ABSTRACT

Investigating The Influence of African American Clergy on Congregants' Medical Decision-Making at the End of Life

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Scientific literature has demonstrated correlations between spirituality and health outcomes at the end of life, both in relation to emotional well-being and treatment options pursued. However, the impact of pastoral visits has yet to be studied as it pertains to congregants' medical decision-making. This thesis utilizes a Grounded Theory approach to study clerical influence through literature review and semi-structured interviews with pastors in McLennan County. Analysis revealed that pastors can in fact play a role in guiding their congregants' medical decision-making, especially when their counsel is sought during a health crisis. Emergent themes from this study indicate that pastors may impact the healthcare model by influencing the doctor-patient relationship, improving emotional health through prayer, and providing encouragement for palliative care options such as hospice.

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INVESTIGATING THE INFLUENCE OF AFRICAN AMERICAN CLERGY ON CONGREGANTS' MEDICAL DECISION-MAKING AT THE END OF LIFE

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By

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DEDICATION

To my parents, who have encouraged me every step of the way.

INTRODUCTION

Patients often show an increased interest in their own spirituality when they are receiving treatment for a terminal disease, and strong correlations have been drawn to the positive effects of spiritual support on emotional and psychological well-being (Glombicki, 2014; Trevino, 2014). Although many published articles have documented an interaction between spirituality and end-of-life medical decisions (Phelps, 2012; Yancu, 2014; Walther, 2014), a mechanism to explain published trends has yet to be identified. As the field of palliative care expands to more comprehensively address patients' spiritual needs, it becomes increasingly important that medical professionals have an understanding of how pastoral care impacts the healthcare setting.

As pastors interact with patients, they may encourage the hope for good health outcomes, attainment of emotional peace, or awareness of community support (Kristiansen, 2015; Selman, 2014). These interactions influence medical decisions regarding hospice, palliative care, and aggressive curative measures taken at the end of life. In general, studies have demonstrated that patients who identify as very spiritual tend to be less likely to sign a do-not-resuscitate order or accept hospice care, choosing instead to continue with aggressive treatment (Balboni, 2013; Jaul, 2014; Phelps, 2009;). A better understanding of the role of pastoral visits can increase a physician's capability to effectively have his or her own discussion with the patient about priorities and preferences for treatment.

Within the Christian tradition, African American clergy have been shown to be especially involved in their congregants' lives outside of the church, and numerous

examples have been documented of clergy-initiated health programs (Carter-Edwards, 2015). It is not uncommon for African American patients to delay making end-of-life medical decisions until they can discuss those decisions with a local clergy member. Whether these meetings result in spiritual and emotional encouragement, direct guidance on medical treatment decisions, or a mixture of the two has yet to be catalogued in a systematic way. It is hoped that interviewing a representative clerical sample will prove valuable to local physicians as they attempt to understand the spirituality of their patients as it relates to medical decision-making. While qualitative investigations are not intended to be widely generalizable, our hope is that what is learned in the Waco area can be transferable and applied more widely.

In an effort to study the relationship between pastoral care and medical decision-making in the African American church, this study makes use of a Grounded Theory method. Grounded Theory makes it possible to study the human experience as it is lived, especially in relation to subjective phenomena that may not lend themselves to quantitative analysis. The method involves a continuous combination of literature review and semi-structured interviews with African American pastors from the McLennan County area. This sample was obtained through the recommendations of the Waco Regional Baptist Association and recommendations from study respondents. The sample consisted of nine males, aged 43 to 71, with seven identifying as Baptists, one as Methodist, and one as a Pentecostal. Studying the conclusions and findings of other researchers while also receiving new data points from local pastors has allowed for a more comprehensive analysis of the decision-making model in the area.

Following Glaser & Strauss' (1967) protocol, the interview field notes were coded

for emergent themes and compared using Grounded Theory's procedure of "constant comparison." Constant comparison, when used by Grounded Theory researchers, means that each interview is compared to what has been heard in earlier interviews. Data was analyzed for emergent themes at each individual interview, and again once all interviews were completed. In accordance with similar Grounded Theory projects, these codes reached "theoretical saturation" before all interviews were conducted. In theoretical saturation, Glaser & Strauss (1967) and Glaser (1998) suggest the point is reached when additional data collection seems to be offering no substantially new perspectives. Questions in the interview guide were meant to assure complete collection of data on the topics of interest in this study.

One essential difference between classic Grounded Theory and other qualitative data analysis methodologies is that in Grounded Theory, the literature review is conducted alongside interviews and is seen as data in its own right (Creswell, 2013; Glaser, 1998). Typically (as in this study) preliminary literature review is done to assure a salient question in need of further study; extensive review of the literature is reserved for the period during and following interviews so that previous study results do not "cloud" the researcher's judgment. This allows for the proposed theory to fluidly integrate new data with already published literature.

Though Grounded Theory is a scientific method of analysis, it should be noted that the nature of the study content might prevent a completely logical model from emerging. Paradoxical thinking is common in many faith traditions, and for many clergy members and congregants such juxtapositions do not damage the integrity of their belief system. Some such paradoxes have been noted in pastoral interviews, and later analysis

has not attempted to alter the meaning of those firsthand reports in order to make a "clean theory" of spirituality and medical decision-making. Rather, it is important that the interviews are studied as they are, to achieve the most accurate understanding of the clerical perspective on medical treatments at the end of life. It is hoped that this accurate, though sometimes complex representation of local perspectives will prove more helpful to healthcare professionals than a misleadingly simple description of African American culture and spirituality.

In addition to the sometimes-paradoxical nature of spiritual discussions, it should be noted that not all pastors share the same doctrines and beliefs. In the interview setting, each clergy member spoke from a unique background, sharing different stories and speaking from varied educational, socio-economic, and spiritual backgrounds. Some of these pastors gave statements that seemed complementary to the statements of other respondents, and these recurring themes have become the central focus of this study. On the other hand, there were certain instances where one interview provided data that seemed to be in contrast to, and even contradictory of other interviews. It is understood that church members, like their spiritual leaders, may also vary on their beliefs in certain aspects. Therefore, special care is taken to study each interview by its own merit and report findings to reflect as many perspectives as possible.

Lastly, it is important to give a clear description of the purpose of this study. It is perhaps best to begin this description with an example of what this study is not. This research is not intended to serve as a guide for compelling patients to accept a physician's recommendations for end-of-life care. Interviews were carried out with respect for each pastor's unique background and experiences with the church and with medicine, and each

pastor provided a unique perspective on how decades of history, culture, and economic factors come to impact church members' spiritual beliefs and healthcare preferences. These stories and doctrines are studied with humility, with the understanding that a "doctor knows best" mentality may not always serve in the best interest of the patient. It is important to recognize that the spirituality of a person can be fundamental to his or her entire life. In these cases, patients may choose to cling to their long held spiritual beliefs rather than follow medical directives, and it is not the place of a researcher to critically judge such decisions.

With this said, it is hoped that the findings of this study will aid healthcare professionals in providing the best care possible to this patient population. Understanding the role of a spiritual leader in medical decision-making will enhance a physician's understanding of what is important to a patient, and will ultimately further the trust that is so integral in the patient-provider relationship.

CHAPTER ONE:

Establishing Pastors' Influence In the Healthcare Setting

As historical leaders in many African American communities, pastors hold influence in a domain more far-reaching than Sunday morning worship services. Congregants' respect for a pastor's eloquence of speech and station as a spiritual representative enable clergymen to direct public opinions and influence decision-making in a wide variety of settings. Hamilton (1967) illustrates the vastness of community-wide roles played by the African American pastor as including that of a cultural leader who links "The old with the new, the familiar with the unfamiliar, [and] tradition with modernity". This description holds especially true in the field of medicine, where advancements in research and technology have created a new series of treatment options for those with terminal illnesses. The process of dying takes longer than ever in America, and the decisions that must be made by patients and their families raise qualms on financial, emotional, and spiritual levels.

According to Hicks (1977), the pastor's guidance is highly sought after in these circumstances. In a sample of 206 African American Christians in Houston, over half "agree that in a crisis situation, they might turn to the Black preacher for advice." When this occurs, pastors may respond by providing encouragement in the form of prayer or personal testimony, or by providing their own guidance for the situation at hand. This chapter will aim to establish the African American pastor as an influential player in the healthcare setting and provide a few examples of pastors making direct contributions to medical decision-making at the end of life.

Foundations Of Pastoral Influence in Healthcare

Interviews with clergy in the McLennan county area have revealed the perception that a pastor's presence in itself is of benefit to a terminally ill patient. Respondent 8 was emphatic in his statement that pastors should not speak as if they truly understand the church member's individual pain and distress, but rather that the most comforting thing a pastor can say is simply "I'm here." Other respondents also spoke to the importance of group support for terminally ill church members, and that the pastor's presence can combat feelings of isolation and loneliness for those in the hospital. In Young's (1954) guidebook for hospital visitations, he states, "the greatest resource at the pastor's command is the traditional role embodied in his own person." More than the credibility of a single individual, a pastor may represent a spiritual tradition that has lasted centuries. This station gives the pastor a special significance, and his presence in the sick room is perceived to have a real influence on the emotional and spiritual state of the church member being visited.

This understanding of the power of a pastor's presence has in some cases translated into a clerical duty to visit the sick in his congregation. Respondent 6 professed a belief that pastors had a responsibility to be present for ill church members when he described that he would travel great distances to visit a member in the hospital. Others also commented on the necessity of visiting terminally ill patients to provide prayer and encouragement to them and their families.

Once the pastor has entered the patient's room, credibility may be established in part through the pastor's own experiences with sickness and faith-healing. In his interview, Respondent 6 spoke to his own medical history and explained that he would

assure his sick church members that "the source of where my strength came from is where your strength comes from too." Other pastors spoke of stories of church members who had unexplained recoveries or who had maintained strong faith in spite of physical pain or emotional suffering. The personal testimony of the pastor, when explained through the lens of spiritual healing, increases pastoral authority in the healthcare setting.

In addition to retelling the stories of past medial experiences, it should be noted that the role of the pastor allows these men to become well acquainted with end-of-life medical decisions. The familiarity of a well-seasoned pastor with crises for the terminal patient and his ability to offer insight on treatment options can make him invaluable to a church member who is overwhelmed with the urgency of upcoming health decisions. Multiple pastors explained this principle by explaining how they make a conscious effort to have a positive demeanor when they enter a hospital room, in order to not give off the impression that they are surprised by the church member's health condition. Rather, it is important for the pastor to be viewed as confidently trusting in the medical staff and in God for the church member's health.

Spiritual Reconciliation and Purpose

As part of their spiritual ministry, pastors may comfort patients who struggle with guilt and anxiety at the end of life. Respondent 7 acknowledged a personal belief that religious offenses can sometimes cause sickness and that church members sometimes worry that their sickness was brought about by their own sins. The same respondent continued to tell a story that indicated the possibility that in some cases being visited by a pastor might initially increase guilt by reminding patients of their own mistakes in life. Respondent 5 clearly addressed the guilt of past sins when he stated that an important

spiritual need at the end of life is "assurance that stuff [the members] did when they were young is not going to affect where they are now." In his notes on ministering to dying churchgoers, Scherzer (1963) also acknowledged that it is a common pastoral duty to hear confessions in order to alleviate guilt at the end of life. Other pastors echoed similar sentiments when they explained the importance of assuring patients of their salvation as they have thoughts of what may come after death. This comfort, when provided by a pastor, may help the church members to cope with their own emotional stresses near the end of life.

Beyond addressing a patient's guilt and anxiety related to illness, pastoral interviews revealed that some clergy might go one step further in efforts to raise the spirits of their church members. Respondent 9 spoke in his interview of helping his congregants to find renewed purpose in their illness. Urging patients to hold strong to their faith, he would remind them "sickness can be for God's will and purpose." Specifically, the respondent noted faith in the midst of illness as a form of worship and as an evangelical method of sharing their faith with non-Christians. Reminding church members of a purpose in a spiritual context represents another way pastors may strengthen the atmosphere of spirituality in the sick room, further establishing their influence as encouragers and counselors for their congregants.

Pastoral Contributions to Decision-Making

After establishing their influence in the medical setting through presence and encouragement, African American pastors are in some cases able to make their own contribution to the patient's medical decision-making at the end of life. These decisions often involve whole families, and in many cases the pastor is held in such high esteem

that decisions might not be reached until he has arrived. Levin (1986) explains this special access by remarking that pastors "represent the most important source of non-kin group support, as the cult fellowship may itself resemble a large extended family network."

In the interview setting, multiple pastors recalled times when they had visited church members who were on life support. In these instances, respondents recalled that physicians had halted treatment, but that families had not removed patients from life sustaining technology. Respondent 2 recalled such a situation, in which he was able to provide guidance for the patient's family.

> "I've seen people that wanted their loved ones to live, and they were in pain 24/7, they were in pain 24/7. They were not conscious, they were lying there, no brain function… and the only thing causing them to breathe was a machine, but we as humans don't want to go, and so I said to the family "Look, this person is critical, they are in pain, they have no lifestyle because they are just there, and you're wanting them to remain for your benefit, not theirs."

Speaking from a position of spiritual authority, a pastor may be able to provide guidance in a more direct way than a medical doctor. It is possible that these pastoral directives allow families to remove life support with an understanding that they are acting in God's will and not as an act of abandonment.

In addition to encouraging families to "let go" of their loved ones, pastors may at times also speak to patients about accepting death as a natural part of life. Respondent 2 also acknowledged an understanding that in some cases, patients will continue with life sustaining therapy even though they would personally prefer to begin more palliative routes. He described the driving force for this mindset to be the idea that the patient does not want to "abandon" their family. In these cases, the respondent stated he would encourage the patient not to worry, and that "God will take care of your family after you

are gone." Interactions like these may help to resolve tension for church members who want to have quality of life while also serving their own immediate families. This may allow patients to seek out options like hospice and home health rather than continue with intensive treatments.

Church leaders have held a central position in the African American social hierarchy for centuries, and their authority in the lives of their congregants allows them to be present at many of life's critical moments. With the role of the clergyman in the healthcare setting established, it remains to discuss in what particular ways pastors may influence end-of-life medical decision-making for their church members.

CHAPTER TWO

The Pastor-Physician Dynamic

Doctors and pastors are two major influences for Christians at the end of life. In some African American traditions, the division between these two roles is blurred, as pastors give guidance on medical decisions and healthcare professionals consider the patient's spirituality as part of holistic care. Sweet (1994) describes an evangelical understanding of health to be right standing with God in terms of balance in mind, body, and spirit. Therefore, physicians and clergy serve two essential roles as caretakers, one for the body and one for the soul. It is important that doctors and clergy members are able to recognize the importance of their respective services, as they both strive to improve the quality of life for their church members and patients. In the interview setting, Respondent 6 described the complementary roles of pastor and physician by saying that doctors are "the instrument that God uses to provide the best for the physical body…just as [pastors] have been designed or called, equipped to strengthen the spiritual body."

While some of the respondents spoke to their willingness to provide counsel in medical situations, the same respondents emphasized that their main realm of support is in spiritual, not physiological health. Respondent 7 described his purpose for doing hospital visits by saying "It's not [the pastor's] job to go into a hospital room and even speak medical. Our job is to go and simply lay hands on them and pray." In accordance with this line, most clergy in this study's sample demonstrated a professional respect for

physicians. For the most part, perceptions of healthcare providers were positive, reflecting their expertise and service-oriented mission.

Pastoral perceptions of doctors and the medical system in general are important to assess when studying medical decision-making. Especially at the end of life, when emotions are high and mutual respect and trust are essential, it is important that doctors be seen in a positive light if their recommendations for treatment are to be considered. Throughout many semi-structured interviews, thematic elements in pastoral perceptions of physicians arose. This chapter will make use of local interviews combined with established literature to summarize a few important points to consider in "the pastor-physician dynamic." Specifically mentioned themes include distrust for the healthcare system due to historical mistreatment of African Americans, the perceived benefits of a spiritual physician, and special instances where pastors may contradict doctor's suggestions.

Mistrust of the American Healthcare System

The history of African Americans is marked with episodes of persecution and mistreatment. In his interview, Respondent 1 indicated that past injustices continue to impact medical decision-making, especially in a "doctor weary" generation of older African Americans. There remains a fear of "being used," and that they have been called by the physician "for tests, not to be healed." This diction is reminiscent of past breaches in medical ethics such as the Tuskegee Syphilis Experiment, which took place from 1932 to 1972 and included 400 poor, mostly illiterate African American sharecroppers (Reverby, 2000). These individuals did not give informed consent, were not informed of their diagnosis, and did not receive treatment for their disease. Respondent 2's diction

was reminiscent of this mindset when he described a fear that medical professionals might possibly "treat us like we're test tubes."

With this fear of unethical medical treatments still in the minds of some African Americans, the clergyman can sometimes step in as a mediator. Respondent 1 discussed in his interview that pastors have historically served as a kind of translator between healthcare providers and their patients. In these cases, pastors would read medical release forms and documents and provide assurance to patients that the treatment was in their best interest. This correspondence improved the confidence of the patient and made delivery of healthcare more fluid.

Preferences for Christian Physicians

Other interviews have revealed that some African Americans perceive benefit from physicians who understand the patients' spirituality. There seems to be an understanding that a Christian, or at least a spiritual doctor, will be better equipped to deliver the care that church members need, especially at the end of life. While interviewees tended to recognize Christian and non-Christian doctors as both having abilities, several pastors reiterated the theme of a special value for a Christian physician. This phenomenon is also present in the literature, where Townsend (2015) acknowledges that African American Christians value cultural competency in healthcare providers, which would include religious knowledge for hospice staff and physicians.

One perceived benefit of a Christian physician is that his faith background will augment his limited body of scientific knowledge. Respondent 2 described how secular medicine might be unsatisfactory when he stated, "That doctor that has the Spirit of God working in them, they believe in science, but science in itself has a lot of unexplained

things." It is implied that the Christian doctor be able to provide more answers, or more explanations, through faith than a doctor who relied purely on physical evidence. The same pastor continued to say, "knowledge never exceeds faith." It is possible that a physician who speaks and acts like he has complete knowledge of his specialty may be perceived negatively for this reason. Because God is not completely describable through scientific means, the physician who relies on science alone is missing an important piece of the puzzle for these patients.

A failure to recognize the value of comprehension beyond a scientific level can have negative implications for a physician's reputation among pastors. Respondent 2 described a possible deficiency doctors may experience if they do not share the faith of their patients by saying "A physician who has spirituality will get good results, whereas one without some may not be able to get those same results… because they are unable to give the patient hope, because they are purely scientific." While spirituality is a quality in many aspects of African American life, it seems that the state of spiritual awareness is heightened at the end of life. It is at this point that patients look to their doctors not only for curative care but also for a special amount of compassion, dignity, and encouragement. Several interviewees recognized hope as a high-priority spiritual need for church members at the end of life, and it seems that someone who shares the same spiritual background may be best qualified to provide this hope.

Respondent 7 also had words to say about the importance of a spiritual physician:

> "The value of having a Christian physician is that they know how to comfort you when you need to be comforted… Christians know how to comfort each other. We don't have any control over life or death, but we at least know what to say and how to commend you to a higher power."

By saying this, the pastor recognizes that the role of a doctor encompasses more than just extending life. Because God ultimately decides when each patient will die, it is important for the physician to at least be able to comfort the patient by acknowledging the power of his or her God. Previous studies have shown how critical this is, especially for African American Christians at the end of life. In Townsend's (2015) study on faith and hospice, an entire focus group agreed that a hospice professional must share the patient's faith background to be optimally effective. One individual elaborated by saying "I can't separate my God from my transition. I need someone who believes in the living God. And someone who does not believe in the living God that I believe in cannot go through that experience with me."

The Pastor-Physician Dynamic

These are strong sentiments, but do how do patients actually ascertain the spiritual background of their healthcare providers? It is fair to say that there are instances when a physician's words and actions speak for themselves, and the patient never feels the need to follow up with questions on religious affiliation. On the other hand, pastoral interviews have revealed that there are other times when clergy members actually encourage church members to ask these questions of their physician. Respondent 5 stated that he would sometimes encourage church members to ask their physicians about their spiritual backgrounds, with the understanding that "people who are spiritual have a greater sense of confidence in the doctor if they feel that the doctor is spiritual." This pastor also touched on the theme of scientific knowledge, and talked about how a spiritual doctor has more to draw from for delivering care than one who does not have that background.

The perception that a spiritual doctor carries certain benefits, combined with the gumption to actually ask a physician about his personal views, raises an important question. Are these pastors taking this line of thought one step further and dissuading church members from seeing physicians who are not Christians? From data gathered in the interview setting, it would seem that this is not the case. Respondent 2 noted that "the doctor that is not spiritual…he honestly has a good mind because he has made it through medical school and residency." This could represent an understanding that while spirituality is a component of healthcare, it is not the only consideration when making decisions. Doctors are trusted not only because of shared spiritual interests but also because of their own credentials and abilities demonstrated through their educational achievements.

When asked directly about the guidance he gives to congregants seeing non-spiritual doctors, Respondent 2 had this to say.

> "I wouldn't just say that because they won't tell me whether or not they are spiritual that they ought to change doctors, I wouldn't tell people that. I would say "are you comfortable with the care you are getting?" I think we have a tendency to feel more comfortable if we feel that our doctor is spiritual, but that should not be the only issue that would allow us to deal with this particular doctor."

So, while there is an established theme within this clerical sample of the benefits of a spiritual physician, it is not the only thing to be considered when counseling church members. Oral Roberts, a Methodist pastor who was well-known in the 1970s, shared a similar sentiment as he began to undertake the mission of building The City of Faith Medical Center in Oklahoma. In the interest of making use of all resources, church members were counseled to receive "prayer, but more than prayer. Medical science, but more than medical science" (Broad, 1980). All in all, these pastors want their church

members to be healthy, and this involves receiving high-quality medical care. While acknowledging the patient's spirituality is associated with quality care, it does not trump other qualities that traditionally have marked excellent physicians. Respondent 2 concluded that his guidance for church members could be summed up with "Let's get you the best care we can," regardless of the spirituality of the physician.

Interviews revealed that pastors often counsel their church members to follow their doctor's advice. In these cases, the belief in miraculous healing from God does not prevent pastors from also putting stock in the power of Western Medicine. In many cases, the skills and abilities of physicians are linked with God, as Respondent 1 made clear when he stated, "Doctors do have a gift given by God." The same pastor goes on to say that medicine is also God's gift to the world, and so taking medicine is not a betrayal of faith. Rather, a pastor may be more likely to advise his congregants "God made that medicine for you to take, to help heal you."

Linking God's provision with the healthcare services of physicians can make the act of receiving medical care more spiritual in nature. This example is representative of the widespread reach of spirituality for many African Americans and again suggests how important pastors can be in counseling congregants in matters not directly related to the church.

Contradicting Physician Orders

On the other hand, there are certain times when a pastor may encourage extra actions or a period of waiting before complying with a physician's suggestions. These pastoral interventions tend to be more of an exception than the rule, and are frequently associated with special convictions or directives from God. In his interview, Respondent

2 gave the following statement to explain his answer for when a church member asks for advice on healthcare alternatives.

> "More than often, I tell them to take your doctor's advice. More than often. But there are times when I feel led in my spirit to say 'hold on, why don't you try holding off on that for a minute, and let's take that to God in prayer… As a result of that, they will go back, and the doctor will say, "Hmm, I see things have changed since the last time you're here."

When asked about how responsive church members tend to be, the respondent replied that some church members do indeed follow these pastoral directives. He described that having a strong relationship with the patient and his or her family increases the likelihood that a pastor can successfully offer medical advice during these high-stress situations. Additionally, the respondent mentioned that high spirituality in the patient, or a strong "relationship with the Lord," usually relates to being more receptive to pastoral counseling. Respondent 2 continued to describe what this situation may look like by recounting a story.

> "Not very long ago, there was a lady that came in with x-rays and the doctors had said that she had cancer. And they wanted to operate immediately. But I said, "Hold off on that a little, and let them do a follow up test." And they gone back for the follow up and the doctors said, "Things look different from when you were here last. I don't think we need to perform this surgery." Because prayer does work. In our church we believe in supernatural healing… I believe that because I've seen it happen too many times. There have been times when I've prayed for healing and it did not happen. There have been many times in the last 40 years when I've prayed and I've watched God do miraculous things through the power of prayer, through the power of prayer, through the power of prayer."

If the respondent's memory is accurate, this story provides an interesting example of a pastor offering guidance in direct conflict with urgent medical directives from a physician. It demonstrates that patients can be prone to following their pastor's advice over their doctor's, in some part because of testimonials of miraculous healings in the past. If church members have heard the same story that the pastor described in his

interview, it is possible that they would be even more susceptible to following his guidance to "Hold off on that for a little."

Concluding Remarks on Prayer

When considering the weight of these pastoral directives, it is worth acknowledging that interviews utilized only pastoral perspectives and not those of congregants. While the pastor's understanding of clerical roles and duties is important in understanding spirituality and medicine, it is possible that laypeople may hold different perspectives on clerical roles in healthcare. A better understanding of congregants' perspectives on the rightful role of pastors in healthcare may demonstrate consistency with data collected thus far, or possibly reveal that pastors are overestimating their own influence.

It is worth noting again that the purpose of this study is not to judge the rightness of physician or pastoral advice, or the response made by the patient. Rather, these interviews are important to study in that they give a glimpse at how influential these spiritual leaders can be. It is necessary for healthcare providers to recognize what factors are playing into a patient's decision-making model as they strive to deliver the best possible care. In Klar's (2016) ethics commentary, he makes a point that a physician has an obligation to preserve a patient's autonomy throughout healthcare delivery. Physicians have a responsibility to attempt to understand what quality of life looks like for the individual patient, rather than competing to be the most influential voice in the decision-making model. After this perspective is attained, the medical team can work to provide care in accordance with the patient's own goals for living.

CHAPTER THREE

Prayer and the Instillation of Hope

When asked about the most important spiritual needs for terminally ill church members, respondents provided numerous qualities that they tried to instill during their visits. However, throughout the interviewing process, one spiritual need was predominant across age and denominations. Several pastors stated that hope was one of the most important spiritual needs for terminally ill church members, and this hope is often fostered by prayer. Though pastors may pray for a variety of things, including physical healing, peace, and release from suffering, the theme of hope remains through each petition. This chapter will examine the pastoral role as a prayer-provider in the healthcare setting. Next, pastoral perceptions of prayer will be examined in relationship to miraculous healing and hope at the end of life, and how this hope may impact medical decision-making.

Perceptions of Prayer on Physical and Emotional Health

In the interview setting, the theme of prayer as an important element in pastoral visits quickly emerged. Most pastors explained that they will pray with their church members "some of the time," and Respondent 5 stated that he always makes a point to offer prayer during visits. Though it is common for non-clerical Christians to pray without a pastor's presence, the pastor appears to have a special role as a prayer-provider for important petitions. Respondent 8 described this role by explaining how some members may view a pastor as "the one who can get God's attention." This is significant, as prayer as a means of healing is especially documented in some African American traditions. Studies have shown African Americans to be likely to partake in

prayer as a complement to their medical treatments for chronic illness and to be more likely to use prayer for healing than their non-Hispanic European American Counterparts (Gillum, 2009; Jones, 2007; Brown, 2007).

In order to discuss prayer and miraculous healing in the medical setting, it is first necessary to have a working definition for a miracle. Christian theologian C.S. Lewis provides a succinct one when he states that "We do not mean that they are contradictions or outrages; we mean that, left to [nature's] own resources, [nature] could never produce them" (Lewis, 1947). So miracles are understood to be acts of God that cannot be predicted or explained through natural or scientific means. Wachholtz's (2013) analysis of prayer trends indicates that associations with spirituality and health are still common in America. In a survey conducted in 2007, data on prayer practices was recorded for 23,000 adults. Results showed that 52.6% of the total American sample prayed for their health, compared to 72% of the African Americans sampled. Respondent 1 described that these prayers may continue even after doctors have reported terminal prognoses. This is echoed in Respondent 1's statement regarding situations where doctors have exhausted medical options. In situations where natural cures are suspended, he explained, "where man stops, God picks up." The pastor described that this mentality is especially indicative of the African American church in light of its historic persecutions and mistreatments. According to the respondent, there is a perception of God delivering African Americans from slavery, segregation, and persecution from centuries past to the present. The theme of God as a deliverer from hardship carries over to illnesses, where God is thought of as the healer of all disease.

The diction used in interviews reveals how seriously respondents view spiritual healing. Usage of medical terminology and references to emotional well-being indicates that prayer is seen as a practical therapy that really does affect health outcomes. Respondent 2 described prayer as a means of combatting fear, which has an impact on health:

> "When I surrender to [fear], then the disease more than often escalates at a much much faster pace. If I fight through faith, sometimes it will stabilize… fear is said to release certain enzymes in the brain that affects bodily function…because fear affects your blood flow, fear reflects your blood vessels, which can certainly hinder your health."

The technical tone of this description demonstrates how the respondent views his own role as a prayer-provider. This concrete understanding of the role of prayer may explain the persistence with which it appears across respondents. Interestingly, the view of prayer and "fear enzymes" is not unheard of in the scientific literature. Tartaro's (2005) study on prayer and cortisol levels during a frustrating task resulted in individuals with higher prayer frequency exhibiting lower cortisol reactivity compared to those who did not pray at all.

More often than affecting body chemistry, prayer is described as playing a role in the emotional well-being of the patient. This psychological benefit may then in turn play a role in the physical healing process. Respondent 1 acknowledged this when he described that most of his prayers were for the spiritual health of his church members. The same pastor also implied that this might affect other health elements, as "A cheerful heart is always good for the soul and the body." Sharp (2010) views prayer as a type of social support, which facilitates "individual emotion management strategies." Under this model, patients are able to vent negative emotions while attaining positive assessments of

such actions, thereby reducing anxiety. Prayer has been demonstrated to quantitatively impact emotional well-being as a coping mechanism for stress and fear (Maltby and Lewis, 1999; Bremner, Koole, & Bushman, 2011).

Transitions in Hope

Prayer serves a key role in the instillation of hope, but what is hoped for may change as patients near the end of life. Kristiansen's (2013) longitudinal study on hope in patients with life-limiting illness found that although hope seems to be integral to emotional well-being, patient goals may become less grand as prognosis and quality of life decline. Throughout the study, individual patients hoped for full recovery, preservation of certain functions, and eventually, comfortable death. Respondent 6 described this transition of hope as being determined by the patient, and being signaled by lines such as "I'm ready to go."

In the interview setting, there were some instances where multiple hopes were held at the same time. For instance, Respondent 1 stated that he would pray for miraculous healing in all circumstances, but also described death as "better than the day of birth" and a "peaceful rest." The contrast between petitioning God for a miraculous recovery while also holding the afterlife as a valued prize may be aptly described as a paradox of the faith, and the two ideals are held simultaneously without apparent cognitive dissonance. It is possible that these opposing ideas may provide theological grounds for pastors and church members to accept palliative care measures. As quality of life declines, patients may be able to make the shift from a hope for recovery to a hope for the afterlife, and a peaceful transition towards death.

Pastoral Praying Styles

With all the complexities involved, it may be impossible to procure a single theory for how all prayer impacts medical decision-making. Pastoral interviews revealed that although prayer is widely practiced, it may vary in subject matter and expectations of the petitioner. At the risk of over-simplifying the subject, prayer petitions have been divided into two main categories. The names of these categories are based on phrases recorded during interviews, and will be referred to as "Until the Last Breath" and "Thy Will Be Done." While each prayer style is performed with the intention of improving quality of life, influences on decision-making may vary between the two.

Until The Last Breath

For this discussion, the first category of prayer petitions will be referred to as "Until the Last Breath" prayers. These prayers are characterized by continued petitions for a full recovery, regardless of health conditions or physician prognosis. Respondent 8 characterized the essence of this type of prayer when he described how he "always prays for physical healing, as long as there is life." This mentality stems in part from the expectations of church members and their families for the role of a minister. According to Respondent 1, if a pastor stops praying for miraculous healing of the body, relatives of the patient may begin to mistrust the pastor. In these cases, the pastor may be perceived as giving up on the patient or not having the faith that God can work miracles. This mindset provides some pastors with a strong incentive to maintain credibility through prayer.

Other interviews reinforced the concept that petitioning for miraculous healings is a sign of strong faith in a pastor. Respondent 8 colloquially stated, "Ridiculous faith

expects a ridiculous miracle." There seems to be a perception that praying for miraculous restoration, as opposed to more subtle health improvements, may increase the likelihood that such a miracle will occur. Respondent 8 continued to explain his perspective that pastors who are viewed as "strong in the faith" have witnessed God's miracles in their own life and, therefore, request miracles with confidence. On the other hand, those pastors who begin to pray for a comfortable death instead of rescue from illness may be seen negatively, with an understanding that they do not have the faith that God can restore the church member to health.

In addition to affirming their spirituality, pastors ascribing to the "Until the Last Breath" style hold that praying for healing is important for the ill church member's spiritual and emotional well-being. Respondent 1 described the importance of giving a patient hope for physical recovery, and described the role of the pastor as "to put as much assurance in [the patient] as if they hadn't even been diagnosed." Here, there is a view that holding onto hope for a full recovery will preserve spiritual and emotional strength and thereby increase the likelihood for a positive medical outcome. Respondent 6, though more intermediate in his prayer style, explains why he is at times reluctant to bring up a church member's terminal prognosis:

> "I don't ever talk about death and dying at that particular juncture, because I don't want to rob anyone of hope, and hope can carry us to the very end, and faith can carry us to the very end. If we lose our hope, and we lose our faith in the process, I think it sends the negative energy into our body and causes the inevitable to become even more rapid."

This mindset again alludes to the idea that hope attributed to prayer can affect health conditions. It is assumed that speaking of death and dying could cause the patient to lose their hope, which would have negative consequences psychologically. Therefore,

it is best for the church member to hold onto hope for a physical recovery, regardless of the current medical condition or physician predictions. It is possible that this mindset may create boundaries to certain palliative treatment options at the end of life. As pastors, patients, and their families continue to pray for miraculous healings, it may be seen as a betrayal of faith to cease curative treatment. Patients may see choosing palliative care, such as hospice, as a kind of "giving up" on God to answer their prayers.

Thy Will Be Done

In contrast to the "Until the Last Breath prayers," the "Thy Will Be Done" style of praying allows for an easier transition to end-of-life discussions. Making up the majority of this study's sample, these prayers are distinguished by qualifications attached to petitions and the flexibility with which hopes may be altered. While the hope for miraculous healing is still predominant, "Thy Will Be Done" prayers frankly acknowledge the human condition of mortality. Under this model, pastors are flexible to shift from prayers of healing to prayers for a good end of life. Respondent 6 indicates that the patient usually initiates this shift, with a statement such as "I'm ready to go." At this point, the focus of prayer may shift to topics not related to quantity of life, such as wisdom, affirmation of relationships and comfort at the end of life.

This transition is made possible because of a special emphasis on death as a form of healing. Respondent 6 described death as a release from suffering and thus a mercy of God, while Respondent 2 referred to death as a "form of transportation" to paradise. This change in language accepts the nearness of death for terminal patients and allows them to find hope outside of their medical condition. As this occurs, patients may feel more liberated to pursue palliative care options, with an understanding that quantity of life is

not of the utmost spiritual value. It also shields the faith of the pastor and family members in the event of death, as it is not viewed as a failure of prayer or an absence of God.

As is evident by the name, pastors under the "Thy Will Be Done" category hold their ultimate faith in the will of God rather than physical healing. Prayers for restoration of the body still abound in most circumstances, but these petitions are guarded with concessions that death is a natural and divinely appointed part of the human life. While pastors of the first style of prayer petitions may describe this as a lack of faith for God's miracles, pastors under the "Thy Will Be Done" style may be more likely to shift the patient's hope away from curative medical options. Respondent 5 was particularly emphatic on this point and described it as dishonest for the pastor to raise expectations for miraculous healing in the face of terminal prognoses. Rather, he described it as a pastoral responsibility to help the patient transition to a hope independent of their body, particularly the hope for heaven.

Here, hope is built on a trust that God's plan is in the best interest for each church member, and that that plan will always come to fruition. This message is preached both to the patient and the affected family, and may sometimes affect decision-making at the end of life. Patients may be more likely to pursue palliative care options as prayers shift away from healing requests, and relatives may be more accepting of options such as hospice when heaven is described as something to be looked forward to.

It is possible that for some pastors a transition is made from an "Until the Last Breath" to a "Thy will be done" style as the minister becomes more experienced in visiting terminally ill church members. When describing his acceptance that God's will

is the ultimate good for a patient, Respondent 9 remarked "It took me a while to get to this point in my life, where I truly trust the will of God." The pastor recounted personal stories where he prayed for healing but was forced to reexamine his mindset after a patient did not recover. Respondent 2, a Pentecostal pastor in McLennan County, also made remarks of a change in prayer style as a result of church member deaths. This respondent explained that faith healing is common in Pentecostal church, and that this practice hastens a pastor's development into the "Thy Will Be Done" style, lest it appear that God does not answer his prayers whenever a church member dies.

Final Discussions on Prayer

At this point, it is important to emphasize that these two prayer styles are not mutually exclusive; that is, "Until the Last Breath" style pastors may also reference God's plan, and "Thy Will Be Done" style pastors may still make petitions or requests. More realistically, these terms would be located on two ends of a spectrum, with most pastors falling somewhere in the middle. In the same way, the degree to which a pastor focuses on God's power to heal or God's sovereign plan may correlate to the influence in congregants' medical decision-making in one way or another.

Though pastoral interviews have provided consistent data on perspectives on prayer, their effect on medical decision-making remains a complex subject that cannot be easily quantified. It is unclear how attitudes regarding "Until the Last Breath" and "Thy Will Be Done" petitions contribute to pastoral perceptions, which was consistent between both groups when discussing hospice. It may well be that prayer should be factored in as a possible element, rather than a sole determining factor, that plays a role in medical decision-making at the end of life.

CHAPTER FOUR

Pastors and Hospice

As palliative medicine becomes more established as a treatment option, hospice use has become increasingly common. The National Hospice and Palliative Care Organization reports that the number of patients served by hospice in the U.S. has risen from 700,000 in 2000 to 1,542,000 in 2013 (www.nhpco.org). However, this trend has not held uniformly across all demographics. Specifically, African Americans have been shown to utilize hospice less than the general population. Although they constitute 13% of the U.S. population, African Americans only make up 8% of hospice patients in America, despite the fact that they have the highest cancer rates of all ethnicities (Frykholm, 2013). Within this demographic, African American Christians show even lower rates of hospice utilization.

The distinctly low level of hospice utilization among African Americans is a complex topic that has roots back to centuries of mistreatment by the government and medical system. Theological reservations are also hypothesized to play a role in African American Christians' especially low utilization of hospice and do-not-resuscitate orders. When faced with these complex social issues, it is important to recognize that empathy and understanding must be achieved in order to resolve disparities in care for this population. Rather than dismissing obstacles as "cultural barriers," health professionals and researchers have a responsibility to strive for a fuller understanding of this community to facilitate communication for these critical topics.

This chapter will attempt to explore the issue of African American hospice usage from several viewpoints. First, I will examine published claims regarding the source of these trends in light of pastoral interviews in McLennan County. Next, I will analyze the general perceptions of hospice care in the African American Church, and comment on the special role of a pastor in counseling church members on end-of-life medical treatments. Lastly, I will present the institution of the church as a possible vehicle for improving attitudes and awareness of hospice care.

Past Claims on Spirituality and Hospice

Several quantitative studies have shown lower use of hospice care for both African American and religious patient populations. Balboni's (2013) study enrolled 343 patients with advanced cancer in an effort to record data on spiritual support and medical decisions at the end of life. Results showed that terminally ill patients who show high levels of support by their religious community are less likely to receive hospice care and more likely to pursue aggressive medical treatments at the end of life (Balboni, 2013). These results were shown to be magnified in racial minorities. In an attempt to explain these patterns, Balboni offers two possible explanations:

1. Religious people consider medicine to be a primary means of divine intervention.
2. Religious communities may frequently emphasize perseverance through and hope found within suffering.

While Balboni's research methods may be sound, his postulations as to the explanations for his data have not been confirmed by pastoral interviews. Multiple respondents, when asked about hospice care, explained that a transition from curative to

palliative medicine is not perceived as "giving up on God." Rather, these pastors tell their congregants that if God plans on working a miracle, He can do so without any doctor's intervention. Therefore, the likelihood of spiritual healing is independent of what medical treatments are currently being pursued. One respondent summed up this idea when he stated, "where man's understanding ends is where God's work begins."

Balboni's second premise does hold true in some circumstances and is reflected in a long history of oppression and persecution for African Americans. In describing the development of African American spirituality during the time of slavery and Jim Crow laws, Best (2003) describes how survival became an important theme in prayer tradition. Under a dominant, controlling culture, there developed a dichotomy between the struggle for the next day and the hope for a better life in heaven (Best, 2003). In this way, though there is an acknowledgment of the immense effort and suffering required for basic life necessities, there is also recognition that death brings release from toil. This contrast may best be explained through an excerpt from a traditional African American prayer (Carter, 1984).

> Lord, when this ol' world can afford us a home no longer, when we have to lay down our swords and spears and study war no more, we want to hear your welcoming voice, saying, "Well done! Well done! Thou good and faithful servant, thou hast been faithful over a few things; come up higher, and I will make you ruler over many.

In this prayer, the battle-like imagery gives the impression that it is a Christian's duty to continue fighting until you hear God's "welcoming voice." The difficulty, then, is in recognizing when that voice has come. Is the diagnoses of the doctor to be taken as the welcome to heaven, or is surrendering the fight for survival tantamount to a loss of faith that God can make a way?

Pastoral Perspectives on Hospice

While Balboni sees the virtue of suffering as a barrier to accepting end-of-life care, pastors in Mclennan county have revealed a stronger value of the acceptance of death as a natural, even a beneficial phenomenon for Christians. This belief of accepting death is demonstrated by Respondent 9's statement that "Until the rapture…people are going to die, young and old alike. Death is a part of this life. But in the next life there is no death." Even the death of young church members is accepted as a natural part of life, and death is consistently linked with the hope for an end of all suffering in heaven. Respondent 7 directly addressed a positive perception of death by saying that "death is a form of healing." Because death is seen as an ultimate freedom, it is unlikely that a spiritual preoccupation with suffering creates barriers to palliative medicine.

It is possible that African Americans are less likely to accept palliative measures at the end of life because of a historical mistrust for the American healthcare system in general. In his short essay on medical decision-making in African American communities, Ronald (2008) explains how signing an advanced directive is understood to be placing the ultimate trust in a physician. However, in a world where racial prejudice is still alive, many find this relationship to be difficult, if not impossible (Ronald, 2008). It is easier to push aside the thought of advanced directives and instead focus on trusting in God to decide when the final moments of life will occur.

Latson and Ramsey (2004) also point to a mistrust of the medical system in their commentary on advanced directive usage in African Americans. In comparing curative and palliative options, there may be evidence of a mistaken belief that "any option that

fails to include aggressive treatment is a breach of the standard of care to which the patient feels legally entitled" (Latson & Ramsey, 2004). The understanding that receiving high quality medical care will also involve high quantity of treatment leads to a misperception that hospice care is a way to "get rid of" the patient, rather than alleviate suffering. This only serves to enhance the worries of patients who are skeptical that their physician is truly looking after their best interest.

While the above research makes intuitive sense in light of the history of African Americans in healthcare, pastoral interviews illuminated a much different perception of hospice care. The interviews conducted in this study demonstrate that African American clergy members may have a different view of hospice than the general population, with the majority of respondents interviewed stating their perception that "hospice is a good thing." While many respondents recognized that some congregants perceive hospice as a death warrant, the clergy members themselves tended to have a more positive view.

In describing the negative stigma associated with hospice, Respondent 9 explained that racial divisions were not the primary motivation against hospice. Rather, the collectivist family values of the African American community seem to play a role. In older generations, sending elders and grandparents to nursing home facilities was equated with "abandonment." In many cases, families may not pursue hospice care as an option because it is perceived as a betrayal of family responsibilities.

While being cognizant of this negative stigma, Respondent 9 still had positive things to say about hospice care. After personal experience with hospice care, this pastor recognized the positive effects of hospice for the patient and also for the whole family.

He reported that after his own experience, he has had the opportunity to encourage congregants to also consider the positive benefits of hospice care.

Additionally, Respondent 5 directly addressed the "abandonment" issue associated with hospice. In his interview, the pastor explained his understanding that contrary to being abandoned by family members, patients were able to receive more social support in hospice than in the hospital. He talked about how receiving care from hospice providers in a home setting would allow for a greater community presence than receiving care in a hospital setting.

It should be noted that the African American clergy person, by nature of his position, might have more experience with end-of-life care options than a typical church member. Because a pastoral role involves supporting church members through the loss of loved ones, it is likely that pastors will have seen the events of hospice care in multiple situations. This allows pastors to be less influenced by fear caused by unfamiliarity in health crises.

In focus-group interviews for African American church members, it is not uncommon to hear beliefs that hospice means certain death (Townsend, 2015). In speaking of some of his church members, Respondent 8 said hospice is viewed as "the last step before death." While it is true that hospice does not provide curative care, it has been noted that in many situations hospice can actually extend life beyond what might be possible under intensive medical treatment (Gawande, 2010). Through pastoral interviews, it has become clear that although they may not be aware of statistical evidence, many pastors recognize the benefits of hospice.

The majority of respondents expressed a consistent belief that "[hospice] can do a lot for a person," with several benefits to both the patient and their family. In describing what hospice does, common responses included that hospice is "comfort care," that it provides support for a patient and their family, and that it allows for spiritual components of care to take a more central role. Respondent 7 described the transition to hospice care, saying "hospice can probably redirect the mission statement…perhaps many don't know the mission statement…I think they minister to the physical and spiritual [needs of the patient]." Rather than seeing hospice as a sub-optimal treatment for those resigned to death, this pastor perceived hospice to be a holistic form of care for those at the end of life.

Pastoral interviews revealed that African American clergy members see spiritual and emotional benefits to receiving hospice care. Respondent 1 spoke to the benefits of hospice from a spiritual standpoint. In describing hospice as "comfort care" he explained that relief from physical pain could allow church members to re-focus on their spirituality, which allows them to prepare for death. Respondent 9 spoke from personal experience with a family member in hospice to explain the broader benefits of hospice for the patient's family. When hospice was utilized, tensions among family members decreased as they relinquished the stressful role of caretaker to hospice professionals who provided skilled care at home. In explaining the benefits of hospice, many pastors were able to clearly recall their own experiences with family members in hospice or experiences of their church members. One pastor explained an experience with a church member who went to hospice. His perception was that for this patient, hospice served to "make those final days the best quality possible." It is possible that telling first-hand

stories such as this allows pastors to break through the barriers of fear that prevent some church members from receiving hospice care.

Beyond explaining the benefits of hospice in an end-of-life setting, many pastors were quick to remark "hospice is not always unto death." Several pastors recalled stories of church members who had graduated hospice and called on these examples as signs of God's sovereignty over death. Respondent 8 explained that:

> "A stronger pastor would be one that experiences trials... and things they have witnessed that a sovereign God has done in the past…when you come out of one obstacle, and you have seen things that only God can do, I think it helps you and strengthens your faith for the next obstacle… I think that's what makes us stronger in life: the things we have experienced, the things we have seen God do that only God can do."

So, in addition to assuaging the fear that hospice is emotionally unsettling, pastors are also able to effectively communicate that hospice does not always mean certain death. Through speaking from personal experience they are able to share their own understanding of God's sovereignty as they guide their congregants through trials in life.

Clinical Applications

While it has been demonstrated that African American Christians share some negative stigmas regarding hospice care (Townsend, 2015), it is possible that the institution of the church may be able to counteract these perceptions. Programs that involve local churches in the education, and sometimes implementation, of hospice care have proved largely successful (Frykholm, 2013). Pastors in the McLennan area have largely demonstrated a strong understanding and support of what hospice provides. Respondent 6 had one of the most positive remarks on hospice when he said

> "They don't just let you dwindle away and die…they make you as comfortable as they can as you move towards end of life. They prepare you to die…but in a good

> way. They aren't rushing you to die, but I think they enable you to, as comfortable as possible, move towards that particular point."

The same respondent expressed that he had previously thought of working in a hospice facility through administration or service. The pastoral role as a spiritual leader and one who has already had experience guiding other church members through the end of life makes clergy members prime candidates for bridging the gap between African American Christians and palliative medicine.

CHAPTER FIVE

Study Limitations and Concluding Remarks

Study Limitations

Denscombe (2007) describes a phenomenon known as the *interviewer effect*, by which a study's sample may respond differently based on the age, sex, or ethnic origin of the interviewer. It is possible that pastors' responses were formatted in a way to affirm the research design, or that more controversial ministry styles were not mentioned for fear of criticism. However, it is hoped that this possibility was minimized, as the interviewer was not a medical professional or a member of a news or media team. Pastors were led through a consent form, which guaranteed anonymity, with the goal of allowing for a free discourse of ideas and explanations.

It is also possible that pastors may subconsciously exaggerate their own role as influencers in their congregants' medical decision-making. Congregants may have different views regarding their pastor's role as an encourager and spiritual authority in the healthcare setting.

The sample used in this study may not be representative of other African American pastor populations. Specifically, further interviews including African American Catholics, women, rural pastors, and pastors from northern states may be helpful in attaining a more complete representation of clerical perspectives. Additionally, it should be noted that this study exclusively utilized pastoral interviews, and understanding congregant perspectives, such as those found in Johnson's (2016) study, may assist in developing a comprehensive theory on patient-pastor interactions.

Concluding Remarks

Despite these limitations, it is hoped that the findings of this study may prove useful to medical professionals treating African American Christians at the end of life. Pastoral interviews revealed a rich variety of experiences and perspectives on ministering to ill church members, but throughout the process, consistent themes emerged. These concluding statements will summarize the study's main themes and offer some suggestions for medical staff when treating African American Christians.

The breadth of spirituality for many African Americans allows pastors to establish themselves as key influencers in the healthcare setting. Pastors enter into the sick room with a certain reverence, as they recognize the magnitude of stress and pain for patients and their families. Respondent 7 stated in his interview that "a hospital is a sacred place," and in some ways, the use of prayer and Scripture reading makes the hospital a little more similar to a sanctuary.

As pastors speak in a language of spirituality, they can sometimes increase a church member's confidence in his or her medical providers. Descriptions of doctors as God's healing agents, or as medicine as God's provision, may promote trust in the medical system in general when spoken from a spiritual authority. Medical staff may further this trust by acknowledging the patient's faith, thereby demonstrating a degree of cultural competency and a willingness to relate to a patient on more than physiological issues. It should be noted that in the majority of cases pastors serve as a supporting role to physicians and encourage congregants to follow through with treatments as suggested. However, there are also exceptions to this rule, where a pastor may give guidance in slight or direct opposition to a physician's treatment plan. In these circumstances, the

actions of the patient likely depend on personal trust and relationships both with the pastor and physician.

During many pastoral visits, the central issue is not on medical issues, but on the congregant's emotional and spiritual well-being. Many pastors acknowledged the use of prayer as a means of maintaining hope and improving emotional stability for church members. Though different styles of prayer may have different implications for medical decision-making, these effects are more indirect in their nature and are secondary to the goal of improving the patient's emotional state. Medical staff may find it beneficial to encourage religious patients to make use of their spiritual support systems during high-stress circumstances as a means of coping with the unfamiliarity accompanied with medicine at the end of life.

With so many topics varying along a spectrum of responses, the most stable pastoral perspective recorded was regarding hospice. On the whole, the sample of respondents demonstrated a nearly uniform understanding about the purpose and care provided in hospice facilities, and stated attitudes that "hospice is a good thing." Multiple respondents told stories about times when they had encouraged a reluctant church member to consider hospice as a beneficial and spiritually acceptable option. This may serve to counter common fears in the African American church that hospice delivers sub-par care, or that accepting hospice is equivalent to a betrayal of the Christian faith. There may be potential for pastors to assist healthcare professionals in education about hospice, both on individual and society-wide levels.

Though research involving spiritual interactions does not always lend itself to quantitative analysis, this study has demonstrated that African American pastors can play

powerful roles in influencing their congregants' medical decision-making at the end of life. Examining this role is an essential component for understanding the spirituality of a church member and equipping medical professionals to provide the best care possible.

APPENDIX

APPENDIX

Semi Structured Interview Guide:

What do you hope happens when you visit a patient in the hospital?

Would you most likely pray with a church member every time you visit? If so, what do you pray for?

What specific spiritual needs have you commonly seen in patients at the end of life? (may need to clarify this question) What do you think are the biggest spiritual needs that seriously ill people have.

What is your view on miraculous healing? "So pastor, I'm curious, how do you suppose you and the people in your church make sense of miraculous healing today?" is softer.

What is your view of the role of hospice?

Tell me about a time when a patient asked you for guidance in making a medical decision

Tell me about a time you visited a terminally ill patient

Is there anything else you would like for me to know about spirituality and medicine?

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