Original Article

U.S. Clergy Religious Values and Relationships to End-of-Life Discussions and Care

Michael J. Balboni, PhD, ThM, MDiv, Adam Sullivan, PhD, Andrea C. Enzinger, MD, Patrick T. Smith, MDiv, PhD, Christine Mitchell, MDiv, John R. Peteet, MD, James A. Tulsky, MD, Tyler VanderWeele, PhD, and Tracy A. Balboni, MD, MPH

Department of Psychosocial Oncology and Palliative Care (M.J.B., J.R.P., J.A.T., T.A.B.), Dana-Farber Cancer Institute; Initiative on Health, Religion, and Spirituality within Harvard (M.J.B., T.V., T.A.B.), Boston, Massachusetts, USA; Department of Biostatistics (A.S.), Brown University, Providence, Rhode Island; Departments of Medical Oncology and Palliative Care (A.C.E.), Dana-Farber Cancer Institute, Boston; Harvard Medical School Center for Bioethics (P.T.S.), Boston; Gordon-Conwell Theological Seminary (P.T.S.), S. Hamilton; Department of Social and Behavioral Health (C.M.), Harvard School of Public Health, Boston; Division of Palliative Medicine (J.A.T.), Department of Medicine, Brigham and Women's Hospital, Boston; Department of Epidemiology and Department of Biostatistics (T.V.), Harvard School of Public Health, Boston; Department of Radiation Oncology (T.A.B.), Dana-Farber Cancer Institute; and Brigham and Women's Hospital (T.A.B.), Boston, Massachusetts, USA

Abstract

Context. Although clergy interact with approximately half of U.S. patients facing end-of-life medical decisions, little is known about clergy-congregant interactions or clergy influence on end-of-life decisions.

Objective. The objective was to conduct a nationally representative survey of clergy beliefs and practices.

Methods. A mailed survey to a nationally representative sample of clergy completed in March 2015 with 1005 of 1665 responding (60% response rate). The primary predictor variable was clergy religious values about end-of-life medical decisions, which measured belief in miracles, the sanctity of life, trust in divine control, and redemptive suffering. Outcome variables included clergy-congregant end-of-life medical conversations and congregant receipt of hospice and intensive care unit (ICU) care in the final week of life.

Results. Most U.S. clergy are Christian (98%) and affirm religious values despite a congregant's terminal diagnosis. Endorsement included God performing a miracle (86%), pursuing treatment because of the sanctity of life (54%), postponement of medical decisions because God is in control (28%), and enduring painful treatment because of redemptive suffering (27%). Life-prolonging religious values in end-of-life medical decisions were associated with fewer clergy-congregant conversations about considering hospice (adjusted odds ratio [AOR], 0.58; 95% CI 0.42−0.80), $P < 0.0001$), stopping treatment (AOR 0.58, 95% CI 0.41−0.84, $P = 0.003$), and forgoing future treatment (AOR 0.50, 95% CI 0.36−0.71, $P < 0.001$) but not associated with congregant receipt of hospice or ICU care. Clergy with lower medical knowledge were less likely to have certain end-of-life conversations. The absence of a clergy-congregant hospice discussion was associated with less hospice (AOR 0.45; 95% CI 0.29−0.66, $P < 0.001$) and more ICU care (AOR 1.67; 95% CI 1.14−2.50, $P < 0.01$) in the final week of life.

Conclusion. American clergy hold religious values concerning end-of-life medical decisions, which appear to decrease end-of-life discussions. Clergy end-of-life education may enable better quality end-of-life care for religious patients. J Pain Symptom Manage 2017;■:■−■. © *2017 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.*

Key Words

End of life, religion, spirituality, clergy, hospice, palliative care, religious communities

Address correspondence to: Michael J. Balboni, PhD, ThM, MDiv, LW-666A, Dana-Farber Cancer Institute, 375 Longwood Avenue, Boston, MA 02120, USA. E-mail: michael_balboni@dfci.harvard.edu

Accepted for publication: December 29, 2016.

0885-3924/$ - see front matter
http://dx.doi.org/10.1016/j.jpainsymman.2016.12.346

Introduction

Approximately three-quarters of terminally ill patients indicate that religion is important to their illness experience,[1,2] particularly among blacks and Latinos.[3–5] Studies suggest that patients' religious beliefs can conflict with the acceptance of palliative care[3,6] and may lead to greater medical interventions at the end of life, especially among minority patients.[7–10] Religious communities also influence patients' end-of-life (EOL) decisions and care.[2,6,11–13] In a prospective cohort study, cancer patients reporting high spiritual support from religious communities were less likely to receive hospice, more likely to receive aggressive EOL measures, and more likely to die in an intensive care unit (ICU).[14] In contrast, when patients report high spiritual support from their medical teams, they have a *reduced* chance of aggressive interventions and *greater* adoption of hospice care.[14,15] The contrast in outcomes of religious community vs. medical team spiritual care suggests that the particular religious content that is emphasized can influence medical decisions in opposing directions at the EOL. Spiritual care at the EOL is a variegated construct that may depend on *what* is provided and by *whom*.

Whereas approximately 10,000 hospital chaplains in the U.S. offer spiritual care,[16] 330,000–350,000 community clergy leaders[17,18] provide the large majority of patient spiritual support. Studies suggest that clergy spend a half-day per week visiting the ill[19] and perhaps more so among those in certain U.S. ethnic and minority groups.[20] Additionally, approximately half of all terminally ill patients in the U.S. receive some EOL spiritual care from clergy.[2] Community clergy are recognized as principal providers of spiritual care within national palliative care guidelines,[21,22] but little is known concerning the degree of influence that clergy hold in EOL medical decisions, their impact on patient outcomes, or the religious rationales pervading these decisions.[14]

The National Clergy Project on End-of-Life Care is a National Cancer Institute-funded cross-sectional study of a random sample of U.S. community clergy designed to measure the prevalence of clergy beliefs and practices on EOL care. The study included two primary aims: 1) to describe the prevalence of U.S. clergy religious EOL values and frequency of clergy-congregant EOL conversations and 2) to describe associations between clergy religious EOL values, clergy-congregant EOL conversations, and congregants' receipt of hospice and ICU care in the final week of life.

Methods

Sample

From August 2014 to March 2015, a confidential, self-administered, eight-page questionnaire in English and Spanish 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.

Primary Measures

Demographics. Clergy age, race, gender, geographic location, educational level, congregational position, and religious/denominational affiliations were collected by database or self-report. Clergy estimated congregational size and average congregational annual household income. Clergy indicated previous EOL educational experiences and estimated number of hours per week visiting the ill and aged.

Life-Prolonging Religious Values. All participants rated their level of agreement with six statements that assessed religious values applied to end-of-life decisions by terminally ill congregants. An expert panel identified potential religious beliefs that may be related to life-prolonging medical decisions within largely Christian patient populations. These beliefs included assessment of four theological domains: belief in a miracle (resulting in the certainty of cure), sanctity of life (resulting in accepting all medical procedures and rejection of do-not-resuscitate [DNR] orders), trust in divine control (resulting in deferral of future medical decisions and not stopping treatment), and redemptive suffering (resulting in acceptance of painful medical procedures). Item ratings were summed to generate an overall religious values score (possible score 6–30).

Clergy-Congregant Conversations. Clergy were asked to identify their congregant who had most recently died and to whom they had provided pastoral care. They reported when the congregant had died and the length of their congregant-clergy relationship. Clergy reported if they had discussed medical decisions with the patient or family, including going into hospice care, DNR orders, stopping current or forgoing future treatment, or increasing pain medications.

Hospice and ICU Care in the Final Week of Life. Clergy reported on the congregant's location during the final week of life including hospice and ICU care.

Secondary Measures

Extending Life. Clergy responded to the previously developed question assessing views regarding treatment at the end of life: "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?"[23]

Pastoral Priorities During Cancer. Clergy rated on a five-point scale how important it was that pastoral care to terminally ill patients include: discussing life after death, encouraging acceptance of dying as part of God's plan, asking if earthly affairs were in order, and praying for physical healing.

End-of-Life Medical Knowledge. Clergy completed a nine-item questionnaire on knowledge of hospice, palliative, and ICU care, generating a composite score on EOL knowledge (possible scores 4–20).

Distrust in Health Care. Clergy completed a modified four-item validated questionnaire assessing level of distrust in the health care system,[24] generating a composite score on distrust of health care (possible scores 0–9).

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 linear and logistic regression analyses were used to identify predictors of clergy discussion of EOL medical decisions, receipt of hospice in the final week of life, and ICU care in the final week regarding the most recent congregational member who died under pastoral care. Multivariable models adjusted for clergy gender, age, years in ministry, position, race, geographical region, and congregational median income.

All reported *P*-values are two sided and considered significant when less than 0.05. Statistical analyses were performed with STATA (Stata/MP 13.1; College Station, TX).

Results

Among eligible clergy, the response rate was 60% (1005 of 1665) based on the American Association for Public Opinion Research definition IV.[25] Case weights accounted for different response rates among white (69%), black (43%), and Hispanic (43%) clergy.

Sample Characteristics

Most community clergy identify with Christian denominations (98%). These findings are similar to other national representative congregational studies with higher response rates.[26,27] Clergy demographic characteristics, receipt of previous EOL education, and information concerning the most recent clergy-congregant interaction are listed in Table 1. Most (92%) clergy-congregant EOL interactions included conversations about medical decisions, with the most common being discussions about entering hospice care (56%).

Religious End-of-Life Values

Table 2 provides clergy responses to EOL attitudes and religious EOL values. Many clergy expressed at least some ("a little" to "completely") affirmation of life-prolonging religious values including God performing a miracle despite a terminal diagnosis (86%), the importance of pursuing treatment because of the sanctity of life (54%), postponement of medical decisions because God is in control (28%), and redemptive suffering justifying the endurance of painful medical procedures (27%).

Clergy also highlighted the religious leader's role in discussing life after death (81%), encouraging acceptance of dying as part of God's plan (66%), asking if earthly affairs were in order (60%), and praying for physical healing (60%). Fewer prioritized encouraging treatment to extend life (21%) or believed that doctors should "always extend life" (16%).

In multivariate analysis, clergy who were more likely to affirm life-prolonging religious values included black ministers, those serving congregations of lower income, and evangelical and Pentecostals (Table 3). Religious values were associated with affirming the global EOL treatment value to "always extend life," but they were not associated with clergy EOL medical knowledge or distrust in the health care system.

Predictors of Clergy-Congregant End-of-Life Medical Discussions

Clergy endorsement of religious EOL values—as a composite score and as single-item measures—was associated with not having EOL discussions with congregants who most recently died (Table 4). As a composite score, clergy that endorsed life-prolonging religious values were approximately half as likely as other clergy to have a discussion concerning entering hospice (adjusted odds ratio [AOR] 0.58; 95% CI 0.42–0.80, $P < 0.0001$), stopping treatment (AOR 0.58, 95% CI 0.41–0.84, $P = 0.003$), or foregoing treatment (AOR 0.50, 95% CI 0.36–0.71, $P < 0.001$) after adjustment for clergy demographic and vocational characteristics. Each of the individual life-prolonging religious values was significantly associated with not having a conversation about stopping treatment or foregoing treatment, and individual items

Table 1
Characteristics of U.S. Clergy, Associated Congregations, and Most Recent Congregant Who Died ($n = 1005$)

Respondent Characteristics	No./Total No. (%)
Clergy demographic information	
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)
Region	
South	385/983 (39.2)
Midwest	292/983 (29.7)
Northeast	146/983 (14.8)
West	160/983 (16.3)
Current position	
Senior, Solo, Interim Minister	919/974 (94.4)
Associate or Assistant Minister	28/974 (2.9)
Lay (non-ordained) Minister	16/974 (1.6)
Highest level of education	
Non-college graduate	51/952 (5.3)
Four-year Bachelor's degree	109/952 (11.5)
Non-Master's certificate from seminary	118/952 (12.4)
Master's degree (e.g., Master of Divinity)	517/952 (54.3)
Doctor of Ministry (D.Min.)	112/952 (11.8)
Ph.D.	45/952 (4.7)
Clergy religious information	
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	97/986 (10.8)
Mainline	174/986 (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)
Congregational information	
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	107/953 (11.2)
>501	107/953 (11.2)
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)
End-of-life education and practices	
Average hours per week visiting the sick and shut-ins	4.44 hours (4.02, 4.84)
Prior training in ministering to the sick and dying	
Clinical pastoral education	434/909 (47.8)
A seminary course	672/915 (73.4)
Online resource	275/880 (31.3)
One-on-one mentorship from another minister	644/903 (71.3)
A book	755/905 (83.4)
Desire future training in care of the sick and dying	540/939 (57.5)
Pastoral care provided to congregant who most recently died from illness	
Time between congregant's death and survey report	
<3 Months	438/952 (46.1)
3–6 Months	193/952 (20.3)
6–12 Months	148/952 (15.5)
A year or more	142/952 (15.0)
Length of clergy-congregant relationship	
<6 Months	90/919 (9.8)
About a year	62/919 (6.7)
1–2 Yrs	128/919 (13.9)
3 Years or more	639/919 (69.5)
Types of clergy-patient medical discussions	
Having a do-not-resuscitate order	392/892 (44.0)
Going into hospice care	498/893 (55.8)
Stopping current medical treatment	279/880 (31.7)
Forgoing future medical treatment	336/879 (38.2)
Increasing medication to lessen pain	385/880 (43.8)
Any medical discussion above	713/776 (92.4)
Cause of death	
Cancer	437/803 (54.4)
Heart disease	119/803 (14.8)
Lung Infection	81/803 (10.1)
Stroke	59/803 (7.3)
Dementia	54/803 (6.7)
Not sure	41/803 (5.1)
Accident	12/803 (1.5)

were significant or trended toward significance for not having a conversation about entering hospice. The attitude to "always extend life" was associated with fewer of all types of EOL conversations; low medical knowledge was associated with fewer conversations about stopping current treatment, forgoing future treatment, and having a DNR order. In contrast, greater distrust in health care was associated with more conversations about forgoing future treatment, having a DNR order, and increasing pain medication.

Table 2

Clergy Attitudes and Priorities on Life-Prolonging Religious Values in End-of-Life Care and Views on Always Extending Life ($n = 1005$)

Question and Response	No./Total No. (%)
Life-prolonging religious values in end-of-life care: Imagine visiting a congregational member with a cancer and doctors said that the patient was extremely likely to die in the next six 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?	
1. Because of my faith I do not need to think about future medical decisions (e.g., DNR order, use of breathing machines).	684/952 (71.8)
Not at all	186/952 (19.6)
A little or somewhat	82/952 (8.6)
Quite a bit or completely	
2. I accept every medical treatment because my faith says to do everything I can to stay alive.	438/949 (46.1)
Not at all	344/949 (36.3)
A little or somewhat	167/949 (17.6)
Quite a bit or completely	
3. Having a do-not-resuscitate order is immoral.	845/948 (89.2)
Not at all	59/948 (6.3)
A little or somewhat	44/948 (4.6)
Quite a bit or completely	
4. I would be giving up on my faith if I stopped cancer treatment.	827/949 (87.1)
Not at all	89/949 (9.4)
A little or somewhat	33/949 (3.5)
Quite a bit or completely	
5. I believe that God will cure me of this cancer.	135/949 (14.2)
Not at all	515/949 (54.3)
A little or somewhat	299/949 (31.5)
Quite a bit or completely	
6. I endure painful medical procedures because suffering is part of God's way of testing me.	695/949 (73.3)
Not at all	205/949 (21.6)
A little or somewhat	49/949 (5.1)
Quite a bit or completely	
Pastoral priorities in end-of-life care: 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?	
Resisting death	
Pray for physical healing	
Not at all	42/944 (4.4)
A little or somewhat	336/944 (35.6)
Quite a bit or completely	566/944 (60.0)
Encourage treatment to extend life	
Not at all	272/944 (28.8)
A little or somewhat	477/944 (50.5)
Quite a bit or completely	195/944 (20.7)
Accepting death	
Encourage acceptance of dying as part of God's plan	
Not at all	98/943 (10.4)
A little or somewhat	313/943 (33.2)
Quite a bit or completely	532/943 (56.4)
Ask if earthly affairs have been taken care of	
Not at all	54/944 (5.7)
A little or somewhat	321/944 (34.0)
Quite a bit or completely	569/944 (60.3)
Talk about heaven and life after death	
Not at all	17/934 (1.8)
A little or somewhat	164/934 (17.6)
Quite a bit or completely	753/934 (80.6)
Suggest hospice as a good idea	
Not at all	56/941 (6.0)
A little or somewhat	254/941 (26.9)
Quite a bit or completely	631/941 (66.9)
Always extend life: 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)

DNR = do-not-resuscitate.

Table 3
Demographic Predictors of Life-Prolonging Religious Values Among U.S. Clergy on End-of-Life Medical Decisions

	High Endorsement of Life-Prolonging Religious Values in Medical Decisions[a]				
	$n = 718$				
Demographic Predictors	%	OR	P[f]	AOR[b] (95% CI)	P[f]
Male gender	88	4.02	<0.001	2.25 (0.98–5.17)	0.06
Age		1.00	0.4	1.00 (0.98–1.01)	0.80
Race					
White	87	1.0		1.0	
Black	7	5.72	<0.001	3.60 (1.73–7.42)	**0.001**
Hispanic/Latino	4	4.0	0.001	2.10 (0.82–7.42)	0.12
Other	2	1.60	0.41	1.71 (0.46–6.33)	0.42
Senior/Solo position	94	1.37	0.36	1.35 (0.54–3.41)	0.52
Educational level			<0.001		0.59
Less than Master's degree	26	2.09		1.14 (0.72–1.80)	
Master's degree or more	74	1.0		1.0	
U.S. region					
Northeast	15	1.0		1.0	
Midwest	31	1.33	0.27	1.28 (0.69–2.37)	0.43
South	39	2.05	0.004	1.39 (0.77–2.51)	0.28
West	16	1.60	0.11	1.32 (0.67–2.60)	0.42
Congregational income		0.63	<0.001	0.83 (0.69–0.98)	**0.03**
Spiritual tradition					
Liberal/mainline	32	1.0		1.0	
Evangelical/fundamentalist	41	4.40	<0.001	2.56 (1.56–4.23)	**<0.001**
Pentecostal	9	15.7	<0.001	6.48 (2.93–14.3)	**<0.001**
Roman Catholic	8	2.40	0.01	1.7 (0.82–3.43)	0.15
Orthodox	1	3.20	0.09	2.07 (0.34–12.6)	0.43
Non-Christian	2	2.23	0.21	1.51 (0.43–5.30)	0.52
Latter-day Saints	2	1.96	0.28	1.38 (0.34–5.56)	0.65
None apply	5	3.45	0.001	1.67 (0.67–4.52)	0.27
Always extend life[c]	13	10.2	<0.001	5.85 (2.20–10.7)	**<0.001**
Lower EOL knowledge[d]	34	1.84	<0.001	1.4 (0.99–2.10)	0.06
Distrust in health care[e]	50	0.85	0.30	0.88 (0.61–1.28)	0.51

AOR = adjusted odds ratio; EOL = end of life; OR = odds ratio.
[a]High religious end-of-life values was based on a median split of the six-item summed score where "High" is a score of 11 or more and "Low" is a score of less than 11. Total scores ranged from 6 to 30.
[b]Multivariate regression analysis adjusted for gender, age, years in ministry, position, race, 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.).
[c]Defined as endorsement of "always extend life" 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."
[d]Lower 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.
[e]Distrust in health care based on a median split of four-item summed score where "Distrust" was defined as a score of 9 or less and "Trust" was defined as a score of 10 or higher. Total scores ranged from 4 to 19.
[f]Bold denotes statistical significance.

Predictors of Hospice and ICU Care in the Final Week of Life

Clergy's life-prolonging religious beliefs about EOL care were largely unrelated to actual EOL care reportedly received by the deceased congregant (Table 5). In multivariate analysis, clergy who affirmed congregant trust in divine control leading to deferral of medical decisions was the only religious value predicting ICU utilization in the final week of life (AOR 1.79, 95% CI 1.16–2.75, $P = 0.008$). Other religious EOL values were not significantly associated with congregants' receipt of hospice or of ICU care, neither were attitudes to always extend life, EOL medical knowledge, or trust in the health care system. In contrast, a lack of clergy-congregant discussions about hospice were strongly associated with decreased hospice use (AOR 0.45, 95% CI 0.29–0.66, $P < 0.001$) and increased ICU use (AOR 1.67, 95% CI 1.14–2.50, $P = 0.01$).

Discussion

This is the first report among a representative sample of U.S. clergy indicating that clergy hold religious values related to patients' medical considerations at the EOL. These values include a majority of clergy who support belief in a divine miracle in the face of terminal diagnosis and in the sanctity of life requiring pursuit of all means to stay alive. Just over a quarter of clergy affirmed at least some belief that faith justifies deferring future medical decisions and that divine testing supports endurance of painful EOL medical procedures. These life-prolonging religious values are prevalent among many clergy (Table 2), especially

Table 4

Predictors of U.S. Clergy End-of-Life Discussions With Congregants Facing Life-Threatening Illness

		Clergy Indicated a Discussion With Congregant Who Most Recently Died From Illness Concerning:									
		Going Into Hospice		Stopping Current Treatment		Forgoing Future Treatment		Having a Do-Not-Resuscitate Order		Increasing Pain Medication	
		$n = 721$		$n = 748$		$n = 777$		$n = 755$		$n = 710$	
	%	AOR[a] (95% CI)	P[f]	AOR[a] (95% CI)	P[f]	AOR[a] (95% CI)	P[f]	AOR[a] (95% CI)	P[f]	AOR[a] (95% CI)	P[f]
Clergy life-prolonging religious values											
High Endorsement of Life-Prolonging Religious Values Composite Score[b]	40	0.58 (0.42–0.80)	0.001	0.58 (0.41–0.84)	0.003	0.50 (0.36–0.71)	<0.001	0.96 (0.69–1.33)	0.78	0.76 (0.55–1.06)	0.11
1. Because of my faith I do not need to think about future medical decisions	26	0.83 (0.58–1.18)	0.29	0.55 (0.37–0.83)	0.004	0.55 (0.37–0.81)	0.003	0.82 (0.57–1.17)	0.27	0.95 (0.66–1.35)	0.76
2. I accept every medical treatment because my faith says to do everything I can to stay alive	54	0.67 (0.49–0.92)	**0.01**	0.50 (0.36–0.70)	<**0.001**	0.50 (0.36–0.69)	<**0.001**	0.81 (0.59–1.11)	0.19	0.75 (0.55–1.03)	0.08
3. Having a do-not-resuscitate order is immoral	9	0.61 (0.36–1.03)	0.06	0.47 (0.24–0.92)	**0.03**	0.52 (0.29–0.95)	**0.03**	0.54 (0.31–0.94)	**0.03**	0.83 (0.47–1.44)	0.50
4. I would be giving up on my faith if I stopped cancer treatment	13	0.70 (0.45–1.10)	0.13	0.53 (0.30–0.93)	**0.03**	0.40 (0.23–0.70)	**0.001**	0.66 (0.41–1.06)	0.08	0.51 (0.31–0.85)	**0.01**
5. I believe that God will cure me of this cancer	86	0.65 (0.42–1.01)	0.06	0.59 (0.37–0.92)	**0.02**	0.52 (0.34–0.81)	**0.003**	0.86 (0.56–1.32)	0.48	1.18 (0.76–1.83)	0.46
6. I endure painful medical procedures because suffering is part of God's way of testing me	26	0.71 (0.51–1.01)	0.06	0.67 (0.46–0.99)	**0.04**	0.56 (0.39–0.82)	**0.002**	0.69 (0.48–0.98)	**0.04**	0.69 (0.48–0.98)	**0.04**
Clergy EOL attitudes, knowledge, and distrust in health care											
Always extend life[c]	14	0.54 (0.35–0.83)	**0.01**	0.35 (0.19–0.65)	**0.001**	0.30 (0.17–0.54)	<**0.001**	0.50 (0.31–0.82)	**0.01**	0.68 (0.43–1.07)	0.10
Low Medical Knowledge[d]	33	0.80 (0.57–1.09)	0.17	0.58 (0.41–0.85)	**0.004**	0.80 (0.57–1.11)	0.18	0.70 (0.51–0.97)	**0.03**	0.80 (0.57–1.11)	0.18
Distrust in health care[e]	51	1.31 (0.96–1.78)	0.09	1.34 (0.97–1.87)	0.80	1.42 (1.04–1.95)	**0.03**	1.45 (1.09–2.03)	**0.01**	1.63 (1.18–2.23)	**0.003**

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

[a]Multivariate regression analysis adjusted for gender, age, years in ministry, position, race, 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.).

[b]High religious end-of-life values was based on a median split of the six-item summed score where "High" is a score of 11 or more and "Low" is a score of less than 11. Total scores ranged from 6 to 30.

[c]Defined as endorsement of "always extend life" 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."

[d]Lower 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.

[e]Distrust in health care based on a median split of 4-item summed score where "Distrust" was defined as a score of 9 or less and "Trust" was defined as a score of 10 or higher. Total scores ranged from 4 to 19.

[f]Bold denotes statistical significance.

Table 5
Clergy Predictors of Patient Receipt of Hospice and ICU Care in the Final Week of Life

	Receipt of Any Hospice in Final Week of Life		Receipt of Any ICU Care in Final Week of Life	
	$n = 714$		$n = 714$	
Clergy life-prolonging religious values	AOR[a] (95% CI)	P[f]	AOR[a] (95% CI)	P[f]
High endorsement of life-prolonging religious values composite score[b]	1.36 (0.90–2.03)	0.14	1.21 (0.80–1.81)	0.36
Because of my faith I do not need to think about future medical decisions	1.44 (0.92–2.25)	0.11	**1.79 (1.16–2.75)**	**0.008**
I accept every medical treatment because my faith says to do everything I can to stay alive	1.25 (0.84–1.85)	0.27	0.97 (0.65–1.45)	0.89
Having a do-not-resuscitate order is immoral	1.02 (0.49–2.12)	0.95	1.50 (0.78–2.91)	0.23
I would be giving up on my faith if I stopped cancer treatment	1.23 (0.68–2.20)	0.49	1.46 (0.85–2.50)	0.17
I believe that God will cure me of this cancer	0.99 (0.58–1.69)	0.97	1.08 (0.61–1.88)	0.80
I endure painful medical procedures because suffering is part of God's way of testing me	1.15 (0.74–1.78)	0.54	0.80 (0.50–1.27)	0.33
Lack of clergy-congregant EOL medical discussions				
Did not discuss going to hospice	**0.45 (0.29–0.66)**	**<0.001**	**1.67 (1.14–2.50)**	**0.01**
Did not discuss having a do-not-resuscitate order	0.94 (0.60–1.32)	0.56	0.85 (0.58–1.25)	0.41
Did not discuss stopping current treatment	0.94 (0.63–1.43)	0.80	0.74 (0.50–1.11)	0.14
Did not discuss forgoing future treatment	1.16 (0.78–1.72)	0.45	0.81 (0.55–1.20)	0.29
Did not discuss increasing pain medication	0.83 (0.56–1.22)	0.33	0.86 (0.58–1.28)	0.47
Clergy attitudes and understanding of EOL care				
Always extend life[c]	0.83 (0.46–1.51)	0.54	1.50 (0.90–2.52)	0.12
Low medical knowledge[d]	0.96 (0.38–1.49)	0.87	1.11 (0.73–1.69)	0.62
Distrust in health care[e]	1.17 (0.78–1.74)	0.46	0.97 (0.66–1.44)	0.90

[a]Multivariate regression analysis adjusted for gender, age, years in ministry, position, race, 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.).
[b]High religious end-of-life values was based on a median split of the six-item summed score where "High" is a score of 11 or more and "Low" is a score of less than 11. Total scores ranged from 6 to 30.
[c]Defined as endorsement of "always extend life" 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."
[d]Lower 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.
[e]Distrust in health care based on a median split of four-item summed score where "Distrust" was defined as a score of 9 or less and "Trust" was defined as a score of 10 or higher. Total scores ranged from 4 to 19.
[f]Bold denotes statistical significance.

religious leaders who are black, evangelical, Pentecostal, and those serving congregations of lower income (Table 3). The study also provides evidence that clergy actively engage in conversations (92%) with dying congregants about medical decisions, including discussions about hospice, DNR orders, pain medications, and stopping or foregoing treatment. However, initial evidence suggests that clergy who were more likely to endorse life-prolonging religious values were both more likely to agree that doctors should always extend life (Table 3) and less likely to report having an EOL conversation with a dying congregant (Table 4). Notably, in the absence of a clergy-congregant hospice discussion there was a twofold reduced odds of receiving hospice care and a near twofold increased odds of receiving ICU care in the last week of life (Table 5). These preliminary findings imply that clergy hold a role in how some congregants approach EOL medical decisions and call for the medical community to engage and partner with community religious leaders in end-of-life care.

In a previous study, terminally ill patients highly supported by religious communities were prospectively found to be less likely to receive hospice care and more likely to receive ICU care at the EOL.[14] Our study findings suggest that possible mechanisms operating within these associations may include certain religious values about EOL care, which in turn were more generally associated with fewer discussions concerning decisions about comfort-focused medical care, e.g., hospice and DNR orders (Table 4). Specific mechanisms of how religious values influence medical decisions are unclear although one hypothesis is that shared clergy-congregant religious values may render more comfort-focused medical decisions, even at the EOL, as inconsistent. For example, advance care planning decisions may be considered by patients as either taking matters "out of God's hands"[28] or may be deemed so complex that they are best left in God's control, resulting in deferral of decisions.[29] Additionally, entering hospice may be perceived as a decision that undermines one's faith in a God who may intervene with a miracle through medical treatment. Our findings suggest that although very few clergy are categorically opposed to comfort-focused EOL care, many are nevertheless willing to support religiously reasoned medical decisions that appear to lead to aggressive interventions.

Although medical professionals must uphold and honor such religious values as part of culturally and religiously competent medical care, a key issue remains:

Are clergy desiring or intending these aggressive medical outcomes for their congregants? In addressing this question, most religious leaders prioritized a spiritual care approach within EOL care that includes acceptance of and preparation for death as a faithful religious approach to dying (Table 2). These include discussing life after death, encouraging acceptance of death, suggesting hospice care, and inquiring as to whether earthly affairs were in order. Only small proportions endorsed always extending life or indicating that DNR orders were immoral. Thus, many clergy appear to hold religious values that may lead to decisions for aggressive interventions within terminal illness simultaneous with religious values focused on acceptance and preparation for dying. Endorsement of accepting and preparing for death implies that clergy may not desire or intend only life-prolonging religious values to inform EOL decision making for their congregants.

Why, then, may life-prolonging religious values be more emphasized than values undergirding acceptance of terminal illness or preparation for death? One potential reason may be a lack of understanding of the medical realities surrounding terminal illness, which may stem from insufficient training as part of pastoral education. Although most clergy reported having received training in ministering to the ill (Table 1), few clergy education programs specifically address the intersection of religious values and medical issues at the EOL. Supporting this hypothesis, clergy with lower EOL medical knowledge trended to significance with life-prolonging values (Table 3) and were less likely to engage in certain EOL conversations (Table 4). Likewise, in a study where clergy identified the characteristics of a good death, most clergy did not recognize that some medical settings are more, and others less, compatible with the characteristics identified with a good death.[30] This highlights the importance of a deeper understanding of EOL medical care, e.g., how location of death influences patient and family well-being,[31] enabling clergy to apply their religious values within the context of the medical realities of the EOL experience. Furthermore, clergy may not adequately recognize or foresee how certain pastoral actions in terminal illness—such as praying for a cure or refraining from discussion about hospice—are influencing terminally ill congregants and facilitating the unintended consequence of more aggressive care at life's end. Additional training and increased EOL knowledge could better enable clergy to apply the full spectrum of religious values informing spiritual care to their dying congregants, thereby facilitating an approach to medical decisions that balances beliefs in miracles, the sanctity of life, that God is in control, and redemptive suffering, along with pastoral perspectives that already acknowledge the importance of preparing congregants for dying and death. Perhaps most important among future interventions and training would be enabling discussions on hospice care where that is fitting with clergy-congregant religious values at the EOL. Such training can aid in orienting clergy to the limits of medical interventions and to how clergy can play key roles in helping patients and families faithfully navigate the complexities of religious values and EOL medical decision making.

This study also identified characteristics of U.S. clergy who were more likely to hold to life-prolonging religious values. Clergy who are black, serving in congregations with lower income, and who identify as evangelical, fundamentalist, and Pentecostal were more likely to endorse life-prolonging religious values (Table 3). These groups together represent a majority of U.S. religious congregations and are growing in total number of adherents.[23] In the general population, 50% attend religious services at least once a month,[32] 30%−41% describe themselves as evangelical or born again,[23,32] and approximately half of U.S. terminally ill patients are visited by community clergy.[2] Likewise, religiousness tends to increase with age[33] and in the setting of serious illness.[34] These larger patterns imply that clergy and religious perspectives will continue to hold a significant role in shaping the values of many patients facing life-threatening illness, including EOL medical decisions.

Although these data suggest that clergy's religious values are related to EOL conversations with congregants and that such conversations in turn influence patient EOL care, there are important limitations to note. First, as seen in other well-done national congregational studies, most clergy in the U.S. are Christian.[26,27] Because our study design did not oversample non-Christian congregations, these results are restricted to Christian viewpoints and the 70% of the US population that currently identifies with Christianity.[23] Also, our study is limited by cross-sectional data collection. Although it seems more likely that clergy beliefs precede the experience of the most recent death of a congregant for whom they cared, influence in the other direction is possible. Additionally, some reported associations in our study could reflect other unmeasured determinant variables in the population, of which clergy are representative. Clergy-congregant EOL discussions and congregant outcomes in the last week of life are also based on clergy self-report and are not independently verifiable.

Conclusion

In summary, this study demonstrates that U.S. clergy frequently endorse life-prolonging religious values including prayer for a miracle within advanced illness and acceptance of every medical treatment because of life's sanctity. Endorsement of life-prolonging religious

values was associated with less clergy-congregant conversations about comfort-focused care, such as hospice care. Fewer conversations about hospice between clergy and their terminally ill congregants was associated in clergy reports with lower congregant hospice use and higher ICU care in congregants' last week of life. Community-centered and holistic approaches to improving quality of end-of-life care may need to include additional training and engagement of clergy, especially within advanced illness.

Disclosures and Acknowledgments

The study was made possible by the National Cancer Institute #CA156732, The Issachar Fund, and supporters of the Initiative on Health, Religion, and Spirituality within Harvard University. The authors thank the following scholars for their input and suggestions regarding the survey methods and instruments: Mark Chaves, PhD (Duke University) and Jonathan Imber, PhD (Wellesley College). Research staff provided critical support including Rebecca Quinones, MTS, and Sarah Novereske, BS. The authors declare no conflicts of interest.

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