

## Original Article

## The Views of Clergy Regarding Ethical Controversies in Care at the End of Life

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## Abstract

**Context.** Although religion often informs ethical judgments, little is known about the views of American clergy regarding controversial end-of-life ethical issues including allowing to die and physician aid in dying or physician-assisted suicide (PAD/PAS).

**Objective.** To describe the views of U.S. clergy concerning allowing to die and PAD/PAS.

**Methods.** A survey was mailed to 1665 nationally representative clergy between 8/2014 to 3/2015 (60% response rate). Outcome variables included beliefs about whether the terminally ill should ever be “allowed to die” and moral/legal opinions concerning PAD/PAS.

**Results.** Most U.S. clergy are Christian (98%). Clergy agreed that there are circumstances in which the terminally ill should be “allowed to die” (80%). A minority agreed that PAD/PAS was morally (28%) or legally (22%) acceptable. Mainline/Liberal Christian clergy were more likely to approve of the morality (56%) and legality (47%) of PAD/PAS, in contrast to all other clergy groups (6%–17%). Greater end-of-life medical knowledge was associated with moral disapproval of PAD/PAS (adjusted odds ratio [AOR], 1.51; 95% CI, 1.04–2.19,  $P = 0.03$ ). Those reporting distrust in health care were less likely to oppose legalization of PAD/PAS (AOR 0.93; 95% CI, 0.87–0.99,  $P < 0.02$ ). Religious beliefs associated with disapproval of PAD/PAS included “life’s value is not tied to the patient’s quality of life” (AOR 2.12; 95% CI, 0.1.49–3.03,  $P < 0.001$ ) and “only God numbers our days” (AOR 2.60; 95% CI, 1.77–3.82,  $P < 0.001$ ).

**Conclusion.** Most U.S. clergy approve of “allowing to die” but reject the morality or legalization of PAD/PAS. Respectful discussion in public discourse should consider rather than ignore underlying religious reasons informing end-of-life controversies. *J Pain Symptom Manage* 2017;■:■–■. © 2017 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.

## Key Words

*Bioethics, physician aid in dying, physician-assisted suicide, religion, spirituality*

## Introduction

Respectful public discourse about the ethics of care at the end of life (EOL) requires attention to the reasons that underlie the opinions offered on both

sides of moral controversies, reasons that often are religious, or have a religion-like character.<sup>1,2</sup> In discourse about PAD/PAS, this includes fundamental views regarding the meaning of a good life and a good death,

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the nature of suffering and freedom, and the role of medicine in human life. Because many U.S. citizens are religious,<sup>3–6</sup> it is important to understand how religion shapes opinions on EOL care if they are to be included in public discourse about such controversial issues. Political philosophers such as Habermas<sup>7</sup> and Sandel<sup>8</sup> have argued that mutual respect among citizens of a good society that includes both religious and nonreligious persons requires an attempt to understand the positions of others on their own terms.

The majority of Americans rely on their religious beliefs to cope with life and its challenges, especially with increasing age<sup>9</sup> and within serious illness.<sup>10,11</sup> Similarly, multiple studies have reported associations between religion and attitudes about legalization of PAD/PAS within the American population,<sup>12,13</sup> among patients,<sup>14,15</sup> U.S. physicians,<sup>16</sup> and concerning suicide generally in international comparisons.<sup>17</sup> In addition, half of terminally ill patients are visited by their community religious leaders,<sup>2,18</sup> who have formed opinions about a good death<sup>19</sup> and of how to provide spiritual care at the EOL,<sup>20,21</sup> and whose religious care is associated with end-of-life medical discussions<sup>2</sup> and outcomes.<sup>22</sup> The salient role of community clergy has also been recognized by the medical community in EOL care, including within national palliative care guidelines.<sup>23,24</sup> However, while recognized to have a clear role at life's end, what religious leaders believe about controversial EOL ethical issues such as PAD/PAS is not well defined. For example, prominent religious leaders, from Desmond Tutu to Pope Francis, have both supported and opposed the legalization of PAD/PAS.<sup>25,26</sup> Yet little is known about what proportion of religious leaders favor or oppose PAD/PAS or why they hold these opinions.

The National Clergy Project on End-of-Life Care is an NCI-funded cross-sectional study of a nationally random sample of religious leaders in the U.S. designed to measure attitudes related to EOL ethics, including opinions concerning “allowing to die” and PAD/PAS. Community clergy were chosen because of their direct influence over congregants’ ethical perspectives and because they have a symbolic moral voice that many Americans look to for guidance in the formation of their own beliefs. This study aims to describe religious leaders’ attitudes and opinions of PAD/PAS, and identify predictors of clergy viewpoints.

## Methods

### Sample

Methods for the study are previously reported.<sup>2</sup> From August 2014 to February 2015, a confidential, self-administered, eight-page questionnaire in English and Spanish (see [Supplementary Appendix](#)) was developed by an interdisciplinary, expert panel, and

mailed to a random sample of 2000 practicing U.S. clergy. Clergy were randomly selected from a third-party business file (Infogroup, Inc. Papillion, NE) intended to include all houses of worship in the U.S. ( $N = 368,407$ ). Of the 2000 potential respondents, an estimated 16.8% could not be contacted because of incorrect addresses and telephone numbers or because the institution no longer existed leaving an actual potential sample of 1665. The study oversampled minorities to compare clergy views based on race. Clergy received up to four mailings, a telephone call, and e-mail and were offered a \$10 gift card in the initial mailing. The study was approved by the Dana-Farber/Harvard Cancer Care institutional review board.

### Dependent Variables

*Sometimes Allow to Die.* Clergy responded to the previously used Pew question<sup>13</sup> assessing views regarding treatment at the EOL: “Which comes closer to your view: In all circumstances, doctors and nurses should do everything possible to extend the life of a patient, or, sometimes there are circumstances where a patient should be allowed to die?”

*Physician Aid in Dying or Physician-Assisted Suicide.* All participants rated on a five-point scale their degree of agreement with five statements that assessed ethical opinions related to PAD/PAS. The question frame (see [Table 1](#)) was developed by a diverse expert panel, which included different opinions on PAD/PAS to neutrally frame the questionnaire.<sup>27</sup> Clergy responded to statements that assessed their opinions concerning the morality and legality of PAD/PAS. Participants also responded to statements that assessed PAD/PAS views including whether choosing the time of death gives dignity, when pain is unrelenting and uncontrollable, and the applicability of the term “suicide.”

### Independent Variables

*Demographics.* Clergy age, race, gender, geographic location, educational level, congregational position, and religious/denominational affiliations were collected by database or self-report. Clergy estimated average congregational annual household income.

*End-of-Life Medical Knowledge.* Clergy completed a nine-item questionnaire (see on-line supplement) on knowledge of hospice, palliative care, pain treatment, and ICU care, generating a composite score on EOL knowledge (possible scores 0–9).

*Distrust in the Health care System.* Clergy completed a modified four-item validated questionnaire assessing level of distrust in the health care system,<sup>28</sup> generating a composite score on distrust (possible scores 4–20), with higher scores meaning increasing distrust.

Table 1  
**U.S. Religious Leaders' Attitudes on Controversial End-of-Life Ethical Decisions (N = 1005)**

Question and Response	No./Total No.	%
Which comes closer to your view? In all circumstances, doctors and nurses should do everything possible to extend the life of a patient. Or, sometimes there are circumstances where a patient should be allowed to die.		
Always extend life	154/972	15.8
Sometimes let a patient die	776/972	79.8
Not sure	33/972	3.4
We would like to ask you about what some call "physician aid in dying" and others call "physician-assisted suicide." This refers to patients who doctors say cannot be cured by medicine and will likely die in less than six months. Some states allow patients to request from their doctor a dose of drugs intended to cause death. Some argue that this gives patients a level of choice within dying and avoids unnecessary suffering. Others see this as an act of killing because the drugs, not the disease, cause death. To what extent do you agree with the following statements?		
It is immoral no matter the circumstances		
Disagree strongly	135/969	14.0
Disagree somewhat	138/969	14.2
Not sure	60/969	6.2
Agree somewhat	163/969	16.8
Agree strongly	473/969	48.8
It should be a legal right to end life this way		
Disagree strongly	519/963	53.9
Disagree somewhat	142/963	14.8
Not sure	89/963	9.2
Agree somewhat	145/963	15.0
Agree strongly	68/963	7.1
Choosing the time of death gives back dignity		
Disagree strongly	491/966	50.9
Disagree somewhat	168/966	17.4
Not sure	82/966	8.5
Agree somewhat	161/966	16.7
Agree strongly	64/966	6.6
It is morally OK if pain is unrelenting and uncontrollable		
Disagree strongly	404/962	42.0
Disagree somewhat	166/962	17.2
Not sure	85/962	8.9
Agree somewhat	201/962	21.0
Agree strongly	106/962	11.0
It is suicide even when the patient is actively dying		
Disagree strongly	173/962	18.0
Disagree somewhat	153/962	15.9
Not sure	88/962	9.1
Agree somewhat	160/962	16.6
Agree strongly	388/962	40.4

*Life's Value Not Tied to Quality of Life.* On a five-point scale, participants rated their level of agreement with the statement: "The value of a patient's life is not tied to the patient's quality of life."

*Pain and Suffering Have Purpose.* On a five-point scale, participants rated their level of agreement with a congregant stating: "I endure painful medical procedures because suffering is part of God's way of testing me."

*Only God Numbers Our Days.* On a five-point scale, clergy indicated the level of importance to express to dying congregants that "Only God numbers our days."

### Analysis

Weighted analysis accounts for sampling strategy and differences in response rates according to respondents' race including black clergy (11.2/22.4 = 0.5), Hispanic clergy (4.4/8.4 = 0.52), and white/other (84.4/69.2 = 1.22). Multivariate logistic regression analyses were used to identify predictors of clergy viewpoints on sometimes "allowing to die" and PAD/PAS. Multivariable models adjusted for clergy gender, age, years in ministry, race, educational level, geographical region, congregational median income, higher EOL medical knowledge, distrust in the health care system, and agreement with religious beliefs including the value of life apart from quality of life, spiritual purpose in suffering, and that only God numbers our days.

All reported *P*-values are two sided and considered significant when less than 0.05. Statistical analyses were performed with STATA (Stata/IC 14.1, College Station, TX).

### Results

Among eligible clergy, the response rate was 60% (1005/1665) based on the American Association for Public Opinion Research definition IV.<sup>29</sup> Case weights accounted for different response rates among white (69%), black (43%), and Hispanic (43%) clergy.

### Sample Characteristics

Clergy and congregational characteristics are listed in Table 2. Most religious leaders surveyed identified with Christianity (98%).

### Views on End-of-Life Ethical Decisions

A large majority of religious leaders agreed that "sometimes there are circumstances where a patient should be allowed to die" (80%) versus doing "everything possible to extend the life of a patient" (16%).

A majority of religious leaders indicated (Table 1) that PAD/PAS is immoral no matter the circumstances (66%) and should not be legal (69%) in the U.S.; 6% were unsure on the moral question and 9% were unsure concerning legality; 28% disagreed that PAD/PAS is immoral no matter the circumstances; and 22% affirmed that PAD/PAS should be a legal right. A majority disagreed that choosing the time of death gives back dignity (68%), while 23% agreed. A smaller majority (59%) disagreed, while 32% agreed that PAD/PAS is moral if pain is unrelenting or uncontrollable. Regarding whether PAD/PAS should be classified

**Table 2**  
**National Characteristics of U.S. Religious Leaders and Associated Congregations (N = 1005)**

Clergy Characteristics and Responses	No./Total No.	%
<b>Clergy Demographic Information</b>		
Male gender	816/982	83.1
Age, mean (SD)	54.3	13.2
Self-reported race/ethnicity		
Asian	12/952	1.3
Black or African-American	104/952	10.9
American Indian or Alaskan Native	5/952	0.5
White or Caucasian	809/952	85.0
Other	34/952	3.6
Do you consider yourself Hispanic or Latino?	37/952	3.9
<b>Region</b>		
South	385/983	39.2
Mid-West	292/983	29.7
Northeast	146/983	14.8
West	160/983	16.3
<b>Current position</b>		
Senior, Solo, Interim Minister	919/974	94.4
Associate or Assistant Minister	28/974	2.9
Lay (nonordained) Minister	16/974	1.6
<b>Highest level of education</b>		
Noncollege graduate	51/952	5.3
Four-year bachelor's degree	109/952	11.5
Nonmasters certificate from seminary	118/952	12.4
Master's degree (e.g., Master of Divinity)	517/952	54.3
Doctor of Ministry	112/952	11.8
PhD	45/952	4.7
<b>Clergy religious information</b>		
Religious identity		
Buddhist	2/959	0.2
Orthodox	15/959	1.6
Jewish	5/959	0.6
Jehovah's Witness	1/959	0.1
Latter-Day Saints	19/959	2.0
Muslim	2/959	0.3
Roman Catholic	85/959	8.9
Protestant	781/959	81.5
Christian Other	39/959	4.0
Other	8/959	0.9
Christian tradition		
Fundamentalist	41/896	4.6
Evangelical	344/896	38.4
Pentecostal	97/896	10.8
Mainline	174/896	19.4
Liberal or progressive	109/896	12.1
Catholic	56/896	6.3
Orthodox	13/896	1.5
None apply	62/896	7.0
<b>Congregational information</b>		
Average annual household income in congregation		
<\$40,001	261/932	28.1
\$40,001–\$60,000	349/932	37.5
\$60,001–\$75,000	205/932	22.0
>\$75,001	116/932	12.5
Average congregational weekly attendance		
<51	153/953	16.0
51–100	289/953	30.3
101–250	297/953	31.1
251–500	106/953	11.1
>501	61/953	6.4

(Continued)

**Table 2**  
**Continued**

Clergy Characteristics and Responses	No./Total No.	%
Racial composition of congregation		
100% of congregation of one race	193/952	20.2
75%–99% of congregation of one race	650/952	68.2
50%–74% of congregation of one race	94/952	9.9
<50% of congregation of one race	15/952	1.6

as “suicide” if the patient is actively dying, 57% agreed while 34% disagreed.

*Predictors of Allowing to Die*

Table 3 shows multivariate predictors of religious leaders' likelihood of agreeing that there are circumstances where a patient should be allowed to die. Mainline and Liberal clergy (97%) were more likely to endorse “allowing to die” compared to other denominational affiliations such as Pentecostals (63%), Fundamentalist (77%), Evangelicals (81%), or Catholics (84%). In addition, black (60%) and Hispanic (58%) religious leaders were less likely than whites (88%) to agree in “allowing to die.” Religious leaders serving in congregations of higher income and with higher measures of distrust in the health care system were more likely to agree with “allowing to die”; similarly, clergy who believed that suffering holds spiritual purpose were less likely (AOR 0.59; 95% CI, 0.38–0.96, P = 0.03).

Figure 1 portrays clergy responses to “allowing to die” and legalization of PAD/PAS.

*Multivariate Predictors of Religious Leaders' Moral and Legal Opinions on PAD/PAS*

Table 4 provides associations of religious leaders' opinions that PAD/PAS is immoral and should be illegal.

*Demographics.* Other than gender, no other demographic factors including age, race, congregational income, U.S. region, or educational level were associated with opinions related to the morality or legality of PAD/PAS (Table 4). Analysis also examined clergy views comparing those serving in locations that have legalized PAD/PAS as of the time of the survey (OR, WA, MT, and VT) versus the 46 U.S. states where laws prohibit it, but results were comparable.

*Denominational Identity.* Affiliation was the strongest predictor of both moral and legal views among religious leaders (Table 4). Clergy in Mainline and

Table 3  
Demographic Predictors of U.S. Religious Leaders' Agreement That "Sometimes There Are Circumstances Where a Patient Should Be Allowed to Die"

Clergy Characteristics and Responses	"Sometimes Allow to Die" <sup>b</sup>	
	AOR (95% CI) <sup>c</sup>	P <sup>d</sup>
	N = 793	
Male gender	0.81 (0.60–1.08)	0.16
Age	1.01 (0.99–1.03)	0.36
Years in ministry	1.00 (0.98–1.02)	0.83
Race		
White	Reference	
Black/African American	0.24 (0.13–0.45)	<0.001
Hispanic	0.27 (0.12–0.59)	0.001
Other race	0.29 (0.08–1.11)	0.07
Higher congregational income	1.47 (1.16–1.86)	0.001
U.S. region		
Northeast	Reference	
Midwest	2.25 (1.04–4.89)	0.04
South	1.06 (0.54–2.10)	0.87
West	1.08 (0.48–2.40)	0.87
Educational level		
<Master of Divinity Degree	Reference	
≥Master of Divinity Degree	1.02 (0.62–1.68)	0.07
Denominational identity		
Mainline/Liberal	Reference	
Fundamentalist	0.16 (0.04–0.57)	<0.01
Evangelical	0.24 (0.11–0.56)	0.001
Pentecostal	0.15 (0.06–0.37)	<0.001
Roman Catholic	0.28 (0.09–0.90)	0.03
Eastern Orthodox	0.20 (0.03–1.44)	0.11
Latter-Day Saints (Mormon)	0.16 (0.02–1.72)	0.13
Other Christian	0.39 (0.14–1.09)	0.07
Other World Religions	0.09 (0.02–0.43)	<0.01
Medical knowledge and trust		
Higher EOL medical knowledge <sup>d</sup>	1.30 (0.83–2.05)	0.25
Distrust in the health care system <sup>e</sup>	1.12 (1.03–1.20)	<0.01
Religiously informed beliefs		
Life's value not tied to quality of life <sup>f</sup>	0.73 (0.45–1.17)	0.19
Pain & suffering have spiritual purpose <sup>g</sup>	0.59 (0.38–0.96)	0.03
Only God numbers our days <sup>h</sup>	0.68 (0.42–1.08)	0.10

AOR = adjusted odds ratio; EOL = end of life.

<sup>a</sup>Bold denotes statistical significance.

<sup>b</sup>"Sometimes Allow to Die" is defined as endorsement of "sometimes there are circumstances where a patient should be allowed to die" in response to the question: "Which comes closer to your view? In all circumstances, doctors and nurses should do everything possible to extend the life of a patient. Or, sometimes there are circumstances where a patient should be allowed to die."

<sup>c</sup>Multivariate regression analysis adjusted for gender, age, years in ministry, position, race, congregational median income, geographical region, congregational median income (position defined as 1 = Senior/Solo Minister, 0 = all else, geographical region defined as by U.S. census 1 = Northeast, 2 = Midwest, 3 = South and 4 = West. Race defined as 1 = white, 2 = black/African American, 3 = Hispanic, 4 = other).

<sup>d</sup>Higher end-of-life medical knowledge was based on a median split of a nine-item summed score where "lower EOL knowledge" was defined as a score of 5 or less and "higher EOL knowledge" was defined as a score of 6 or higher. Total scores ranged from 0 to 9.

<sup>e</sup>Distrust in health care is a continuous variable based on a four-item summed score with possible scores ranging from 4 to 20, with increasing scores meaning greater distrust.

<sup>f</sup>QOL does not measure life's value is measured by the question: "The value of a patient's life is not tied to the patient's quality of life." Response options dichotomized between "agree somewhat" and "agree strongly" versus "disagree somewhat," "disagree strongly," and "not sure."

<sup>g</sup>"Pain and suffering have purpose" is measured based on clergy agreement with a congregant stating: "I endure painful medical procedures because suffering is part of God's way of testing me." Agreement measured on a five-point scale from "not at all" to "completely." Agreement was defined as endorsement from "a little" to "completely," whereas disagreement was "not at all."

<sup>h</sup>"Only God numbers our days" is measured based on clergy indicating that it was a pastoral priority to "express that only God numbers our days" when visiting a congregant with less than six months to live. Participants were dichotomized if they answered "not at all," "a little," or "somewhat"; and considered to endorse the statement if they answered "quite a bit" or "completely."

Liberal denominations were most likely to believe PAD/PAS to be moral and should be legal (56%/47%), in contrast to Fundamentalists (14%/6%), Evangelicals (17%/11%), Pentecostals (11%/11%), and Catholics (14%/11%), who were considerably less likely to agree.

*Medical Knowledge and Distrust.* Clergy with higher scores in EOL medical knowledge were more likely than those who scored lower to conclude that PAD/PAS is immoral (AOR 1.51; 95% CI, 0.104–2.19,  $P = 0.03$ ). However, those with greater distrust in the health care system were less likely to oppose legalization (AOR

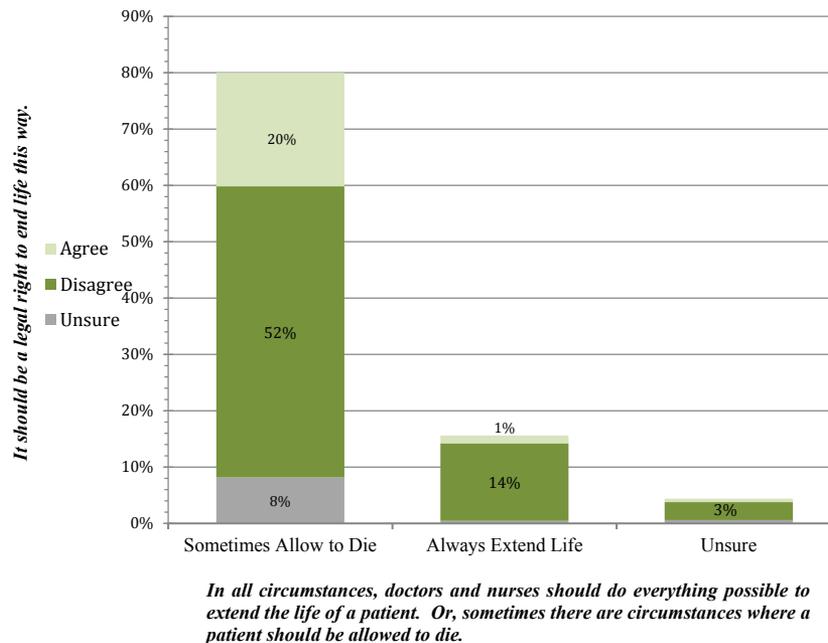


Fig. 1. Religious leaders' perspectives on "sometimes allow to die" and views of legalization of physician-assisted suicide (PAS)/physician aid in dying (PAD). The largest clergy group (52%) said "sometimes allow to die" but opposed PAD/PAS. A second group (20%) affirmed "sometimes allow to die" and favored PAD/PAS. A third group (14%) said "always extend life" and opposed PAD/PAS.

0.93; 95% CI, 0.87–0.99,  $P < 0.02$ ) compared to clergy who had more trust.

**Religiously Informed Beliefs.** Certain beliefs were associated with negative opinions toward PAD/PAS (Table 4). Religious leaders who agree that the value of a patient's life is not tied to the patient's quality of life" (59%) were more likely to view PAD/PAS as immoral (AOR 1.91; 95% CI, 1.34–2.71,  $P < 0.001$ ) and should be illegal (AOR 2.12; 95% CI, 0.1.49–3.03,  $P < 0.001$ ). Similarly, those who believe that suffering has spiritual purpose (27%) were more likely to hold that PAD/PAS does not give back dignity. Clergy who uphold the belief that "only God numbers our days" (82% "a little" to "completely"; 50% "quite a bit/completely") opposed the legality of PAD/PAS (AOR 2.60; 95% CI, 1.77–3.82,  $P < 0.001$ ).

#### *Multivariate Predictors Concerning Dignity, Unrelenting Pain, and Terminology*

As shown in Table 5, denominational identity and religiously informed beliefs consistently predicted religious leaders' responses to statements related to dignity, unrelenting and uncontrollable pain, and adoption of suicide terminology for PAD/PAS. Mainline/Liberals were most likely to agree that PAD/PAS gives back dignity (47%), was moral if pain is unrelenting/uncontrollable (58%), and should not be termed "suicide" (66%). Contrastingly, fewer Christian Fundamentalists, Pentecostals, Evangelicals, or Catholic leaders agreed that PAD/PAS gives dignity

(6%–11%), is morally warranted even with unrelenting/uncontrollable pain (14%–19%), and most believe "suicide" is a warranted term (68%–74%).

#### **Discussion**

This is the first study among a representative sample of U.S. clergy showing that a large majority believe that there are circumstances where the terminally ill patients should be allowed to die (80%). Furthermore, a minority of U.S. religious leaders endorse moral (28%) and legal (22%) rationales in favor of PAD/PAS. Although most reject that PAD/PAS offers patients' dignity, smaller majorities consider PAD/PAS immoral with unrelenting and uncontrollable pain (59%) or agree that PAD/PAS should be termed "suicide" when a patient is actively dying (57%). These findings suggest a level of diversity in how religion and religious leaders view PAD/PAS, including a notable minority who are proponents in certain circumstances. The strongest predictors related to opinions concerning PAD/PAS were not demographic factors (e.g., race or socioeconomic status), but denominational identity (Mainline/Liberals who were most favorable of PAD/PAS vs. most other major religious identities), and specific religious beliefs, followed by clergy understanding of medical knowledge, and their level of distrust in health care.

In comparison to the U.S. population, clergy are more accepting of "allowing to die" but also more circumspect pertaining to PAD/PAS. Notably, although 31% of the general population say "do

Table 4  
Demographic Predictors of U.S. Religious Leaders' Perspectives on Physician Aid in Dying/Physician-Assisted Suicide

Clergy Characteristics and Responses	Immoral No Matter Circumstances N = 826		Should Not Be Legal N = 825	
	AOR <sup>b</sup> (95% CI)	P <sup>c</sup>	AOR <sup>b</sup> (95% CI)	P <sup>c</sup>
Male gender	0.75 (0.58–0.97)	<b>0.03</b>	1.00 (0.74–1.36)	0.98
Age	0.99 (0.97–1.00)	0.13	0.99 (0.97–1.00)	0.12
Years in ministry	1.00 (0.98–1.01)	0.59	1.00 (0.98–1.01)	0.88
Race				
White	Reference		Reference	
Black/African American	1.09 (0.63–1.92)	0.74	0.95 (0.54–1.68)	0.86
Hispanic	0.66 (0.28–1.54)	0.34	0.53 (0.22–1.22)	0.14
Other race	2.77 (0.64–12.1)	0.17	2.83 (0.64–12.6)	0.17
Higher congregational income	1.03 (0.87–1.22)	0.68	0.95 (0.81–1.12)	0.60
U.S. region				
Northeast	Reference		Reference	
Midwest	1.10 (0.62–1.96)	0.74	1.16 (0.65–2.09)	0.60
South	0.64 (0.37–1.12)	0.12	0.79 (0.45–1.40)	0.43
West	0.64 (0.34–1.21)	0.17	0.77 (0.40–1.46)	0.42
Educational level				
< Master of Divinity Degree	Reference			
≥ Master of Divinity Degree	0.73 (0.47–1.14)	0.17	0.82 (0.52–1.28)	0.38
Denominational identity				
Mainline/Liberal	Reference		Reference	
Fundamentalist	5.53 (1.71–17.9)	< <b>0.01</b>	5.38 (1.67–17.3)	< <b>0.01</b>
Evangelical	3.45 (2.19–5.44)	< <b>0.001</b>	4.44 (2.77–7.09)	< <b>0.001</b>
Pentecostal	5.24 (2.61–10.6)	< <b>0.001</b>	5.96 (2.91–12.2)	< <b>0.001</b>
Roman Catholic	6.41 (2.73–15.1)	< <b>0.001</b>	8.92 (3.48–22.9)	< <b>0.001</b>
Eastern Orthodox	2.97 (0.30–29.0)	0.35	2.96 (0.30–29.1)	0.35
Latter-Day Saints (Mormon)	2.55 (0.41–15.6)	0.31	2.63 (0.44–15.9)	0.29
Other Christian	3.07 (1.65–5.71)	< <b>0.001</b>	2.47 (1.34–4.55)	< <b>0.01</b>
Other World Religions	0.62 (0.17–2.33)	0.48	1.15 (0.33–3.98)	0.82
Medical knowledge and trust				
Higher EOL medical knowledge <sup>c</sup>	1.51 (1.04–2.19)	<b>0.03</b>	1.04 (0.71–1.51)	0.86
Distrust in the health care system <sup>d</sup>	0.96 (0.90–1.03)	0.26	0.93 (0.87–0.99)	<b>0.02</b>
Religiously informed beliefs				
Life's value not tied to quality of life <sup>e</sup>	1.91 (1.34–2.71)	< <b>0.001</b>	2.12 (1.49–3.03)	< <b>0.001</b>
Pain and suffering have spiritual purpose <sup>f</sup>	1.44 (0.93–2.22)	0.11	1.34 (0.85–2.12)	0.21
Only God numbers our days <sup>g</sup>	2.93 (2.02–4.26)	< <b>0.001</b>	2.60 (1.77–3.82)	< <b>0.001</b>

AOR = adjusted odds ratio; EOL = end of life.

<sup>a</sup>Bold denotes statistical significance.

<sup>b</sup>Multivariate regression analysis adjusted for gender, age, years in ministry, race, congregational median income, geographical region, congregational median income (geographical region defined as by U.S. census 1 = Northeast, 2 = Midwest, 3 = South and 4 = West. Race defined as 1 = white, 2 = black/African American, 3 = Hispanic, 4 = other).

<sup>c</sup>Higher end-of-life medical knowledge was based on a median split of a nine-item summed score where "lower EOL knowledge" was defined as a score of 5 or less and "higher EOL knowledge" was defined as a score of 6 or higher. Total scores ranged from 0 to 9.

<sup>d</sup>Distrust in health care is a continuous variable based on a four-item summed score with possible scores ranging from 4 to 20, with increasing scores meaning greater distrust.

<sup>e</sup>QOL does not measure life's value was measured by the question: "The value of a patient's life is not tied to the patient's quality of life." Response options dichotomized between "agree somewhat" and "agree strongly" versus "disagree somewhat," "disagree strongly," and "not sure."

<sup>f</sup>"Pain and suffering have purpose" was measured based on clergy agreement with a congregant stating: "I endure painful medical procedures because suffering is part of God's way of testing me." Agreement measured on a five-point scale from "not at all" to "completely." Agreement was defined as endorsement from "a little" to "completely," whereas disagreement was "not at all."

<sup>g</sup>"Only God numbers our days" was measured based on clergy indicating that it was a pastoral priority to "Express that only God numbers our days" when visiting a congregant with less than six months to live. Participants were dichotomized if they answered "not at all," "a little," or "somewhat" and considered to endorse the statement if they answered "quite a bit" or "completely."

everything possible to save the patient's life,"<sup>13</sup> only 16% of clergy agree. Similarly, whereas 47% of the U.S. population approve of the legality of PAD/PAS,<sup>13</sup> only 22% of religious leaders approve. This suggests that many religious leaders perceive a middle ground between accepting circumstances of "allowing to die" while largely disfavoring PAD/PAS. Figure 1 combines response options between "allowing to die" and clergy opinions of legalization. The largest group comprises of religious leaders (52%) who agree that although there are circumstances when patients

should be allowed to die, PAD/PAS should not be legal. Fewer either combine perceptions such as "allowing to die" with PAD/PAS legalization (20%), or its opposite, "always extend life" and PAD/PAS illegalization (14%). Hence, a majority of clergy appear to maintain an ethical distinction that accepts circumstances for physicians to allow the terminally ill to die but do not include circumstances where a physician intends death.

In addition to religious leaders' viewpoints, this study aims to identify the underlying rationales driving

Table 5  
Predictors of Religious Leaders' Views Concerning PAD/PAS and Dignity, Pain, and Terminology

Clergy Characteristics and Responses	Choosing Time of Death Gives Back Dignity		Morally OK if Pain Is Unrelenting and Uncontrollable		It Is Suicide Even When Actively Dying	
	N = 812		N = 824		N = 818	
	AOR <sup>b</sup> (95% CI)	P <sup>a</sup>	AOR <sup>b</sup> (95% CI)	P <sup>a</sup>	AOR <sup>b</sup> (95% CI)	P <sup>a</sup>
Denominational identity						
Mainline/Liberal	Reference		Reference		Reference	
Fundamentalist	0.10 (0.01–0.82)	<b>0.03</b>	0.30 (0.11–0.84)	<b>0.02</b>	5.14 (1.83–14.4)	< <b>0.01</b>
Evangelical	0.30 (0.18–0.51)	< <b>0.001</b>	0.29 (0.19–0.46)	< <b>0.001</b>	2.43 (1.58–3.73)	< <b>0.001</b>
Pentecostal	0.18 (0.08–0.43)	< <b>0.001</b>	0.17 (0.08–0.35)	< <b>0.001</b>	2.89 (1.56–5.38)	<b>0.001</b>
Roman Catholic	0.25 (0.09–0.64)	< <b>0.01</b>	0.17 (0.07–0.41)	< <b>0.001</b>	3.28 (1.63–6.62)	<b>0.001</b>
Eastern Orthodox	—		0.40 (0.04–3.74)	0.42	—	
Latter-Day Saints (Mormon)	—		1.82 (0.35–9.42)	0.47	1.17 (0.22–6.13)	0.85
Other Christian	0.40 (0.20–0.81)	<b>0.01</b>	0.43 (0.24–0.78)	< <b>0.01</b>	2.24 (1.27–3.98)	< <b>0.01</b>
Other World Religions	1.27 (0.36–4.47)	0.71	1.44 (0.43–4.79)	0.55	1.27 (0.37–4.27)	0.70
Medical knowledge and trust						
Higher EOL medical knowledge <sup>c</sup>	1.44 (0.93–2.23)	0.10	0.79 (0.55–1.14)	0.21	1.27 (0.91–1.78)	0.16
Distrust in the health care system <sup>d</sup>	1.07 (0.99–1.15)	0.07	1.05 (0.99–1.12)	0.10	0.98 (0.92–1.04)	0.43
Religiously informed beliefs						
Life's value not tied to quality of life <sup>e</sup>	0.49 (0.33–0.73)	< <b>0.001</b>	0.54 (0.38–0.75)	< <b>0.001</b>	2.33 (1.69–3.21)	< <b>0.001</b>
Pain & suffering have spiritual purpose <sup>f</sup>	0.49 (0.28–0.87)	<b>0.02</b>	0.66 (0.43–1.02)	0.07	0.91 (0.62–1.32)	0.61
Only God numbers our days <sup>g</sup>	0.44 (0.28–0.68)	< <b>0.001</b>	0.53 (0.37–0.77)	<b>0.001</b>	1.80 (1.29–2.52)	< <b>0.01</b>

PAD = physician aid in dying; PAS = physician-assisted suicide; AOR = adjusted odds ratio; EOL = end of life.

<sup>a</sup>Bold denotes statistical significance.

<sup>b</sup>Multivariate regression analysis adjusted for gender, age, years in ministry, race, higher congregational income, educational level, geographical region, and all covariates listed in model.

<sup>c</sup>"Higher end-of-life medical knowledge" was based on a median split of a nine-item summed score where "lower EOL knowledge" was defined as a score of 5 or less and "higher EOL knowledge" was defined as a score of 6 or higher. Total scores ranged from 0 to 9.

<sup>d</sup>"Distrust in health care" is a continuous variable based on a four-item summed score with possible scores ranging from 4 to 20, with increasing scores meaning greater distrust.

<sup>e</sup>"QOL does not measure life's value" was measured by the question: "The value of a patient's life is not tied to the patient's quality of life." Response options dichotomized between "agree somewhat" and "agree strongly" versus "disagree somewhat," "disagree strongly," and "not sure."

<sup>f</sup>"Pain and suffering have purpose" was measured based on clergy agreement with a congregant stating: "I endure painful medical procedures because suffering is part of God's way of testing me." Agreement measured on a five-point scale from "not at all" to "completely." Agreement was defined as endorsement from "a little" to "completely," whereas disagreement was "not at all."

<sup>g</sup>"Only God numbers our days" was measured based on clergy indicating that it was a pastoral priority to "express that only God numbers our days" when visiting a congregant with less than six months to live. Participants were dichotomized if they answered "not at all," "a little," or "somewhat"; and considered to endorse the statement if they answered "quite a bit" or "completely."

perspectives on PAD/PAS. We hypothesized both nonreligious variables and three particular religious beliefs that would be relevant.

Regarding nonreligious influences, both medical knowledge and distrust in health care were associated with PAD/PAS in multivariate analysis. Religious leaders who have higher scores of EOL medical knowledge, a composite measure that included understanding about pain treatment and palliative care, were more likely than clergy with lower medical knowledge to believe that PAD/PAS was immoral no matter the circumstances (Table 4). One possible explanation is that as clergy understand palliative care's present-day abilities to mitigate pain within terminal illness, they may be more likely to conclude that PAD/PAS is morally inconsistent with their faith tradition. In addition, those reporting greater distrust in health care were more likely to accept "allowing to die" and legalization of PAD/PAS. This association is surprising, and reasons for this association are less clear. One hypothesis is that increasing trust in the health

care system is connected to a confidence in the medical profession's aim to both strive for the patient's health against all odds and alleviate suffering. Contrastingly, distrust in health care may result in a legal preference for all decision-making powers to reside exclusively with a terminally ill patient rather than on external authorities such as physicians, who are perceived to not always have the patient's sole interests in mind. Higher trust may correlate with a view that decision making need not rest on patients alone, whereas distrust may indicate that termination of one's life is a decision that should legally rest on the patient alone. Future study should include evaluation of EOL medical knowledge and health care distrust in other population samples.

Three particular religious beliefs were hypothesized to influence clergy opinions of PAD/PAS. First, a majority of clergy agreed (59%) that the value of a patient's life is not tied to the patient's quality of life. This was the only religious belief associated with all five PAD/PAS questions (Tables 4 and 5). This belief

suggests that because human life has intrinsic value, even burdensome circumstances at the EOL do not detract from life's sanctity. Nonetheless, this belief was not associated with doing everything possible to extend life (Table 3), corroborating that most clergy do not equate "allowing to die" with medical actions intending death. Second, a majority of religious leaders recognized a belief that "only God numbers our days," which was associated with dispositions opposing PAD/PAS (Tables 4 and 5). This belief highlights that the locus of authority in the timing of death rests solely in the prerogative of God, who superintends life and death. Within this rationale, PAD/PAS is interpreted as a human action that rejects divine authority by conferring the locus of authority on the individual patient to choose the timing of death. Clergy who did not endorse this statement may believe that God grants freedom of will including timing over one's own death. Third, a minority of clergy (27%) affirmed that physical pain and suffering has spiritual purpose, and this was associated with views of "always extend life" (Table 3) and opposition to choosing the time of death gives back dignity (Table 5). This view presupposes that although pain is an inherent evil and not to be sought,<sup>19</sup> within the burdensome experience of terminal illness, the virtue of patience within suffering holds promise of transcendent meaning and exemplifies human dignity despite illness' oppression. Although PAD/PAS discontinues a temporary trial of physical pain, it simultaneously severs the patient from the possibility of spiritual growth yielded within suffering at the EOL. Clergy who reject this view may perceive no redeemable or necessary meaning within pain and suffering. Hence, all three religious issues seem to hold a role in forming religious leaders' viewpoints of PAD/PAS.

Finally, larger religious and secular trends in the U.S. may also partially suggest (barring unforeseen changes in immigration, fertility patterns, etc.) how religion might influence future attitudes of PAD/PAS. Within the general population, there has been a continued decline among those who identify with Christianity, from 78% in 2007 down to 71% in 2014.<sup>3</sup> Correspondingly, those with no religious affiliation have increased, from 16% to 23% as of 2014.<sup>3</sup> An increasing number of Americans may thus form opinions concerning PAD/PAS without traditional religious influence. On the other hand, the Mainline and Liberal Protestant traditions have in the last few decades dramatically decreased in proportional size to the population (e.g., from 18%-2007 to 15%-2014) as well as in absolute numbers (from 41 to 36 million).<sup>3</sup> In contrast, conservative Protestant groups such as white and black Evangelicals continue to grow in absolute numbers, for example. Evangelicals expanded from 59.8 million in 2007 to 62.2 million in 2014.<sup>3</sup> If

these trends continue, it suggests that an increasing proportion of religious leaders will likely oppose its legalization or practice. However, it is unclear how those without religious affiliation will perceive the moral authority of clergy or if a greater proportion of clergy opposing PAD/PAS would affect future public viewpoints.

This study has important limitations to note. Although it seems likely that more basic religious identities and beliefs precede opinions regarding PAD/PAS, the study design demonstrates association only not causation. In addition, although religious leaders are likely adequate representatives for their respective traditions, it is not clear if religious lay people would answer similarly regarding particular religious beliefs or if they hold similar levels of medical knowledge or distrust in the health care system. The interplay between religious beliefs, medical knowledge, and trust needs to be evaluated in future studies within the general population and among patients facing life-threatening illness. Finally, because our sample is derived from U.S. congregations, data on views of religious leaders of other world religions are limited, although other studies suggest similar attitudes toward suicide more generally.<sup>17</sup>

### Conclusion

This study demonstrates that U.S. clergy agree that sometimes the terminally ill should be allowed to die, and although a notable minority of religious leaders are proponents of PAD/PAS, most do not agree in the morality or legalization of PAD/PAS. The depth and respectfulness of public discourse and deliberation concerning controversies in care at the EOL may be improved through the evaluation and discussion of the underlying reasons, including religious reasons, that inform opinions on these topics.<sup>7,8</sup>

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*Appendix*

# HARVARD UNIVERSITY



## The National Clergy Project On End-of-Life Care

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**WHO IS RECEIVING THE SURVEY?**

You are one of only a few ministers selected from around the United States to respond to these questions. Your view is important because you may be the only representative from your denomination or local area. This will take only **18-20 minutes** and is completely **confidential**.

**HOW IS THIS GOING TO BE USED?**

We believe medicine needs to be better informed by the views and experiences of clergy. Your responses will help the medical community better incorporate the views of clergy and faith communities. Results will be presented to schools in the U.S. (including seminaries you recommend). We will be working with many schools in order to create resources for future congregational leaders. Our goal is for patients and families facing difficult medical decisions to receive better spiritual and medical care. If you choose, you will also receive the final results of this project by email.

**WHO IS LEADING THE PROJECT?**

The survey is being conducted by Harvard researchers with funding from the National Institute of Health. Rev. Michael Balboni is a licensed minister and theologian leading the study in cooperation with Harvard University. You can contact Michael directly if you have questions or suggestions: [Michael\\_Balboni@dfci.harvard.edu](mailto:Michael_Balboni@dfci.harvard.edu) or 617-582-9186.

**HOW TO COMPLETE THE QUESTIONNAIRE?****MAIL**

1. Complete enclosed questionnaire
2. Return with self addressed stamped envelope

**INTERNET**

1. <https://www.surveymonkey.com/s/harvardclergy>
2. password:



**THANK YOU FOR YOUR HELP! \$10 Amazon Gift Card**

1. If you would like to complete the survey online, you may do so at the link on the front page. If not, please proceed:

**(MINISTER).** Are you a minister or clergy person in your congregation?

If “NO,” please give questionnaire to a recognized minister in your congregation.

<sub>1</sub> NO <sub>2</sub> YES

**(MINYEARS).** How many years have you been a clergy member?

**(POSITION).** How would you describe your current position as a congregational minister?

- <sub>1</sub> Senior minister  
<sub>2</sub> Solo minister  
<sub>3</sub> Associate minister  
<sub>5</sub> Assistant minister  
<sub>6</sub> Interim minister  
<sub>7</sub> Lay leader (only if your congregation does not ordain clergy)

### SECTION 1: VIEWS ON HEALTHCARE

**(SUPPORT95)** Which comes closer to your view? In all circumstances, doctors and nurses should do everything possible to extend the life of a patient. Or, sometimes there are circumstances where a patient should be allowed to die.

- <sub>1</sub> Always extend life  
<sub>2</sub> Sometimes let a patient die  
<sub>3</sub> Not sure

6. **(PAS)** We would like to ask you about what some call “physician aid in dying” and others call “physician-assisted suicide.” This refers to patients who doctors say cannot be cured by medicine and will likely die in less than six months. Some states allow patients to request from their doctor a dose of drugs intended to cause death. Some argue that this gives patients a level of choice within dying and avoids unnecessary suffering. Others see this as an act of killing because the drugs, not the disease, cause death. To what extent do you agree with the following statements?

Do you agree?	Disagree strongly	Disagree somewhat	Not Sure	Agree somewhat	Agree strongly
<b>(PAS1)</b> It is <u>immoral</u> no matter the circumstances.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>(PAS2)</b> It should be a <u>legal</u> right to end life this way.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>(PAS3)</b> Choosing the time of death gives back dignity.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>(PAS4)</b> It is morally OK if pain is unrelenting and uncontrollable.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>(PAS5)</b> It is suicide even when the patient is actively dying.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**(KNOW)** The following assess knowledge about medical issues at the end of life. Don’t worry if you are unsure of the answer. Just choose “Not sure.”

**(KNOW1).** Hospice care focuses on the comfort of patients who have:

- <sub>1</sub> 12-18 months to live <sub>2</sub> 6-12 months to live <sub>3</sub> 6 months or less <sub>4</sub> Not sure

**(KNOW2).** In the hospital, what do you think is the percentage of people who survive CPR when their heart or breathing stops?

- <sub>1</sub> 25% or less

- <sub>2</sub> 25-49%
- <sub>3</sub> 50-75%
- <sub>4</sub> 75% or more
- <sub>5</sub> Not sure

When a person is intubated or has a tube connected to a machine that helps them breathe:

	True	False	Not Sure
<b>(KNOW3)</b> They can talk.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
<b>(KNOW4)</b> They can eat with their mouth.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
<b>(KNOW5)</b> They are usually sedated (not conscious).	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>

**(KNOW6)** Which of the following statements about palliative care is true? Palliative care is...

- <sub>1</sub> Care that helps with symptoms (e.g., pain) of incurable disease
- <sub>2</sub> Care that helps patients live longer
- <sub>4</sub> Care that hastens death
- <sub>5</sub> Care that helps cure life-threatening illness
- <sub>6</sub> I'm not sure

Please decide whether each of the following statements about relieving pain from cancer are true or false:

	True	False	Not Sure
<b>(KNOW7)</b> There is little that can be done for cancer pain.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
<b>(KNOW8)</b> Cancer patients frequently become addicted to pain medications.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
<b>(KNOW9)</b> There are effective treatments if you have side effects to pain medicines.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>

Please indicate your agreement on the following statements regarding a patient who is extremely likely to die in the next 6 months no matter the medical care provided.

	Disagree strongly	Disagree somewhat	Not Sure	Agree somewhat	Agree strongly
<b>(KNOW10)</b> The value of a patient's life is not tied to the patient's quality of life.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>(KNOW11)</b> By entering hospice most patients will miss out on medical treatment that would be helpful to them.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>(KNOW12)</b> Stopping medical treatment violates my religious beliefs.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**(TRUST)** To what extent do you agree with the following statements regarding today's American Health care system?

	Not at all	A little	Somewhat	Quite a bit	Completely
<b>(TRUST1)</b> Patients receive high quality medical care from the Health care system.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>(TRUST2)</b> The health care system experiments on patients without them knowing.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>(TRUST3)</b> Patients get the same medical treatment from the healthcare system, no matter what the patient's race.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
<b>(TRUST4)</b> The health care system does its best to make patients' health better.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**SECTION 2: PASTORAL CARE AND A RECENT DEATH**

**(DEATH1).** Think back to the most recent person who died from an illness to whom you provided pastoral care. When did that person die?

Less than 3 months ago	3-6 months	6-12 months	A year or more	Not applicable (skip to section 3)
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**(DEATH2).** How long did you know the patient?

Less than 6 months ago	About a year	1-2 years	3 years or more
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**(DEATH3).** In your understanding, was the patient's goals of care near the end of his/her life to...

- <sub>1</sub> Extend life as long as possible, even if it causes increased pain  
<sub>2</sub> Relieve pain or discomfort as much as possible, even if it may cause some shortening of life  
<sub>3</sub> Not sure

**(DEATH4).** Please describe the spiritual care that you provided to the patient during his/her illness (**check all that apply**)

- <sub>A</sub> Talk about being at peace with God? <sub>F</sub> Read Scripture?  
<sub>B</sub> Talk about reconciliation with others? <sub>G</sub> Listen to spiritual questions or struggles?  
<sub>C</sub> Pray for physical healing? <sub>H</sub> Talk about heaven or life after death?  
<sub>D</sub> Help sort through medical decisions? <sub>I</sub> Help resolve family conflict?  
<sub>E</sub> Offer a religious ritual (e.g. communion)? <sub>J</sub> Other: \_\_\_\_\_

**(DEATH5).** What was the patient's approximate cause of death?

- <sub>A</sub> Cancer <sub>E</sub> Accident  
<sub>B</sub> Heart Disease (e.g. heart attack) <sub>F</sub> Lung infection (e.g. pneumonia, flu)  
<sub>C</sub> Stroke <sub>G</sub> Don't know or Other  
<sub>D</sub> Dementia <sub>H</sub> Other: \_\_\_\_\_

**(DEATH6).** Did you talk with the patient or family about:

- A  NO  YES Having a DNR Order (Do-Not-Resuscitate)  
B  NO  YES Going into hospice care  
C  NO  YES Stopping current medical treatment  
D  NO  YES Forgoing future medical treatment  
E  NO  YES Increasing medication to lessen pain

**(DEATH7).** Where did the patient die?

- <sub>A</sub> Hospice facility <sub>E</sub> Patient's home or other's home  
<sub>B</sub> Hospital ward <sub>F</sub> Hospice facility  
<sub>C</sub> Intensive Care Unit (ICU) <sub>G</sub> Don't know  
<sub>D</sub> Nursing home

(DEATH8). In the patient's last seven days of life, please estimate how many days the patient spent in each location.

Total number should equal 7	{	A	Hospice facility
	{	B	Hospital ward
	{	C	Intensive Care Unit (ICU)
	{	D	Patient's home or other's own home
	{	E	Hospice facility
	{	F	Nursing home
	{	G	Don't know

(DEATH9). In your opinion, on a scale of 0 to 10, rate the patient's overall level of physical and psychological distress?

0	1	2	3	4	5	6	7	8	9	10	
None Observed											Extremely Upset

**SECTION 3: RELIGIOUS BELIEFS AND INCURABLE DISEASE**

(RELBEL). Imagine visiting a congregational member with a cancer and doctors said that the patient was extremely likely to die in the next 6 months regardless of medical care provided. Consider the following statements a patient might make. To what extent do you agree with these statements made by the patient?

*How much do you agree with the patient's statement?*

<b>The patient says to you:</b>	<b>Not at all</b>	<b>A little</b>	<b>Somewhat</b>	<b>Quite a bit</b>	<b>Completely</b>
(RELBEL1) Because of my faith I don't need to think about future medical decisions (e.g., DNR order, use of breathing machines).	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(RELBEL2) I accept every medical treatment because my faith says to do everything I can to stay alive.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(RELBEL3) Having a do-not-resuscitate order is immoral.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(RELBEL4) I would be giving up on my faith if I stopped cancer treatment.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(RELBEL5) I believe that God will cure me of this cancer.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(RELBEL6) I endure painful medical procedures because suffering is part of God's way of testing me	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

(DEN). Please write the full name of your denomination (examples: "Non-denominational," "Southern Baptist," "Assembly of God," "Orthodox Jewish," "Muslim," etc.).

(SPCARE). When you visit a patient with cancer and no hope of medical cure and doctors say that the patient has less than six months to live, how important do you feel it is to talk about the following issues?

How important is it for you?

I WOULD:

Not at all   A little   Somewhat   Quite a bit   Completely

	Not at all	A little	Somewhat	Quite a bit	Completely
(SPCARE1). Talk about being at peace with God.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(SPCARE2). Talk about reconciling with others.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(SPCARE3). Pray for physical healing.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(SPCARE4). Talk about heaven and life after death.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(SPCARE5). Talk about illness as a test to endure.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(SPCARE6). Express that only God numbers our days	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(SPCARE7). Encourage treatment to extend life.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(SPCARE8). Ask if earthly affairs are taken care of (like a legal will).	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(SPCARE9). Encourage acceptance of dying as part of God's plan.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(SPCARE10). Suggest hospice as a good idea.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(SPCARE11). Ask who will make medical decisions if the patient can't	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(SPCARE12). Help families come to agreement on medical decisions.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

**SECTION 4: MORE ABOUT YOU**

(REL). Which religious category comes closest to describing you?

- 1 Buddhist
- 2 Christian
- 3 Hindu
- 4 Jewish
- 5 Muslim
- 6 Other: \_\_\_\_\_

(XTRAD) Which Christian tradition describes you ?

- 1 Roman Catholic
- 2 Orthodox
- 3 Protestant
- 4 Jehovah's Witness
- 5 Latter-Day Saints
- 6 None Apply: \_\_\_\_\_

(XIAN) If Christian which approach describes you?

- 1  Fundamentalist
- 2  Evangelical
- 3  Pentecostal
- 4  Mainline
- 5  Liberal or progressive
- 6  None apply

(AGE). Your age? \_\_\_\_\_ (in years)

(TRAIN). Have you ever received training in any of the following ways in ministering to the sick or dying?

	NO	YES		(TRAINRATE 1-5)		
				If "YES," How helpful was it?		
				A Little	Somewhat	Quite a bit
(TRAIN1)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Clinical Pastoral Education (CPE)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
(TRAIN2)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	A course from seminary or divinity school?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
(TRAIN3)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	On-line resource?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
(TRAIN4)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	One-on-one mentorship from another minister?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

(TRAINS) <sub>1</sub> <sub>2</sub> A book? | <sub>1</sub> <sub>2</sub> <sub>3</sub>

(TRAINFUT). Do you desire future training in the pastoral care of the sick or dying?  
<sub>1</sub> NO <sub>2</sub> YES

(LEGAL). Please respond to the following questions about yourself:

	NO	YES	
LEGAL1	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	Do you have a legal will?
LEGAL2	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	Have you legally appointed a "health care proxy" (a document that names a person you appoint to make medical decisions in case you are unable)?
LEGAL3	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	Would you like to receive information about wills and advanced care planning?

(THEO). Please indicate your agreement with the following theological statements:

	Disagree strongly	Disagree somewhat	Not Sure	Agree somewhat	Agree strongly
(THEO1) My religion's understanding of God is truer than other religions.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(THEO2) The Bible is the Word of God and is not mistaken in its statements and teachings.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(THEO3) Sometimes God disciplines or punishes using illness.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(THEO4) Sometimes illness is caused by evil forces like demons.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(THEO5) Sometimes God does not heal because of lack of faith.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(THEO6) Medicine is a gift from God.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(THEO7) Alternative therapies such as acupuncture or Reiki are consistent with my religious faith.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

(THEORATE). How would a typical person in your congregation describe your theology?  
<sub>1</sub> More on the conservative side  
<sub>2</sub> More on the progressive or liberal side  
<sub>3</sub> Right in the middle  
<sub>4</sub> Not sure

(RACE). What race or races do you consider yourself to be:  
**RACE\_ASI** <sub>1</sub> Asian  
**RACE\_AA** <sub>2</sub> Black or African-American  
**RACE\_INA** <sub>3</sub> American Indian or Alaskan Native  
**RACE\_W** <sub>4</sub> White or Caucasian  
**RACE\_O** <sub>5</sub> Other (please specify) \_\_\_\_\_

(RACE\_LAT). Do you consider yourself Hispanic or Latino?  
<sub>1</sub> NO <sub>2</sub> YES

(CITIZEN). Where were you born?  
CITIZEN1 United States CITIZEN\_O Other (specify country)?  
 CITIZEN\_NA \_\_\_\_\_



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**(SCH).** What is the **HIGHEST** level of training you have completed?

<input type="checkbox"/> <sub>1</sub> Did not graduate from High School:	<input type="checkbox"/> <sub>5</sub> Master's degree (examples: M.Div, MA)
<input type="checkbox"/> <sub>2</sub> High School Graduate	<input type="checkbox"/> <sub>6</sub> Doctor of Ministry (D.Min)
<input type="checkbox"/> <sub>3</sub> 4-year Bachelor's degree (example: BA, AB, BS)	<input type="checkbox"/> <sub>7</sub> Doctoral degree (Ph.D)
<input type="checkbox"/> <sub>4</sub> Certificate from seminary or denomination	

**(SEM).** What theological school do you today most closely identify with and respect?

\_\_\_\_\_ / \_\_\_\_\_  
**(SEM)** **(SEM\_LOC)**

**(VISIT).** In the last seven days how many hours did you spend visiting the sick and shut-ins? \_\_\_\_\_

**(PREACH).** In the last four weeks was the main topic in a sermon that you gave on:

	NO	YES
<b>(PREACH1)</b> Life after death?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
<b>(PREACH2)</b> Going through illness?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
<b>(PREACH3)</b> Dying well?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
<b>(PREACH4)</b> Caring for or visiting the sick?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

43. In 2014 has your congregation:

	NO	YES
<b>(CONG1)</b> Offered prayers for the sick in public meetings?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
<b>(CONG2)</b> Organized lay persons to visit the sick?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
<b>(CONG3)</b> Sent congregational leaders to pray with the sick?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
<b>(CONG4)</b> Held a public healing service?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
<b>(CONG5)</b> Commissioned medical professionals in medical work?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

**(MIRACLE).** In 2014 was any ill person in your congregation miraculously healed through prayer alone?

<sub>1</sub> NO     <sub>2</sub> YES    **(MIRACLE\_TYPE)** If "Yes," what were they healed from?  
 \_\_\_\_\_

**(PARNURSE).** Does your congregation have a parish nurse or faith community nurse?

<sub>1</sub> NO     <sub>2</sub> YES    **(PARANURSE\$)** If "Yes," are they paid by the congregation?  
 <sub>1</sub> NO     <sub>2</sub> YES

48. Please estimate the number of physicians and nurses who regularly participate in your congregation:

**(MD)** # of Physicians: \_\_\_\_\_    **(RN)** # of Nurses: \_\_\_\_\_

**(CONG\$\$).** Using your best guess, what is the average annual income for households in your congregation?

<input type="checkbox"/> \$0-\$25,000	<input type="checkbox"/> \$60,001-\$75,000
<input type="checkbox"/> \$25,001-\$40,000	<input type="checkbox"/> \$75,001 - \$100,000
<input type="checkbox"/> \$40,001-\$60,000	<input type="checkbox"/> \$100,001 or more

(CONGSIZE). How many people on average attend weekly worship services?

- under 50
- 51-100
- 101-250
- 251-500
- 501-750
- 751-1000
- 1001-1500
- 1501+

(CONGRACE). What is the approximate percentage of each racial group in your congregation? (total percent=100%)

<b>Asian (ASI)</b>	<b>Black or African-American (AA)</b>	<b>American Indian or Alaskan Native (IN)</b>	<b>White (W)</b>	<b>Other (O)</b>
<input type="text"/> %	<input type="text"/> %	<input type="text"/> %	<input type="text"/> %	<input type="text"/> %

THANK YOU! If you would be willing to participate in additional work related to the national clergy survey on end-of-life issues, please provide us contact information. Results of this survey will also be emailed to you in early 2015.

Phone number (\_\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_  
*[Please print for readability]*

**Please write any additional suggestions or feedback.**