

Original Article

How Community Clergy Provide Spiritual Care: Toward a Conceptual Framework for Clergy End-of-Life Education

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Abstract

Context. Community-based clergy are highly engaged in helping terminally ill patients address spiritual concerns at the end of life (EOL). Despite playing a central role in EOL care, clergy report feeling ill-equipped to spiritually support patients in this context. Significant gaps exist in understanding how clergy beliefs and practices influence EOL care.

Objectives. The objective of this study was to propose a conceptual framework to guide EOL educational programming for community-based clergy.

Methods. This was a qualitative, descriptive study. Clergy from varying spiritual backgrounds, geographical locations in the U.S., and race/ethnicities were recruited and asked about optimal spiritual care provided to patients at the EOL. Interviews were audio taped, transcribed, and analyzed following principles of grounded theory. A final set of themes and subthemes were identified through an iterative process of constant comparison. Participants also completed a survey regarding experiences ministering to the terminally ill.

Results. A total of 35 clergy participated in 14 individual interviews and two focus groups. Primary themes included Patient Struggles at EOL and Clergy Professional Identity in Ministering to the Terminally Ill. Patient Struggles at EOL focused on existential questions, practical concerns, and difficult emotions. Clergy Professional Identity in Ministering to the Terminally Ill was characterized by descriptions of Who Clergy Are (“Being”), What Clergy Do (“Doing”), and What Clergy Believe (“Believing”). “Being” was reflected primarily by manifestations of presence; “Doing” by subthemes of religious activities, spiritual support, meeting practical needs, and mistakes to avoid; “Believing” by subthemes of having a relationship with God, nurturing virtues, and eternal life. Survey results were congruent with interview and focus group findings.

Conclusion. A conceptual framework informed by clergy perspectives of optimal spiritual care can guide EOL educational programming for clergy. *J Pain Symptom Manage* 2016;51:673–681. © 2016 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.

Key Words

Religion, spirituality, spiritual care, end of life, clergy, palliative care, education

Introduction

Spiritual concerns are particularly pressing at the end of life (EOL),¹ and roughly half of all terminally

ill patients in the U.S. rely on community-based clergy for spiritual support.² Clergy spend an average of 3–4 hours per week visiting the ill³ and are especially

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important in meeting the spiritual needs of minority patients.⁴ Despite their central role in ministering to terminally ill patients,^{5,6} most clergy report inadequate knowledge regarding EOL care and a desire for more EOL training.⁷⁻⁹ This lack of knowledge regarding EOL care among community-based clergy is an issue of critical importance, given recent data that show patients who receive significant community spiritual support are less likely to use hospice and more likely to receive intensive medical care near death.¹⁰

In essence, community-based clergy—who provide the most spiritual support to patients at EOL^{11,12} and can have a dramatic impact on the patient's death experience—receive minimal, if any, EOL training. Also, little is known about actual clergy practices and goals in counseling patients at EOL. This study aims to address these gaps by 1) exploring clergy perspectives on optimal spiritual care provided to terminally ill patients and 2) using these findings to inform a conceptual framework for clergy EOL education. This study is part of the larger National Cancer Institute-funded “National Clergy Project on End-of-Life Care,” a mixed-methods study examining clergy beliefs and practices in providing EOL spiritual care in the U.S.

Methods

Sample

Methods for the study have been previously reported.¹³ In brief, this study used interviews, focus groups, and surveys to describe community clergy experiences with EOL care and their perceptions of optimal spiritual care. We sought to recruit a sample representative of U.S. clergy (not the general population) demographics, and we oversampled from minority clergy to capture a diverse range of perspectives. A key informant with access to local community clergy, in consultation with M. J. B., recruited clergy leaders currently serving in a community congregation based on preselected criteria including race/ethnicity, congregational size, and denomination. Thirty-five clergy were interviewed in one-on-one interviews ($n = 14$) and two focus groups (with a total of 21 participants) 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. An interdisciplinary panel of medical educators and religion experts developed a semistructured interview guide to explore clergy perspectives

regarding EOL care. Relevant to this report, clergy were asked the following open-ended questions from the interview guide: “When you care for patients who may be facing death, such as terminal cancer, how should a minister in a congregation provide spiritual care? What does spiritual care ideally look like in your opinion and experience?” Research staff underwent a half-day training session in interview methods and received ongoing supervisory guidance from M. J. B., to ensure homogeneous interview procedures. Interviews and focus groups were conducted in English or Spanish ($n = 2$) and ranged between 45 and 120 minutes in duration. Participants received a \$25 gift card as a token of appreciation for their participation.

Quantitative Measures

Before the interview or focus group, participants completed a survey assessing age, race, gender, educational level, denominational affiliation, prior EOL training, and experiences in ministering to the terminally ill. As part of the survey, participants were asked to recall the most recent incident in which they provided spiritual care to a dying individual and to describe the length of the patient-clergy relationship, the types of spiritual care provided to the patient, and the timing of death relative to the survey.

Analytical Procedures

Interviews were audio taped, transcribed, translated, and verified if in Spanish, and participants were deidentified. Following principles of grounded theory,¹⁴ transcripts were reviewed by R. Q. and C. N., and an initial set of subtheme categories along with corresponding coding frequencies was generated. Subtheme categories were then refined after further independent review of the transcripts by additional members of the research team, and a broader set of conceptual codes (themes) was created during an interactive data analysis session representing the interdisciplinary perspectives of nursing (V. T. L.), psychology (C. N.), and theology (M. J. B., R. Q.). After finalizing the coding schema, transcripts were then reanalyzed (NVivo 10; QSR International, Burlington, MA) by R. Q. and C. N., each coding independently based on derived subtheme categories and themes (Kappa = 0.68). Descriptive statistics were used for quantitative items of the participant surveys.

Results

Quantitative

Clergy demographic information and types of spiritual care provided to the most recent patient who died are provided in [Table 1](#). Offering prayer and reading scripture were the most common

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