end-of-life care is to prevent or relieve as much suffering as possible for the dying patient and improve their quality of life while respecting their needs and wishes (Rome, Luminais, and Bourgeois, 2011).

In order to help minimize pain for patients (and their families) in all aspects of life, a palliative care team is made up of interdisciplinary partners. It is composed of healthcare providers, social workers, and spiritual advisors including chaplains (National Institute of Aging, 2017, para 4). According to the National Comprehensive Cancer Networks Guidelines (NQF),
“interdisciplinary palliative care teams, including board-certified palliative care physicians, advanced practice nurses, and physician assistants, should be readily available to provide consultative or direct care to patients/families who request or require their expertise.” Although the NQF’s Clinical Practice Guidelines for Quality Palliative Care makes no mention of pharmacists, these medical professionals can play an active role in hospice and palliative care, through a wide variety of approaches, including medication order assessments and counseling the hospice team (Barbor, 2015, para 3).

Historically, pharmacists’ role in healthcare was limited. Their work was focused on preparing and dispensing prescriptions and counseling patients and other healthcare providers on the safe and appropriate delivery of medications (Avalere Health, 2014, para 3). Over time, pharmacists’ roles have expanded to become dynamic to include much more direct patient care, team-oriented care, and opportunities to work in very diverse healthcare settings (Chiara, 2019, para 3). Within interdisciplinary palliative care teams, pharmacists play a valuable role because many of the symptoms that manifest near the end of life can be ameliorated with medications (Balick, 2018).

According to the American Society of Health-System Pharmacists, the pharmacist’s role in hospice care can include the following responsibilities: evaluating the appropriateness of the patient’s medication orders; verifying the medications’ timely provision for symptom control and management; counseling the interdisciplinary team about the use of medication therapy for the patients; and ensuring that patients and caregivers understand and adhere to the directions provided with medications (Barbor, 2015, para 2). In 2011, an Australian study examined the role of a pharmacist in a community palliative care multidisciplinary team; the results suggested that the inclusion of a pharmacist in a community palliative care team can improve the
medication-related knowledge and skills of its members and lead to better patient medication management (Hussainy, Box, and Scholes, 2011, para 5).

In palliative care, prescribed medications that can successfully reduce pain and discomfort can provide needed comfort to a terminally ill or dying patient. A patient’s physical symptoms can also negatively influence their psychosocial and spiritual state. Thus, pharmacists are vital in helping palliative care teams develop an individualized treatment plan that caters to the patient’s care goals and improves their comfort and quality of life, while also reducing costs, unnecessary prescriptions, and the adverse effects of medications (American Society of Health-System Pharmacist, 2016). However, studies have shown that there is a link between spirituality and treatment adherence. Due to this, pharmacists need to have a sufficient understanding of spiritual and religious beliefs in order to provide culturally competent care to palliative patients.

What is Spirituality?

Spirituality can be defined in many ways. It can be described as the process of human unfolding and a powerful force that searches for meaning. Spirituality has also been defined as the “feelings, thoughts, experiences and behaviors that arise from a search for the sacred” (Hill et al., 2000), or the center or core of humanness. However, what is common to all descriptions of spirituality and spiritual care are the concepts of meaning, wholeness, or completeness, the absence of which results in spiritual distress. In a sense, spirituality is what gives humans meaning and purpose in their lives.

According to Chaplain Sandra Waldron from Lumina Hospice & Palliative Care, “Spirituality can be as simple as wanting a chocolate milkshake.” Since the concept of spirituality is open to different interpretations, this statement could be interpreted to mean that it is the material objects that makes an individual feel whole again. On the other hand, someone
else could interpret this statement and say that it is their loved ones that make them feel like their life has value because they go to the effort to provide a chocolate milkshake for the patient. Therefore, the material act of giving a milkshake can also be seen as a tangible manifestation of the care and love people have for the patient, which can be tied to the latter’s spirituality.

Spirituality is not necessarily dependent on religion. In the United States, there are approximately one in five Americans that identify as “spiritual but not religious” (SBNR) (Lipka and Gecewicz, 2012). These individuals’ beliefs are not affiliated with any organized religion, but they still have faith in something larger than themselves (Parsons, 2017, para 4). Due to its positive association, the term “SBNR” has been used by many people who would also consider themselves as atheists because in certain communities, the negative stigma around atheism is still prevalent. For those who struggle with their faith, saying that “I’m spiritual but not religious” also leaves their door open to different possibilities. According to Professor Matthew Hedstrom, who teaches religion at the University of Virginia, the SBNR designation is about “seeking for something you believe in, rather than blindly accepting something that, while comfortable and familiar, does not feel quite right.” (Kitchener, 2018, para 8). Therefore, an individual's spiritual beliefs do not have to align with a particular organized religion. Ultimately, while pharmacists should absolutely have a bit of knowledge about the five major religious groups, as time goes by, they may encounter more and more people who are "spiritual but not religious.” However, religion can still help develop a person's spiritual self in terms of finding existential meaning and a sense of purpose in their life and help them cope with the physical and mental aspects of their life-threatening diagnosis.

Therefore, providing spiritual care also means understanding that spirituality is not wholly religiously based. Discussions about spirituality with a palliative patient can include
conversations about religion. Due to this, healthcare providers, including pharmacists need to have a greater understanding of at least the five major world religions in order to deliver culturally competent care for the community. By having this kind of understanding, healthcare providers can properly serve and address their communities’ health needs and be able to avoid disputes that may arise out of the opposing views between patients and the healthcare system.

**Major Religions**

What is religion? There is no clear definition of religion that every scholar agrees on (Harrison, 2006). Some have stated that religion is “a system of beliefs and practices by means of which a group of people struggle with the ultimate problem of human life” (Yinger, 1970). Others have defined it as “the belief in an ever-living God, that is, in a Divine Mind and Will ruling the Universe and holding moral relations with mankind,” (Sunderland, 2013). According to Bruce Lincoln, a historian of religious studies, the definition of religion consists of four domains: discourse, practice, community, and institution (Lincoln, 2003).

However, no matter how it is defined, religion has played an integral role in the development of human societies and cultures because it provides a framework for experiencing, understanding and making meaning of the world. There are currently thousands of variations of religious practices worldwide, but the five major world religions are Buddhism, Hinduism, Judaism, Islam, and Christianity (Bellaimey, 2013). By learning about the values of the five major world religions, healthcare providers will become more aware of how religion plays a role in an individual’s overall health. In conversation with active Chaplains who specialize in end-of-life care, the point was made that simplifying to five major world religions is another problematic issue. This is reflected in the literature as well, because each person's expression of
their religion is unique to them. Yet, a basic understanding of the most common religious views on death is a necessary starting point.

This thesis will consider some of the values and beliefs of these five major world religions, and how their views about death can relate to end-of-life care. Learning about the central beliefs of the five major world religions is the first step toward gaining religious understanding in terms of cultural competency. However, due to socio-cultural variations and different cultural backgrounds, not every individual will believe or practice the values of their respective religions. As a result, healthcare providers are always encouraged to initiate dialogue with patients about their respective religious beliefs if they have any; by doing this, the healthcare providers can make sure to provide patients with the best care possible while also respecting and supporting their individual needs.

**Christianity**

Christianity is a monotheistic religion based on the life, teachings and miracles of Jesus of Nazareth (Ferngren, 2014). With at least 2.2 billion followers, Christianity is the world’s largest religion (Pew Research Center, 2012, para 2). The United States also contains the world’s largest Christian population, accounting for about 11.3% of Christians worldwide (Liu, 2011, para 8). Catholic, Protestant, Orthodox, and Mormons are among the many denominations of the Christian church; therefore, all Catholics are Christian, but not all Christians are Roman Catholic (Peikan, n.d., para 2).

The central principle of Christianity is the belief in forgiveness and eternal life from the acceptance of Jesus Christ as the Messiah, whose coming was foretold in the Old Testament (Woodhead, 2004, 4). According to the Old Testament, the angel Gabriel was sent by God to ask a young woman named Mary to bear his son. This son was Jesus, who at the age of 30 years old,
spread the living word of God to crowds until he died by an agonizing painful crucifixion. When his tomb was found empty, his followers came to believe in Jesus’ resurrection. Adherents continue to spread his message throughout the world. His main message was the following: “love one another as I have loved you” (Bellaimey, 2013). This message of nonviolence is a common thread among all the major world religions.

Overall, Christian understanding towards death and end of life care is heavily influenced by two major points: the fact that human life is precious because it was given by God; and not fearing death because of the hope of reconciling with God (Engelhardt and Iltis, 2005). Before his suffering by crucifixion, Jesus had an acceptance of death. He modeled compassion and forgiveness for his enemies, and a belief in resurrection leading to being in an eternal communication with God (Vogt 2003). Due to this, the assurance of the forgiveness of sins and confidence in unity with God are the heart of Christians’ journey towards the end of life. (Choundry, Latif, and Wabuton, 2018).

**Bible Verse:** Romans 14:8 NIV

8 If we live, we live for the Lord; and if we die, we die for the Lord. So, whether we live or die, we belong to the Lord.

In palliative care, healthcare providers should recognize that Christian patients who are nearing the end of their life may wish to be visited by someone from their churches. They may want to do prayers at the bedside, and take the Holy Communion, which is a ritual commemoration of Jesus’ Last Supper on the night before his crucifixion in the New Testament (Vogt, 2003). Since Christians believe that life is a sacred gift from God, they often do not believe that life should be prolonged at all costs. However, most denominations accept the use of
medication to relieve a patient’s terminal suffering as long as it does not consciously take away their purpose or opportunity for repentance (Choundry, Latif, and Wabuton, 2018).

**Islam**

One of the tools that healthcare professionals can use to deliver culturally competent spiritual care is knowledge about the values of the five major religions. Islam is a monotheistic religion based on the teachings of Muhammad, the Islamic prophet and messenger of Allah, the God of Abraham; in Arabic, the term Islam can be translated to ‘the state of peace through following God’s guidance’ (Ferngren, 2014). Islam is the world's second largest religion, and it is practiced by over 1 billion Muslims worldwide (Pew Research Center, 2012, para 2). In the United States, Muslims make up about 1.1% of the population (Mohamed, 2018, para 2).

The Islamic faith is centered around Allah’s love and words for humanity, which was given to his believers by Muhammad. When the young man was in the Arabic desert, the angel Gabriel delivered to him the words of Allah (Bellaimey, 2013). As more and more messages came, Muhammad memorized the verses and recited them to others. All of the revelations that Muhammad received formed the Qura. This is regarded by Muslims as the verbatim word of God that continues to guide humanity. According to the Quran, death is the next step in life’s plan. After an individual dies, God will judge them; based on their deeds in life, the individual will either be rewarded in paradise or punished in hell (Choundry, Latif, and Wabuton, 2018).

In palliative care, healthcare workers need to recognize that due to the sociocultural variations, Islam is not a monolithic set of beliefs so Muslim patients will have varying spiritual considerations and needs (Abou El-Fadl, 2017). This is similar to the variation in Christian churches. Many Muslims may expect that their last words will be a final profession of their faith. Due to this, Muslim patients who are undergoing end-of-life care are encouraged to pronounce
this message: "I testify that there is no god but Allah, and Muhammad is the messenger of Allah.” In some cases, this profession of faith is whispered into the ear of the patient (Buturovic, 2016). Muslims also believe that life is sacred, and that God alone possesses the rights to end life (Leong et al., 2016). As a result, euthanasia and assisted suicide are prohibited in Islam, but many Muslims do support medications being used to ease a patient’s suffering during the natural dying process (Leong et al., 2016).

**Judaism**

By learning about the values of the five major world religions, healthcare providers will become more aware of how religion plays a role in an individual’s overall health. Judaism is one of the oldest monotheistic religions in the world (BBC, 2014, para 1). It is based on the ‘Halacha’, an ancient law of God that is the foundation for the 613 commandments in the Torah, the first five books of the Hebrew Bible (Kinzbrunner, 2004). There are about 14 million Jews worldwide, with 5 million of them located in the United States (Pew Research Center, 2012, para 2). Judaism began 4,000 years ago when God, or Yahweh, called upon pious figures, Abraham and Sarah, to leave Mesopotamia and migrate to Canaan. God then promised them that in return for their faith in the one true God, they would have land and many descendants in the promised land of Israel (Bellaimey, 2013).

The central teaching of Judaism is that there is one God who created the universe and wanted humans to do what is just and compassionate (Mendes-Flohr, 2006). Jews’ approach to end-of-life care is influenced by *Pikuach nefesh*, which is the Jewish principle in the Halacha that states that the preservation of life surpasses any other religious rule (Kinzbrunner, 2004). According to this Jewish law, healthcare providers are required to do everything they can to prolong life. However, there are certain circumstances where this principle is not applicable,
such as with terminally ill patients whose treatments do not prolong life or cause severe suffering (Loike et al., 2010). Among Jewish patients, Rabbi involvement with the family’s medical decision making is very common (Kinzbunker, 2004). Therefore, healthcare providers need to be prepared to work together with the family’s Rabbi to make decisions regarding treatments, medical interventions, and prognosis. For example, in palliative care, health providers and Rabbis will take into consideration the terminally ill patient’s suffering when determining which treatment option should be employed to prolong life (Choundry, Latif, and Wabuton, 2018).

**Hinduism**

During end-of-life care, addressing patients’ spirituality and religious beliefs is just as important as providing them physical comfort to alleviate suffering. Hinduism is the third largest religion in the world, with over 1 billion followers (Pew Research Center, 2012, para 2). It is also one of the world’s oldest religions (Klostermaier, 2007). Hinduism is not a single religion; instead, it is a variety of related beliefs and spiritual practices that share the central themes of family, karma, and reincarnation (Bellaimey, 2013). Due to this Hinduism has often been described as more of a philosophy or a way of life (Deshpande, Reid, and Rao, 2005).

Unlike other religions, Hinduism has no central text or founder (Klostermaier, 2007). However, many Hindus follow the teachings of the Bhagavad Gita, which is considered to be one of the most important religious scriptures within Hinduism (Mark, 2020, para 1). Many followers believe in Brahman as the Supreme Spirit in the entire universe and that Hindu gods represent different manifestations of Brahma (Bellaimey, 2013). These gods’ roles and forms differ according to various beliefs, but the three principal deities of Hinduism are Brahma, the universe’s creator; Shiva, the one who destroys the universe; and Vishnu, the preserver of the universe (BBC, 2003).
Hindus’ understanding of death and reincarnation is heavily influenced by the concept of karma. They believe that karma is a law of cause and effect and their rebirth into a new life is determined by the accumulation of good and bad karma they have gathered throughout their multiple lifetimes (Thrane, 2010). Hindus also believe that all life events are the result of karma and that any suffering they may encounter is the consequence of their past karma in a previous life (Shanmugasundaram, O’Connor, and Sellick, 2010). In addition, Hindus value the notion of a ‘good death,’ which is signified by the individual's long life and their opportunity to say goodbye and fulfill their duties and responsibilities before they naturally depart from Earth (Firth, 2005). Hindus fear the prospect of a ‘bad death,’ which can be defined as death that occurred unpleasantly, prematurely, or in an undesirable place (Firth, 2005). Due to this, many Hindus believe that life should not be unnecessarily prolonged by aggressive medical interventions during palliative care.

Hinduism is also often intertwined with a strong family-orientated culture. The patient’s family is heavily involved in the medical decision making; some Hindu patients, especially the elderly, may also wish for their family to make the decisions on their behalf (Deshpande, Reid, and Rao, 2005). However, this may create a dilemma for healthcare professionals because of issues regarding consent (Choundry, Latif, and Wabuton, 2018). Therefore, healthcare professionals need to navigate carefully and be open-minded while undergoing shared decision making with the patient’s family members, especially regarding palliative care treatment options.

**Buddhism**

Every individual’s spiritual or religious background will play a role in how they will seek end-of-life care. Buddhism is a spiritual practice that focuses on achieving enlightenment in
order to gain insight into the true nature of reality. Unlike other major world religions, Buddhism does not focus on a belief in a supreme deity or existential questions about the world’s origins (Bellaimey, 2013). Due to this, many Western scholars consider Buddhism to be more of a philosophy, rather than a religion (Masal, Schur, and Watze, 2012). There are about 1 billion Buddhists around the world. In the United States, Buddhists make up roughly 1% of the adult population (Pew Research Center, 2012, para 1).

The origin of Buddhist teachings began thousands of years ago with Prince Siddhartha, who left his lavish lifestyle to investigate why all human beings had to experience suffering. Siddhartha found his answer while meditating under a bodhi tree and through this revelation, he became the Buddha, or the enlightened one (Bellaimey, 2013). As summarized in the Four Noble Truths, Buddha’s revelations taught others that the root of all suffering are selfish desires and craving for one’s own fulfillment at the expense of others (Masal, Schur, and Watze, 2012).

The Buddha also gave believers a way to end suffering. He taught that by following an eight-step plan called the Noble Eightfold Path, they can learn to reduce their selfish desires and cravings, and free themselves from their suffering; if an individual is able to follow through the Noble Eightfold Path, they are able to achieve enlightenment, or a state of inner peace, compassion, and wisdom (Laumakis, 2008). In Buddhism, death is perceived as a natural part of life; but an individual's final moments can significantly impact their rebirth (Masal, Schur, and Watze, 2012). Therefore, when death is imminent, Buddhists do not usually focus on prolonging the individual’s life through unnatural means (Ratanakul, 2004, para 11). Instead, they value giving them a peaceful death to ensure them a good rebirth. A peaceful death for a patient can be described by four core qualities: 'knowing death was impending, preparing for a tranquil state of
During palliative care, healthcare professionals need to be aware that some Buddhist patients may not wish for their life to be prolonged by medical interventions because they do not want to undergo unnecessarily suffering. However, Buddhist patients are willing to take medication, like morphine, to ease their pain and suffering (Cheng, 2017). They may also practice meditation and self-reflections to identify the cause of their suffering and the meaning of their life; through these methods, the patients’ suffering is reduced because they are able to accept the reality of their situation (Keng, Smoski, and Robins, 2011, para 5). When death is imminent, Buddhist monks may come to a patient’s bedside to read them prayers and verses; these actions can help the patient have a calm and peaceful state of mind in face of death. The Buddhist monk will also encourage the dying patient to focus on the good deeds they have done throughout their life through methods such as meditation and chanting (McCormick, 2011).

**Providing Spiritual Care**

Following the diagnosis of a life-threatening disease, spirituality is utilized as a key coping strategy for many patients and their various stressors associated with facing mortality. Studies have shown that patients with a life-threatening illness become increasingly aware and attune to their spiritual needs. During any phase of the disease many patients and their families often suffer under spiritual distress, which can occur when they are unable to find sources of meaning, hope, love, peace, comfort, strength, and connection in their life (Anandarajah and Hight, 2001). In an interdisciplinary palliative care team, healthcare providers need to be familiar with aspects of spirituality because if not addressed, spiritual distress can have a harmful effect on the physical and mental health of patients and their loved ones.
Spiritual care can be defined as recognizing and responding to the “multifaceted expressions of spirituality we encounter in our patients and their families” (Derrickson, 1996). It can involve compassion, presence, listening, and the encouragement of realistic hope, and it might not involve any discussion of God or religion at all (Anandarajah & Hight, 2001). According to Chaplain Petros Savva from Lumina Hospice & Palliative Care, spiritual care can just be listening to the patient and seeing them as not just a patient, but also a person. By hearing where they are coming from, you are then able to fathom what aspects of their life are giving them either peace or distress. In an interdisciplinary palliative care team, healthcare providers, including pharmacists, need to be familiar with aspects of spirituality in order to properly deliver and address their patient’s spiritual needs.

In palliative care, chaplains are integral members of the interdisciplinary care team because they are trained extensively to provide spiritual care for patients and their families. Chaplains can assess patients’ spirituality informally, by asking open questions about their spiritual beliefs and needs, or they can assess their spirituality formally through a spiritual assessment. Both methods are efficient at eliciting a patient's thoughts about their own spirituality and determining if the patient is also experiencing spiritual distress or not. In addition, conducting the spiritual assessment can help strengthen the care team-patient relationship because the interdisciplinary care team is able to connect with the patient on a more personal level (Anandarajah & Hight, 2001). Overall, spiritual assessments allow the interdisciplinary care team to support patients’ spirituality by promoting empathetic listening, recommending community resources for the patients and their families based on their spiritual preferences, and incorporating patients' spiritual values into treatment plans. Spiritual interventions in the treatment plan may include reflective listening, prayer, empathetic support,
contacting the faith community, performing a life review, and assisting patients in integrating their spiritual beliefs with their new medical reality (Weinstein et al., 2017).

While chaplains are trained extensively in this particular area of care, anyone in the interdisciplinary palliative care team can emulate these approaches. Pharmacists can also initiate conversations about spirituality to encourage patients to explore their beliefs, even to those patients who are not sure of their religious beliefs or those whose beliefs do not align with a particular organized religion. Providing spiritual care means understanding that spirituality services are not reserved for the chaplain; rather, spiritual care should be focused on the health of the whole patient and can be provided by anyone.

In addition, spiritual care can complement medical therapies by enabling patients to cope better with the physical aspects of their disease and side effects of treatment. By understanding how a patient’s spiritual beliefs influence their orientation towards life, the interdisciplinary palliative care team can individualize the patient’s treatment plan based on the patient’s spiritual beliefs and needs. However, it is also important for healthcare providers to be aware of the limits of their competence in providing spiritual care, and to refer patients to the chaplain or other spiritual support personnel when necessary.

The Use of Psychedelics in Palliative Care

Another intervention that pharmacists can provide to palliative care patients to address their spiritual distress is psychedelics, which are psychoactive substances that have been used to enhance spiritual experiences by causing mind-altering effects that influence an individual’s perception, mood, and cognitive processes (Griffiths et al., 2019). In recent years, there has been medical interest and research in psychedelics as treatments for anxiety, depression, and
posttraumatic stress disorder” (Rosenbaum et al., 2016). For palliative care patients in end-of-life care, psychedelics can alleviate the anxiety of their spiritual distress.

As mentioned previously in the introduction, death is inevitable, but every human being is afraid to answer its call. Many patients facing life-threatening diseases like cancer experience spiritual distress, which can be related to a loss of meaning or purpose in life and significantly diminish their quality of life. This spiritual distress can be associated with feelings of perceived burdensomeness, hopelessness, powerlessness, and a desire for hastened death. These feelings are also main contributors to the anxiety and depression that cancer patients experience after their diagnosis (Griffiths et al., 2019).

The therapeutic application of psychedelics alleviates patients’ spiritual distress by fostering feelings of happiness and connection. According to studies, psychedelic treatments have provided relief for patients who have anxiety in the face of a terminal illness diagnosis. In the weeks after psychedelic treatments, the results of patients’ depression and anxiety assessments revealed a “sustained reduction in anxiety” (Rosenbaum, et al, 2016). In addition, after taking the psychedelic treatment, more patients in palliative care have reported feeling more uplifted, connected, and less afraid of death. This connection and reduced fear of death causes patients to become less likely to pursue every medical intervention available to prolong their life. Instead, these patients become more interested in the quality of their remaining life with their loved ones.

As of the 21st century scientists are still in the early stages in researching the medical benefits and applications of psilocybin for various conditions. However, in March 2019, the Federal Drug Administration approved esketamin, a psychedelic drug, which could be used as an antidepressant for the treatment of depression (FDA, 2019). Multiple clinical trials must be done
to test the practicability and effectiveness of psychedelic-assisted therapy for cancer patients undergoing end-of-life care. One of these trials is being conducted by Dr. Charles Brob, a psychiatrist at Harbor-U.C.L.A. Medical Center. His study is investigating the studies regarding the use of psilocybin for end-stage cancer patients. Although the size of his study had only 12 people, he “saw remarkable and sustained changes in cancer patients’ spiritual disposition in a positive manner” (Griffiths et al., 2019).

In 2020, the FDA held phase III clinical trials for psychedelic as a prescription medicine for end-of-life anxiety treatment options (Nuwer, 2021). Although death is a natural progression of life, many patients endure anguish and spiritual distress before and during the dying process. Spiritual distress can decrease the quality of life of patients facing terminal diseases. If the FDA does approve of psychedelics, the medication’s therapeutic application can be used to help cancer patients in palliative care overcome their spiritual distress and fear of death in order to have an improved quality of life.

**Buddhism’s Approach to Death in Palliative Care**

In palliative care, the philosophy of Buddhism and its approach to death have also been utilized as a key coping strategy for many patients as they face the mortality of death. A book widely praised for illustrating to readers of all faiths how the Buddhist’s approach to death can be is *Being with Dying: Cultivating Compassion and Fearlessness in the Presence of Death* by Joan Halifax. A Buddhist teacher herself, the author goes over guided meditations and wise spiritual lessons to help readers face death not with fear, but with courage. Her lessons also help train caregivers in providing compassionate end-of-life care for their dying loved ones. While the dominant perspective towards death is mainly avoidance in Western culture, “Buddhists have studied the question of how one can best live in the presence of death for over 2,500 years...and
in a sense, a life-threatening injury or disease makes Buddhists of us all, waking from the illusion of immortality, suddenly and from that time forth” (Halifax, 2008).

The underlying philosophy in Buddhism’s approach to death is that suffering is inevitable and universal. By observing death from only a scientific perspective, the medical community risks not recognizing the patient as a human and addressing their suffering as valid. However, in Buddhist philosophy, addressing death and the impermanence of life is crucial because death is considered to be a natural part of life. In addition, Buddhism encourages people to start contemplating death long before they experience the dying process so that when they are faced with it, fear, anxiety, and suffering won’t interfere in their ability to accept their present reality. According to the Buddhist Dharma, or teachings, one can reduce their suffering through meditation, acceptance of their present reality, and recognition that human existence is painful.

In terms of palliative care, Buddhist teachings help reduce the pain, suffering, and spiritual distress of terminally ill patients by encouraging them to recognize and process the inevitability of their situation. In one case study, Mrs. B was a breast cancer patient of Protestant faith. She was suffering from breakthrough pain when she was regularly visited by a Buddhist master, who told her, “If you experience pain, do not think about how strong it is or when it will pass. Think: ‘This is pain!’” This advice made it easier to deal with her pain because she was able to openly face her situation instead of avoiding it (Masal, Schur, and Watze, 2012).

In another case study, a terminally ill patient felt overwhelmed with their disease. When the Buddhist Master went to see them, he placed a drop of water in his hand. After asking the patient what was in his hand, he blew the drop away and said: “You think it is a drop but within a second it has changed into another form. You cannot control any of this. It just happens” (Masal, Schur, and Watze, 2012). From this encounter, the patient realized that there was no point in
focusing on what may happen next because the future is unpredictable, and wasting time worrying about it will cause nothing but sorrow. In addition, Buddhism philosophy helps the patient’s mind to not be solely preoccupied by their disease and their upcoming death.

For healthcare providers, Buddhism can be helpful in reminding them that in palliative care, being present with compassion can be one of the most important tools to relieve human suffering. If the healthcare provider is present with the patient, that means that they “make a great effort to listen, and make it clear that they are listening, rather than just tapping away at the keyboard” (Salleh, 2018). By being there and present with the patient, the healthcare provider is able to foster a stronger patient relationship and help relieve any human suffering and spiritual distress that they may feel.

In palliative care, healthcare providers do not need to explicitly talk about Buddhism with their patients. However, they can use its philosophy, meditations, and other practical mindfulness techniques to provide compassionate caregiving and spiritual support for any terminally ill patient, no matter what belief system they may or may not identify with. Overall, Buddhist’s approaches to death can teach healthcare providers and caregivers how to respectfully be present with another person’s spiritual experience and help them cope with the mortality of death.

**The Relationship Between Religion, Spirituality & Medicine Adherence**

Every individual's spiritual or religious background will play a role in how they will seek end-of-life care. For pharmacists, having a greater understanding and awareness of spirituality, religious beliefs, and spiritual care is vital because socio-cultural perspectives have a large influence on a patient’s medicine use and adherence. According to the World Health Organization, a patient’s outcomes, like their overall quality of life, can be more directly influenced by medication adherence than a specific treatment. (Brown and Bussel, 2011). In
most cases, a medical adherence rate of 80% or more is usually required for optimal therapeutic efficacy and outcomes. After the initial prescription is written, adherence barriers, such as lack of communication and understanding, may increase over time. However, in the United States, cases of non-adherence have contributed to over 50% of treatment failures, and approximately 25% of hospitalizations every year (Kim et al., 2018). Therefore, successful end-of-life treatment also requires ongoing medication adherence and persistence.

In terms of religious and spiritual beliefs, patient concerns with excipients of animal origin are the main conflicts that pharmacists encounter with medication use and adherence. In pharmacy, excipients are substances besides the active pharmaceutical drug that are intentionally included in the drug development and administration process (Pirzada, 2004). One of the most common excipients used in prescribed medications are gelatin capsules. In 1843, gelatin capsules were a revolutionary invention in the pharmaceutical industry because they allowed pharmacists to encapsulate powered forms of medicine (Rousselot Biomedical, 2020). Gelatin capsules increased medication adherence because when the capsules were filled with medicine, patients could swallow the medication without tasting its dreadful flavor. However, gelatin capsules are produced from collagen, a protein obtained from raw animal materials, such as pork and bovine (Rousselot Biomedical, 2020). For many religious practices, like Islam, eating pork is prohibited and seen as impure. If a patient’s spiritual beliefs are aligned with these practices, consuming animal-derived medications can have negative effects on a patient’s medicine adherence (Eriksson, Burcharth, and Rosenberg, 2013).

If a patient has a dietary issue with the medication due to their religious or spiritual background, it is important for pharmacists to educate themselves of what animal-derived ingredients are used in the drug development process. By having this knowledge, pharmacists
can then disclose it to their patients and ask them for their dietetic beliefs; this act can also build a stronger relationship between the pharmacist and their patients because ongoing communication and patient education are critical for successful medical adherence.

Patients who are undertaking religious fasting may also refuse treatment and medications. For example, during Ramadan, which is a month-long abstinence from food and drinking between dawn and sunset, taking prescribed medications orally would be considered to be breaking the fast (Attum et al., 2021). The Orthodox Christian church also undergoes periods of voluntary abstention from specific foods like meat every year; if they discover their medication used animal-derived products, like gelatin or stearic acid, these patients may discontinue their medication regimen fast (Daher, Chaar, and Bandana, 2015).

If a pharmacist encounters cases like this, it is important for them to not question the patient’s religion because that can potentially leave negative effects on their physical, mental, and spiritual well-being. Instead, they need to maintain a blame-free environment and take an informed and respectful approach as they explain the negative consequences of nonadherence to the patient. By taking this approach, the trusting relationship between the pharmacist and their pharmacist will not be compromised so that when spiritual rituals such as the Ramadan fast occur, the pair can work together to find a mindful approach that addresses both the patient’s medical and spiritual needs.

Unfortunately, the lack of transparency from pharmaceutical companies can make it difficult to identify the origin of drug ingredients. Studies have indicated that some pharmacists had to wait over 20 minutes on phone with pharmaceutical companies to confirm if a medication they produced was animal-based or not, or to find gelatin-free alternatives for a specific medication (Daher, Chaar, and Bandana, 2015). At the end of that call, some pharmacists are still
unable to get a 100% confirmation from pharmaceutical companies that medication is animal-free or not. Despite these, pharmacists can still substitute gelatin excipients with animal-free alternatives, like antibiotic liquids or halal gelatin tablets, as a strategy to decrease the risk of inadvertently prescribing oral medication that contravene with a patient’s dietetic preferences (Eriksson, Burcharth, and Rosenberg, 2013). However, another barrier that pharmacists face with specific medication is that sometimes, there are only limited alternatives, some of which are not confirmed to be 100% derived from animal products. Due to this, it is likely that there are cases where patients have decided to choose their spiritual beliefs over their health needs; when this event occurs, even during end-of-life, pharmacists have to respect the patient's autonomy.

Conclusion

There are numerous reasons why every future pharmacist needs to have a sufficient understanding of spiritual and religious beliefs in order to provide culturally competent care to their patients. With a growing diverse population, learning about the values of the five major world religions is the first step that pharmacists can take to become more aware of how religion plays a role in an individual’s overall health. For pharmacists, medication adherence and patient concerns with excipients of animal origin are the main conflicts that they can encounter regarding religious and spiritual beliefs. In these situations, pharmacists need to either have a sufficient understanding of spiritual and religious beliefs, or be willing to initiate dialogue with the patient, in order to act accordingly to provide culturally competent care and treatment for them and their loved ones. In addition, having a greater understanding of how different religious practices view death and end-of-life care can make healthcare providers more open-minded about the patient’s autonomy regarding their treatment decisions.
Spirituality is not dependent on religion, but religion can still help develop a person's spiritual self in terms of finding existential meaning and a sense of purpose in their life and help them cope with the physical and mental aspects of their life-threatening diagnosis. Therefore, future pharmacy students need to learn about the importance of spirituality and religion in patient care through the pharmacy school curriculum and training. This thesis did not explore pharmacy school training regarding spirituality and religion; however, potential strategies that pharmacy schools could use to encourage religion and spiritual competency is by implementing more Spiritual Aspects of Patient Care (SAPC) courses into the schools’ curricula and inviting local chaplains for workshops on campus.

In the end, providing spiritual care means understanding that spirituality services are not reserved for the chaplain; rather, spiritual care should be focused on the health of the whole patient and can be provided by anyone, even pharmacists. Due to socio-cultural variations and different cultural backgrounds, not every individual will believe or practice all of the values of their respective religions. As a result, every healthcare provider should always be encouraged to initiate dialogue with patients about their respective religious beliefs if they have any; by doing this, the healthcare providers can make sure to provide patients and their loved ones with not only the best care possible but also a good humane death that respects and supports their individual needs. During the interview with chaplains from Lumina Hospice & Palliative Care, a question was asked to them: “What wisdom do you have to offer to a pharmacist, or any healthcare provider, when they know their patient is dying?” In response, they answered the following: “As a healthcare provider, you are a wounded healer. Never forget to recognize that the patient in front of you is a fellow human, and that sometimes, the best thing you can do for them is to sit there and listen to them and their loved one’s needs.”
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