Provision of Spiritual Support to Patients With Advanced Cancer by Religious Communities and Associations With Medical Care at the End of Life

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**Importance:** Previous studies report associations between medical utilization at the end-of-life (EoL) and religious coping and spiritual support from the medical team. However, the influence of clergy and religious communities on EoL outcomes is unclear.

**Objective:** To determine whether spiritual support from religious communities influences terminally ill patients’ medical care and quality of life (QoL) near death.

**Design, Setting, and Participants:** A US-based, multisite cohort study of 343 patients with advanced cancer enrolled from September 2002 through August 2008 and followed up (median duration, 116 days) until death. Baseline interviews assessed support of patients' spiritual needs by religious communities. End-of-life medical care in the final week included the following: hospice, aggressive EoL measures (care in an intensive care unit [ICU], resuscitation, or ventilation), and ICU death.

**Main Outcomes and Measures:** End-of-life QoL was assessed by caregiver ratings of patient QoL in the last week of life. Multivariable regression analyses were performed on EoL care outcomes in relation to religious community spiritual support, controlling for confounding variables, and were repeated among high religious coping and racial/ethnic minority patients.

**Results:** Patients reporting high spiritual support from religious communities (43%) were less likely to receive hospice (adjusted odds ratio [AOR], 0.37; 95% CI, 0.20-0.70 [P = .002]), more likely to receive aggressive EoL measures (AOR, 2.62; 95% CI, 1.14-6.06 [P = .02]), and more likely to die in an ICU (AOR, 5.22; 95% CI, 1.71-15.60 [P = .004]). Risks of receiving aggressive EoL interventions and ICU deaths were greater among high religious coping (AOR, 11.02; 95% CI, 2.83-42.89 [P < .001]; and AOR, 22.02; 95% CI, 3.24-149.58 [P = .002]; respectively) and racial/ethnic minority patients (AOR, 8.03; 95% CI, 2.04-31.55 [P = .003]; and AOR, 11.21; 95% CI, 2.29-54.88 [P = .003]; respectively). Among patients well-supported by religious communities, receiving spiritual support from the medical team was associated with higher rates of hospice use (AOR, 2.37; 95% CI, 1.03-5.44 [P = .04]), fewer aggressive interventions (AOR, 0.23; 95% CI, 0.06-0.79 [P = .02]) and fewer ICU deaths (AOR, 0.19; 95% CI, 0.05-0.80 [P = .02]); and EoL discussions were associated with fewer aggressive interventions (AOR, 0.12; 95% CI, 0.02-0.63 [P = .01]).

**Conclusions and Relevance:** Terminally ill patients who are well supported by religious communities access hospice care less and aggressive medical interventions more near death. Spiritual care and EoL discussions by the medical team may reduce aggressive treatment, highlighting spiritual care as a key component of EoL medical care guidelines.

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SPIRITUAL CARE—CARE THAT recognizes patient religion and/or spirituality and attends to spiritual needs—has been incorporated into national care quality guidelines, including those of the National Consensus Project for Quality Palliative Care1 and the Joint Commission.2 Data suggest that provision of spiritual care by medical teams to terminally ill patients is associated with better patient quality of life (QoL), greater hospice utilization, and less aggressive medical interventions at the end of life (EoL).3 However, spiritual care from the medical team is infrequent in the setting...
of advanced illness, an omission likely due to multiple factors, including practical barriers such as insufficient resources (eg, chaplaincy staff, practitioner training, and time) and concerns regarding offending patients.

Though spiritual care from the medical team is typically absent, patients facing advanced illness often are connected to religious communities that act as key providers of spiritual support. Hence, spiritual care guidelines include religious communities as principal providers of spiritual care to patients. Understanding the impact of religious community spiritual care on patient EoL outcomes is critical to characterizing optimal spiritual care provision. Furthermore, given the salient role that religious communities often play among racial/ethnic minorities, and high religious coping patients—patients at risk for greater aggressive EoL care and EoL outcomes is of particular relevance in these populations.

The Coping With Cancer Study is a multi-institutional study of patients with advanced cancer designed to investigate how psychosocial and religious and spiritual factors influence patients' medical care and QoL near death. The purpose of this study was to examine how provision of spiritual care by religious communities influences patient QoL and medical care at the EoL, particularly among high religious coping and racial/ethnic minority patients.

## METHODS

### STUDY SAMPLE

Patients were recruited from September 1, 2002, to August 28, 2008, from 7 outpatient sites: Dana-Farber Cancer Institute and Massachusetts General Hospital, Boston; New Hampshire Oncology Hematology, Hookset; Parkland Hospital and Simmons Cancer Center, Dallas, Texas; Veterans Affairs Connecticut Comprehensive Cancer Clinics, West Haven; and Yale University Cancer Center, New Haven, Connecticut. Eligibility criteria included an advanced cancer diagnosis with disease refractory to first-line chemotherapy; age 20 years or older; presence of an informal (nonpaid) caregiver; and adequate stamina to complete the interview. Exclusion criteria included patient or caregiver meeting criteria for dementia or delirium by neurocognitive examination and inability to speak English or Spanish. All participants provided written informed consent according to protocols approved by each participating center's human subjects committee.

### STUDY PROTOCOL

Research staff underwent 2 days of training in the study's operating procedures. Potential participants were identified from outpatient clinic schedules. On enrollment, patients underwent a baseline interview. Patients' medical records were reviewed to extract disease and treatment variables. A second assessment was performed within 2 to 3 weeks after the participant's death, including medical record review to obtain EoL medical care information and a postmortem interview of a formal or informal caregiver familiar with the care the patient received in the final week of life.

Of 944 eligible patients approached, 670 (71%) accepted participation. The most common reasons for nonparticipation included “not interested” (n = 109) and “caregiver refuses” (n = 33).

There were no significant differences between nonparticipants and participants in sex, age, race, or education. At the time of completion of active study follow-up (August 28, 2008), 379 had died and a postmortem interview was performed. Of these 379 patients, 36 lacked complete postmortem or spiritual care data, resulting in a final sample of 343 (91%).

### BASELINE MEASURES

#### Spiritual Care Variables

Spiritual care from religious communities was assessed by the question, “To what extent are your religious/spiritual needs being supported by your religious community (eg, clergy, members of your congregation)?” Spiritual care from the medical team was assessed with the question, “To what extent are your religious/spiritual needs being supported by the medical system (eg, doctors, nurses, chaplains)?” Response options to both items included “not at all,” “to a small extent,” “to a moderate extent,” “to a large extent,” or “completely supported” and were dichotomized (median split for religious community spiritual support) into low (“not at all,” “to a small extent,” or “to a moderate extent”) and high (“to a large extent” or “completely supported”) spiritual support. Patients were also asked whether they had received chaplaincy services (yes/no).

#### Religious Variables

Patients rated religion as “not at all,” “somewhat,” or “very important.” Pargament’s Brief RCOPE, a previously validated questionnaire, measured positive religious coping (score range, 0-21). Given our previous report indicating greater aggressive EoL care among patients endorsing high (median score, >12) positive religious coping, positive religious coping was similarly dichotomized.

#### Other Baseline Variables

The McGill QoL questionnaire is a validated instrument designed to measure QoL at all stages of life-threatening illness and includes physical, psychological, overall, existential, and social support subscales. The patient-physician relationship was assessed with 5 items measuring trust, mutual respect (2 items), feelings viewed as a whole person, and comfort asking questions about care (range of possible scores, 0-5). Patient reports of having had an EoL discussion with their physician (yes/no), documentation of advance directives (yes/no), and the SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment)-validated question regarding patients' preferences for aggressive vs comfort care also were assessed. Age, sex, race/ethnicity (dichotomized to non-Hispanic whites vs racial/ethnic minorities), education, and insurance status were patient reported. Karnofsky Performance Status Scale score was obtained by physician assessment.

### EoL OUTCOMES

#### EoL Care

Hospice care at EoL was defined as receipt of inpatient or outpatient hospice vs no hospice in the last week of life. Receipt of aggressive EoL care was defined as receipt of care in an intensive care unit (ICU), ventilation, or resuscitation in the last week of life. Location of death was assessed and categorized as death in an ICU vs other settings.
Caregivers assessed patient QoL near death with 3 items assessing psychological distress, physical distress, and overall QoL near death that were summed (range of possible scores, 0-30, with greater values indicating better QoL). Caregiver assessments of patient QoL near death are considered an adequate surrogate based on the significant positive association between caregiver and patient assessments of baseline patient QoL (McGill QoL scale, r = 0.53; P < .001).
mains and spiritual support from the medical team.3 Addi-
tional confounders considered for EoL care and QoL models
were age, sex, race and health insurance status (automatically
entered for EoL care models), education, marital status, per-
formance status, chaplaincy services, and religious tradition.
Variables were entered into the model if the bivariable asso-
ciation was \( P < .10 \) and retained when \( P < .05 \) after controlling
for other confounders.

To examine associations of religious community spiritual care
and EoL outcomes among high religious coping and racial/
ethnic minority patients, multivariable models were repeated
according to median split positive religious coping and among
racial/ethnic minority patients. For these analyses, we tested
statistically for heterogeneity in odds ratios (ORs) across sub-
groups defined by minority race and by religious coping. Wald
\( x^2 \) tests assessed differences in estimates according to source
of spiritual support (religious communities vs medical teams).
After determining that high religious community spiritual sup-
port was associated with greater aggressive EoL care, we as-
essed whether spiritual support from the medical team and
EoL discussions—interventions associated with reduced ag-
gressive EoL care—\( ^{21,22} \)—may have utility in reducing aggressive
EoL care among these patients. Multivariable logistic regres-
sion models were used to examine relationships of medical team
spiritual support\( ^{6} \) and EoL discussions\( ^{21} \) among patients re-
porting high spiritual support from religious communities. Fur-
thermore, among patients well-supported by religious com-
unities, rates of EoL medical care according to receipt of
medical team spiritual support and EoL discussions were ex-
amined with \( x^2 \) tests.

Statistical analyses were performed with SAS version 9.2 (SAS
Institute Inc). All reported \( P \) values are 2-sided and consid-
ered significant when \( <.05 \).

RESULTS

SAMPLE CHARACTERISTICS

Sample characteristics are given in Table 1. Patients
reporting high support of their spiritual needs were more likely
to be racial/ethnic minorities, were less educated,
and had lower rates of health insurance. They
also reported better QoL, existential well-being,
and social support. There were no differences in frequency
of EoL discussions or treatment preferences; however,
patients receiving high levels of support from religious
communities were more likely to be aware that they
were terminally ill and less likely to have advanced care
planning.

RELIGIOUS COMMUNITY SPIRITUAL
SUPPORT AND EoL QoL

Patients died a median of 116 (interquartile range,
54-255) days after the baseline interview. Univariable
and multivariable regression analyses showed no sig-
nificant relationships between patients’ baseline spiri-
tual support from religious communities and QoL near
death (\( \beta \) [SE], 0.82 [0.86] [\( P = .34 \)] and 0.24 [0.95]
[\( P = .80 \)], respectively). Among high religious coping
and racial/ethnic minority patients, no significant
associations were found between religious community
spiritual support and QoL near death in adjusted
analyses (\( \beta \) [SE], \(-1.58 \) \([-1.31] \) [\( P = .45 \)] and \(-2.17
[1.48] \) [\( P = .15 \)], respectively).

RELIGIOUS COMMUNITY
SPIRITUAL SUPPORT
AND EoL MEDICAL CARE

Figure 1 shows EoL medical care received among
patients reporting low and high spiritual support from
religious communities in the full sample, high reli-
gious coping patients, and racial/ethnic minority
patients. Table 2 gives multivariable regression
analyses examining the relationships between spiritual
support from religious communities and EoL medical
care, revealing significant associations between high
spiritual support and less hospice, greater aggressive
medical interventions, and greater ICU deaths. Asso-
ciations with aggressive care were stronger in high
religious coping and racial/ethnic minority patients;
formal interaction tests were statistically significant for
aggressive care (\( P \) values for interaction, \(.04 \) for race
and \(.01 \) for religious coping) and trending for death in
an ICU for religious coping (\( P \) value for interaction,
\(.06 \)). Figure 2 shows the contrasting influence of
the source of spiritual support on EoL care outcomes. In
all cases, the associations between spiritual support
from religious communities and EoL outcomes were
significantly different from, and in the opposite direc-
tion of, spiritual support from medical teams; differ-
ences were more pronounced for high religious coping
and racial/ethnic minority patients.

MEDICAL TEAM SPIRITUAL SUPPORT
AND EoL DISCUSSIONS AMONG PATIENTS
RECEIVING HIGH SPIRITUAL SUPPORT
FROM RELIGIOUS COMMUNITIES

Figure 3 shows rates of EoL medical care among pa-
patients receiving high spiritual support from religious
communities according to receipt of medical team spiritual
support and EoL discussions. In multivariable regres-
sion analyses, patients highly supported by religious com-
unities who reported receipt of spiritual support from
their medical team had greater odds of receiving hos-
This study demonstrates that patients receiving high levels of spiritual support from religious communities are less likely to receive hospice care and are more likely to receive aggressive medical interventions at the EoL and die in an ICU setting. These findings remained after controlling for potential confounding factors, such as race and advance care planning. Furthermore, these findings were strongest among racial/ethnic minority and high religious coping patients, populations at greater risk for aggressive interventions at the EoL. Among patients receiving high levels of spiritual support from religious communities (43% of our sample), provision of spiritual support by the medical team and EoL discussions were associated with reduced aggressiveness of EoL care. These findings suggest that a possible intervention among patients receiving high religious community spiritual support is the medical team's provision of spiritual support and EoL discussions in order to reduce aggressive care near death in this population.

Our results suggest that the content of spiritual care is a key factor influencing patients' medical decisions, particularly given the disparate influences of spiritual care from religious communities compared with spiritual care provided by medical teams. In contrast to medical teams, religious congregations may be unaware of the biomedical realities surrounding terminal illness and hence may not be addressing issues of death and dying owing to lack of clarity regarding when or whether death will occur. In addition, within many religious traditions including Christian traditions—most of our sample, in keeping with US religious demographics—there is a strong belief in miracles. Religious communities, in supporting their ill congregants, may be emphasizing and reinforcing a belief in the potential for miraculous healing. Why might this belief result in more aggressive medical care, when one might rather conclude that this should motivate a belief in divine miracles that do not require medical technologies? One possibility is that religious people consider medicine to be a primary means of divine intervention. This is supported by findings of a telephone survey of 1033 individuals living in the Southeast, within which 80% endorsed a belief that God acts through physicians to cure illness. Hence, religious congregations may view choosing to withhold medical technologies as curtailing the principal avenue by which divine healing can take place or even taking the trajectory of the person's life out of "God's hands." This latter concept touches on religious sentiments regarding the sanctity

Figure 1. Spiritual support from religious communities. Rates of hospice care (A), aggressive medical interventions (B), and intensive care unit (ICU) death (C) in the full sample (N = 343), patients with high religious coping (n = 175), and racial/ethnic minority patients (n = 128). *Hospice is inpatient or home hospice care in the last week of life, and aggressive medical interventions include receipt of ventilation, resuscitation, or care within an ICU in the last week of life. Full sample rates of hospice care, aggressive medical interventions, and death in an ICU are 73.2%, 13.1%, and 7.3%, respectively. †Religious coping is a patient's reliance on their religious/spiritual beliefs to cope with and understand illness and was measured using Pargament's validated RCOPE (religious coping) instrument (score range, 0-21). Patients with high religious coping were those who scored at or above the median, and of these patients, 63% (n = 109) reported high spiritual support from religious communities and 37% (n = 66) reported low spiritual support from religious communities.

or dying in an ICU (AOR, 0.19; 95% CI, 0.05-0.80 [P = .02]). End-of-life discussions were associated with less aggressive medical interventions near death (AOR, 0.12; 95% CI, 0.02-0.63 [P = .01]) but were not associated with hospice care (AOR, 2.37; 95% CI, 0.95-5.91 [P = .06]) or ICU deaths (AOR, 0.22; 95% CI, 0.04-1.29 [P = .09]).
of human life and ethical concerns regarding the potential to violate that sanctity, which may further motivate the continuation of aggressive medical therapies, even in the setting of advanced terminal illness.

Another possible mechanism by which religious community spiritual support may result in greater aggressive care is that religious communities may frequently emphasize perseverance through and hope found within suffering. Coupled with a strong belief in the potential for miraculous healing, religious communities’ emphasis on hope, meaning, and perseverance in illness may not only uphold but also may constrain patients’ spiritual approach to terminal illness to fighting their disease. This buttressing of patients’ hope and endurance in illness is perhaps in part reflected in the baseline association of high religious community spiritual support with better patient QoL and existential well-being (as well as greater social support), though the patients were more aware of the terminal nature of their illness and their performance status did not differ from those not well-supported by religious communities. However, high religious community spiritual support was not associated with patient QoL near death (even after adjusting for medical care received), in contrast both to its association with QoL at baseline and to the previously reported prospective association of medical team spiritual support with better patient well-being near death. These contrasting findings may again reflect religious communities’ focus on spiritual support in fighting disease—a form of support that may uphold QoL earlier in the course of advanced illness when combating illness remains feasible but may become increasingly incongruent or even in conflict with patients’ spiritual needs as death becomes imminent. Conversely, medical teams providing spiritual support may be better addressing spiritual needs that become increasingly central to patient QoL as terminal illness progresses, such as finding acceptance and spiritual peace in dying.

The study findings suggest possible means of reducing the risk of greater aggressive EoL care among patients receiving high spiritual support from religious communities— provision of spiritual care and of EoL discussions from the medical team—and highlight these central elements of quality palliative care. The results also underscore the potential role of spiritual care in addressing EoL racial/ethnic disparities because racial/ethnic minorities are at risk for greater aggressive EoL care and are frequently highly supported by religious communities (55% of the racial/ethnic minority patients in this sample). The findings suggest that by addressing EoL decisions in a manner that embraces patients’ spiritual values and goals, the medical team is assisting patients in avoiding aggressive interventions at the EoL. Mechanisms for these associations may be that medical teams are engaging those religious/spiritual factors influencing EoL medical decisions (eg, belief in miracles) and that this engagement is encouraging patients to adopt less-intensive approaches to EoL care. For example, through such engagement, some patients and families may discover that a belief in miracles can be as firmly held in the hospice setting as it is in the ICU or that choosing to withhold aggressive EoL measures does not constitute taking matters out of “God’s hands.” Furthermore, these findings emphasize the need for clinician spiritual care training, particularly given their frequent lack of training and its association with increased spiritual care provision. Finally, these findings highlight the potential value of faith-based initiatives among religious communities regarding EoL issues, as evidenced by faith-based programs successfully addressing health disparities in other settings.

Study limitations include the unclear content of spiritual support provided by religious communities. Furthermore there may be incomplete adjustment or unknown confounders not incorporated into the multivariable models. The study’s generalizability to those with noncancerous terminal illnesses and to other cultural contexts with differing religious demographics also remains unclear. Further studies on spiritual care and EoL outcomes within other patient populations examining specific spiritual care content are required.

In conclusion, terminally ill patients receiving high spiritual support from religious communities receive less-intensive EoL medical care, including less hospice, more aggressive interventions, and more ICU deaths.
ICU in the last week of life. §Wald interventions include receipt of ventilation, resuscitation, or care within an inpatient or home hospice care in the last week of life and aggressive medical care. ‡Hospice is advance care planning, and end-of-life discussions. Sex was included with race, positive religious coping, religious tradition, and region. *Spirit Support, end-of-life treatment preferences, terminal illness awareness, advance care planning, and end-of-life discussions. *Spirit Support; Med Team Spirit Support, Medical Team Spiritual Support. ICU indicates intensive care unit; Rel Com Spirit Support, Religious Community Spiritual Support; Full Sample. Patients With High Religious Coping*. Patients With Racial/Ethnic Minority Patients*. Patients Receiving High Spiritual Support From Religious Communities, %.

EOL discussions by medical teams to patients highly supported by religious communities is associated with reduced medical care intensity near death. These findings underscore the need for research defining optimal spiritual care provision to patients with advanced illness, greater clinician spiritual care training, and faith-based initiatives engaging religious communities regarding EOL issues.

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Figure 2. Comparison of sources of spiritual support and their adjusted associations with end-of-life medical care in the full sample, patients with high religious coping, and racial/ethnic minority patients. ICU indicates intensive care unit; Rel Com Spirit Support, Religious Community Spiritual Support; Med Team Spirit Support, Medical Team Spiritual Support. *Sample size reduced from 343 (total sample), 175 (patients with high religious coping), and 128 (racial/ethnic minority patients) owing to missing data (<3% for all variables). †Odds ratios and 95% confidence intervals are shown. Models adjusted for race, positive religious coping, religious tradition, northeast vs southern region, health insurance status, Med Team Spirit Support, end-of-life treatment preferences, terminal illness awareness, advance care planning, and end-of-life discussions. Sex was included in models examining receipt of hospice and death in an ICU. ‡Hospice is inpatient or home hospice care in the last week of life and aggressive medical interventions include receipt of ventilation, resuscitation, or care within an ICU in the last week of life. §Wald \( \chi^2 \) for comparison of odds ratios.
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Advancing Research on Spiritual Influences at the End of Life

Balboni and her team continue to highlight the role that religiousness and spiritual support play in the lives of patients with advanced cancer. Given the accumulating evidence linking aspects of religion and spirituality to a variety of health and health care-related outcomes, this line of work is needed to expand the literature to end-of-life (EoL) treatment decisions and well-being. The current study adds to the discussion by addressing the role of religious communities, in addition to spiritual support offered by health care providers and personal religiousness. This study also provides an ideal stepping point from which to discuss several conceptual and methodological issues.

To begin, studies in this area would benefit from the decades of work within the pastoral care field concerning the conceptualization and assessment of spiritual needs among medical patients. Although there is still a lack of consensus over what constitutes core spiritual needs and how to best measure them, most investigators agree that multiple dimensions are involved. For example, one prominent model of spiritual assessment includes the following dimensions: (1) beliefs and meaning; (2) vocation and obligations; (3) experience and emotions; (4) courage and growth; (5) ritual and practice; (6) community; and (7) authority and guidance. Given the theoretical foundations and clinical experiences used to develop such models, attempts to measure these complex ideas with single items are likely to be inadequate. At the very least, it is important to distinguish between spirituality, which is the broader of the 2 constructs, and religion, which refers primarily to the social-institutional component within this domain. In the current study (and in the numerous other studies based on the Coping With Cancer data set), these 2 concepts are conflated within the measures of spiritual care. Specifically, the primary measure of spiritual care asks how well the patient's religious/spiritual needs are being met by his or her religious community.

The measures of spiritual support used by Balboni et al are also hampered by a lack of specificity regarding the timing and content of the support. In respect to the former, the spiritual support questions were asked in the outpatient clinic approximately 3 to 4 months before death (on average). Nothing is known about support received during the remainder of their illness, including the final stage. Thus, ideal measures should address at what point, and how frequently, the support is provided. Objective measures of support, such as from chaplains' documentation in medical records, would be one example of how to address some of these concerns. In regard to the content of the spiritual support, it would be valuable to know more about (1) how such assistance is being provided to the patient and (2) which types of support are most or least helpful. Recent developments in theory and research on congregational support systems are useful for thinking about how to advance this line of work related to support received from religious communities. Dimensions of congregational support include instrumental support (goods and services), socioemotional support (making the recipient feel loved, valued, and cared for), and spiritual support (reinforcing core beliefs and helping the recipient understand and live out his or her faith commitments more fully). These and other types of assistance can be provided by religious groups via formal programs, informal contacts among religious group members, or interactions with clergy members. Future research on religion/spirituality and EoL decisions would be strengthened by the inclusion of questions related to these kinds of supports in meeting spiritual needs.

Other aspects of religiousness and spirituality that predict well-being in the general population may also deserve consideration in relation to EoL outcomes for terminally ill patients. Among these constructs are (1) meaning or the sense that one's life has had a purpose or positive impact; (2) forgiveness and reconciliation; and (3) emotions such as gratitude. In addition, the role of “spiritual struggles” or negative experiences of spirituality encountered by patients at EoL may be consequential. Three types of spiritual struggles might be particularly relevant. The first is “divine struggles,” in which case a patient might wonder why God, especially a good and loving God, would allow them to suffer so much. This may lead to feelings of divine abandonment or a questioning of divine caring or power. A second type of spiritual struggle may involve religious doubts, in which the patient comes to question core elements of his or her belief system as a consequence of the illness experience and prognosis. Yet, a third type of spiritual struggle is interpersonal, involving relationships with individuals in one's religious community. In the context of terminal illness,