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Assessment of Seminary Education on End of Life Issues

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by

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To my Lee Ann

"Imagining themselves highly sophisticated in their emancipation from religion, they give themselves to the most absurd hopes about the possibilities of man's natural history"

– Reinhold Niebuhr,

Beyond Tragedy

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I am greatly appreciative of Dr. Elizabeth Turf for her guidance

Abstract

Background: The US health care system faces increased costs from end of life (EOL) care. The intensive approach to EOL treatment with greater use of procedures in ICUs has led to decedent spending six times greater than that of survivors in the hospital. Experts in ICU and Palliative care fields have called for greater utilization of end of life planning and education. To date, EOL education has been dominated by the technologically driven medical field and the church has been under-utilized. The US population relies on clergy support for many mental health and EOL issues. Clergy report feeling uncomfortable in their ability to provide EOL care and desire more education. Research in clergy preparation for EOL education is relatively small and no studies in Virginia have been completed.

Purpose: Document the current state of Richmond, VA, seminary education on EOL issues and document graduating seminarians' desire for more EOL education.

Methods: A two-page questionnaire was approved by the VCU IRB and distributed amongst graduating seminarians at the three Richmond Theological Consortium seminaries: Union-PSCE, Baptist Theological Seminary at Richmond, and Virginia Union University Seminary. The first section of the survey evaluated education on EOL issues received while in seminary. Experience with counseling the dying and bereaved along with placement at medical institutions was also evaluated. The second section evaluated the desire for more didactic and practical education. Desire for future Continuing Education Classes was also evaluated along with demographics. SAS was utilized to create frequencies and chi square associations and odds ratios.

Results: Overall, 75 surveys were returned, a 35% response rate. Eighty-six percent of respondents stated that pastoral care overall education was covered (missing = 20), while 38.3% stated that medical aspects of dying was covered (missing = 9). Fifty-seven percent had some kind of placement at a medical institution. Sixty-nine percent had experience in an EOL situation. Approximately 75% wanted more education, with practical education and pastoral care predominating. Forty-eight percent desired more theologically-focused EOL continuing education classes. Prior education in preaching sermons and pastoral care of the bereaved was associated with desire for further education in those respective topics, OR = 3.42, 95%CI 1.58, 11.05 and OR = 4.64, 95%CI 1.10, 19.50, respectively. Placement at an institution was associated with desire for more didactic (OR = 3.10, 95%CI 1.03, 9.35) and practical education (OR = 3.89, 95%CI 1.22, 12.35). Experience with counseling the bereaved was associated with a decreased likelihood of wanting more education on how to interact with medical and hospice staff. Demographics were not statistically associated with desire for more education.

Conclusions: Several EOL topics do not receive full coverage, specifically self care of the pastor, teaching adults about end of life planning, the medical aspects of end of life, and mobilizing the laity for the care of the dying and bereaved. Placement at an institution or experience was absent in 30-40% of participants. The majority of participants wanted more education. Placement along with previous education was associated with desire for further education. Curriculum change to reflect these findings may benefit in increasing the overall confidence and competence of pastors, increase the ministerial goals of the church, and aid in preparing the public for the end of life, thus decreasing the burden on the health care system.

Introduction

Health Care Burden of the Intensive Approach to Death and Dying

As medical technology advances, human life has been extended and concurrently costs of medical care have increased dramatically. The Center for Medicare and Medicaid Services predicts that over the next ten years a 9% annual increase in hospice spending will be greater than the increases predicted for home health services, skilled nursing facilities, physicians, and hospitals[1]. Angus et al., in a study of all patients dying in non-federal hospitals in six US states in 1999, observed an average $16,000 increase for ICU versus non-ICU terminal hospitalizations as well as a longer hospital stay by four days[2]. Because of the increasing use of these ICU services by 20% of dying Americans, and the predicted two-fold increase in persons aged 65 and older by the year 2030, Angus states that for dying patients, a system-wide expansion of ICU care is needed. He proposes that the alternatives would be health care rationing, caring for the dying in other settings outside of the ICU, and / or greater utilization of advanced care planning[2].

A 2004 study by Barnato et al. reviewed the trends of inpatient treatment intensity for Medicare beneficiaries at the end of life[3]. This study showed that there has been an increasing trend of patients dying outside of the hospital, in other settings. Despite this trend, the total cost in Medicare expenditures for those in their last year of life has not decreased. This was attributed to higher use of intensive procedures for patients at the end of life, 0.27 procedures per patient in 1985 and 0.55 per patient in 1999[3]. Between the years of 1985 and 1999, the total expenditure of the Medicare fee-for-service rose by 60% to $90 billion. Of this total increase in costs, 25% was accredited to decedents[3]. Previously it has been shown that 30% of Medicare expenditures are accrued from the 5% of Medicare beneficiaries who die each year, making decedent spending six times greater than survivors[4,5].

Barnato addressed crucial policy questions regarding hospice, ICU care, and Medicare particularly because much of the intensive care being given is ineffective and thus quality of life may not be actually improved[3], especially amongst ICU readmissions[6]. Although ICU literature on effectiveness is vast, meta-analyses have shown that the inconsistencies between studies make evaluation of long term survival and efficacy difficult[7,8,9]. Smaller studies from individual hospitals report equivalent quality of life ratings pre and post ICU admission and discharge amongst ICU survivors[10,11,12]. On an individual level, intensive care can prolong life in certain instances; the problem is that one cannot know which patients receiving intensive care will respond appropriately[3]. Ultimately, Barnato sees hospice as the solution because of its creation by Congress to aid suffering in those with terminal illness and to decrease overall medical cost as a solution[3]. Although the use of hospice, palliative care, and dying outside of the hospital are on the rise, those that still die in an acute care hospital are treated more intensively and thus have driven up the overall cost of dying in the US[3]. The intensivist community acknowledges the impending failure of the current state of ICU care[13]. If it were not for the existence of hospice, alternatives to in-hospital death, and end of life planning, overall medical costs at the end of life would be much higher[3].

Palliative Care – the Specialty

The field of palliative and end of life (EOL) care has been growing throughout the past several decades. Palliative care is involved with alleviating suffering of patients on physical, social, and spiritual bases[14]. The field has led to better understanding of symptom management in end of life situations, changes in the philosophy of symptom management, and greater emphasis toward holistic care. For many patients spirituality and their religious views play a great role in their choices for end of life care[15].

The Current State of Informed End of Life Decision Making

Past research is mixed over finding clear definitive benefit of advance directives on issues of clinical interventions, decision-making and cost[16,17,18]. However, the mere initiation of conversation between the family, patient, and physician on end of life issues has been shown to be of benefit. US ICU's have very low rates (10%) of having any log of advance directives on their patients[19,20]. These low rates of advanced directives within ICU's were also found in French[21], Spanish[22], and Italian studies[23].

This failure to plan also impacts on the utilization of hospice and symptom management. One third of the 2.4 million who died in 2006 were on hospice, this leaves 2/3 of the dying population possibly without full symptom management as available through hospice. Despite the benefits of hospice and palliative care, enrollment in these services are often halted by fear of under-financed hospices, delayed referral to hospice, and a personal desire for total treatment despite a terminal disease process[24].

Oftentimes patients feel forced into a hard choice between undergoing expensive, sometimes painful treatments, in lieu of symptom management by hospice[24]. When seen from a financial standpoint, hospice is often limited as to how many services it can provide by its average payment of $126 for a typical outpatient day. When a patient is switching from expensive total treatment to hospice, this change can be overwhelming[24]. A blend of symptom treatment and disease treatment is the rational solution. In the only study before 2002 comparing a hospice group versus a hospital treatment group without hospice, Finn et al. found there was no difference in survival rates amongst those with terminal cancer. However, in the hospice group there was an increase in quality of life, a 27% decrease in cost, fewer hospitalizations, and decreased diagnostic testing and chemotherapy utilization[25].

Delayed referral is a second cause of decreased utilization of hospice, potentially a six month program, but often cut short. The median hospice stay in 2005 was less than one month, 26 days. This delay is attributed to physicians, primarily oncologists who overestimate the lifespan of a dying patient[24,26]. This not only causes decreased utility of hospice symptom management but fails to reduce medical costs[27].

Thirdly, we sometimes see a desire by the patient for greater intervention at the end of life, often obtaining marginal benefit at the cost of toxic chemotherapy[28,29] . However, a 2007 study showed that palliation was generally preferable to life-prolonging measures amongst Medicare beneficiaries[30]. Medication that might be life shortening but would result in palliation was desired 75% of the time, whereas medications that made them feel worse but could extend life were desired 15% of the time[30]. Education of the patient about their end of life options will help inform their decision to accept total treatment versus symptom management.

The Current Main Source of Patient Education on End of Life Issues

The vast majority of the advances in end of life planning have been through education within the health care field, in particular hospital based health care workers[31,32,33,34,35,36,37,38,39,40,41,42,43,44,45]. Over the period of 1994-2004, The Robert Wood Johnson Foundation and the Project on Death in America of the Open Society Institute contributed $250 million to professional development programs for end of life care, primarily directed toward medical school[46]. As part of the holistic model of palliative care, interdisciplinary care teams are vital to this education, and much more needs to be done to increase communication between the family and the doctors[47]. Although education about end of life is prevalent in the medical community, studies still show the relative inadequacy of medical student and resident level education on end of life discussions[48,49,50,51]. One study showed that

only 27% of fourth year medical students discussed end of life issues with a patient, and only 61% could provide the definition of advance directives[49]. Another study reported on the manner of medical school end of life education, finding that it is primarily elective, given in pre-clinical years, academic and not attitude / skill-oriented, and having few physician role-models[51].

Kaufman delineates four factors of how end of life education by physicians within the hospital influences the process of American death and dying[52]. First, medicine has now become the overriding framework that Americans look to for considering views on death and dying. This has replaced previous frameworks of religion, family, and ethnic culture. Secondly, no longer are values primary in determining end-of-life events, rather technology leads the way. Thirdly, those involved in the decision making process often have competing reasons for their decisions and may be unclear as to what their goals actually are. Fourthly, when evaluating the patient, family, physician relationship the patient and family are not knowledgeable about the implications of the technology that is or can be used. Their knowledge level of the technology is low, and they are often not prepared for the degree of involvement that is placed upon them during end of life decision making[52]. Adherence to a solely biomedical approach is unlikely to meet the multi-dimensional needs of a patient.

Movement in Medical Community to Introduce Earlier End of Life Education

Seeing that end of life education is currently led by physician to physician education in the hospital, there are moves to start the process of end of life medical care planning earlier in the path of illness, such as by primary care physicians. A Canadian review article by Gallagher shows that advanced care planning, particularly by family physicians, enables patients to obtain care that is similar to their goals, and can decrease suffering at the end of life[53].

Family members of the patient must often take on the surrogate role, or the power of attorney, which may cause lasting ripples in family dynamics[54]. Meeker's review article showed that clinicians can provide beneficial guidance to a family facing end of life decision making. The clinicians can offer their understanding of experiences and needs to surrogate decision makers. This can come in the form of advising families to take on a shared decision making responsibility, one that decreases the long-term psychological, cognitive, moral, emotional, and physical impacts of being a sole decision maker[54].

There is also a movement to introduce more end of life care topics into medical school curriculum, with 84% of 51 medical school deans stating that the area was very important. All deans wanted more integration of end of life care with the existing curriculum, but time constraints were the limiting factor. Only 27% of deans felt that students viewed end of life care in the curriculum as very important, thus underestimating other reports of actual student interest by half[46]. The Association of American Medical Colleges Medical School Objectives Project, the Liaison Committee on Medical Education (LCME)[55], and the American Board of Internal Medicine[56] have introduced training requirements and recommendations on end of life care for medical schools.

Clergy as Under-utilized Resources

On a public health level, palliative care must be viewed through a preventive care lens. In much of preventive care we rely on patient education to increase the likelihood of patients making choices that will ultimately decrease their suffering in the long-term. If issues of palliative care are introduced to patients at a point in their life when they are concerned about their health, but not in a situation of impending demise, the patient may make a clear decision on his/her wishes of palliative and end of life care measures. This can be done in primary care based

education sessions via the physician. It is also possible to deliver education through community leaders outside of the explicit realms of medicine[15]. As seen by palliative care's goals of decreasing spiritual suffering, the church is a vital area in which community engagement and education surrounding palliative care can occur. The church, as a community gathered around forgiveness, sin, suffering, justification, and the afterlife, is seen as a natural and beneficial place for patients to be educated on end of life care.

Clergy see many individuals with mental health and end of life decision-making issues. The National Institute of Mental Health has shown that clergy are sought after for mental health concerns more than psychologists and psychiatrists combined. Furthermore, clergy were as likely as mental health workers to see patients with depression or complicated bereavement[57]. During the years of 1957 to 1976 when someone close died, Americans went to clergy five times more often than all other mental health workers combined[58]. Articles spanning from the early 1980's to 2000 show that end of life issues are the most common problem brought before Christian and Jewish clergy in the US, Canada, and the United Kingdom[59,60,61,62,63,64].

Clergy continue to have a large impact on the populace. In 1999, 70% of Americans were members of a church or synagogue and of those, 40% attended worship weekly[65]. In addition, clergy are viewed as one of the most trusted professionals[65]. The US Department of Labor in 1999 listed 353,000 Christian and Jewish clergy[15]. The National Funeral Director's Association credits clergy with 1.5 million funerals per year[15], along with various other end of life care and bereavement support. A 1997 Gallup pole showed that 36% of people would go to clergy first for end of life support and comfort as opposed to 30% for physicians. Going to family members was highest with 81% and close friends with 61%[66].

Several articles have described the health advantages associated with religious institution membership such as decreased mortality[67,68] and decreased rates of depression following the

death of a spouse [69]. Having a close relationship with God was associated with maintenance of quality of life amongst those with end stage cancer[70]. The church aids individuals in associating their pain and suffering with a higher meaning thus increasing thankfulness, joy, stability despite crisis, and increased coping skills[71]. A positive association was seen between religion and one's health in the systematic analysis of 35 review articles and 329 studies that addressed religion and health[72]. Cohen et al. redirects the ethical concern away from the health effect back to the key issue of treating the patient as a whole person, in-line with palliative care holism[73].

Despite the impact clergy have on the health of the nation, there is a relatively small body of literature addressing the role of clergy in end of life issues. A review by Flannelly et al. researched the articles mentioning clergy or chaplains in three of the main palliative care journals from 1990 – 1999[15]. They found that of the 838 articles, chaplains or clergy were mentioned or addressed in only 5.6% of them. In studies completed by Weaver et al., clergy were mentioned in approximately 1% of articles found in eight major psychology journals[70], in six marriage and family journals[74], and three oncology nursing journals[75].

Clergy are greatly sought after for guidance on end of life issues, but the adequacy of their preparation and confidence in dealing with complex mental health issues and end of life issues is in question. Two older studies from 1979 and 1981 showed that clergy did feel adequately prepared[76,77]. More recent studies show that most often the norm is clergy desiring more education, training and experience in end of life issues[15,78,79,80,81,82,83]. These findings were corroborated in a personal communication with Dr. Weissman, a palliative care physician at the Medical College of Wisconsin, where an unpublished study of Wisconsin clergy showed that clergy desired more education and did not feel completely prepared for providing end of life associated care.

Clergy also feel inadequate to provide the vast amount of mental health support that people come to them for[84,85]. When clergy are not able to provide for the people that come to them, there is often frustration for both the layperson and the clergyperson[78]. In an analysis of death and dying related spiritual care, Cobb calls for greater training and more integrated clergy education in end of life issues,[86] a call repeated by Lloyd-Williams[78].

Clergy confidence in interacting with medical professionals increases with Clinical Pastoral Education (CPE). CPE is an intensive practicum in an institutional setting such as a hospital. Growing use of CPE by seminaries will advance the numbers of seminarians trained to undertake end of life care[15]. In professional relationships, nurses are the most likely to refer terminally ill or dying patients to the chaplain[87]. Chaplains receive 88% of referrals by nurses, 8% by physicians, and 4% by social workers[88]. Clergy are the most likely to provide spiritual care to dying patients in the hospital followed by nurses, with social workers providing the least spiritual care[89].

Clergy, referred to as chaplains, are on staff at nearly a quarter of all medicine residency program facilities[90]. The involvements of community-based clergy in end of life care help decrease the patient load of chaplains[15]. Although it seems that overall end of life education may be lacking amongst clergy, efforts to increase interaction with other medical staff are increasing in number[15].

If clergy are to take on a greater role in helping individuals make wise and appropriate end of life choices, the issue centers on how well educated seminarians are in the realm of end of life care. When considering the seminarians' education, increased clergy involvement in end of life care should not be viewed from a purely utilitarian angle, one of exploring how clergy can be useful in decreasing the burden on the health care system. Rather, the issue should be seen from a theological perspective; pastoral care is a driving theme to church ministry.

A study conducted by Kalish et al. between 1971-1972 surveyed 185 US seminaries that belonged to the American Association of Theological Schools[91]. The survey assessed the availability of death and dying courses for seminarians as reported by seminary administrators. Responses were received from 48% of seminaries and of those respondents, 43% had a course related to death and dying. Additionally, of those respondents not having an official course, 73% stated this course material was adequately covered in other courses. These courses represented a new movement of death and dying education since previous to the date of this study, death and dying courses were not readily available within seminaries[91].

Kalish et al. explained this new interest in end of life education as stemming from society's increasing consciousness of western rationalism's and technology's limits[91]. This awareness led to an "increased sense of personal vulnerability," feeding an all-encompassing desire to find meaning in one's life and come back into connection with the topic of death and dying. Previous to this new feeling of vulnerability, western rationalism was built around the notion of the ability to control nature, and thus humanity was seen as invulnerable. From a theological perspective, western humanity's main faith ("faith" to be read as main purpose, goal, drive, direction in life) was directed toward medicine and life prolongation. Despite the fact that life truly has an end, cultural hopes in medicine have led to a false sense of immortality through medicine[91].

The new sense of vulnerability described by Kalish et al. arose due to four main reasons, the first being the Vietnam war[91]. Secondly, technological advances were seen more and more to cause many biological hazards and ecological imbalances. Thirdly, medical technology was incurring its own self-limiting destructiveness. Fourthly, Eastern religions and their decreased sense of control over nature were making inroads into the social consciousness[91].The third point bears emphasis. Kalish et al. spoke of death of personhood in the wake of increasing medical

efficiency, cost, and isolation. In the same processes that achieve prolongation of life, human relationships are abused, stress mounts, isolation is increased, and sensory deprivation occurs. If the aim of medicine is to aid in the patient's health then it must assist in producing healthy relationships among people and not just curing pathology. If the cure of a disease causes limited humanness then the cure-all of medical technology must be questioned.

In describing the nature of the death and dying courses, as identified by the Kalish et al. study in the 1970s, 68% respondents indicated pastoral counseling as the primary goal of the course, with other reasons being biblical scholarship or philosophic[91]. The study also examined students' desire for more end of life pastoral care education. Of seminaries with courses, 49% stated the course was offered because of student interest.

Kalish et al. also found that the issue of death and dying education was deemed important because congregants facing those issues were seen as an under-represented / under-served group[91]. As opposed to other under-represented groups, the dying are wholly unable to organize as a cohesive group, they must be supported by outside groups[91]. In place of self-organization, Kalish et al. recommended that seminarians are primed to be the leaders of death and dying support, and that issues closest to the dying such as searches for meaning in the midst of pain and suffering is more the realm of the clergy, than the physician[91].

Palliative Care in Congregations

There is a relatively small amount of literature regarding congregational needs and end-of-life education[92,93]. There has been interest in some seminary dissertations regarding end of life education[94,95,96,97,98,99,100,101,102,103,104]. One dissertation in particular gave recommendations to seminaries to deliver high quality formal and continuing education to seminarians that stresses

practical experiences, educational content, discussion, interaction between professional groups, and personal reflection[104].

Education in State Run Initiatives and Lack of a Virginia Initiative

In the late 1990's and early 2000's a series of state run initiatives supported by the Robert Woods Johnson (RWJ) Foundation disseminated end of life education through congregations. These states included Hawaii[105], Florida[92], and Montana[106].

One of the prime reasons for the Hawaii study was that a few churches in the state were involved in extensive projects to facilitate end of life care; and the RWJ study looked at the best role for the church's involvement[105]. Researchers assessed people's definition of a good death, and found results similar to other studies: spiritual / existential pain issues are addressed, pain is managed, there is family support, and inappropriate prolongation of life is avoided[105]. They identified important roles for the church, which mirrored the components of a good death. First, to spiritually and practically prepare congregants for death. Second, to assist in the process of conflict and forgiveness amongst their various relations. Thirdly, to delineate how the concepts of theology should shepherd thoughts and actions related to death and dying. Fourthly, to give the appropriate rituals related to clergy. And fifth, to facilitate the process of support amongst ill, dying, and bereaved congregants[105]. Authors suggest that membership of churches would increase with greater end of life education programming[105]. This research also echoes the earlier 1971 research from Kalish et al.[91], stating that the western, biomedical model has significant disadvantages in its approach to death, particularly in its change from a communal to individualistic experience[91]. This process of individualization has decreased Americans' ability to cope with death[105]. In the Hawaii study, focus group participants were supportive of early end of life planning and discussions such as wills and power of attorney[105]. In terms of overall

priority, it was essential to be spiritually prepared, whereas discussing wishes with one's physician was of lowest priority.

The Life's End Institute Missoula Demonstration Project was a model of evaluating secular and church partnership in end of life education[106]. This project surveyed community groups, clergy, and physicians in the city of Missoula, Montana, using a 31-item Quality of Dying and Death Questionnaire (QODD)[107]. The findings showed that respondents felt that death was improved with lower symptom burden, death in the home or desired place, better symptom management, communication about treatment preferences, compliance with treatment preferences, family satisfaction regarding communication with the health care team, and availability of the health care provider at night or on weekends. This showed the importance of communication about treatment preferences as well as the many aspects of end of life care not related to costly interventions[107].

In Florida, a Statewide Clergy End of Life Education project was conducted through the Hospice Foundation of America[92]. This group produced a one-day workshop designed for clergy so that they could receive convenient continuing education on end of life issues. The workshop consisted of seven different modules: Cultural Considerations, The Dying Process, EOL Options, The Grief Process, Assisting Families, The Roles of Spiritual Care, and Self-Care for Clergy. The 21 educational sessions were attended by 613 participants. Evaluation consisted of pre and post workshop questionnaires in which the participants self-assessed their knowledge of EOL care, and evaluated the individual modules. Of the 536 who answered the evaluation, 54% listed themselves as clergy, 7.5% as social worker / bereavement care, followed by lay worker (4.2%) and church administrator (2.9%), with the remainder describing themselves as "other". Participants rated education regarding "the dying process" and "the grief process" the highest. The least helpful education was on "the role of spiritual care." Seventy percent of respondents

stated they had a higher level of knowledge of EOL care after the workshop[92]. These state-wide studies highlight the need for greater clergy education on end of life issues with the ultimate goal of improving the health and dying experience of congregants and patients.

Lloyd-Williams Study

Dr. Lloyd-Williams from the United Kingdom published results from a study in 2006 that evaluated the level of education in end of life issues among a recent cohort of practicing clergy[78]. One of the main ideas leading to this study was the lack of literature on how well prepared community clergy are in end of life matters. Although a number of researchers have looked at the spiritual support by chaplains of patients who are dying within hospices, hospitals, or nursing homes, little work has been done on the role of the community clergy in providing this care[78].

The study surveyed both individual clergy as to their level of competence, comfort, and desire for more training, as well as seminaries to assess the level of training given. With 125 responses out of 312 (40%) surveys given to clergy, 71% indicated they would like further training in pastoral care of the dying, 66.3% desired training in care of the bereaved and 13% felt they possessed none or little skill in pastoral care of the dying. Of the 50% of seminaries that responded, the number of hours of training on pastoral care of the dying ranged from six to 36 hours (median 23 hours and mean 25 hours) and only 26% believed that their training in pastoral support skills was comprehensive. This study suggests that community-based clergy would like to know more about the care of the dying and the bereaved and that these courses should be part of the seminary core curriculum. The study also examined possible denominational differences of end of life knowledge and training but there was no significant difference found[78].

Objective

Overall, experts predict that the health care system will be severely burdened by the aging population and intensive approach to medical care. The symptom management approach of hospice and palliative care is effective in increasing overall quality of life along with decreasing health care cost among persons who are dying. Hospice and palliative care have not been utilized to the fullest potential, partly because of lack of advanced planning in end of life decision-making. Currently, the medical community dominates the existing end of life education field. The populace seeks support from clergy regarding their end of life care but clergy report a lack of comfort or adequate preparation to provide this care.

Student interest in death and dying courses has in the past led to a change in seminary curricula but there has not been a study in Virginia to determine whether or not seminarians here desire more end of life education and experience. Therefore, this study was designed to determine the level of education in end-of-life issues received by students graduating from three seminaries in Richmond, Virginia, and whether or not these seminarians desired more of this type of education and experience prior to serving in community congregations.

Methods

Four seminaries were initially selected to participate in this study. Three of these are part of the Richmond Theological Consortium, comprised of Union-PSCE (Presbyterian School of Christian Education), BTSR (Baptist Theological Seminary at Richmond), and VUU (Virginia Union University): The Samuel DeWitt Proctor School of Theology. The fourth seminary was Trinity Lutheran Seminary in Columbus, Ohio, but not enough responses were received from Trinity to be included in the analysis. As a declaration of possible conflict of interest, the author

has obtained a degree at Union-PSCE, attended classes at BTSR, and is denominationally affiliated with the Evangelical Lutheran Church in America.

A two page questionnaire (see Appendix A) was developed to assess seminary education on end of life issues. The questionnaire was pilot tested prior to distribution. This study and questionnaire had approval from the Virginia Commonwealth University IRB.

The anonymous questionnaire consisted of 180 items with a demographic section assessing the respondent's age, sex, race, county of residence, denominational affiliation, degree track, ministry placement, and an open-ended section for comments. The questionnaire consisted of two main sections, the first to assess previous didactic / practical education obtained in seminary, and the second to assess one's desire for further didactic / practical education. For all topics, respondents were asked to quantify any education in a particular area. For all previous education questions, topics were broken into previous didactic sessions and previous practical education (in the field). Selected main topics consisted of "Teaching adults about Planning for end of life issues," "Pastoral Care of the Dying (Overall)," "Conduct of Funerals (Overall)," "Pastoral Care of the Bereaved (Overall)," "Interacting with Medical Staff," "Interacting with Hospice Staff," and "Self-Care and Renewal of the Pastor and the Church." For the main topics of pastoral care of the dying, conduct of funerals and pastoral care of the bereaved, sub questions were asked regarding Pastoral Support regarding the topic, Relating Theology to the topic, Mobilizing Lay Support for the topic, Psychology of the topic, and Legal Aspects of the topic. Additional topics included "Medical aspects of Dying," "Do Not Resuscitate / Intubate (DNR / DNI)," and "Clinical Pastoral Education (CPE)" [an intensive practical pastoral care experience undertaken in a hospital]. Respondents were asked to describe their history of institutional placements while in seminary, answering if placement had occurred, was it required, and the number of hours spent at the placement for four different sites; hospital, hospice, nursing home,

and funeral home. To help quantify experience with end of life issues, the number of funerals conducted, dying supported, and bereaved counseled was also assessed.

The second section assessed seminarians' desire for either more didactic education or more practical training in each of the selected main topics as described above and interest in continuing education courses in any one of the following topics: Medical / Theological / Lay Support / Psychological / Legal Aspects of End of Life.

With approval from the four seminaries' administrations, the surveys were distributed to students just prior to their graduation. In all cases, the surveys were collected in an anonymous fashion with students placing the finished survey in a centralized locked box.

EXCEL and SAS were utilized for data manipulation and analysis. Frequencies and chi squares of demographics / previous education / experience / placement vs. desire for more education were examined. Certain variables were categorized. Age was reformatted as two groups; 24-30 and 31 – 61. Race was split into White and non-White. Denomination was split into four categories of Baptist, Cooperative Baptist Fellowship, Presbyterian and other. Denomination was then reformatted as socially Liberal (Presbyterian, AME, Lutheran, American Baptist, Episcopalian, Alliance of Baptists, Cooperative Baptist Fellowship, Progressive, Methodist, United Methodist Church, Brethren, United Church of Christ, vs. socially Conservative (Baptist, Disciples of Christ, Southern White, Southern Baptist Convention, Pentecostal, Non-denominational, Kingdom). Ministry placement was reformatted as pastoral or other. Degree track was reformatted into two groups of pastoral / education and academic. The former group consisted of M.Div. (Master of Divinity) and MACE (Master of Arts in Christian Education), while the latter group was composed of D.Min. (Doctorate of Ministry) and MATS (Master of Arts of Theological Studies). Area of residence was reformatted into Virginia and non-Virginia. All continuous variables quantifying one's experience in counseling the dying /

conducting funerals / and counseling the bereaved experience were converted to ordinal variables; yes (some) or no (none) experience levels. In addition, experience was categorized based on whether the student had absolutely no experience counseling the dying or doing a funeral or aiding the bereaved vs. if they had any experience in one of those areas. Placement was viewed as present if the student had been placed at any one of the listed institutions (hospital, hospice, nursing home, funeral home) or absent if there was no placement overall. Desire for more education and/or practical experience was reformatted into 4 categories, representing the relative degree of interest a respondent had in further education/practical experience on the whole.

Due to an unexpected high incidence of missing responses, some variables were not included in the analysis, specifically questions regarding previous practical education. Initial arrangements with the seminaries guaranteed anonymity so all analysis was done on aggregated data from the three seminaries.

Results

Overall 75 surveys were collected. By seminary: Union had 14 respondents (28.6% of 49 graduating students); BTSR had 36 respondents (83.3% of total of 42 graduating students); VUU had 25 respondents (20.3% of 123 graduating students), 35.0% response rate for all three seminaries (Table 1).

The ages of the sample population were distributed widely with a mean age of 39, range of 24 to 61 and a slight bimodal distribution with peaks in the 24-30 (40%) and the 30-61 (60%) ranges (Table 1). Females accounted for 52%, African Americans were relatively overrepresented at 38.8%, and Asians comprised 4.5%. Twenty denominations were represented with the most frequently reported as an indication of the seminaries surveyed: Baptist 37.7%,

Cooperative Baptist Fellowship (CBF) 17.4%, Presbyterian 15.9% and other 29.0%. The great majority of respondents (89.2%) were on a pastoral as opposed to a solely academic degree track, with corresponding Pastoral Ministry Placement (79.4%) after seminary. Residence was overwhelmingly in Virginia (81.8%) with 7.6% from Maryland (Table 1).

Regarding education topics covered during seminary, Pastoral Care Overall was covered at the highest frequency (85.5%) followed by Pastoral Care of the Bereaved (81.8%), Conduct of Funerals (77.4%) and Self Care of the Pastor and the Church (68.2%) (Table 2). The four least covered topics were: Interacting with Medical Staff (36.4%), DNR/DNI (36.4%), Medical Aspects of Dying (38.3%), and Interacting with Hospice Staff (38.5%) (Table 2). The frequencies were compromised by high missing values counts ranging from nine to 20 missing data values per topic.

By sub-topic of education covered it was seen that pastoral support for the dying, funerals, and the bereaved (75 - 89%) were covered the most with Legal aspects covered the least (33.3 – 40.4%) (Table 3). The second most covered sub-topic was Relating Theology to the Process (78.1 – 83.3%), thirdly Psychology (46.7 – 73%), and fourth, Mobilizing the Laity at 40-50% coverage.

Placement was highest at hospitals (30.8%), then nursing homes (12.3%), then hospices (4.8%), then funeral homes (3.1%) (Table 4). Those having any kind of experience at an institution was 56.7%. Experience with others dealing with end of life issues was greatest with Bereavement (65.7%), Deaths (57.1%), and Funerals (38.6%). Sixty-nine percent of respondents reported having any kind of experience (dying, funerals, or bereavement) (Table 4).

In considering desire for education, four categories were identified based on the number of topics each respondent selected: no topics (25.3%), 1-4 topics (13.3%), 5-9 topics (25.3%), and all 10 didactic topics (36.0%), and 1-10 topics “any interest at all” (74.7%). Desire for

practical education was similarly assessed: no topics (22.7%), 1-4 topics (16.0%), 5-9 topics (28.0%), and all 10 practical topics (33.3%), and 1-10 topics "any interest at all" (77.3%) (Table 5).

In assessing respondents' desire for more education according to individual topic; more practical education was desired than didactic education (Table 5a). It was seen that of the top five topics, the top three were desire for more practical experiences, the two others being a desire for more didactic education. In descending order, Practical Self Care of the Pastor and Church was desired most with 66.7%, along with Practical Pastoral Care Overall (66.7%), then Practical Pastoral Care of the Bereaved (65.3%), Didactic Self Care of the Pastor and the Church (65.3%), and the fifth, a desire for more Didactic Education in Pastoral Care of the Bereaved (65.3%). The five least desired areas of education in descending order were Didactic Conduct of Funeral (53.3%), Practical Training in Interacting with Medical Staff (52.0%), Didactic Interacting with Hospice Staff (52.0%), Didactic CPE (52.0%), and Practical CPE (48.0%) (Table 5).

Assessing for interest in continuing education classes, Theological education of EOL was desired the most (n = 36, 48.0%), followed by psychology of EOL (n=21, 28.0%), Legal aspects of EOL (n=19, 25.3%), Lay Support for EOL (n=13, 17.3%), and Medical Education Continuing education (n = 12, 16.0%) (Table 5b).

Associations between previous education / experience / placement / demographics and desire for more education were evaluated (Table 6). In all comparisons of demographics with desire for more education while in seminary, no statistical significance was found except for in the age groups. Younger age groups showed greater interest in more education than the older group (OR 3.74, CI 1.01-13.55).

Past education in a topic was associated with further desire for education in that same topic (Table 6), but results were limited by missing values. Those having previous education in

Preaching Sermons on End of Life Issues were 3.42 times as likely to want more education in that same topic than those who did not receive previous education (p-value 0.0351, 95% CI (1.58, 11.05)). Similarly, those having education on Interacting with Medical Staff were 3.0 times as likely to want more education in that same topic as those who did not have previous education (p-value 0.0469, 95%CI (1.02, 8.80)).

In contrast, respondents with previous experience with counseling the bereaved were less likely to want further education on interacting with Medical (OR 0.333, 95%CI (0.11, 0.99), p-value 0.0439) and Hospice staff (OR 0.28, 95%CI (0.09, 0.83), p-value 0.019). Having experience counseling the dying did not have any effect on whether a person wanted more education regarding leading end of life planning classes.

Previous placement at an institution (hospital, hospice, nursing home, or funeral home) associated significantly with a desire for further education in Didactics Overall (OR 3.10, 95%CI (1.03, 9.35), p-value 0.04), Practical Overall (OR 3.89, 95%CI (1.22, 12.35), p-value 0.0176) and the specific topics of Medical Staff Interaction (OR 3.49, 95%CI (1.21, 10.1), p-value 0.0185), and Hospice Staff Interaction (OR 3.243, 95%CI (1.15, 9.13), p-value 0.0235) (Table 6).

Other relationships were studied, none of which were statistically significant. No real trend or difference was found when comparing one's ministry placement and one's desire for further education. Six respondents wrote comments on the survey instrument. Three commented on the difficulty of filling out the survey, two addressed why CPE was not taken, and one stated "Desperate Need for this linking of Theology and Medicine".

Discussion

Participants

The sample population in this survey appears to be representative of protestant seminaries, illustrating the previous education and desire for further education amongst seminarians of three theologically diverse seminaries. Response rates for all three seminaries (35.0%) was similar to that of the Lloyd-Williams study (40%)[78]. This response was low and significance would be improved with greater numbers.

Age was split into two main groups of 24-30 and 31-61 years of age, probably due to the phenomena of first career and second career seminarians, respectively. This is a helpful distinction as the second career seminarians have different life experiences prior to coming to seminary. This may involve completely disparate careers from seminary, or a career in hospice, or the death of previous friends and family members. Second career seminarians may also be more apt to focus on their own past experiences rather than learning new ones. First career seminarians often come to seminary straight from college or from a period of discernment, often a period less than five years in the workforce. These individuals may be more eager for new experiences and may not have experienced death within their own families.

Gender was not skewed, representing the equality of women and men at protestant seminaries. Race was slightly over-represented by African Americans, secondary to the large graduating class size of VUU. Denominational breakdown followed seminary affiliations, but several denominations were found in more than one seminary, specifically those individuals who listed themselves as Baptist. Regarding Degree and Ministry type, the vast majority of students were pastorally trained. Those not on this path still share many classes with the pastoral education track. The distinction between residents of Virginia, Maryland and other states is important in that those not living in Virginia are likely commuter students, who come to the

seminary occasionally. These students are more likely to be second career, part time and have other interests outside of seminary.

Education Received

In assessing the amount of education graduating seminarians received during their formal schooling, certain topics of education were not completely covered. Eighty-nine percent of seminarians were on a pastoral degree track, yet only 85.5% stated that pastoral care overall was covered. The same pattern was seen when we examined Pastoral Care of the Bereaved (81.8%), and Conduct of Funerals (77.4%) two essential skills of being a pastor. This trend should be studied further to understand possible reasons for this lack of exposure. A low percentage of seminarians were taught about leading classes about planning for end of life issues (42.4%). This lack of leadership training might translate into decreased discussions of end of life planning when pastors are with congregants. The last four main topics of Table 2, all addressing medical issues, showed that only 36.4 – 38.5% of seminarians were educated on some of the medical aspects of dying. This lack of knowledge might result in a diminished ability of the pastor to engage with the technologically complex realm of end of life.

The sub-topics of education related to EOL covered while in seminary followed the priorities of church work. Pastoral support was of highest priority, followed by relating theology to the dying process. Psychology of death was a lower priority, but what was surprising was that only 40-50% of respondents were taught about mobilizing the laity in caring for the dying and bereaved. The laity of the church represent a large potential workforce that could enable the formation of closer community during times of life stresses. In addition, enabling congregants to aid in counseling of the dying and bereaved would potentially decrease the stress on the pastor, thus improving self care of the pastor and congregation, a main education topic that was taught

to only 68.2% of seminarians, and has been previously characterized by Lloyd-Williams as below adequate levels[108]

Seminarian placement at institutions was relatively low. Looking at placement as an aggregate, only 56.7% of seminarians spent time in a hospital, hospice, nursing home, or funeral home. As a pastor, visiting these places is a mainstay of pastoral care. Placement at these institutions during seminary training would likely decrease the level of stress pastors have when entering these situations while caring for congregants.

The amount of experience seminarians received while in seminary was likewise concerning. Specifically, 38.6% of seminarians were able to participate in a funeral while in training. It is likely that all pastors will conduct a funeral and this event is often very important in starting the grieving process for the decedent's survivors. More training might make this transition more meaningful. Although not as low, only 65.7% of seminarians had experience counseling the bereaved and 57.1% had experience counseling the dying while in training. The self-rated competency of pastors is likely to improve if these experience levels are improved while under the guidance of seminary professors. For those 31.4% of respondents without any end of life experience while at seminary, first experiences will occur while at their first call location, likely increasing stress levels and decreasing the quality of services provided.

Education Desired

Approximately 75% of seminarians surveyed desired more education overall in both didactic and practical education. This was similar to the 71% of clergy surveyed in the Lloyd-Williams study who wanted further training in pastoral care of the dying[78]. Furthermore, 36% wanted more education in all ten main education topics listed. This shows a need to supplement the current seminary curriculum with these educational topics. More education in all topics was

desired by more than 50% of seminary students, but adding those topics that seminarians desired most would be of greatest benefit. This would include a higher proportion of practical classes, specifically geared to self care, pastoral care overall, and pastoral care of the bereaved to name the top three. Lloyd-Williams cited 66.3% of clergy wanting more training in the care of the bereaved, whereas 65.3% of this study's participants desired further care of the bereaved training. This is complemented by the topics desired in continuing education; nearly half wanting further studies on the theology of end of life issues.

As described in Table 6, previous education was associated with greater interest in further education for some topics. During one's training period while in seminary this eagerness for education should be addressed to the fullest to prevent feelings of incompetence in pastors after graduation. Conversely the decreased interest in further education seen in those without education may hint at a false sense of competency that could be potentially harmful.

The finding that those having experience counseling the bereaved were less likely to want further educating in interacting with medical and hospice staff might arise from previous experiences interacting with medical and hospice staff, such that they feel that no further education is needed. Whether this finding was positive or negative is beyond the scope of this study.

Placement at an institution was seen as associating with a student's desire for further education in both didactic and practical areas. To increase the seminarian's interest in end of life matters, making high quality institution placement more readily available, or possibly a requirement, would be of benefit.

The only demographic that was associated with desire for further education was being in the younger age group. As stated above, first career seminarians might be more open to new experiences or not have experienced a death within their family. Interest within the younger

communities regarding end of life matters should be bolstered to support a preventive model of end of life discussions, implementing them throughout the life cycle and not exclusively in old age.

Seminaries as Under-utilized Resources

Seminary education on end of life issues has clearly progressed from the time period before Kalish et al.[91] studied seminary involvement with death and dying courses. One of the free write statements recognizes the Kalish et al. call for a greater harmonization between medicine and the church, "Desperate Need for this linking of Theology and Medicine." It is the hope that as seminaries identify relatively uncovered areas of education within their curriculum, such as education on the medical aspects of dying, the gap between the church and end of life care can decrease. Through addressing the voiced interests of graduating seminarians, end of life education can be refocused on church leadership, supplying the public with a source of end of life education outside of the technologically-driven medical establishment. As the public will be engaged in earlier discussions of end of life with clergy and the church, their concerns and sufferings can be incorporated within the rich tapestry of meaning making that is the beauty of the church. With greater emphasis on appropriate theology taught to seminarians, hopeful and realistic views of the end of life can be achieved, something that may be lacking in a seminarian who is not fully equipped during seminary. The framing of death is a vital aspect of church leadership and the ongoing care of the congregation. Seminarians must be fully prepared to compassionately and wisely prepare congregants, care for the dying, and shepherd the bereaved.

As the public health community observes a continuously stressed intensive medical system, prevention and planning for the end of life must be utilized. By working together with

seminaries to improve their end of life curriculum, the mutual goals of church ministry and a more robust medical system can be achieved.

Study Limitations

A long survey of 180 variables resulted in study participants who did not fill out all survey responses. Because of missing variables some of the desired analysis could not be performed and some of the data must be interpreted with caution. The survey would have been improved if the number of topics was decreased along with eliminating the need to write in yes or no. Instead, utilizing a check mark for 'yes,' and leaving the response box blank for 'no' would have decreased survey time. The survey also had many other categories that were not represented in the data analysis such as whether a topic was required, how many class hours was it covered for, and what importance did the seminary grant to the topic. These extra topics contributed to participant fatigue and likely added missing values to the essential variable of "education covered".

A greater response rate would have been beneficial and could have been achieved through greater planning with seminarian student activities representatives. In future studies, an even wider breadth of seminaries would be beneficial, including Roman Catholic, Eastern Orthodox, Jewish, Islamic, Buddhist, and Hindu places of clergy training. As it stands, the survey results are applicable only to Protestant Christians. Some study participants listed themselves as on an academic track. These participants may not have a future in pastoral care, but since the issue of preparation for death is inherently theological, their responses to questions were retained within the study. Bias toward more previous education and greater desire for further education may be present if those electing to complete the survey were at baseline more interested in end of life matters.

Conclusion

Graduating seminarians from three Protestant Richmond, Virginia, seminaries were surveyed to assess their previous education and desire for further education in end of life matters. Several end of life topics did not receive full coverage, specifically self care of the pastor, teaching adults about end of life planning, the medical aspects of end of life, and mobilizing the laity for the care of the dying and bereaved. Placement at an institution or experience with end of life matters was not present in 30-40% of participants, but placement along with previous education in an area was well associated with increased desire for further education. Three quarters of participants wanted some form of further education with self care of the pastor and congregation being chief followed by pastoral care overall and of the bereaved, and teaching adults about planning for the end of life.

As seminary curriculum changes have been led by student desire in the past, curriculum change to reflect the desires of these participants would benefit in increasing the overall confidence and competence of pastors, increase the ministerial goals of the church, and aid in preparing the public for the end of life, thus decreasing the burden on the health care system.

Table 1: Demographics (N=75)

Seminary	Total graduating (N)	Respondents (N)	Response Rate %
Union-PSCE	49	14	28.6%
BTSR	42	36	83.3%
VUU	123	25	20.3%
Total	214	75	35.0%

Age	(N)	%
24-30	28	40.0%
31-61	42	60.0%
Missing = 5		

Gender	(N)	%
Male	33	47.8%
Female	36	52.2%
Missing = 6		

Race	(N)	%
White	38	56.7%
African-American	28	38.8%
Asian	3	4.5%
Missing = 6		

Denomination	(N)	%
Baptist	26	37.7%
Cooperative Baptist Fellowship	12	17.4%
Presbyterian	11	15.9%
Other	21	29.0%
Missing = 5		

Degree type	(N)	%
Pastoral / education	58	89.2%
Academic	7	10.8%
Missing = 10		

Ministry type	(N)	%
Pastoral	50	79.4%
Other	13	20.6%
Missing = 12		

State	(N)	%
Virginia	54	81.8%
Maryland	5	7.6%
Other	7	10.6%
Missing = 9		

Table 2: Main Topics Covered in Didactic Education (N=75)

Education Topic Covered	Yes %	No %	Missing
Pastoral Care Overall	85.5%	14.5%	20
Pastoral Care of the Bereaved	81.8%	18.2%	20
Conduct of Funerals	77.4%	22.6%	13
Self Care Pastor	68.2%	31.8%	9
Teaching adults about planning	42.4%	57.6%	16
Interacting w Hospice Staff	38.5%	61.5%	10
Medical Aspects of Dying	38.3%	61.7%	15
Do Not Rescucitate / Intubate	36.4%	63.6%	20
Interacting w Medical Staff	36.4%	63.6%	9

Table 3: Sub-topics Covered in Didactic Education (N=75)

Sub-topics covered in education	Yes %	No %	Missing
Pastoral Support of the Dying	89.1%	10.9%	11
Pastoral Support of Funerals	75.4%	24.6%	14
Pastoral Support Bereaved	87.1%	12.9%	13
Relating Theology to Dying	78.1%	21.9%	11
Relating Theology to Funerals	78.3%	21.7%	15
Relating Theology Bereaved	83.3%	16.7%	15
Psychology of Dying	46.9%	53.1%	11
Psychology of Funerals	46.7%	53.3%	15
Psychology of Grief	73.0%	27.0%	12
Mobilizing Laity for the Dying	45.2%	54.8%	13
Mobilizing Laity for Funerals	40.0%	60.0%	15
Mobilizing Layity for the Bereaved	50.0%	50.0%	15
Legal Aspects of Dying	40.4%	59.7%	18
Legal Aspects of Funeral	33.3%	66.7%	15
Legal Aspects of Estate	39.0%	61.0%	16

Table 4: Placement at Institution and Practical Experience with End of Life (N=75)

Placement	Yes %	No %	Missing
Placement in Hospital	30.8%	69.2%	10
Placement in Nursing Home	12.3%	87.7%	10
Placement in Hospice	4.8%	95.2%	12
Placement in Funeral Home	3.1%	97.9%	11
Total Placement (Any placement)	56.7%	43.3%	5

Experience	Some Experience	No Experience	Missing
Counseling the bereaved	65.7%	34.3%	5
Deaths	57.1%	42.9%	5
Funerals	38.6%	61.4%	5
Total Experience (sum of all 3 types)	68.6%	31.4%	5

Table 5: Desire for Didactic or Practical Education (N=75)

Desire More Seminary Education	Didactic Alone (10 topics)		Practical Alone (10 topics)	
None	19	25.3%	17	22.7%
1-4 topics	10	13.3%	12	16.0%
5-9 topics	19	25.3%	21	28.0%
All 10 topics	27	36.0%	25	33.3%
Any Desire (1-10 topics)	56	74.7%	58	77.3%

Table 5a: Topics Requested (N=75)

Didactic or Practical topic	Yes %	No %
Self Care Pastor Practical	66.7%	33.3%
Pasoral Care Overall Practical	66.7%	33.3%
Pastoral Care of Bereaved Practical	65.3%	34.7%
Self Care Pastor Didactic	65.3%	34.7%
Pastoral Care of Bereaved Didactic	65.3%	34.7%
Teaching adults planning Practical	64.0%	36.0%
Pastoral Care Overall Didactic	62.7%	37.3%
Preaching Sermons on EOL Didactic	57.3%	42.7%
Conduct of Funeral Practical	57.3%	42.7%
Preaching Sermons on EOL Practical	56.0%	44.0%
Leading Classes Planning Didactic	56.0%	44.0%
Teaching adults planning Didactic	54.7%	45.3%
Leading Classes Planning Practical	54.7%	45.3%
Interacting Hospice Staff Practical	54.7%	45.3%
Intereracting Medical Staff Didactic	54.7%	45.3%
Conduct of Funeral Didactic	53.3%	46.7%
Intereracting Medical Staff Practical	52.0%	48.0%
Interacting Hospice Staff Didactic	52.0%	48.0%
CPE Didactic	52.0%	48.0%
CPE Practical	48.0%	52.0%

Table 5b: Interest in Continuing Education Classes after Graduation

Topic of Cont Ed	(N=75)	Percent
Theological Education	36	48.0%
Psychology of End of Life Care	21	28.0%
Legal Aspects at the End of Life	19	25.3%
Lay Support for End of Life	13	17.3%
Medical Education	12	16.0%

Table 6 Association Between Desire for further Education and Education Previously Covered (N=75)

Education Covered, Age group, Experience level	Total	Desire for more Education Yes N	Yes (%)	p-value	OR	95% CI Low	High
Education Covered							
Preaching Sermons on EOL							
Yes	24	19	79.2%	0.04	3.42	1.58	11.05
No	38	20	52.6%				
Pastoral Care of the Bereaved							
Yes	45	34	75.6%	0.03	4.64	1.10	19.50
No	10	4	40.0%				
Interacting with Medical Staff							
Yes	24	18	75.0%	0.05	3.00	1.02	8.80
No	42	21	50.0%				

Experience with the Bereaved	Total	Desire for Ed on Medical Staff Interaction Yes N	Yes (%)	p-value	OR	95% CI Low	High
Some	46	23	50.0%	0.04	0.33	0.11	0.99
None	24	18	75.0%				

Experience with the Bereaved	Total	Desire for Ed on Hospice Staff Interaction Yes N	Yes (%)	p-value	OR	95% CI Low	High
Some	46	21	45.7%	0.02	0.28	0.09	0.83
None	24	18	75.0%				

Placement	Total	Desire for more Didactics Overall Yes N	Yes (%)	p-value	OR	95% CI Low	High
Yes	29	23	79.3%	0.04	3.10	1.03	9.35
No	38	21	55.3%				

Placement	Total	Desire for more Practical Overall Yes N	Yes (%)	p-value	OR	95% CI Low	High
Yes	29	24	82.8%	0.02	3.89	1.22	12.35
No	38	21	55.3%				

Placement	Total	Desire for Ed on Medical Staff Interaction Yes N	Yes (%)	p-value	OR	95% CI Low	High
Yes	29	22	75.9%	0.02	3.49	1.21	10.10
No	38	18	47.4%				

Placement	Total	Desire for Ed on Hospice Staff Interaction Yes N	Yes (%)	p-value	OR	95% CI Low	High
Yes	29	21	72.4%	0.02	3.24	1.15	9.13
No	38	17	44.7%				

Age	Total	Desire for More Education Overall Yes N	Yes (%)	p-value	OR	95% CI Low	High
24-30	28	25	89.3%	0.05	3.74	1.01	13.55
31-61	42	29	69.1%				

Assessment of Seminary Education on End of Life Issues

Introduction:

Thank you for taking the time to complete this totally anonymous questionnaire.
Completion of the survey is entirely voluntary and you need not answer any questions you do not wish to answer.
This survey is designed to assess the amount of education seminary students receive regarding the dying process and how to deal with this important issue among congregants. We hope the findings will help programs enhance their curriculum in this important area.

Education and Practical Training:

1. Please answer Yes or No (Y/N) to indicate which topics you received education or practical experience while at seminary.
   Practical training may include Clinical Pastoral Education (CPE), internship, teaching parish(s), or similar experiences.
2. List the importance **given by your program** to a topic:
   5 = very important; 4 = important; 3 = more than a little; 2 = a little; 1 = none
3. Please state if Education or Practical Training in these areas was Required as part of the Core Curriculum.
4. Lastly, please indicate the number of real-time hours, not semester hours, devoted to a general topic area.

	Education				Practical Training			
	Was this Covered? Y/N	Importance 1-5 (5=Very important)	Required Y/N	No. of Hours	Was this Covered? Y/N	Importance 1-5 (5=Very Important)	Required Y/N	No. of Hours
Teaching adults about planning for End of Life Issues								
Leading classes on planning for End of Life Issues								
Preaching Sermons on End of Life Issues								
Pastoral Care of the Dying (overall)								
Pastoral Support								
Relating Theology to the Dying Process								
Mobilizing lay support of the Dying								
Psychology of Dying								
Medical Aspects of Dying (overall)								
Do Not Rescucitate / Intubate (DNR/ DNI)								
Clinical Pastoral Education (CPE)								
Legal Aspects of Dying: Ex. Health Care Proxy / Living Will / Durable Power of Attorney								
Conduct of Funerals (overall)								
Pastoral Support								
Relating Theology to Death								
Mobilizing lay support for the Funeral								
Psychology of Death								
Legal Aspects of Death								
Pastoral Care of the Bereaved (overall)								
Pastoral Support								
Relating Theology to the Bereaved								
Mobilizing lay support of the Bereaved								
Psychology of Grief								
Legal Aspects after Death - Estate								
Interacting with Medical Staff								
Interacting with Hospice Staff								
Self - Care and renewal of the Pastor and the Church								

Thank you for aiding in this research. Please turn over to page two.

Seminary: _____

Desire for more Education or Practical Training

Please indicate whether or not you would like more Education or Practical Training in each of the following areas.

	Desire for More Education (Y/N)	Desire for More Practical Training (Y/N)
Teaching adults about planning for End of Life Issues		
Leading classes on planning for End of Life Issues		
Preaching Sermons on End of Life Issues		
Pastoral Care of the Dying		
Clinical Pastoral Education (CPE)		
Conduct of Funerals		
Pastoral Care of the Bereaved		
Interacting with Medical Staff		
Interacting with Hospice Staff		
Self-Care and renewal of Pastor and the Church		

Placement

During Seminary, have you had a placement at the following? Mark (Y/N)
Indicate if this placement was required as part of the core curriculum.
Indicate the number of real-time hours, not semester hours, at this placement.

	Placement (Y/N)	Required (Y/N)	Number of Hours
Hospital			
Hospice			
Nursing Home			
Funeral Home			

Experience

Please list the number of instances during seminary that you have done the following:

	Number
Number of funerals you have conducted	
Number of dying you have supported	
Number of beareaved you have counseled	

Interest in Continuing Education Course

After graduation, would you be interested in a continuing education course covering: (Circle topics of interest to you)

medical / theological / lay support / psychological / legal aspects of end of life?

Demographics:

Age: _____ Sex: _____ Race: _____ County / State of Residence: _____

Denominational Affiliation: _____ Degree Track: _____

Ministry Placement (please circle or fill in if other):

Pastor of a church / Chaplain / Minister of Music / Minister of Education / Other: _____

Please insert any extra comments here: _____

Thank you for taking the time to complete this questionnaire

Research through Virginia Commonwealth University (VCU) - Office of Research
Office of Research 800 East Leigh Street
P.O. Box 980568 Richmond, VA 23298

Contact Stefan Pomrenke
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