Karmic suffering in the western world: exploring cultural and spiritual goals at the end of life

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As the United States grows increasingly multicultural, palliative care must adapt to interface with diverse patients.[1] Recent work highlighted cultural competence and spirituality as essential patient end-of-life (EOL) wishes.[2] With much of the wishes of both the patient and family at EOL being influenced by culture, religion, or spirituality, culturally competent EOL care is imperative. Here, we explore barriers to non-Western EOL practices in palliative care by analysing karmic suffering, and we provide opportunities for individual and systems-level changes.

Karmic suffering and debt are predominantly observed in Asian countries, intertwining medical management with spirituality. These multi-faceted concepts interpret karma as consequences of the intent and actions of past as well as current lives that influence our present along with future lived experiences. Therefore, mental and physical suffering are considered direct extensions of karmic debts accrued over lifetimes.[3] This perspective can lead to varied, individualistic interpretations of "pain" and "suffering" at the EOL. Many patients may desire to balance their karmic debts by accumulating "good karma", while others may welcome physical pain to mitigate spiritual suffering. Similarly, for some this practice may challenge their internal strength, while for others it is a path to atonement.

Implementing these ideas in Western settings poses unique challenges. Patients refusing pain medications to clear their karmic debts[4] can be conflicting to numerous physicians as this differs from Western outlooks towards death.[5] For providers with minimal awareness of this topic, such requests may be resisted. Consequently, patient-provider relationships weaken, leading to dissatisfaction. Presently, US healthcare is ill-equipped to incorporate and address unfamiliar existential models. In turn, patients may feel misunderstood, making them less likely to achieve their EOL desires.[6]

Providers of patients who value karma can improve value concordant care in three main ways.

1. Understand patients' definitions of karma and karmic suffering – pivot to forms of relieving pain that although not widely acknowledged, better align with a patient's wishes. In doing so, it can bolster a patient's sense of autonomy and strengthen trust in the patient-provider relationship.
2. Recognize opportunities for non-medication interventions – establish a social, psychological, and spiritual support system that is culturally competent. Efforts to promote access to spiritual leaders at EOL may help to reverse the medicalisation of EOL and improve the preservation of patients' humanity and dignity at death.
3. Increase diversity in research and healthcare teams – broaden representation to reflect our multicultural population, expand team views, and learn from exposure. Additionally, learners at all levels should be educated about the diversity of cultural perspectives towards EOL and the existential modes that patients may hold. Medical education should prioritise educating current and future providers on how to elicit and respond to these needs.

For many, the end of life is a culmination of an individual's values, background, traditions, and sense of self. In our quest to provide compassionate care, we must expand our conceptions of "the proper" end of life as seen by Western medicine today and embrace our diverse patients' visions for a dignified death.

Contributors
SS, SRR, ECD, and NS were responsible for the conceptualization and design of the manuscript. This included writing, extensive literature review, and editing. All authors approved of the final version.

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References

1 Chandratre S, Soman A. End of life care practices for Hindu patients during COVID-19. *J Palliat Care*. 2022;37(1):3–7.

2 Lee MC, Hinderer KA, Alexander CS. What matters most at the end-of-life for Chinese Americans? *Gerontol Geriatr Med*. 2018;4:2333721418778195.

3 Pahwa M, Babu N, Bhatnagar S. Fighting cancer is half the battle… living life is the other half. *J Cancer Res Ther*. 2005;1(2):98–102.

4 Rao SR, Viswanath V, Simha S. Spiritual healing in cancer care: a hindu perspective, India. In: Silbermann M, Berger A, eds. *Global perspectives in cancer care: religion, spirituality, and cultural diversity in health and healing*. Oxford University Press; 2022. [cited 2024 May 7] https://doi.org/10.1093/med/9780197551349.003.0022.

5 Sharma H, Jagdish V, Anusha P, Bharti S. End-of-life care: Indian perspective. *Indian J Psychiatry*. 2013;55(Suppl 2):S293–S298.

6 Swami NS, Mahal BA, Dee EC. Looking beyond the Western lens: how culture and identity influence perceptions of empathy in patient-clinician relationships. *Cancer*. 2022;128(7):1545–1546.