The Relationship of Faith-Related Characteristics to Attitudes and Behaviors Regarding End-of-Life Care

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The effects of faith-related characteristics on attitudes toward end-of-life (EOL) care were examined using the Pew Research Center's (2014) Survey of Aging and Longevity. Results showed that frequency of religious service attendance and importance of religion were related to less support for the right to end one's life or for stopping medical treatment due to pain/incapacitation, while frequency of prayer was associated with less support for stopping medical treatment. Similarly, Evangelical Christians and those who identified as "other Christian" were least likely to support these outcomes, while those with no religious affiliation were most likely to support them. Individuals identifying as "other Christian" and those with no religious affiliation were most likely to have prepared an advance directive.

At some point in life, end-of-life (EOL) care decisions and wishes present pressing challenges for most individuals and their loved ones. Cicirelli (2008) notes that such decisions may involve the types of medical care one prefers; whether treatment be aggressive or palliative; the time, manner, and/or place of one's death; and who will make decisions when one is incapable of doing so. Such decisions also may involve preparations for funerals and involvement of one's faith community in rituals of celebrating the life of the deceased. End-of-life care issues also may arise in the period following an individual's death, and include decisions or wishes regarding autopsy, organ donation, and disposition of the body.

To adapt and prepare for the challenges presented by EOL issues, individuals may employ a variety of strategies, including discussing EOL care preferences with others and preparing formal advance directives (ADs)—such as living wills or durable powers of attorney for health care—that explicitly outline personal wishes for medical care. Individuals also may think about and formulate personal views and preferences about these and other similar issues, including refusing/withholding treatment that would extend life or facilitating/assisting/expediting of the end of one's life.

A number of studies have observed that ethnicity is related to views and behaviors involving end-of-life issues (e.g., Balboni et al., 2007; Fischer, Sauaia, Min, & Kutner, 2012; Johnson, Kuchibhatla, & Tulsky, 2008; Karches, Chung, Arora, Meltzer, & Curlin, 2012; Smith et al., 2008; True et al., 2005). Kwak and Haley (2005), in their review of 33 empirical studies, observed that non-White individuals were less likely than White persons to support advance directives, and that African American individuals consistently favored the use of life support. Other factors that have been shown to be related to EOL preferences/decisions include socioeconomic status (e.g., Carr, 2012b), relationship quality (e.g., Boerner, Carr, & Moorman, 2013; Carr, Moorman, & Boerner, 2013), and the quality of a significant other's death (e.g., Carr, 2012a).

Research also has shown that religious affiliation, beliefs, and practices can influence individuals' EOL preferences/decisions. However, for the most part these studies have used either clinical or non-nationally representative samples. For example, several studies using clinical samples (Balboni et al., 2007; Jacobs, Burns, & Jacobs, 2008; Phelps et al., 2009; Smith et al., 2008; True et al., 2005) have shown that individuals who tend to use religion to cope with stress and adversity are more likely to prefer pursuing heroic measures to extend one's life than individuals who don't use such religious coping, and also are less likely to have prepared an AD.

Karches et al. (2012), using a relatively large clinical sample (N = 8,308) of predominantly African American and female internal medicine patients, found that those with high intrinsic religiosity or high spirituality were more likely to have a designated decision-maker than those with low intrinsic religiosity or high spirituality. However, they found that individuals' religious characteristics were not significantly related to having an AD or a "do-not-resuscitate" order. Shinall and Guillamondegui (2015) examined data from 172 trauma patients and found that more religious patients tend to receive more aggressive EOL care than less religious patients, and also found that pastoral care can reduce unnecessary (and futile)

EOL care. Neimeyer, Currier, Coleman, Tomer, and Samuel (2011) gathered data from patients enrolled in hospice and found that those with an internalized religious worldview showed greater acceptance of death, and that intrinsic religiosity was associated with increased acceptance of impending death.
Other researchers have used non-clinical samples to investigate the associations between religion and EOL treatment preferences/decisions. Nevertheless, the generalizability of these samples to the overall adult US population is limited. For example, several studies (Carr & Khodyakov, 2007; Carr & Moreman, 2009; Sharp, Carr, & Macdonald, 2012) used the Wisconsin Longitudinal Study (WLS)—which consists of primarily older (60 and over), White, non-Latino individuals—to study the association between end-of-life treatment preferences/decisions These studies indicated that fundamentalist Protestants and fundamentalist Catholics are more likely than their non-fundamentalist peers to favor life-extending treatment when presented with EOL scenarios. Winter (2013), using a non-clinical convenience sample of 304 older individuals recruited through display ads, flyers, and mailings, found that religiosity significantly predicted stronger preferences for life-prolonging interventions.

Because of the limited nature of the samples used in previous studies that investigate the relationship between religion and EOL treatment preferences, there is warrant for research that investigates these relationships using a large, nationally representative dataset. The purpose of the present study is to use a nationally-representative data set to investigate the extent to which religious beliefs, practices, and affiliation are associated with various attitudes and behaviors regarding EOL care, such as the agreement with the right to end one's life or withhold treatment, assisting/facilitating the end of life discussion of EOL care, preparation of advance directives. To this end, we asked the following research questions:

1. When controlling for personal/demographic characteristics, do religious beliefs and practices predict attitudes and behaviors toward end-of-life medical care?
2. When controlling for personal/demographic characteristics, does religious affiliation predict attitudes and behaviors toward end-of-life medical care?

Method

Participants

The data used in the present study were secondary data from the Pew Research Center's (2014) Survey of Aging and Longevity, collected as part of the Center's Religion and Public Life Project. Survey respondents included N = 4,006 adults age 18 years or older living in the United States. Data were collected from March 21 to April 8 2013, and included queries about respondents' experiences and views about EOL decisions, aging, older-age quality of life, medical advances, the potential for life extension, and other topics. A split-form design was employed in which one sample of persons was asked one subset of queries (Forms 1 and 2), and a second sample was asked a distinct subset of queries (Forms 3 and 4). The present study made use of data from the two forms that included the variables of interest in this study—Forms 1 and 2 (N = 1,937).

Instrumentation

Table 1 details the dependent variables used in this study. Two of these variables are multi-item measures of respondents' attitudes and preferences toward EOL treatment and care. The first of these is a composite measure that assesses respondents' attitudes toward the legal and moral right to end one's life in the face of disease, pain, or burden. The second is a composite measure of the extent to which respondents' would choose to end EOL treatments in the face of disease and suffering (versus doing everything possible to extend one's life). These composite scores were computed as the mean of the associated item scores. Evidence of internal consistency reliability was evident for each of these two measures, with alpha = 0.85 and alpha = 0.73, respectively.

The remaining two dependent variables are binary (yes/no) indicators of whether respondents had personally engaged in any EOL treatment preparations. Specifically, (1) whether the respondent t had discussed preferences for their EOL medical treatment with another person, and (2) whether the respondent had prepared an AD.

The predictor variables of interest consisted of self-reported religious beliefs, practices, and affiliations. Indicators of religious beliefs included two binary (yes/no) variables reflecting belief in God and self-identification as a "born-again" Christian, an ordinal variable measuring satisfaction with one's spiritual life (poor to excellent), and an ordinal variable measuring the importance of religion in one's life

Table 1. Outcome Variables Related to End-of-Life Issues

Measure	Items	Response options
Support for the moral right to end one's life (4 items)	Do you think a person has a moral right to end his or her own life when this person… • has a disease that is incurable? • is suffering great pain and has no hope of improvement? • is an extremely heavy burden on his or her family? • is ready to die because living has become a burden?	For each item: 0 = *No* 1 = *Yes*
Support for stopping medical treatment (3 items)	• If you had a disease with no hope of improvement and were suffering a great deal of physical pain, would you tell your doctor to do <u>everything possible</u> to save your life, or tell your doctor to <u>stop treatment</u> so you could die? • How about if you had a disease with no hope of improvement that made it hard for you to function in your day-to-day activities? • How about if you had an illness that made you totally dependent on a family member or other person for all of your care?	For each item: 0 = *Do everything possible to save your life* 1 = *Stop treatment so you could die*
Had end-of-life discussion (1 item)	Have you had a discussion with someone about your own wishes for medical treatment in these kinds of circumstances, or haven't you done this?	0 = *No* 1 = *Yes*
Prepared advance Directive (1 item)	Are your own wishes for medical treatment in these kinds of circumstances written down somewhere, or not? Just to clarify, do you have a living will, or not?	0 = *No* 1 = *Yes*

(not at all important to very important). Religious practices included how often the respondent attends religious services (never to more than once a week), and (outside of religious services) how often the respondent prays (never to several times a day). We also employed several control variables in the analysis. These included gender, age, marital status, attainment of college degree, non-White or Hispanic ethnicity, satisfaction with finances, political liberalism, and personal health rating.

Procedure

To address the first research question, we carried out ordinary least-squares (OLS) regression using the continuous outcomes (support for the moral right to end one's life and support for stopping medical treatment), and logistic regression for the binary outcomes (having an end-of-life discussion with another person, and preparation of an AD). Predictor variables were entered in two blocks, corresponding to (1) personal/demographic characteristics (gender, age, marital status, college degree status, ethnicity, self-rating of personal financial situation, political orientation, and self-rating of health), and (2) religious beliefs and practices (belief in God, self-rating of spirituality, importance of religion, frequency of religious service attendance, and frequency of prayer). To address the second research question, we carried out OLS and logistic regression analyses using the same outcome variables described previously. Predictor variables were entered in two blocks, corresponding to (1) personal/demographic characteristics (as described previously), and (2) religious affiliation (evangelical Protestant, mainline Protestant, Catholic, other Christian, other non-Christian, and none). For all statistical analyses in the present study, we used the supplied sampling weights, and employed an a priori alpha level of .05 as the criterion for statistical significance.

Results

Table 2 provides frequency distributions for selected personal/demographic characteristics of the sample. The relative frequency of females vs. males was balanced, approximately one-half of respondents were married, approximately half had at least some college education, and approximately two-thirds of

Table 2. Frequency Distributions for Personal/Demographic Characteristics of Sample Respondents.

Characteristic	Freq.	Percent	Characteristic	Freq.	Percent
Gender			Political orientation		
Female	1025	51.9%	Very conservative	123	6.7%
Male	951	48.1%	Conservative	643	35.1%
Education			Moderate	621	33.9%
Less than College degree	1432	73.0%	Liberal	314	17.1%
College degree	530	27.0%	Very liberal	130	7.1%
Marital status			Health self-rating		
Married	1012	51.4%	Poor	149	7.6%
Not married	955	48.6%	Only fair	357	18.1%
Ethnicity			Good	921	46.8%
Non-White	657	33.7%	Excellent	540	27.4%
White	1290	66.3%	Religious affiliation		
Satisfaction w/personal financial situation			Mainline Protestant	569	14.8%
Poor	305	15.7%	Evangelical Protestant	842	22.0%
Only fair	582	29.9%	Roman Catholic	857	22.3%
Good	790	40.0%	Other Christian	520	13.6%
Excellent	269	13.8%	Other non-Christian	210	5.5%
			None	837	21.8%

Note: Cases have been weighted by sampling weights.

respondents were White. The mean age of the respondents was 46.67 years (SD = 17.84). Roman Catholic individuals constituted the largest percentage of the sample (22.3%), while Evangelical Protestants, Roman Catholics, and those with no religious affiliation were approximately uniformly distributed. Table 3 provides distributional information for religious beliefs, practices, and affiliations of the sample. A very large percentage (92.2%) of respondents expressed belief in God. Strong percentages of respondents (81.7%) also indicated "good" or "excellent" satisfaction with their spiritual lives, and that religion was "somewhat important" or "very important" in their lives (80.1%). Slight majorities reported attending religious services once or twice per month or more (52.6%) and praying once a day or more (55.39%). A strong majority (82.1%) of respondents self-reported as Christian.

Table 4 shows the results for the OLS regression models predicting respondents' support for (1) the moral right to end one's life and (2) stopping medical treatment. Each regression model significantly predicted its outcome [$F(14, 1602) = 27.31$, $p < .001$ and $F(14, 1589) = 18.98$, $p < .001$, respectively]. Considered together, the personal/demographic predictors (Block 1) accounted for 8.5% of variation in supporting the right to end one one's life, and 11.3% of the variation in support for stopping medical treatment. Among these personal/demographic predictors, statistically significant effects on both outcomes were observed for age and non-White or Hispanic ethnicity. Non-White or Hispanic individuals showed less support than White persons for the right to end one's life and to stop medical treatment, while increased age was associated with increased support for these outcomes. Compared to males, females showed more support for stopping medical treatment in the presence of incurable illness with great pain, but no difference from males in support for the right to end one's life. Political liberalism was associated with significantly increased support for the right to end one's life, but was not related to support for stopping medical treatment.

Religious beliefs/practices as predictors of these two outcomes were considered next. Taken together, and controlling for personal/demographic characteristics of individuals, these faith-related characteristics accounted for 11.1% of the variation in support for the right to end one's life, and 8.0% of the variation in support for stopping medical treatment (see Table 4). Considered individually, importance of religion and frequency of religious service attendance both significantly and negatively predicted support for the right to end one's life. That is, greater satisfaction and more frequent attendance were associated with increased support for this outcome. Frequency of prayer was a significant, negative predictor of support for stopping medical treatment; i.e., those who reported praying more frequently showed less support for this outcome.

Table 3. Frequency Distributions for Religious Beliefs/Practices.

Belief/behavior	Frequency	Percent
Belief in God		
No	148	7.7%
Yes	1779	92.3%
Satisfaction w/spiritual life		
Poor	67	3.5%
Only fair	281	14.7%
Good	854	44.8%
Excellent	705	37.0%
Importance of religion		
Not at all important	164	8.4%
Not too important	227	11.6%
Somewhat important	486	24.9%
Very important	1077	55.1%
How often attend religious services		
Never	256	13.1%
Seldom	333	17.0%
A few times a year	342	17.5%
Once or twice a month	297	15.2%
Once a week	458	23.4%
More than once a week	272	13.9%
How often pray		
Never	198	10.4%
Seldom	192	10.0%
A few times a month	118	6.2%
Once a week	71	3.7%
A few times a week	265	13.9%
Once a day	349	18.3%
Several times a day	717	37.6%
Describe self as a "born-again" or evangelical Christian		
No	1166	61.4%
Yes	732	38.6%

Note*:* Cases have been weighted by sampling weights

Table 5 shows results pertaining to how religious affiliation predicted support for the right to end one's life and support for stopping medical treatment, when controlling for personal/demographic characteristics,. These results indicate that, when compared to mainline Protestants, Evangelical Protestants and self-described "other Christian" persons were significantly less likely to express support for the right to end one's life. In contrast, "other non-Christians" and those with no religious affiliation were significantly more likely than mainline Protestants to support this outcome. Those with no religious affiliation also showed significantly more support for stopping medical treatment than mainline Protestants. Only 0.8% of the variation in this latter outcome, however, was explained by religious affiliation.

When (1) having a discussion with someone about end-of-life medical treatment and (2) preparing an AD were considered as outcome variables, each fitted logistic regression model significantly predicted its outcome, with statistically significant ($p < 0.001$) omnibus chi-square tests indicating better-than-chance level prediction, and statistically non-significant Hosmer-Lemeshow tests ($p > 0.05$), reflecting good model fit. Tables 6 and 7 provide the estimated regression parameters and adjusted odds-ratios (AORs). Among the personal/demographic (control) indicators, age, education, ethnicity, and personal health rating each predicted both outcomes. Increased age was associated with greater likelihood of having an end-of-life medical care discussion and with preparing an AD. Those with a college degree also were more likely to have engaged in these behaviors, while individuals of non-White or Hispanic ethnicity

Table 4. Regression Results for Regression of Support for the Moral Right to End One's Life and Stopping Medical Treatment on Personal/Demographic and Religious Beliefs/Practices

	Support for the right to end one's life					Support for stopping medical treatment				
Variable	*B*	*SE*	*β*	R^2	ΔR^2	*B*	*SE*	*β*	R^2	ΔR^2
Block 1: Personal characteristics				.085	---				0.113	---
Female gender	-0.033	0.018	-0.041			0.053**	0.020	0.065		
Age	0.002***	0.001	0.096			0.006***	0.001	0.271		
Married	-0.041*	0.019	-0.051			-0.010	0.021	-0.013		
College degree	0.032	0.021	0.035			0.028	0.023	0.030		
Non-White or Hispanic ethnicity	-0.052*	0.020	-0.062			-0.136***	0.022	-0.155		
Satisfaction with finances	-0.009	0.011	-0.021			-0.013	0.012	-0.029		
Political liberalism	0.057***	0.010	0.146			0.019	0.010	0.048		
Personal health rating	0.013	0.012	0.027			0.001	0.013	0.003		
Block 2: Religious beliefs/practices				0.196	0.111				0.193	0.080
Belief in God	0.008	0.043	0.005			0.051	0.046	0.031		
Satisfaction with spiritual life	0.003	0.013	0.007			0.004	0.014	0.007		
Importance of religion	-0.060***	0.014	-0.139			-0.025	0.015	-0.057		
How often attend religious services	-0.044***	0.007	-0.179			-0.004	0.008	-0.014		
How often pray	-0.018	0.006	-0.092			-0.028***	0.007	-0.138		
Evangelical / "born-again" Christian	-0.0003	0.0003	-0.032			-0.0003	0.0003	-0.026		

Note. *$p < .05$, **$p < .01$, ***$p < .001$.

Table 5. Regression Results for Regression of Moral Right to End One's Life and Stopping Medical Treatment on Personal/Demographic Variables and Religious Affiliation

	Support for the right to end one's life					Support for stopping medical treatment				
Variable	*B*	*SE*	*β*	R^2	ΔR^2	*B*	*SE*	*β*	R^2	ΔR^2
Block 1: Personal/Demographic characteristics				0.097	---				0.104	---
Female gender	-0.060**	0.018	-0.075			0.037*	0.019	0.046		
Age	0.002**	0.001	0.085			0.006***	0.001	0.252		
Married	-0.054**	0.019	-0.068			-0.021	0.020	-0.026		
College degree	0.018	0.021	0.020			0.029	0.022	0.032		
Non-White or Hispanic ethnicity	-0.100***	0.020	-0.119			-0.138***	0.021	-0.159		
Satisfaction with finances	-0.005	0.011	-0.011			-0.009	0.012	-0.020		
Political liberalism	0.076***	0.009	0.197			0.033**	0.010	0.083		
Personal health rating	0.002	0.012	0.005			0.003	0.012	0.005		
Block 2: Religious affiliation				0.158	0.061				0.112	0.008
Roman Catholic	0.019	0.030	0.019			-0.017	0.032	-0.017		
Other Christian	-0.096**	0.033	-0.085			-0.027	0.036	-0.023		
Other non-Christian	0.103**	0.046	0.057			-0.042	0.049	-0.023		
None	0.149***	0.030	0.158			0.066*	0.032	0.067		
Evangelical Protestant	-0.136***	0.030	-0.139			-0.029	0.032	-0.029		

Note. *$p < 0.05$, **$p < 0.01$, ***$p < 0.001$

were less likely to have done so. Additionally, lower personal health ratings were associated with increased likelihood of having end-of-life care discussions or having prepared an AD.

When the effects of religious beliefs/practices on these two binary outcomes was considered, results (Table 6) showed that, when controlling for personal/demographic characteristics, satisfaction with one's spiritual life and frequency of religious service attendance were each significantly and positively associated with having end-of-life medical care discussions and preparing an AD. Interestingly, increased importance of religion in one's life was significantly and negatively associated with having end-of-life care discussions. That is, those for whom religion was more important were less likely to have engaged in such discussion than those for whom religion was less important. Examining the effects of religious affiliation on these two outcomes, results (Table 7) showed that, when compared to mainline Protestants, those identifying as "Other Christian" and those with no religious affiliation were more likely to have engaged in end-of-life care discussions.

Discussion

Individual traits and characteristics as well as religious orientation form an integral part of one's personality and being, and may have effects on a variety of behaviors, views, and decision-making processes. The present study examined how personal and faith-related characteristics predict a very personal and important set of views and behaviors—those involving EOL decisions.

A distinct finding of the present study was that individuals of non-White or Hispanic ethnicity were less likely than White individuals to endorse views or decisions that would hasten the end of life, and were less likely to have either prepared an AD or discussed EOL issues with others. This is consistent with prior research (e.g., Balboni et al., 2007; Caralis, Davis, Wright, & Marcial, 1993; Fischer et al., 2012; Hopp & Duffy, 2000; Johnson et al., 2008; Karches et al., 2012; Kwak & Haley, 2005; Smith et al., 2008; True et al., 2005), and the current study found this effect of ethnicity to be robust even after controlling for other personal characteristics such education, marital status, satisfaction with finances, and perceived health. Although not the primary focus of the present study, this suggests that sociocultural, familial, or relational aspects that could foster these differential views and behaviors are important to consider, and sensitivity to these factors is warranted when discussing EOL issues, particularly for health care providers, ministerial professionals, and those in the legal profession.

Among the other personal characteristics that were examined in this study, increased age was associated with an increased likelihood of favoring the right to end one's life or stop medical treatment, while both age and education each positively predicted the likelihood of preparing an AD or having discussed EOL issues. It certainly is not surprising that age would predict preparation of an AD or discussion of EOL issues, as older individuals will experience more opportunity than younger persons to engage in these actions by simple virtue of age, and the context of growing older naturally brings with it an increasing presence of one's mortality and resultant increased motivation to consider ADs or discussions of EOL issues. Education, too, brings with it increased availability of resources and the ability to utilize them. The association of age, but not education, with increased tolerance for actions that may hasten death—or at least do not prolong life—perhaps holds greater interest. Regarding the effect of age, it may be the case that, as one's life progresses, the notion of death becomes less of an abstraction and more of a pressing reality—less of a tragedy and more a natural and accepted conclusion to one's journey. This age-associated transformation towards acceptance of death has been documented by several researchers (e.g., McCoy, Pyszczynski, Solomon, & Greenberg, 2000; Wong, 2000). Education, too, may bring increased understanding of death's inevitability; however, it may simultaneously bring about increased knowledge about strategies and technologies that might extend one's lifespan, and a corresponding desire to benefit from these advances. This may even lead some highly-educated individuals to subscribe to views that seek to prolong life, as evidenced by the life-extension / anti-aging movement that has gained support from a number of influential public figures.

The most pertinent findings to the purpose of this study involve the effects of faith- and spirituality-based factors. Among the religious beliefs and practices examined, frequency of religious service attendance and importance of religion were related to less favorable views towards the right to end one's life, while frequency of prayer was associated with less support for stopping medical treatment. These findings are congruent with the findings of Winter (2013), but in contrast to the results reported by Neimeyer et al. (2011). The latter study's observed positive effects of religiosity on acceptance of death,

Table 6. Logistic Regression Results for Regression of End-of-Life Discussions and Preparing an Advance Directive on Personal/Demographic and Religious Beliefs/Practices

	Had end-of-life discussion			Prepared an Advance Directive (AD)		
Variable	*B*	*SE*	AOR	*B*	*SE*	AOR
Block 1: Personal/demographic characteristics						
Female gender	0.224	0.115	1.251	-0.005	0.116	0.995
Age	0.011**	0.004	1.011	0.037***	0.004	1.037
Married	0.383**	0.120	1.466	-0.012	0.123	0.988
College degree	0.334*	0.135	1.397	0.311*	0.130	1.365
Non-White or Hispanic ethnicity	-0.860***	0.122	0.423	-0.514***	0.134	0.598
Satisfaction with finances	-0.069	0.071	0.933	0.173*	0.073	1.188
Political liberalism	-0.139*	0.060	0.870	-0.112	0.063	0.894
Personal health rating	-0.237**	0.078	0.789	-0.228**	0.079	0.796
Block 2: Religious beliefs/practices						
Belief in God	0.123	0.254	1.131	-0.167	0.271	0.846
Satisfaction with spiritual life	0.295***	0.081	1.343	0.205*	0.087	1.227
Importance of religion	-0.233*	0.090	0.792	-0.092	0.092	0.912
Frequency of religious service attendance	0.112*	0.046	1.119	0.155**	0.048	1.168
Frequency of prayer	0.068	0.038	1.070	-0.023	0.041	0.977
Evangelical / "born-again" Christian	-0.014	0.135	0.986	-0.219	0.138	0.803

Notes. $*p < .05$, $**p < .01$, $***p < .001$. AOR = adjusted odds-ratio.

however, involved intrinsic religiosity—which Neimeyer et al. describe as "the "extent to which an individual has internalized religion as a master motive in life" (p. 785). Perhaps one reason for the discrepant findings is that the notion of intrinsic religiosity may not precisely parallel the indicators used in the present study (e.g., religious service attendance, frequency of prayer, self-indicated importance of religion). Although the present study offers advantage in the sense that it makes use of a large, nationally representative sample, a limitation lies in the generality of the survey queries, where the specific type of religiosity (e.g., extrinsic vs. intrinsic) cannot readily be determined. Clearly, this is an area where additional, more nuanced study is needed. It is apparent from the results of the present study, however, that individuals reporting higher levels of these beliefs and practices tend to disfavor choices that hastened the end of life. It is important to note that this was true even after controlling for characteristics such as age, education, and political orientation.

The present study also found differences in EOL attitudes and behaviors by religious affiliation. Those with no religious affiliation (i.e., religious "nones," see Pew Research Center 2015) were the most likely to favor the right to end one's life and stop medical treatment, and also were most likely to have prepared an AD. Evangelical Christians and individuals who identified as "other Christian" were the least likely to support the right to end one's life. As a measure of political orientation was included as a control variable, these observed effects appear to go beyond any political/ideological distinctions that may exist among affiliations. One possible explanation is that in Christianity, biblical references such as "fighting the good fight" or "finishing the race" have been commonly used to indicate heroism in fighting

Table 7. Logistic Regression Results for Regression of End-of-Life Discussions and Preparing an Advance Directive on Personal/Demographic and Religious Affiliation

	Had end-of-life discussion			Prepared an Advance Directive (AD)		
Variable	*B*	*SE*	AOR	*B*	*SE*	AOR
Block 1: Personal Demographic characteristics						
Female gender	0.268*	0.108	1.307	-0.044	0.110	0.957
Age	0.016***	0.003	1.016	0.035***	0.004	1.036
Married	0.518***	0.113	1.679	0.108	0.115	1.115
College degree	0.402**	0.128	1.495	0.320**	0.123	1.378
Non-White or Hispanic ethnicity	-0.851***	0.115	0.427	-0.588***	0.128	0.556
Satisfaction with finances	-0.026	0.066	0.974	0.249***	0.069	1.282
Political liberalism	-0.153**	0.056	0.858	-0.067	0.058	0.936
Personal health rating	-0.116	0.070	0.891	-0.165*	0.072	0.848
Block 2: Religious affiliation						
Roman Catholic	0.035	0.179	1.036	-0.005	0.179	0.995
Other Christian	0.408*	0.202	1.505	0.069	0.205	1.072
Other non-Christian	0.132	0.271	1.141	0.080	0.285	1.083
None	0.530**	0.184	1.699	0.120	0.183	1.127
Evangelical Protestant	0.288	0.185	1.333	0.075	0.178	1.078

Notes. *$p < .05$, **$p < .01$, ***$p < .001$. AOR = adjusted odds-ratio.

death, and these values may hold sway where these attitudes and practices are concerned. Additionally, Judeo-Christian and other religious traditions have honored the notion that life is holy, supported by commandments such as "thou shall not kill." Perhaps such traditions inhibit persons of these faiths from hastening the onset of death.

Considering the likelihood of having discussion about wishes for EOL medical treatment and preparing an AD, the results of this study showed that both satisfaction with spiritual life and frequency of religious service attendance significantly and positively predicted these behaviors. Given that individual spirituality has natural connections to life's meaningfulness and teleology, strong satisfaction with spiritual life might reasonably carry with it increased comfort with thinking, talking about, and preparing for the end of life. Similarly, perhaps attendance/participation in religious services affords individuals increased opportunity to interact with like-minded individuals, and to encounter experiences in which discussions/plans concerning the end of one's life are not discouraged and even welcomed. A somewhat contradictory finding of this study, however, was that importance of religion was negatively associated with having an EOL discussion.

It is noteworthy the belief in God did not significantly predict any of the four outcomes. The independence of this rather existential orientation with EOL views and behaviors was somewhat surprising, but suggested that such views and behaviors may be formed or influenced by more outward manifestations of one's orientation, or even social and interpersonal influences, rather than by the orientation itself.

It also is important to consider that the effects of religious beliefs, practices, and affiliations considered in the present study may not necessarily be unidirectional. That is, it is possible that the types of decisions an individual makes or the views one develops about EOL issues may affect religiosity/spiritual development and even choice of religious affiliation. Further, these views or decisions

may incline individuals to seek religious activities and experiences with others who share their values, further reinforcing their perceived importance.

A more overarching implication that results from the present study concerns the question, how do religious communities help persons of faith "die well?" Vaux and Vaux (1996) indicate that to die well is to "to end one's days in old age, relieved of pain, surrounded by one's friends and family, attended by sensitive caregiving, reconciled with all persons, in justice with humanity and the world, at peace with God" (1996: 138). Spiritual communities and leaders have great responsibilities to teach, proclaim, and communicate a notions of "good death" to persons of faith in both sickness and health. When a sound theology of death is in place in congregational life, its members are likely to make EOL decisions with more trust and strength. What, however, constitutes a sound theology of death? Vaux and Vaux systematize a theology of death into three categories: death as friend, death as enemy, and death as magnanimity, and argue that the third understanding is most needed. Magnanimity is defined as "looking death squarely in face, then moving through it in grace toward the saving power of God" (p. 48). A healthy theology of death can lead people of faith to develop more holistic understanding of life and death and, ultimately, to die well.

In many religious communities, death often is an intimate part of congregational life: a beloved, long-time member dies after illness, a young person dies suddenly from an automobile accident, or young parents lose their first child during pregnancy. In such tender times, church members often come together to provide care and support to families who have lost their loved ones. At the same time, death can be rather foreign in its spiritual and theological meaning. Christians simultaneously meditate on a violent crucifixion and celebrate life in the resurrection. Buddhists view death as a transitional state between life forms. Muslims view death as the conclusion of an earthly trial. Even during the funeral services of many religions, death often is implicitly described as something to be conquered, or as a passage that opens to a new realm. Words such as "our deceased are resting peacefully in God," "we will all be together in heaven," or "suffering is over," may be comforting, but also may be confusing as to what it really means to die. It seems that the theological meaning of death and dying is not widely explored in preaching, worship, and teaching. Thus, in addition to future research that focuses on this, individuals and communities can benefit from increased focus by religious leaders on communicating the values and processes which lead individuals to "die well."

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