

Clergy Views on a Good Versus a Poor Death: Ministry to the Terminally Ill

Virginia T. LeBaron, PhD, APRN, FAANP,¹ Amanda Cooke, MD,³ Jonathan Resmini, MDiv,⁴
Alexander Garinther, BS,⁵ Vinca Chow, MD,⁶ Rebecca Quiñones, MTS,² Sarah Noveroske, BA,²
Andrew Baccari, BA,⁷ Patrick T. Smith, PhD,⁸ John Peteet, MD,²
Tracy A. Balboni, MD, MPH,² and Michael J. Balboni, PhD²

Abstract

Background: Clergy are often important sources of guidance for patients and family members making medical decisions at the end-of-life (EOL). Previous research revealed spiritual support by religious communities led to more aggressive care at the EOL, particularly among minority patients. Understanding this phenomenon is important to help address disparities in EOL care.

Objective: The study objective was to explore and describe clergy perspectives regarding “good” versus “poor” death within the participant’s spiritual tradition.

Methods: This was a qualitative, descriptive study. Community clergy from various spiritual backgrounds, geographical locations within the United States, and races/ethnicities were recruited. Participants included 35 clergy who participated in one-on-one interviews ($N=14$) and two focus groups ($N=21$). Semistructured interviews explored clergy viewpoints on factors related to a “good death.” Principles of grounded theory were used to identify a final set of themes and subthemes.

Results: A good death was characterized by wholeness and certainty and emphasized being in relationship with God. Conversely, a “poor death” was characterized by separation, doubt, and isolation. Clergy identified four primary determinants of good versus poor death: dignity, preparedness, physical suffering, and community. Participants expressed appreciation for contextual factors that affect the death experience; some described a “middle death,” or one that integrates both positive and negative elements. Location of death was not viewed as a significant contributing factor.

Conclusions: Understanding clergy perspectives regarding quality of death can provide important insights to help improve EOL care, particularly for patients highly engaged with faith communities. These findings can inform initiatives to foster productive relationships between clergy, clinicians, and congregants and reduce health disparities.

Introduction

RELIGION SIGNIFICANTLY INFLUENCES end-of-life (EOL) care in the United States, as approximately two-thirds of terminally ill patients report religion is very important and more than half are visited by community clergy.^{1,2} Religious communities appear influential in patients’ medical decisions and utilization, especially among racial minorities.^{3,4}

An intriguing finding from a previous multisite, prospective study of terminally ill cancer patients (the Coping with Cancer study) was that spiritual support by clergy and religious communities led to more aggressive care at the end-of-life (EOL).^{1,3–6} Specifically, African American and Latino patients who reported being well supported spiritually by their religious communities were less likely to enter hospice, more likely to receive aggressive medical treatment, and

¹University of Virginia School of Nursing, Charlottesville, Virginia.

²Dana-Farber Cancer Institute, Harvard Cancer Center, Boston, Massachusetts.

³Beth Israel Deaconess Medical Center, Boston, Massachusetts.

⁴Boston University School of Theology, Boston, Massachusetts.

⁵Boston College, Boston, Massachusetts.

⁶Brigham & Women’s Hospital, Boston, Massachusetts.

⁷Harvard Divinity School, Boston, Massachusetts.

⁸Gordon-Conwell Theological Seminary, Boston, Massachusetts.

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more likely to die in the intensive care unit (ICU).⁴ A clearer understanding of this phenomenon is critical, as greater medical care intensity at EOL can result in poorer patient and caregiver quality of life, and significantly impact the death experience.^{7,8} Hence, this follow-up study investigates community clergy perspectives (with an emphasis on Christian-affiliated Black clergy) regarding the quality of the death experience within the participant's spiritual tradition. The broad goal of this research is to improve partnerships among clergy, congregants, and health care providers, and to meet calls to improve care for the dying.⁹

Methods

Sample

Eligible participants included ministers and pastors (i.e., clergy) currently serving in a community congregation. The project preidentified clergy characteristics (race, theological orientation, educational level, and denomination) hypothesized to be associated with more intensive medical utilization at EOL; this led to the selection of a predominantly Christian and theologically conservative sample. Within each geographical region of the United States a key informant with access to local community clergy identified and recruited potential participants in consultation with the principal investigator (MB). Clergy were interviewed in one-on-one interviews ($N=14$) or focus groups ($N=21$) within five U.S. states (California, Illinois, Massachusetts, New York, and Texas). All participants provided informed consent per protocols approved by the Harvard/Dana-Farber Cancer Center institutional review board.

Protocol

Clergy were enrolled between November 2013 and September 2014. Semistructured interview guides were developed by an interdisciplinary panel of medical educators and religious experts. Interviews were organized around a core set of open-ended questions exploring the viewpoints of clergy regarding death (see Table 1). Research staff underwent a half-day training session in interview methods and received ongoing supervisory guidance from MB ensuring homogeneous interview procedures. Two interviews were conducted in Spanish and transcripts were translated into English. Interviews and focus groups ranged between 45 and

120 minutes in duration and participants received a \$25 gift card as compensation.

Qualitative methodology

The protocol's methodology¹⁰ includes triangulated analysis and involvement of multidisciplinary perspectives (nursing, medicine, sociology, theology), maximizing the transferability of interview data.¹⁰ Interviews were audiotaped, transcribed verbatim, and participants were deidentified. Following principles of grounded theory,¹¹ a set of themes and subthemes inductively emerged through an iterative process of constant comparison. Transcripts were analyzed independently by all authors, and the final coding scheme was then derived through a collaborative process of building consensus among all authors. After finalizing the codes, transcripts were then reanalyzed using NVivo 10 (QSR International, Doncaster, Victoria, Australia) by AB and SN, each coding independently based on derived categories and themes.

Results

Demographic information is provided in Table 2. Consistent with the intent of this study, minority clergy were oversampled (including a focus group comprised of all Black clergy) in order to deepen understanding of minority clergy views on death and medical utilization.

Primary themes and key determinants of the death experience

Participant responses focused on perceived qualities and characteristics of the death experience from both their individual perspective as clergy ministering to patients and families with unique circumstances and needs, and within the larger context of their respective faith tradition. The death experience was interpreted broadly by participants and involved preparing for death, the physical and spiritual act of dying, and the bereavement period. Clergy discussed a good death as one characterized by wholeness and certainty; whereas a poor death was characterized by separation, doubt, and isolation. Quality of death was described as involving both positive and negative elements, and location of death was discussed in terms of its potential influence on the death experience.

Characteristics of good and poor dying

Participants frequently described a factor they felt contributed to wholeness and certainty (e.g., a "good" death) and then discussed its absence, or opposite, as consistent with contributing to separation, doubt, and isolation (e.g., a "poor" death):

A good death, I say a "holy death" [you] will be surrounded by family and friends in an atmosphere of prayer in which you have had the chance to reconcile with people ... and you are at peace with God ... and, of course, in the physical part, if you have your medicine that helps you with the pain, that is part of it as well. We can take any one of those elements and remove them, and then you have a poor death (CM1217).

Clergy identified four core factors contributing to either wholeness and certainty (a good death) or separation, doubt, and isolation (a poor death): dignity, preparedness, physical

TABLE 1. SEMISTRUCTURED INTERVIEW GUIDE USED FOR ONE-ON-ONE INTERVIEWS AND FOCUS GROUPS

How would you characterize a "good death" and a "poor death"?
[Interviewer to remain silent after asking question until interviewee responds. Repeat question if asked.]
Prompt 1: Please share any memorable examples of what you would consider a good or poor death.
Prompt 2: Does where someone dies affect your thinking about a good or poor death? For example, does the location of death such as the person's home, or hospice, or a nursing home, or medicalized settings, such as the hospital or intensive care unit, affect whether it was a good or poor death?

TABLE 2. SAMPLE CHARACTERISTICS OF CLERGY PARTICIPATING IN QUALITATIVE INTERVIEWS

<i>Clergy characteristics</i>	N=35	%
Male gender	32	91.4
Average years serving as clergy (N=32) ^c	20 years	
Geographical location		
Northeast	11	31.4
Southwest	11	31.4
Midwest	10	28.6
West	3	8.6
Race (N=32)		
White	16	50.0
Black	14	43.7
Asian	2	6.3
Ethnicity (N=30)		
Latino/Hispanic	2	6.7
Religious tradition		
Protestant ^a	27	77.1
Roman Catholic	4	11.4
Eastern Orthodox	1	2.9
Jewish	2	5.7
Other (Center for Spiritual Living)	1	2.9
Educational level (N=34)		
Below master's degree	6	17.7
Master's degree (e.g., M.Div.)	15	44.1
Doctoral degree	13	38.2
Theological orientation (N=32)		
Theologically "conservative" ^b	21	65.6
Theologically "liberal"	11	34.4
Received prior training in end-of-life care (N=31)	23	74.1

^aProtestant clergy identified with the following Protestant denominations: Assemblies of God (2), Baptist (5), Congregational (4), Episcopalian (1), Methodist (3), Nondenominational (6), Presbyterian (1), and Seventh-Day Adventist (1). Four Protestant clergy did not disclose specific denominational information.

^bClergy were categorized as theologically conservative if they agreed with the following statement: "My religious tradition's Holy Book is perfect because it is the Word of God."

^cNot all participants responded to every question.

suffering, and community. These factors are discussed below in the context of how they contribute to a good versus poor death, supported by illustrative quotes (see Table 3).

Dignity

Clergy described dignity in terms of the theological ideal that each person is made in the image of God. Therefore, maintaining the patient's physical appearance and function, as well as recognizing and honoring the patient's unique personhood, were seen as necessary to uphold this theological ideal. Quality of death was threatened when a patient's dignity was compromised.

Respecting a patient's autonomy was seen as a critical component to ensure dignity at the EOL, and patients with less autonomy were viewed as having a more negative death experience. Autonomy was exercised when the wishes of patients were honored in terms of preferences related to treatment options, location of care, appointment of a health care proxy, and desires regarding interventions such as cardiopulmonary resuscitation or intubation. Autonomy

extended not only to medical choices at the EOL, but also to the extent of spiritual support desired by the patient. Clergy recognized their role in honoring a patient's autonomy at the EOL by actively listening and supporting a patient's choices.

Preparedness

A second key determinant of the death experience was preparedness. Clergy discussed this sense of readiness in multiple, interconnected domains—spiritual/emotional, social, and practical. Adequate preparation depended on acceptance of death (at least to some degree) by the patient and family. Without acceptance, preparation within any domain was impeded, rendering dying more difficult.

Spiritual and emotional preparedness. Spiritual preparedness was seen in the larger theological framework of experiencing peace with God and possessing a confident and hopeful outlook about the afterlife. Rituals that facilitated spiritual preparedness included prayer, baptism, saying confession and seeking forgiveness, making a final commitment of faith, receiving religious rites and sacraments before death, and having the opportunity "to get right with God" (focus group participant, MJB 1030FG-C). Patients unable to achieve these goals—either due to circumstances surrounding their death or an unwillingness or inability to spiritually prepare—were seen to be at high risk for a poor death. Clergy viewed abrupt and untimely deaths that precluded adequate emotional preparation, such as traumatic or violent accidents, sudden medical events, suicides, or the death of a young person, as especially difficult and sad deaths. Spiritual and emotional preparedness, when achieved, were viewed as bringing harmony and overall well-being to the patient and family/caregiving unit.

Social preparedness. Social preparedness manifested as reconciliation between individuals and the resolution of relational conflict. Clergy discussed many examples from their own ministry of how anger, regret, and conflict threatened social preparedness. One participant recalled witnessing two adult children physically fighting at a patient's funeral; another remembered a dying congregant whose lack of regard for others created great strife: "This was an angry, determined person who just said, 'I am not going to let this [illness] get me. ... I don't care who I hurt.'" (MB107).

Practical preparedness. Patients who put their domestic and financial affairs in order, and were able to leave a positive legacy for survivors, demonstrated practical preparedness. Ideally, this sort of practical preparation was handled proactively before a crisis, and involved deliberate and concrete actions, such as executing a will to ensure peaceful distribution of one's assets.

Physical suffering

Clergy were unanimous in their shared opinion that the quality of the death experience depended on the amount of pain and distressing symptoms a patient experienced. Even if a patient was spiritually ready, unrelieved physical pain was viewed to have the potential to transform the EOL experience into a highly negative event. No participant discussed physical suffering as having an inherently positive value.

TABLE 3. SUMMARY OF PRIMARY THEMES AND KEY DETERMINANTS AFFECTING THE QUALITY OF THE DEATH EXPERIENCE^a

	Good death Primary theme: Wholeness and certainty	Poor death Primary theme: Separation, doubt, isolation
Dignity	<i>I think what is important in dying is that a person is able to die with dignity. ... Being able to carry out some of the wishes of the dying, so if that person says, 'I would like to die at home, I want to be at home'—giving them that opportunity to do so is very important—dying with that dignity. (MJB1030FG-E)</i> <i>I think to me a good death is a death with dignity. And also at peace in the person's own heart. (TC1030)</i> <i>A good death is one in which a person's wishes were honored. (MJB1030FG-B)</i> <i>I said, 'Do you want to accept Him [Jesus]?' He [the patient] said, 'Yes.' I said, 'Okay, let me call your family. ... I'm not going to do anything if you personally don't feel a desire that you want to do it.' (MB1021)</i>	<i>[A poor death] is the pain and the deterioration of the health makes the person feel like subhuman or even look like subhuman because of the sickness ... the clothing poorly changed and smell. (TC1030)</i> <i>I knew of a patient who did not want to be resuscitated but the family wanted him to be resuscitated. It was not a good sight. For me a poor death is one who dies and his or her wishes are not honored. (MJB1030FG-B)</i> <i>A poor death would be a death in which a person's freedom of choice and self-determination has been removed. (RT0819)</i> <i>But if a dying patient feels out of control, his life is in the hands of physicians, nurses, other people, hospital administrator, then it is not a good death. (TC1030)</i>
Preparedness	<i>[A good death is] where the person is absolutely confident of what's happening on the other side, where there's no doubts, no uncertainty, where they are sure where they're going. (MB107)</i> <i>When they put in the balance the things that they did and on the other side the things that they could not accomplish or even the wrong things, at the end they are satisfied. (JP414)</i> <i>For me the difference is a good death is when you are prepared; a poor death is when you are unprepared. (MJB1030FG-K)</i> <i>They recognize that this is just another stage, a portal, to something else that God has prepared for us theologically. (MB129)</i> <i>I would characterize a good death ... when people have an opportunity to perhaps reconcile relationships. (MJB1030FG-D)</i> <i>A good death is also [when] they prepare themselves to leave their legacy behind. (MB129)</i> <i>A "good death" is when the person, at various stages in his or her life, put their house in order; they decided who is going to get what; not making that decision at the time when that transition occurs. (MJB1030FG-G)</i> <i>I would say a good death is one that helps you to be reconciled and at peace with yourself, with your past life, with God and with others; so to be at peace in those three areas, with your own life, with God and with others. (CM1217)</i> <i>Then after explaining [to] them some principles and truths about scripture most of them enter into this sphere of peace. Then I ask them again, 'How do you feel now?' And many times I have heard something like, 'I am ready. I am ready.' (JP414)</i> <i>I've witnessed people who have had a good death when they have understood ... that there was definitely going to be closure to life and had an understanding that they need to be prepared for that end. (MB129)</i>	<i>There's another one ... which I considered a bad death, was someone who would not accept it under any circumstances—"I will not die"—even though it was inevitable. And fought the system ... irritated physicians by more and more demands. 'I want alternative treatment and if you can't get me alternative treatment I'll find someone who will.' And ended up going to other places around the world for alternative medicine. ... There's a lot of self-created angst and anxiety by the absolute refusal to accept the death. (MB107)</i> <i>Dying unrepented or not reconciled with God and angry or hating, that would be a terrible and very poor death. (CM1217)</i> <i>There was this Mexican dancer—he was dancing with his dance team ... and a pole fell and hit him dead. And now his family is devastated. 'Our young son is dead and he is twenty-something years old.' I don't know if I would call it a bad death, but it is something that feels abrupt; it feels sad in a different kind of way. (MJB1030FG-A)</i> <i>I would say that the opposite would be reflected for a bad death which is fear. Disorientated, in a way, they don't know where they are going. Many questions, many, many questions to themselves; to God. (JP414)</i> <i>A bad death would be without Jesus. It's a bad one because you're distancing, because you can be saved by accepting Jesus as your savior, so if you do not accept Jesus and you die, according to the Bible, you're lost. (MB1021)</i> <i>Poor death is a lot of fear. Anxiety about what is happening after death, the final destiny. (TC1030)</i> <i>They had a stroke and lasted about a week, but they died with a lot of unresolved issues. I don't think that is the way it should happen. (MB129)</i> <i>It really depends on whether you believe this or not. If you don't believe in this afterlife you are actually going to the termination of your life. It is a terrible process and you will be scared to death. (TC115)</i>

(continued)

TABLE 3 (CONTINUED)

	Good death Primary theme: Wholeness and certainty	Poor death Primary theme: Separation, doubt, isolation
Physical suffering	A 'good one' is one where there's no pain. There are certain people who have cancer and because of the location of it there just isn't any discomfort at all. (MB107) A good death is one in which ... pain is minimized to the degree that is possible. (CG124) In the physical part, if you have your medicine that helps you with the pain, that is part of it [a good death] as well. (CM1217) A good death would be one in which there was a minimum of physical suffering. (RT0819)	The pain was awful. His heart was good; his soul was good, but physically it was very, very difficult. So that's a bad death. (MB107) A poor death is one who suffers physically with cancer and morphine or whatever drugs are used that do not ease the situation. (MJB1030FG-C) A poor death would be one that is in constant pain and the pain cannot be eradicated and the quality of life is awful. (MJG1030FG-I) Let's begin with the physical part—if you are really suffering a lot and that could be avoided, that could be a poor death. (CM1217)
Community	A good death is certainly having those who you love most around you. (MB1030) I firmly believe that we are born into a community and we die in a community. ... We ought to be able to really celebrate a person's life ... and we do that in community as well. (MJB1030FG-H) Comfortable, cared for, loved, family and friends, community around together. (CM1219) A good death, I say a 'holy death' will be surrounded by family and friends. (CM1217)	[A bad death is] one in which the individual dies alone and isolated, filled with regret or bitterness. That death is often characterized by anger or fear. There is a clinging to the anger. (CG124) She pretty much locked herself in hospital room. ... She'd been on staff at this church for 30 years, and wouldn't allow anyone else to come in to see her and spent most of her time weeping. That was a poor death. (MB107) [I have seen] people that are very isolated because of some of the choices they've lived. They have basically broken ties. ... I think that is probably the worst. (CG124) So a poor death would be one ... where the support around the individual is not there in any which way, whether it is hospice or family or friends or whatever. (MJB1030FG-I)

^aParticipant identifiers that include "FG" indicate that the quote is from a focus group; the letter afterwards indicates the specific speaker.

Community

Being surrounded by "loving and concerned persons" (CG124) was articulated by multiple participants as a key factor in determining the quality of the death experience. The absence of a loving community was seen as a potential source of destructive and painful emotions. A loving community was defined broadly, and expanded beyond a patient's immediate family circle; some clergy made a special point to mention that a loving community can include the team of hospice or hospital health care providers. Clergy described an effective and positive community as supportive of the patient's autonomy and easily accessible to the patient and family.

Middle death

Some clergy resisted labeling a death as good or poor and described more nuanced experiences at the EOL. Clergy who verbalized this sentiment acknowledged that the death experience involves both positive and negative elements that occur along a continuum and cannot be easily dichotomized. One participant described this, fittingly, as "middle death" (MB107) (see Table 4).

In describing middle deaths there was a strong sense of conditionality and a recognition that the quality of the death experience was inherently subjective and could only

ever be truly known or characterized by the dying person. Some clergy were particularly attuned to the cultural context and diversity among their congregants that could result in a middle death. In working to help congregants make sense of middle deaths, particularly ones that involved complex or distressing events, clergy discussed their unique ability—and theological obligation—to serve as translators and interpreters to help process these difficult situations.

Location of death

Overall, participants did not describe location of death (e.g., home versus hospital) as a key factor in contributing to a good or poor death (see Table 5). Discussions regarding location of death (similar to middle death) were characterized by a sense of conditionality, based on a patient's previously expressed wishes, family dynamics, cultural beliefs, and medical care requirements. In general, the quality of the microenvironment—access to loving, competent caregivers and feeling secure—and the spiritual status of the dying person, were reported as more important than the location of dying.

Clergy reported that most patients expressed a preference to die at home, and clergy themselves generally perceived home as the more comfortable option. However, clergy also

TABLE 4. CLERGY PERSPECTIVES ON THE CHARACTERISTICS OF A MIDDLE DEATH^a*A Middle Death: A Mixed Event*

And there are some 'middle deaths.' There was a person in the church and it took her a year and a half to die of cancer. And it was kind of a mixed event. It was an interesting combination of experiences there. So that was a mixed death. (MB107)

It's subjective. ... We as humans often see based upon what our own experience is or what we read that experience should be, in the Bible, but that is not necessarily what that person's experience is. (MJB1030FG-I)

We as clergy are called to minister to diverse populations and they are all in our congregations: We might have the gangster, and a good death to him or her is going out in a blaze of glory shooting up somebody. How would you interpret that to your congregation and to that family because most people will agree that it is a poor death, but that person was prepared everyday to go out in that way. And that might be called a good death to him or her in that community to which they exist in. We got guys that have died tragically and they saw it as good. But it is how we as clergy interpret or reinterpret that for the community. (MJB1030FG-K)

It's subjective. And that is subjective to anyone except that individual who is judging it based upon their own experience. (MJB1030FG-I)

So I think a good death for me would be in the eyes of the patient and not so much in my eyes. (RT7292014)

^aParticipant identifiers that include "FG" indicate that the quote is from a focus group; the letter afterwards indicates the specific speaker.

recognized dying at home was not always in the best interest of the patient or family, and that very practical factors could influence the ability to carry out previously expressed wishes, such as the patient's insurance coverage. When discussing location of death, clergy gave multiple examples of congregants dying suddenly in public places; in these abrupt situations location was largely viewed as irrelevant, as specific circumstances were less important than spiritual preparation for the reality of death.

Perhaps most importantly, the prevailing sentiment from clergy was that location may matter "from a dignity point, yes, but not from a theological point" (MJB1030FG-I). Being in relationship with God, and surrounded by love, was more important than the physical site of a patient's death, and clergy believed this goal could be achieved equally well in the home or in a clinical setting.

Discussion

The primary theme that characterized a good death was one of wholeness and certainty. In contrast, the overarching theme that characterized a poor death was one of separation, doubt and isolation. Similar to other studies,¹²⁻¹⁴ clergy emphasized that quality of death involved factors of patient dignity, preparedness, physical suffering, and community. Interestingly, participants also described a middle death, or one that integrated both positive and negative elements. Location of death was not viewed as a particularly strong contributor to a

TABLE 5. CLERGY PERSPECTIVES ON THE INFLUENCE OF LOCATION OF DEATH ON THE QUALITY OF THE DEATH EXPERIENCE^a

I think it all depends. ... More importantly it is the people who are around them. I would say that for most people as long as they are with their loved ones they will be fine. (JP414)

In a sense it [location] does and in a sense it doesn't [matter]. If you're getting good attention and have freedom of visitors in ICU it can be just as positive as being at home. I think it depends on the quality of the environment around them. (MB107)

I would much rather see it at home with people around in a place where they are feeling comfortable and secure as opposed to—I mean you walk into an ICU and it scares the heck out of you. (CM1219)

I think staying in the home would be better because I was in the hospital and no, you cannot sleep there. There is something always beeping or some alarm. (TC115)

In a hospital probably you can receive the best care, because of the staffing and the equipment. Hospice is next, but at home most family members don't know how to handle the situation. And there is also some cultural factor playing in here because most Chinese people don't want a person to die in their house. (TC1030)

It doesn't matter, because what happens is you die. So wherever you die, it doesn't really make any difference. (MB1021)

I think the place does make a difference to the extent that to be the place of the person's choosing, if you have that control, if you are able to say, 'I'm going to die at home' and that is honored, I think that is important. If it is kind of open then it might not make such a difference. (MJB1030FG-H)

It is not about when, where, how, circumstances, heart attack, car crash, disease. The fact is as clergy we need to teach our congregation the fact that death is a reality on this earth. I think we owe it to ourselves as clergy to make sure that we are responsible enough in our ministry to have our congregation informed about death. (MJB1030FG-C)

And I'm not sure it [location of death] is a theological point for me. It is a human dignity point which flows into my theological point. (MJB1030FG-I)

I think it depends on the overall situation, but I think at home around family is a good death. (RT7292914)

^aParticipant identifiers that include "FG" indicate that the quote is from a focus group; the letter afterwards indicates the specific speaker.

good versus poor death, and was generally seen as secondary and contingent to other material factors.

Participants in our study placed a strong emphasis on patient autonomy. Preserving autonomy was viewed as foundational to maintaining dignity, a key criterion to achieve a good death. This finding suggests clergy that share similar theological perspectives regarding the sanctity of dignity may prioritize preserving patient and family autonomy above the potential medical consequences of particular EOL choices. In other words, being allowed to choose may be more important, according to some clergy, than the medical outcome of the choice. Understanding this dynamic may be especially helpful to palliative care clinicians and other health care providers who care for patients supported by clergy at the EOL.

This study also found that location of death was not viewed by most clergy as particularly important in determining a good

death. The absence of a clear emphasis related to location of death was surprising given that surveys consistently indicate that most people prefer to die at home.^{15,16} In contrast, clergy expressed that a good death could happen in a variety of locations—home, an inpatient hospice facility, or the ICU—and verbalized much greater concern for the spiritual status of the dying patient, and the people surrounding them, than for the physical location of the death event. Clergy did not appear to strongly link some of the key factors they felt influenced the death experience (dignity, community, physical suffering, preparedness) to a physical location's ability to support these factors. This may be related in part to a more limited understanding regarding the realities of the death experience in an acute care setting. For example, physicians and nurses are keenly aware that patients who die in the ICU are often subjected to painful procedures (impacting physical suffering), typically have limited access to family and friends (impacting community), and may experience significantly decreased levels of autonomy when sedated and intubated (impacting dignity and preparedness). It may be that clergy lack sufficient medical knowledge or experience in highly technological settings such as the ICU to adequately assess the impact of acute care interventions on quality of life and the death experience.⁸

Another intriguing finding from this study is the pervasive sense of conditionality (“it depends”) as expressed by clergy throughout the interviews. Participants repeatedly mentioned the need to consider situations on a case-by-case basis, and expressed significant appreciation for contextual factors that affect the death experience. This was particularly evident when clergy discussed the death experience as existing along a continuum and struggled to categorize a patient's death as uniformly good or poor. “Middle death” captured the reality that the quality of death often involves both subjectively viewed negative and positive elements.

Many clergy were reluctant to apply a single approach to spiritual counsel at the EOL. In fact, few clergy expressed dogmatic opinions concerning dying. Clinicians may mistakenly assume that theologically conservative clergy counsel patients and families at the EOL with inflexible theological doctrine. In this sample, clergy attempted to closely align themselves with a patient's wishes, and perceived their role more as interpreters or translators.¹⁷ Many participants expressed a strong desire and obligation to help congregants process and make sense of death, particularly sudden or tragic events.

These results confirm factors previously identified by clergy that affect the death experience (such as physical suffering) and expand our understanding of clergy's attention to contextual factors surrounding the death experience. Future work must translate these findings into relevant educational programs for clergy and clinicians (including chaplains), and measure the effectiveness of such programs in improving dialogue between health care providers and religious communities. Our findings are especially salient when one considers that minority patients in the United States are both more likely to be engaged with a faith community^{18,19} and also to experience significant health disparities at the EOL.^{20,21} Understanding and working collaboratively with clergy who support and counsel terminally ill ethnic and racial minority patients is therefore a key strategy to improve care among these patient populations.^{22,23}

Clinical implications

There is a well-documented need for more EOL education and training for pastoral care practitioners,^{24,25} and these results provide evidence for potential content. For example, clergy may need additional training to gain a clearer picture of how location of death can have a direct impact on some of the key factors clergy espouse to be important for a positive death experience. Similarly, it is helpful for health care providers to understand that clergy may perceive a good death not in terms of location, but rather in terms of certain theological goals that transcend physical and material considerations. Clergy who are closely involved with medical decision making at the EOL may need case-specific information about medical consequences of EOL decisions, and how the outcomes of certain decisions may impact the patient's ability to experience a good death according to the patient's religious tradition.

Limitations

This study is designed to be hypothesis-generating and is not generalizable. Results intentionally reflect perspectives from a predominantly Christian-affiliated sample of community clergy within the United States. Consistent with national clergy demographics, the sample was predominantly male and theologically conservative.²⁶ Further studies of EOL views among spiritual leaders of other demographic, cultural, and religious backgrounds are required.

Conclusion

Clergy described a good death as characterized by wholeness and certainty; a poor death as characterized by separation, isolation, and doubt; and middle deaths as consisting of both positive and negative elements. Four key determinants influenced the quality of the death experience: dignity, preparedness, physical suffering, and community. Clergy were attuned to contextual factors that impact the death experience, but did not always recognize how certain factors, such as location of death, may influence dignity, preparedness, physical suffering, and community. These findings can aid in shaping interventions to enhance spiritual care provided by clergy, religious communities, and clinicians and to decrease health care disparities at EOL. An important next step is to implement these results into relevant educational programs for community clergy (and those who collaborate with clergy, such as clinicians and hospital-based chaplains) and find feasible and effective ways to measure such a program's impact on EOL care for patients and family caregivers.

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Author Disclosure Statement

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Address correspondence to:
Virginia T. LeBaron, PhD, APRN, FAANP
University of Virginia School of Nursing
McLead Hall, 202 Jeanette Lancaster Way
Charlottesville, VA 22903

E-mail: vlebaron@virginia.edu