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Healthcare chaplains' perspectives on working with culturally diverse patients and families

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Abstract

Objectives. Considering the ethnic, racial, and cultural diversity in the U.S., we aim to explore the experiences of healthcare chaplains as they provide culturally sensitive care to diverse patients and their families.

Methods. This is a qualitative study. Individual interviews were conducted with 14 healthcare chaplains recruited from 3 U.S. chaplaincy organizations.

Results. Thematic analysis with constant comparison yielded 6 themes in the chaplains' experiences: (1) the diverse roles of chaplains; (2) their high levels of comfort in working with diverse populations, attributed to cultural sensitivity and humility training; (3) cues for trust-building; (4) common topics of diversity, equity, and inclusion discussed; (5) gaps in chaplaincy training; and (6) the importance of collaboration and negotiation with healthcare professionals to accommodate cultural needs.

Significance of results. This research highlights the valuable role of chaplains in providing culturally sensitive care and suggests areas for improving chaplaincy training and education to better serve diverse patient populations.

Introduction

Addressing spirituality and the needs for spiritual care among culturally diverse patients and their families is essential for patient-centered, culturally sensitive care, and cultural diversity is often associated with ethnic and racial diversity. This is especially important in the U.S., with 39% of the population in 2016 as other than non-Hispanic White and projected to increase to 56% by 2060 (Vespa et al. 2020). Within such racial and ethnic groups, religion and spirituality are often important components of cultural identity, shaping beliefs, values, and practices (Elk and Gazaway 2021; Pentaris and Thomsen 2020). Among those who have experienced historical and ongoing discrimination and marginalization, religion and spirituality can be particularly important for individuals coping with serious illnesses (Gazaway et al. 2023). Healthcare providers therefore need to understand the spiritual dimensions of their patients' cultural backgrounds, so that they can provide culturally sensitive care (Best et al. 2020; Wiener et al. 2013). Indeed, research has shown that addressing patients' spiritual needs can lead to better health outcomes (Balboni et al. 2022; Pesut et al. 2012; VanderWeele et al. 2017), whereas patients who feel that their spiritual needs are not being addressed may be less likely to trust their healthcare providers, follow medical recommendations, and seek future care (Coats 2017; Siler et al. 2021).

Chaplains on healthcare teams provide care that is sensitive to patients' religious and cultural beliefs and often act as their cultural brokers and advocates, helping to bridge the gap between patients and healthcare providers who may not share patients' cultural backgrounds (Board of Chaplaincy Certification, Inc 2017; Handzo et al. 2023; Handzo and Puchalski 2021). Healthcare chaplains can thus play a significant role in promoting culturally sensitive care for racially and ethnically diverse patients (Handzo et al. 2020; Majid and Laird 2023). This role may include the recognition of specific religious practices – for example, to help a religious adherent understand that even on days of fasting, eating and drinking are medically necessary without violating one's religion. Of course, the increasing diversity among patients and families can present challenges for healthcare chaplains – cultural differences in beliefs about illness, death, and dying, as well as language barriers and misunderstandings about healthcare practices. In some cultures, for example, individuals believe that discussing death and dying with a patient will hasten death (Searight and Gafford 2005). Nevertheless, although professional healthcare chaplains may be

able to navigate seemingly opposing needs so that patients receive the medical care they need and yet remain true to their beliefs and values, little empirical research has focused on the experiences of healthcare chaplains who work with diverse patients and families. To bridge this gap in research, this study aimed to investigate the experiences of healthcare chaplains who provide services to a culturally diverse patient population and their families.

Methods

Study design

This study adopted the phenomenological research approach to explore the experiences of healthcare chaplains working with diverse patients and families. Phenomenology is used to describe the common meaning or essence of a group of individuals' lived experience of a phenomenon (i.e., in this study, working with diverse patients and families) (Creswell and Poth 2018). In this approach, interviews with the individuals are typically used for data collection, and, through a systematic procedure of data analysis, a composite description of the common meaning of their experience is developed focusing on what and how they experienced it (Moustakas 1994; Creswell and Poth 2018). Rather than using a theoretical framework or a priori coding scheme, the current study took an inductive approach in its study design to be open to the emergent themes that arise from the participants' recount of their lived experience in working with diverse patients and families (Crabtree and Miller 1992; Creswell and Poth 2018).

Recruitment

Participants were board-certified healthcare chaplains in the U.S. who participated in a larger survey study on the role of healthcare chaplains in advance care planning (Kwak et al. 2022 2021) and indicated interest in participating in a subsequent follow-up study. They were recruited from the Association of Professional Chaplains, the National Association of Catholic Chaplains, and the Spiritual Care Association, organizations that offer a formal subspecialty certification for chaplains in hospice and palliative care. Eligibility criteria for the larger study were as follows: (1) work, full- or part-time, as a spiritual care provider, (2) prior use of telechaplaincy (or telehealth) for delivery of spiritual care, (3) prior work with ethnically or racially diverse patients, and (4) prior work in a palliative care-related setting (e.g., intensive care unit, oncology unit, hospice, or palliative care unit). The study was advertised primarily through emails to organization members that provided its purpose, the online survey mode, the principal investigator (PI)'s contact information, and a link to the online survey site. A research assistant sent interview invitations to the original survey respondents who had expressed interest in the follow-up interview study. Fourteen board-certified healthcare chaplains responded to the invitation, and participated. The participants completed a brief online survey and provided their demographic and professional backgrounds and estimates of the racial or ethnic makeup of the patient populations they served. The study received the Institutional Review Board (IRB) approval from the UT Austin IRB (approval number: STUDY00002468).

Data collection

Single interviews were conducted via Zoom with each participant from April to June 2022. Each interview lasted about 60 minutes, and the interviews were audio- and video-recorded and transcribed verbatim. Before the interviews began, participants provided their verbal consent. We used a semi-structured interview questionnaire to explore the participants' experiences as healthcare chaplains working with a diverse population. Open-ended questions addressed different aspects of the chaplains' experiences, including their perceptions of patients' and families' diversity, their level of comfort working with the patients, their chaplaincy training regarding cultural diversity, and institutional barriers to cultural diversity. Additional probing questions were asked when needed. (See Appendix A for the questions.).

Data analysis

Descriptive statistics were conducted using SPSS/WIN 28.0. Descriptive statistics provided respondents' background characteristics, and the interview transcripts were examined with thematic analysis (Braun and Clarke 2006, 2021). The first 3 authors read the transcripts repeatedly to immerse themselves in the data and wrote down their initial thoughts and reflections. Then they individually coded the transcripts for data segments that captured the chaplains' experiences in working with diverse patients and families. Similar codes were combined, with subcodes when a single code entailed too broad a concept or suggested different yet related concepts. As a group, the authors compared their codes and reached consensus through repeated discussions. With the resulting coding scheme, they recoded the interview data to identify themes and then met multiple times with iterative data analysis to discuss and agree upon a final set of themes (Padgett 2016). Throughout the data analysis phase, the team actively reflected on our individual cultural backgrounds and perspectives, critically assessing how these could influence our interpretations and ensuring a multiplicity of viewpoints was considered. Multiple strategies were used to ensure the trustworthiness of the research process and findings of this study. Multiple coders (i.e., 3 coders) were used, and the PI kept an audit trail for all data files, field notes, and coding memos (Creswell and Poth 2018; Saldana 2021). The authors also took reflexive notes individually to challenge their own assumptions during analysis and discussed them in a debriefing session as part of reaching consensus (Lincoln and Guba 1985; Creswell and Poth 2018). In addition, they had peer debriefing sessions with a chaplain researcher who was knowledgeable of the phenomenon explored in this study (Creswell and Miller 2000).

Results

Chaplains' characteristics

The majority of the 14 board-certified chaplains were White (85.7%), female (71.4%), Protestant (50.0%), and employed full-time (78.6%). Academic medical centers were their most common place of employment (57.1%), followed by community hospital settings (42.9%). About 43% were designated for palliative care units or intensive or critical care units. Seven of the 14 participants estimated that 21–40% of their patients were from Hispanic backgrounds. Eight reported that 0–20% of their patients were from non-Hispanic racial/ethnic minority backgrounds (i.e., Black/African American, Asian and Pacific Islanders, American Indians or Alaska Natives), and 3 reported that 21–40% of their patients were from non-Hispanic racial/ethnic minority backgrounds (See Table 1 for details.).

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Table 1. Respondents' background characteristics

Background characteristics	*n*	%
Chaplain characteristics		
Gender		
Male	4	28.6
Female	10	71.4
Other	0	0
Race		
White	12	85.7
Black or African American	0	0
Asian and Pacific Islander	2	14.3
American Indian or Alaska Native	0	0
Hispanic	0	0
Religion		
Protestant	7	50.0
Catholic	1	7.1
Jewish	1	7.1
Other	5	35.7
Employment status		
Full-time	11	78.6
Part-time	2	14.3
Other	1	7.1
Years of practice as a professional chaplain		
<1	0	0
1–5	4	28.6
6–10	4	28.6
11–15	2	14.3
16–20	1	7.1
>21	3	21.4
Work setting characteristics		
Settings[a]		
Academic medical center	8	57.1
Community hospital	6	42.9
Specialty hospital (VA, oncology, rehab, psychiatric)	1	7.1
Extended care facility/assisted living/nursing home	0	0
Inpatient or home hospice	2	14.3
Other	1	7.1
Service-line-designation[b]		
Yes[c]		
Palliative care chaplain	6	42.9
Intensive or critical care unit chaplain	6	42.9
Oncology chaplain	3	21.4
Patients with Hispanic background		
0–20%	4	28.6
21–40%	7	50.0
41–60%	0	0
61–80%	3	21.4
81–100%	0	0
Patients with non-Hispanic racial/ethnic minority background (Black/African American, Asian and Pacific Islanders, American Indians or Alaska Natives)		
0–20%	8	57.1
21–40%	3	21.4
41–60%	1	7.1
61–80%	2	14.3
81–100%	0	0

[a]Work setting: includes multiple responses, so percentages do not add to 100%.
[b]Service-line-designation: assignment to one or more specific clinical service lines such as palliative care as opposed to providing general coverage in the facility.
[c]Yes: includes multiple responses, so percentages do not add to 100%.

Chaplains' experiences in working with patients and families with diverse cultural backgrounds

Six major themes emerged from the chaplains' responses about working with culturally diverse patients and families: (1) varying roles of chaplains; (2) being comfortable in working with culturally diverse patients and families; (3) cues for trust built between patients and families and chaplains; (4) common diversity, equity, and inclusion (DEI) topics; (5) gaps in chaplaincy education and training; and (6) collaboration and negotiation with others to accommodate cultural needs.

Varying roles of chaplains

Chaplains reported varying roles in promoting cultural competency and humility. One chaplain (#4) who worked at a community hospital viewed this role as that of an "advocate for patients and families … to help support them" in "navigating the healthcare system":

> The hospital has a rule that you can only leave the body and the room for four hours, so there have been many times when I have gone to the nursing staff and said, "For this family, this is their belief, when the person dies, can we leave the body untouched for the maximum four hours?" And then I will tell the family that it can only be four hours. So, you just kind of try to negotiate … a mutual understanding that "this is our compromise," and "this is what we can."

In addition to advocating for patients and families' needs, chaplains said that providing emotional and spiritual support was a key role in supporting culturally diverse population. As Chaplain #4 stated, "My role was … gently supporting the family and saying that … we recognize your beliefs and we're praying for her, too." Another chaplain (#9) described being "a conduit to their sources of strength – whether that's a deity, whether that's their own sense of self": "Whatever they call upon and however they call upon it, I'm

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going to allow that to flow through; that spiritual energy is allowed to flow through me."

Being comfortable in working with culturally diverse patients and families

The chaplains felt very comfortable in working with culturally diverse patients and families. Chaplain #9, for example, affirmed being "a hundred percent" comfortable in working with diverse patients. The chaplains often attributed their comfort to the nature and philosophy of chaplaincy, which emphasizes the uniqueness of each person, as well as training in cultural sensitivity and cultural humility:

> I think, for me, the orientation that is supportive in feeling comfortable is not ever pretending like I know someone else's experiences. So within chaplaincy, there used to be a discussion of cultural competency and now the sort of buzzword phrase is "cultural humility," and that's really helpful for me to go in and ask questions and let the person be the expert of their own experience. I think that allows me to feel more comfortable because I'm not expected to know what it's like to be them. (Chaplain #10)

Another chaplain (#6) described chaplains as "a resource for cultural expansion," emphasizing that chaplains have "so much cultural sensitivity training": "if we have all that training and we can train others, then everybody's empowered to be more culturally sensitive."

Cues for trust between patients and families and chaplains

The chaplains built trust with their patients and families through personal interactions – by "sharing things," for example, when patients or their families opened up and were forthcoming about their spiritual challenges or feelings such as fear or anger:

> Patients are opening up and … sharing things. That is a sign of trust that they're able to share more intimate information with you. Or also feel like you are a trustworthy member of the team if you're someone that can be relied on to show up or to do whatever it is that you said you would do. (Chaplain #4)

Changes in an individual's demeanor could also be a telling sign of trust. This might manifest as better eye contact, a warmer tone in interaction, or a longer attention span. Instead of turning the chaplain away while having a meal, an individual might invite the chaplain to sit and eat too. As Chaplain #10 said, "I feel like I knew there was trust with him when his demeanor would soften as I walked in"; such changes in behavior indicated a connection, allowing for more open, meaningful conversations between chaplain and the patient or family.

Common DEI topics

The chaplains reported that DEI topics were important during their healthcare team meetings; these included multicultural traditions, gender diversity, end-of-life and decision-making, language barriers, cultural humility, mistrust, and unconscious bias. During chaplaincy meetings, the topic of respecting and honoring multicultural traditions was frequently discussed, including the acknowledgment of events such as Ramadan, Kwanza, or Black/Asian Pacific Islander History Month. These discussions occurred not just in weekly team meetings but also in daily huddles, where issues of diversity surfaced. Chaplain #10, who worked at an academic medical center, described such discussions thus:

> Well, there's a weekly meeting, but there's a huddle every day, like a five-minute huddle. And in that huddle issues of diversity might come up. … from, like, the Native American culture/religion … we're talking about this stuff all the time.

Gender diversity was also commonly mentioned by the chaplains. For example, Chaplain 4, designated as a palliative chaplain at an academic community hospital, said that "Our hospital has done a lot to try to improve people's understanding and education with regard to transgender patients because we have a gender-affirming surgery program, so there's been … a lot of training for staff around that."

Decision-making regarding end-of-life was also an important DEI topic. Decisions to enact a do-not-resuscitate or do-not-intubate order were often influenced by religion and culture. Chaplain #5, designated for the ICU at an academic medical center without a Muslim chaplain, shared the following experience:

> [We said] "Let's reach out to find out what branch of Islam they follow and reach out to those in the community that could speak more intelligently into that situation." Then they were able to educate us on how they navigate that. Once we are educated and the family was educated, they're able to have more fruitful conversations about navigating the goals of care for the patient who was critically ill and elderly and ended up transferring to a hospital somebody in the end.

The chaplains also spoke of language barriers between themselves and patients. Chaplain #12, designated for palliative care at an academic medical center, described the following challenge:

> So we established that she was Buddhist and that she does meditate, and we could find … Vietnamese meditations and chants for her to use or for the nurses to play in her room if she asked, but just getting there was very, very hard because we had a language barrier and such different assumptions about why a person identifies with a certain religion and what that means to them.

The chaplains also recognized patients' mistrust as well as their own unconscious biases. They stressed the importance of cultural humility and self-reflection to overcome these issues. Thus Chaplain #4 emphasized the need for cultural humility:

> Either cultural humility or being able to identify one's own privilege and areas of privilege and lack of privilege and being able to think critically … [is important] because I don't believe that you can really learn more about different cultures or groups [without cultural humility].

Gaps in chaplaincy training and education

Areas of chaplaincy training relevant to working with culturally diverse patients and families often focused on other religions and cultures:

> I just finished my doctorate in theology in multiphase spiritual direction. So a good portion of that class was reading [about] other religious traditions, becoming more familiar with spiritual direction with them, learning about the expression of their religious traditions, and [I] learned a lot about indigenous people that I didn't know. I thought I knew, but it was one of those things that you don't really know. (Chaplain #2)

Similarly, Chaplain #10 recollected "getting to know religions, faiths across the spectrum" through past training, which had helped this chaplain "to understand different ways of viewing things, different belief systems, different points of orientation that people are coming from." This chaplain added that chaplaincy training had helped to provide "respect, curiosity, and admiration for people of all different types" and "cultivated a desire to be open, accepting, and curious about someone else's experience."

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Most of the chaplains said that their training had helped to prepare them for working with culturally diverse patients and families, but they still spoke of gaps in training. Chaplain #4 involved working with nonreligious individuals:

> I think care for people that are not religious is also really important and something that chaplain training can improve on, especially because most chaplains still come from theistic training. So, it's really hard for them to care for people who aren't theistic.

Recounting the training on systems of oppression, this chaplain also shared:

> We should teach more anti-racism and anti-oppression to really deepen their [chaplains'] understanding of the deep historical inequities and current inequities in healthcare and the way that impacts the people that we provide care to, the ways that we can be forces of structural change in our institutions.

The need for training about potential biases was also discussed:

> I think there can be bias and the reasons that we call security on people.… Looking at certain types of people—based on our own prejudice —[we may] say, "Oh, that person is being violent and they're being angry, we should call security." (Chaplain #4)

The chaplains also made recommendations for chaplaincy training programs to better serve culturally diverse patients. They emphasized education on additional groups (e.g., different denominations within religions, subgroups of ethnic groups, etc.). They also specifically noted the importance of understanding different family systems and cultural traditions regarding end-of-life care in subsets of cultural groups. Thus, with respect to working with Hispanic families, 1 participant stated:

> In his [a Hispanic patient's] family, somebody always stays with the patient; maybe an extended family member.… There's always in the room with a patient, and I do not see that true in any other group.… So, yeah, [it would be helpful] if we could learn more about family systems, especially among Hispanics, maybe Hispanic evangelicals even, which is a growing population. (Chaplain #2)

Finally, participants called for self-reflection as part of chaplaincy training. Using the U.S. Untreated Syphilis Study at Tuskegee as an example of medical racism, Chaplain #8 called for healthcare professionals to recognize racial/ethnic minority groups' distrust in the healthcare system and for self-reflection on any bias or prejudice toward minority patients:

> Like the Tuskegee project … I hope doctors and nurses know about how African Americans might feel differently. So, I think … education about diversity and inclusion should be ongoing for all the professions, … because we're constantly meeting patients and we might not understand where they are coming from.

As Chaplain #4 said, "Unruly or problematic patients and families – sometimes those patients and families are feeling a certain way because of their feelings of distrust at the hospital – their feelings about how they've been treated by hospital staff."

Collaboration and negotiation with others to accommodate cultural needs

Collaborating with other healthcare providers in serving culturally diverse patients was also important. Healthcare chaplains work on interdisciplinary teams, closely collaborating with doctors, nurses, and social workers. The chaplains described negotiating with other professionals about ways to accommodate patients' cultural traditions. One, for example, worked with nursing staff to accommodate a Buddhist family's request to leave the deceased patient's body untouched in the room for a certain period of time, given the time allowed by the hospital's policy. Chaplains reached out to doctors or other team members to accommodate a Muslim patient's and family's request for exorcism using a needle (by sterilizing the needle) or a Native American patient's and family's request to burn sage (with assistance from the hospital's engineering team). Chaplain #8 gave the following example of a Sikh patient:

> They used to carry a knife, but … now they carry a symbolic knife … we had an issue at some point where somebody had that, but you can't have a knife in the hospital, but it's part of their religion … so then the religious team comes in. But in those cases, I just consult with the manager, and she can take care of that stuff.… She can talk to engineering, and she can talk to whoever she wants about that.

Chaplains also reached out to other team members from culturally diverse backgrounds for assistance in learning about patients' cultures and providing culturally appropriate support:

> I consult team members.… If it's somebody, whether they're Buddhist or Christian or what, … if they're coming from Korea or something, I might—I have a colleague who is from Korea. She was born in Korea. She might be able to help me navigate parts of the culture. (Chaplain #8)

Discussion

This phenomenological study explored the lived experiences of healthcare chaplains working with diverse patients and families. Participants of this study described their views on the chaplain role, their sense of comfort in working with the diverse patients and families, and signs of the patients' and families' trust in the chaplains. They also shared their experience with DEI discussions in team meetings and their view of the gaps in the chaplain training they received. Our findings provide support for an interesting comparison to existing studies on the topic of chaplaincy with diverse populations as well as implications for future direction.

As described by the participants of this study, the roles of chaplains in healthcare settings include patient advocacy as well as emotional and spiritual support without being involved in direct clinical care. Such roles can foster increased trust among patients and families of different cultures, which may explain the sign of trust the participants perceived in their interactions with the patients and families and contribute to the sense of comfort the participants felt in working with them. A previous literature review examined the various roles played by healthcare chaplains, which covered a wide extent of activities not only religious or spiritual interventions (e.g., hearing confession or amends, performing a religious rite, praying, meditation, etc.) but also general ones (e.g., life review, patient advocacy, counseling, empathic listening, etc.) (Timmins 2018). Chaplains are playing an increasingly significant role in various settings beyond traditional religious contexts, such as healthcare, social movements, and more (Cadge et al. 2022). This change in chaplaincy reflects their evolving role in American society, offering support in existentially challenging moments. The findings of this study also confirm that healthcare chaplains' roles go beyond providing religious or spiritual activities to include many interventions intended for psychosocial and emotional support, which may help build and strengthen the patients' and families' trust in their healthcare chaplains. However, the role of their various roles and their impact on the patient's and family's

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trust has not been examined in prior research, therefore calling for future research efforts on such a topic.

Considering the participants' views of their training and its impact on their sense of comfort in working with diverse groups, healthcare team members from different disciplines must also underscore and integrate into their education and practice a similar philosophy rooted in valuing and honoring each person's uniqueness. The significance of fostering an appreciation for religious and cultural diversity is also echoed in a recent study by Cadge et al. (2019), which surveyed healthcare chaplain educators on essential topics for training programs. The educators highlighted the cultivation of this appreciation as a crucial skill. According to the healthcare chaplains in this study, the education and training they received emphasized embracing and respecting the distinctive qualities of each individual as well as cultural competence and humility. Such emphasis in the chaplain education may also contribute to the chaplain's ease, comfort, and embrace of working with patients and families from diverse cultural backgrounds. Future research should explore specific strategies chaplains use to establish trust and the underlying factors that facilitate successful chaplain–patient/family relationships. Perhaps chaplains' strategies differ from those in other healthcare disciplines and could contribute to enhancing culturally sensitive practice and training. Qualitative methods such as in-depth interviews, focus groups, and observational studies can capture nuances of chaplain–patient/family interactions and identify verbal and nonverbal communication techniques, active listening skills, and empathetic approaches that chaplains employ to foster trust. Comparing these strategies with those of others in other healthcare disciplines such as nursing or social work may provide valuable insights into the uniqueness of chaplaincy's trust-building. Studies should also examine patients' and families' perceptions of trust-building and factors that positively influence their connection with chaplains.

The chaplains said that they discussed DEI topics both in their regular team meetings and outside of those meetings; topics included multicultural traditions, gender diversity, end-of-life and decision-making, language barriers, cultural humility, mistrust, and unconscious biases. They emphasized the importance of cultural humility and self-reflection in order to overcome DEI-related issues. In healthcare, *cultural humility* means recognizing how individuals' cultural backgrounds can influence their health behaviors, so that one can subsequently treat patients in a culturally sensitive way (Miller 2009; Prasad et al. 2016). Cultural humility's role and importance in health care have been widely acknowledged and studied (Frie and Timm 2023; Ranjbar et al. 2020; Zinan 2021). Given the interdisciplinary collaborative nature of healthcare chaplaincy, it may be useful to compare disciplines (e.g., the work of healthcare chaplains, nurses, physicians, social workers, psychologists, etc.) in order to ascertain their understandings of cultural humility in relation to clinical practice. The impact of cultural humility and self-reflection on chaplaincy practice and patient outcomes should also be explored. Researchers should also consider how healthcare chaplains can be trained to address DEI topics in their interactions with patients and colleagues effectively. The role of chaplains in promoting DEI in healthcare settings should be further examined, as well as the potential benefits of integrating chaplaincy services into DEI initiatives. After all, the demographics of diversity are changing in the U.S. In Los Angeles, according to the last census, 50% of the population were Hispanic and 20% Asian/Pacific Islander. Within the U.S. Black population, the fastest growing group comprises recent immigrants from Africa, whose issues differ from those of African-American descendants of slaves. These demographics differ from those of our largely non-Hispanic White and Christian chaplaincy workforce (White et al. 2021).

The chaplains described areas of their training relevant to working with culturally diverse patients that could be improved. Examples included training to address challenges in working with nonreligious individuals, to discern and mitigate potential biases, to provide knowledge about diversities within cultural and religious cohorts, and to understand varying family systems and cultural customs related to end-of-life care. The chaplains felt a need for further training on the history of systematic oppression and on practices to increase self-awareness and reflection regarding prejudice and biases. They underscored a need to expand current training curricula to address a broader array of religious and cultural groups, to focus more strongly on opposing racism and oppression, and to improve training in self-reflection to address unconscious biases. Examination of barriers and facilitators related to creating, delivering, and disseminating such curricula would enhance their pedagogical feasibility and acceptability.

The chaplains' discussion of the importance of collaboration and negotiation with other healthcare providers to meet patients' and families' diverse cultural needs, as well as the chaplains' reliance on colleagues from other cultures for advice on culturally appropriate practices, suggests a need for open communication and flexible decision-making among interdisciplinary team members to accommodate religious or cultural requests. In line with this perspective, a previous qualitative study involving 23 hospital chaplains highlighted the unique mediating role that chaplains can play between patients from diverse religious backgrounds and healthcare professionals who may not be as versed in those religious practices (Klitzman et al. 2023). Chaplains with an in-depth understanding of the patient' religious beliefs are not only instrumental in fostering cultural sensitivity among their peers but also crucial in correcting misconceptions within the healthcare team (Klitzman et al. 2023). Such peer support and mentoring with regard to other cultures are important for healthcare practice.

Another role of chaplains is to initiate changes in institutional policy to accommodate different cultures. Handzo et al. (2023) have provided examples: In one hospital, Orthodox Jewish families would not use electronic doors on the Sabbath, nor would they use the elevators in the 20-story hospital building. A chaplain's intervention resulted in accommodations. Care of culturally diverse staff is also increasingly one of chaplains' responsibilities; in another example, simple food was provided at a central location for Muslim employees to break their fast during Ramadan without overly disrupting their assignments (Handzo et al. 2023).

A major issue in health care that deserves further research consists of the systems used by different cultures for making healthcare decisions. In much of the world, decisions are made by some combination of the family and leaders of the family or religious group. They are not always made by the patient. This custom is totally at odds with the U.S. insistence on individual autonomy, and it can cause conflicts between patients, families, and staff. Chaplains are often called to mediate these conflicts, often after distrust has reached a high level. Further investigation into the conflicts between U.S. healthcare decision-making norms and those of other cultures is warranted.

Limitations

The findings and implications of this study, however, should be interpreted with caution, given limitations in the study's design.

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Our goal was not to generalize the experiences of healthcare chaplains, and we may not have fully captured perspectives and experiences of chaplains from racial or ethnic minority backgrounds or with different religious affiliations. The chaplains in this study were from a convenience sample of board-certified healthcare chaplains who participated in a large survey. The majority were White (84%) and Protestant (63%). Other chaplains may have different perspectives on the role of healthcare chaplains working with culturally diverse patients and families. Our study's sample homogeneity limits the generalizability of our findings, and future studies should include a more diverse group of chaplains to enhance the study's external validity. Moreover, participants were asked to estimate the racial and ethnic composition of their patient population, which could lead to potentially inaccurate picture of patient diversity. These estimates, however, offer an insight into the diversity of patient populations chaplains believed they served. Additionally, it is important to consider the potential impact of social desirability bias on our findings. The chaplains' responses may have been influenced by the tendency to provide socially acceptable answers, particularly regarding sensitive topics such as cultural competence and interreligious dynamics. This inclination could lead to an overrepresentation of positive self-assessment and underreporting of challenges or biases in working with culturally diverse patients and families. Acknowledging this bias is crucial for interpreting the chaplains' perspectives accurately, and future research should incorporate measures to mitigate its effects, such as triangulation of the data or the inclusion of indirect questioning techniques (Bispo 2022). Furthermore, we have presented chaplains' views only, not those of the patients and families with whom they work. Future studies should be conducted with more diverse chaplain groups in culturally diverse healthcare settings as well as patients and families who receive their services. Lastly, additional strategies to ensure the trustworthiness of qualitative research, such as triangulation or member checking, can be useful to validate its findings.

Conclusions

With a qualitative approach, we have explored healthcare chaplains' experiences and perspectives on working with diverse patients and families. Despite limitations, this study shows that the role of healthcare chaplains is critical in the provision of culturally sensitive, inclusive care. By fostering cultural competency, humility, and trust-building, healthcare chaplains can affect patients' outcomes profoundly and facilitate harmonious interactions within healthcare settings. Continued efforts to advance chaplaincy training, promote DEI initiatives, and embrace changing demographics are essential for advancing chaplaincy and enhancing the care of patients from culturally diverse populations.

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Competing interests. Nothing to disclose.

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Appendix A. Interview Questions

1. What does patients with diverse cultural backgrounds mean to you?
2. How would you describe cultural diversity among patients you work with?
3. How comfortable are you working with your patients coming from diverse cultural backgrounds?
4. Can you please describe any challenges you experienced in serving patients from diverse cultural backgrounds?
5. How do you know if you established trust with patients coming from diverse cultural backgrounds that are different from yours?
6. Do you feel well prepared by the chaplaincy training to work with culturally diverse patients/families now?
7. How has your training in religious/faith traditions influenced your work with culturally diverse patients?
8. What are any institutional cultural or policy issues that you feel that negatively impact culturally diverse patient's experience?
9. Does your team regularly or occasionally discuss or address diversity/equity/inclusion (DEI) related issues among your patients?
10. Can you offer any recommendation for other healthcare professionals regarding culturally sensitive or informed practice?
11. Does your workplace have a designated team that focuses on diversity/equity/inclusion (DEI) issues?

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