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## Health Care Provider Personal Religious Preferences and Their Perspective on Advance Care Planning with Patients

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**Health Care Provider Personal Religious Preferences and  
Their Perspective on Advance Care Planning with Patients**

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SCHOLARONE™  
Manuscripts

Review

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4 **Abstract**

5  
6 **Objective** - To understand how Health Care Providers (HCPs) religious preferences  
7  
8 influence their willingness to undertake Advance Care Planning (ACP) with patients and  
9  
10 their acceptance of other HCP's involvement.  
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12  
13 **Methods** - Online anonymous survey distributed to HCPs in hospital, ambulatory offices,  
14  
15 and hospice settings in Dayton Ohio. We evaluated the associations of HCP religion with  
16  
17 their personal ACP, willingness to facilitate ACP, and acceptance of other HCPs' ACP  
18  
19 participation.  
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22  
23 **Results** - 704 respondents: Nurses (66.2%), physicians (18.8%), other HCPs (15.0%),  
24  
25 white (88.9%), and primarily Catholic (23.3%) or Protestant (32.0%). "No religion" was  
26  
27 marked by 13.9%. Respondents were favorable to ACP with patients. Religious  
28  
29 respondents were more likely to have a living will ( $P = .035$ ) and health care power of  
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31 attorney ( $P = .007$ ), and more accepting of clergy as ACP decision coaches ( $P = .030$ ).  
32  
33 HCP's religion was not associated with willingness to facilitate ACP discussions. There  
34  
35 were minor differences between Catholics and Protestants.  
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39 **Conclusions** Personal religious preference is associated with HCP's own ACP, but had  
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41 little relationship to their willingness to facilitate ACP conversations with patients, or  
42  
43 acceptance of other professional types of HCPs involvement in ACP conversations.  
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45 Regardless of religious affiliation, HCPs have interest in undertaking ACP, and endorse  
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47 other HCPs ACP involvement. As the results of this study suggest that personal religious  
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49 affiliation is not a barrier for HCPs engaging in ACP with patients, attempts to overcome  
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51 barriers to increasing ACP should be directed to other factors.  
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24 **Word Count Abstract:** [241](#)

25

26 **Key Words:** Advance Directives, Physician Patient Communication, Spirituality,  
27 Hospital-Specific Palliative Care Issues, Advance Care Planning, Religion, Living Wills,  
28 Attitude of Health Personnel

29

30 [Introduction](#)

31

32 [Advance Care Planning \(ACP\) ascertains a person's wishes for medical treatment](#)  
33 [should they become unable to speak for themselves. The National Quality Forum Project](#)  
34 [for palliative and hospice care includes attention to spiritual and religious aspects as one of](#)  
35 [the major domains of care.<sup>1</sup> Religion has been documented as a stated significant personal](#)  
36 [factor influencing patients' ACP wishes,<sup>2-6</sup> which is also likely also true for clinicians as](#)  
37 [patients.](#)

38

39 [Conversely, there is little information on how the personal religious beliefs of](#)  
40 [Health Care Providers \(HCPs\) influence their willingness to undertake or their approach to](#)  
41 [ACP or End-of-Life \(EOL\) care with patients. Braun et al reported that physicians in focus](#)  
42 [groups generally did not think their own faith or religious beliefs influenced their ACP,](#)  
43 [although there were some differences by ethnicity.<sup>7</sup> In another study, most physicians](#)  
44 [believed it appropriate to discuss religious/spiritual issues during EOL care when a patient](#)  
45 [brings them up, and would encourage patients in their own beliefs and practices,<sup>8</sup> implying](#)  
[that their own personal religious views would not be determinant.](#)

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5 46 Much of the literature also predates the many advances that increasingly prolong  
6  
7 47 the lives of seriously ill patients, and multiple changes in available types of ACP, such as  
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9 48 the increase in the availability of the MOLST or POLT (Medical or Physician Orders for  
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11 49 Life Sustaining Treatment), now in many states (www.polst.org). Most of the literature  
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13 50 also concerns physicians, whereas many different HCPs can undertake ACP counseling<sup>9</sup>  
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15  
16 51 and are needed if sufficient ACP conversations are to happen prior to a patient's EOL.  
17  
18 52 Thus, prior findings may or may not reflect current practice or needs.

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20 53 In addition, no literature provides clarity on what differences exist for routine  
21  
22 54 advance care planning discussions for different faith groups, nor specifically for the two  
23  
24 55 largest faith groups (Catholic and Protestant) in the United States. Yet, our local Dayton  
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27 56 Area Advance Care Planning community intervention included two large health systems  
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29 57 affiliated with these different religious orientations. To fully inform our efforts to increase  
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31 58 ACP community-wide, we felt it would be important to understand significant differences  
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33 59 that should influence how to accomplish our goals. We hypothesized that there would be  
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35 60 differences in HCPs willingness to participate in ACP with patients, specifically between  
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37 61 religious and non-religious HCPs, and between Catholic and Protestant HCPs. Support for  
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39 62 our hypotheses came from our own experiences, and related literature from Curlin et al<sup>10</sup>  
40  
41 63 who found that those physicians without religious affiliation or low on a religiosity and  
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43 64 spirituality scale were less likely to inquire about religious and spiritual matters and pray  
44  
45 65 with patients, and were also less likely to report encouraging patients religious/spiritual  
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47 66 beliefs and practices. The authors had also found that Protestant physicians were more  
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49 67 likely to discuss their own beliefs and pray with patients. In another paper, religiously  
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5 68 committed physicians gave more support to the duty to preserving life and were less  
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7 69 supportive of advance directive documents.<sup>8</sup> Thus, we hypothesized that 1) religious and  
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9 70 Catholic HCPs would be less willing to undertake ACP activities with patients; and 2) non-  
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11 71 religious HCPs would be more likely to encourage other types of HCPs (particularly clergy  
12  
13 72 or religious leaders) to be involved with patient ACP.  
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## 74 **Methods**

75 **Setting:** This was a pre-survey of local HCPs through the auspices of The Greater Dayton  
76 Advance Care Planning Initiative (GDACPI) – Decide to Be Heard Campaign. In 2015, the  
77 GDACPI was initiated as an area-wide, community-based intervention to increase ACP  
78 and the associated documentation, educational tools, community-led conversations, trained  
79 facilitators, and a regional advance directives tool. The GDACPI board consisted of  
80 members from the two local major healthcare systems (one affiliated with a national  
81 Catholic healthcare organization and the other with the Seventh Day Adventist faith), a  
82 large hospice organization, clinical providers, higher education institutions, faith-based  
83 communities, legal professionals and other interested community individuals. The two  
84 health systems each have multiple hospitals and affiliated outpatient physician groups.  
85 The mission was stated as “to create a culture that embraces advance care planning and  
86 increases conversations between providers, the people and their families by educating and  
87 transforming our community. The shared vision is to ensure that every person in the  
88 Greater Dayton Area is empowered to have advance care planning conversations that

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4 89 reflect their personal values and beliefs.” The GDACPI hired a full-time staff member and  
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6 90 contracted with Respecting Choices® to support the initiative.  
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11 92 **The Survey:** The survey was developed by the GDACPI Data Subcommittee based on  
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13 93 ACP literature and reflective of needs for appropriately planning the overall  
14  
15 94 implementation. [The survey included general demographic information, as evidenced in](#)  
16  
17 95 [Table 1 for profession, practice site, age, and gender and Table 2 for personal ACP](#)  
18  
19 96 [experiences. Additional details include of response items are: Race: American](#)  
20  
21 97 [Indian/Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Black or African](#)  
22  
23 98 [American, White \(not Hispanic\), Hispanic or Latino, more than one race, or other/prefer](#)  
24  
25 99 [not to report; religious preference: Catholic, Seventh Day Adventist, Protestant \(other than](#)  
26  
27 100 [Catholic or Seventh Day Adventist, such as Baptist, Lutheran, Evangelical, Presbyterian,](#)  
28  
29 101 [etc.\), Jewish, Muslim, Non-Denominational, other, none, or prefer not to answer\];](#)  
30  
31 102 [frequency of ACP conversations \[never, rarely \(such as 2-3 times a year\), frequently \(such](#)  
32  
33 103 [as every 1-2 months\), often \(such as couple of times a month, very often \(at least weekly\)\];](#)  
34  
35 104 [training for ACP \(mark all that apply - a few lectures, seminars or conferences of 1 or more](#)  
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37 105 [days, self-taught through past patients experiences and seeking out information, learning](#)  
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39 106 [through personal/life experiences, received mentoring, on-line or other training resources,](#)  
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41 107 [formal fellowship of 3 months or more\).](#) There was a series of questions (based on work by  
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43 108 Aleksova et al<sup>11</sup> on the acceptability for various types of providers to be involved with four  
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45 109 identified levels of ACP interaction (initiate discussions, exchange information, be a  
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47 110 decision coach, and make final decisions). These questions were selected because authors  
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4 111 presented some data on variation by belief models by provider type. The survey was  
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6 112 piloted for clarity and ease of use with various members of the GDACPI board, medical  
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8 113 students, and clinicians, and various corrections were made. Based on pilot testing, it was  
9  
10 114 estimated to take about 5 minutes. Study data were collected and managed using REDCap  
11  
12 115 electronic data capture<sup>12</sup> tools hosted at Wright State University. REDCap (Research  
13  
14 116 Electronic Data Capture) is a secure, web-based application designed to support data  
15  
16 117 capture for research studies, providing: 1) an intuitive interface for validated data entry; 2)  
17  
18 118 audit trails for tracking data manipulation and export procedures; 3) automated export  
19  
20 119 procedures for seamless data downloads to common statistical packages; and 4) procedures  
21  
22 120 for importing data from external sources.

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27 121 Approvals for the survey were obtained first from the Data Subcommittee and  
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29 122 Leadership Council of the GDACPI before approval by Institutional Review Boards (IRB)  
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31 123 of Wright State University and Kettering Health Network, and the research oversight  
32  
33 124 committees of the hospitals within Premier Health associated with the Wright State  
34  
35 125 University IRB. Individual members of the GDACPI Leadership Council coordinated with  
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37 126 their own health care organization to get the survey link with instructions to their  
38  
39 127 respective email lists of targeted participants. A second prompt for responses was sent 2-6  
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41 128 weeks later with an embedded note not to respond twice. [The wording for the survey was:](#)  
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44 129 [“\(Our organization\), in partnership with \(the other GDACPI organizations\), is a](#)  
45  
46 130 [leader in the region’s Greater Dayton Advance Care Planning Initiative. The community’s](#)  
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48 131 [advance care planning initiative is preparing to launch its first pilot sites this spring. To](#)  
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50 132 [support this work, gaining a clear understanding of the use and attitudes of advance care](#)  
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4 133 [planning is a critical first step. Please click on the link below to take a brief, anonymous](#)  
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6  
7 134 [survey which is administered by Wright State University.”](#)  
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11 136 **Study participants:** Physicians, advance care providers (such as nurse practitioners (NP),  
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13 137 physician assistants (PA), and advanced nurse clinicians), nurses (other than advanced care  
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15 138 providers), social workers and clergy associated with the health care organizations  
16  
17 139 involved with the GDACPI participated in the study.  
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22 141 **Data analyses:** For the purposes of data analyses, participants were divided by religious  
23  
24 142 preference (All Religions vs. None/Prefer Not to Answer) and the two largest groups  
25  
26 143 (Protestants vs. Catholics). Descriptive statistics included frequency (percent) of non-  
27  
28 144 missing data for categorical variables, and mean±SD for variables measured on 7-point  
29  
30 145 Likert scales (extremely unwilling/unsupported/ unacceptable to extremely  
31  
32 146 willing/supported/acceptable). Comparisons of categorical variables between groups were  
33  
34 147 made with chi-square or Fisher’s exact tests. For statistically significant differences in  
35  
36 148 univariate analyses, multiple logistic regression was used to control for differences in  
37  
38 149 demographic variables between religious preference groups. Wilcoxon rank sums tests  
39  
40 150 were used for Likert scale variables. *P* values < .05 were considered statistically  
41  
42 151 significant. Analyses were conducted with SPSS v.24 (IBM Corporation). Some  
43  
44 152 categorical variables with multiple levels were collapsed into fewer levels for analyses. In  
45  
46 153 comparing the demographics of those identifying one or another religion to those stating  
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48 154 “none or prefer not to answer”, those with a religious preference were more likely to be  
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4 155 older and had a greater number of years in practice but were otherwise similar. As there  
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6 156 was a high rate of correlation between these two items by Spearman rank correlation ( $r =$   
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9 157  $0.795, p < 0.001$ ), only age category was included in further analyses.  
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## 13 159 **Results**

16 160 Surveys were completed between 05/02/2017 and 09/17/2017. Of 709 returned  
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18 161 surveys, 5 were missing data on one or more grouping variables and were excluded from  
19  
20 162 the analyses. For the included 704 surveys, some had missing data so the sample sizes for  
21  
22 163 each comparison vary by question/statement analyzed. We are unable to identify the exact  
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24 164 response rate, as some individuals could have received the survey link through more than  
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26 165 one organization, and as typical in an anonymous survey. Based on the number of  
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28 166 employees in the distributing organizations, we estimate the response rate in the 10-15%  
29  
30 167 range. As examples, Premier Physician Network includes “more than 600 physicians and  
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32 168 advance practice providers” (<https://www.premierphysiciannet.com>) and Kettering  
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34 169 Physician Network reports 480 physicians and advanced practice providers including some  
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36 170 in Cincinnati ([www.ketteringphysiciannetwork.org](http://www.ketteringphysiciannetwork.org) ). However, the email list could  
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38 171 include some affiliated physicians as well. If we accepted the total as 1,080, then the  
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40 172 response rate would be about 19% for these combined groups. This response rate is not  
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42 173 unusual for an anonymous survey without monetary incentives.  
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49 174 Of the 704 HCPs, 606 (86.1%) indicated a religious preference. See Table 1. Two-  
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51 175 hundred twenty-five (37.1%) were Protestant, 164 (27.1%) Catholic, 136 (22.4%) non-  
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53 176 denominational, 26 (4.3%) Seventh Day Adventist, 10 (1.7%) Jewish, and 45 (7.4%) other.  
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4 177 The number of years in practice was significantly greater in HCPs with a religious  
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6 178 preference compared to those without ( $20.6 \pm 13.0$  vs.  $14.5 \pm 10.8$ ,  $P < 0.001$ ). [No religion](#)  
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9 179 [\(or prefer not to state\) was marked by 98 \(13.9%\)](#). There was no difference in years in  
10  
11 180 practice between Catholic and Protestant HCPs ( $22.1 \pm 12.8$  vs.  $22.1 \pm 13.0$ ,  $P = .971$ ).

13 181 Most of the respondents were hospital-based, consistent with the distribution lists  
14  
15 182 for the survey link. Most were nurses (66.2%) or physicians post-residency (18.8%). As  
16  
17 183 expected based on the demographics of the hospital employees, the vast majority of  
18  
19 184 respondents were White. Consistent with number of years in practice, a higher proportion  
20  
21 185 of non-religious HCPs were in the younger age categories. There were no other differences  
22  
23 186 in demographics between HCPs with vs. without a religious preference, or between  
24  
25 187 Catholic and Protestant HCPs. [As an anonymous survey, we cannot be certain of the](#)  
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27 188 [representativeness of the respondents, however, the general demographics of the](#)  
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29 189 [respondents was similar to that of HCP's in the Dayton area, i.e., predominantly White.](#)

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34 190 As noted in Table 2, HCPs stating a religious preference were more likely to have  
35  
36 191 personal ACP planning, including their own living will and a written designation of a  
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38 192 Health Care Power of Attorney (HCPOA). [After controlling for age category](#) in multiple  
39  
40 193 logistic regression analyses, religious groups [remained](#) more likely to have their own living  
41  
42 194 will (adjusted odds ratio [AOR] [1.69](#), 95% CI [1.04-2.75](#),  $P = .035$ ). They [also](#) remained  
43  
44 195 more likely to have a named HCPOA (AOR [2.01](#), 95% CI [1.21-3.34](#),  $P = .007$ ). [Those with](#)  
45  
46 196 a specific religious preference were less likely to have had a personal near-death  
47  
48 197 experience [in univariate analysis \( \$P = .46\$ \); after controlling for age category the difference](#)  
49  
50 198 [was not statistically significant](#) (AOR [0.8](#), 95% CI [0.22-1.03](#),  $P = 0.060$ ).

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4 199 Those identifying as either Protestant or Catholic provided similar item responses  
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7 200 with a few exceptions. Catholic HCPs were less likely to report having experienced a  
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9 201 comfortable EOL experience for someone personally close to them; and less likely to have  
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11 202 been involved with one or more difficult or uncomfortable EOL experiences at their work  
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13 203 site.

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16 204 There were no differences between religious and non-religious HCPs for any of the  
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18 205 types of training. Catholic HCPs were more likely than Protestant HCPs to say they were  
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20 206 self-taught through past patients' experiences and seeking out information (19.5% vs.  
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22 207 11.6%,  $P = .030$ ). There were no differences in any of the other training types. There were  
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24  
25 208 no differences between religious and non-religious HCPs for concerns that get in the way  
26  
27 209 of talking to patients about EOL wishes. HCPs who identified as Catholic were less likely  
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29 210 to respond "frequently/sometimes" than Protestant HCPs to "you don't want a patient to  
30  
31 211 give up hope" (44.7% vs. 55.3%,  $P = .042$ ), and more likely to respond  
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33 212 "frequently/sometimes that "you're not sure it is the right time" (57.1% vs. 48.1%,  $P =$   
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35 213 .003) as concerns.

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39 214 As noted in Table 3, there was a difference in the acceptability of clergy/ministers/  
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41 215 faith leaders undertaking various levels of ACP discussions by HCP religious preference.  
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43 216 HCPs with religious preferences (vs. none) were more likely (5.26 vs. 4.74 on a 1-7 point  
44  
45 217 Likert scale,  $P = .030$ ), and Protestant HCPs more likely than Catholic HCPs (5.42 vs.  
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47 218 4.99,  $P = .027$ ) to endorse these individuals to be ACP decision coaches for patients or  
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50 219 significant others. Protestants were also more likely to endorse these individuals to  
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220 exchange ACP information. All of these average scores were above the mean of the scale,  
221 indicating substantial willingness to undertake ACP activities.

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## 223 Discussion and Conclusion

224 In this anonymous survey of health care professionals undertaken to inform a  
225 community-wide ACP intervention, religious preferences by two different groupings  
226 (none/prefer not to answer compared to all others, and Catholic compared to Protestant)  
227 were not found to significantly differ on most response items, with a few exceptions. This  
228 lack of differences [suggests](#) that health care professionals can separate their own ACP  
229 beliefs and experiences from the [desires](#) of their patients and significant others, similar to  
230 that found in the Ethicatt study from the Netherlands.<sup>13</sup> Further, our comparison of two  
231 different groupings of religion preferences strengthens the conclusion of a lack of major  
232 differences.

233 While the stated religious affiliation of the HCPs was associated with presence of  
234 their own personal living wills and/or a designated HCPOA, this was partially a function of  
235 age. Those [who were older were](#) more likely to have a written living will and a designated  
236 HCPOA, as well as a stated religious preference. [However, those HCPs with some form of](#)  
237 [religious affiliation remained more likely to have a written designation of a HCPOA.](#)  
238 [While there is no specific recent literature on this finding specific to HCPs, there is some](#)  
239 [information related to patients that may help interpret this. Namely, this association of](#)  
240 [religious affiliation and written HCPOA seems similar to that reported in 2012 for patients,](#)  
241 [i.e., those inpatients with high religiosity were more likely to have a specified decision](#)

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4 242 | [maker but not more likely to have an advance directive.](#)<sup>4</sup> This increased likelihood of a  
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6 243 | designated HCPOA could be a function of reminders related to religious functions such as  
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9 244 | funerals or other unknown factors. Our finding of higher religious [affiliation](#) among the  
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11 245 | nurses (86.3% of nurses stated a religious preference) is consistent with the finding of The  
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13 246 | Ethicatt Study.<sup>13</sup> Also, the rate of having a living will or designated health care power of  
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15 247 | attorney was higher than the general public, with about 37% having an advance directive.<sup>16</sup>

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18 248 |         There were some other, generally small, intriguing differences identified. For  
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20 249 | example, of the small number of individuals who reported their own near-death experience  
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22 250 | (n = 41), 24.4% had no religious affiliation, compared to 13.3% of 663 HCPs who did not  
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24 251 | have a near-death experience. There were modest differences in the experiences with both  
25  
26 252 | comfortable and uncomfortable end-of-life experiences for Catholics compared with  
27  
28 253 | Protestants. For both types of religious comparisons, the identified differences were small  
29  
30 254 | enough to question their clinical importance for development or implementation of ACP  
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32 255 | programs.

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36 256 |         [The strength of this paper lies in its originality and in its relationship to a](#)  
37  
38 257 | [community-wide ACP intervention.](#) The limitations are that, although reflective of the  
39  
40 258 | known employment of the respondents in one city (Dayton, OH), the responses may not  
41  
42 259 | reflect the views by others, particularly by ethnicity, types of religion, or region, as  
43  
44 260 | variation in these characteristics was limited. There were few respondents who identified  
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46 261 | themselves as a clergy/minister/faith leader. A non-response bias could affect the  
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48 262 | responses, [in an](#) unknown [direction](#). As self-report, accuracy of responses cannot be  
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50 263 | assumed.

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4 264 In conclusion, regardless of their personal major religious affiliation category,  
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7 265 HCPs have interest in undertaking ACP, as well as endorsing other types of HCPs  
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9 266 involvement in ACP, with patients and families. [This is in keeping with the view of](#)  
10  
11 267 [appropriate standards of care and ethics for EOL care, including but not limited to patient](#)  
12  
13 268 [autonomy.](#)<sup>17</sup> There were minor differences by HCP religion and acceptance of clergy or  
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16 269 faith leader involvement with ACP. As the results of this study suggest that personal  
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18 270 religious affiliation is not a barrier for HCPs engaging in ACP with patients, attempts to  
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20 271 overcome barriers to increasing ACP should be directed to other factors.  
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274 **Conflicts of Interest: The authors declare no conflicts of interest.**

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**Table 1.** Demographics by Health Care Provider Religious Preference

Survey item	All respondents No. (%)	No religion/ prefer not to report No. (%)	All religions No. (%)	<i>P</i> Value	Catholic No. (%)	Protestant No. (%)	<i>P</i> Value
<b>Profession</b>							
Physician (post residency)	138 (19.6)	21 (21.4)	117 (19.3)	.098	25 (15.2)	37 (16.4)	.735
PA/NP/CNS	48 (6.8)	2 (2.0)	46 (7.6)		16 (9.8)	15 (6.7)	
Nurse	466 (66.2)	64 (65.3)	402 (66.3)		112 (68.3)	157 (69.8)	
Other	52 (7.4)	11 (11.2)	41 (6.8)		11 (6.7)	16 (7.1)	
Total	704 (100)	98 (100)	606 (100)		164 (100)	225 (100)	
<b>Primary practice site</b>							
Hospital-based	519 (73.7)	72 (73.5)	447 (73.8)	.106	125 (76.2)	162 (72.0)	.622
Ambulatory-based	115 (16.3)	21 (21.4)	94 (15.5)		24 (14.6)	37 (16.4)	
Other	70 (9.9)	5 (5.1)	65 (10.7)		15 (9.1)	26 (11.6)	
Total	704 (100)	98 (100)	606 (100)		164 (100)	225 (100)	
<b>Age group (years)</b>							
20-29	50 (7.1)	9 (9.3)	41 (6.8)	.001	13 (8.0)	11 (4.9)	.409
30-39	144 (20.5)	33 (34.0)	111 (18.4)		26 (16.0)	36 (16.0)	
40-49	155 (22.1)	23 (23.7)	132 (21.9)		27 (16.6)	53 (23.6)	
50-59	215 (30.7)	22 (22.7)	193 (32.0)		60 (36.8)	76 (33.8)	
≥ 60	137 (19.5)	10 (10.3)	127 (21.0)		37 (22.7)	49 (21.8)	
Total	701 (100)	97 (100)	604 (100)		163 (100)	225 (100)	
<b>Gender</b>							
Female	558 (80.5)	70 (74.5)	488 (81.5)	.111	138 (85.2)	190 (85.6)	.913
Male	135 (19.5)	24 (25.5)	111 (18.5)		24 (14.8)	32 (14.4)	
Total	693 (100)	94 (100)	599 (100)		162 (100)	222 (100)	
<b>Race</b>							
White	624 (88.9)	89 (90.8)	535 (88.6)	.513	153 (93.9)	203 (90.2)	.198
Non-white	78 (11.1)	9 (9.2)	69 (11.4)		10 (6.1)	22 (9.8)	
Total	702 (100)	98 (100)	604 (100)		163 (100)	225 (100)	

How often discuss ACP with patients  
or their significant others

Never	68 (9.7)	12 (12.6)	56 (9.3)	.318	20 (12.2)	19 (8.5)	.160
Rarely	209 (29.9)	23 (24.2)	186 (30.8)		43 (26.2)	80 (35.7)	
Frequently	145 (20.7)	18 (18.9)	127 (21.0)		30 (18.3)	47 (21.0)	
Often	120 (17.2)	22 (23.2)	98 (16.2)		34 (20.7)	33 (14.7)	
Very often	157 (22.5)	20 (21.1)	137 (22.7)		37 (22.6)	45 (20.1)	
Total	699 (100)	95 (100)	604 (100)		164 (100)	224 (100)	

Have had formal training in  
undertaking ACP discussions

No	521 (74.6)	78 (80.4)	443 (73.7)	.159	118 (73.3)	173 (77.2)	.375
Yes	177 (25.4)	19 (19.6)	158 (26.3)		43 (26.7)	51 (22.8)	
Total	698 (100)	97 (100)	601 (100)		161 (100)	224 (100)	

Would like to be trained to teach  
other HCPs to undertake ACP  
conversations with patients or their  
significant others

No	442 (69.5)	62 (75.6)	380 (68.6)	.198	102 (69.9)	147 (71.7)	.708
Yes	194 (30.5)	20 (24.4)	174 (31.4)		44 (30.1)	58 (28.3)	
Total	636 (100)	82 (100)	554 (100)		146 (100)	205 (100)	

Abbreviations: ACP, Advance Care Planning; CNS, Clinical Nurse Specialist; HCP, Health Care Provider; NP, Nurse Practitioner; PA, Physician Assistant.

**Table 2.** Personal ACP and ACP Associated Experiences of HCPs with Religious Preference vs. None and Catholic vs Protestant

Survey item	All respondents No. (%)	No religion/ prefer not to report No. (%)	All religions No. (%)	<i>P</i> Value	Catholic No. (%)	Protestant No. (%)	<i>P</i> Value
Personally I have:							
My own Living Will	335 (47.6)	31 (31.6)	304 (50.2)	< .001	87 (53.0)	110 (48.9)	.418
Written designation of my own HCPOA	304 (43.2)	25 (25.5)	279 (46.0)	< .001	84 (51.2)	97 (43.1)	.113
Experienced a difficult or uncomfortable EOL for someone personally close to me	216 (30.7)	28 (28.6)	188 (31.0)	.625	44 (26.8)	66 (29.3)	.588
Experienced a comfortable EOL for someone personally close to me	363 (51.6)	51 (52.0)	312 (51.5)	.919	75 (45.7)	126 (56.0)	.045
Had a near-death experience	41 (5.8)	10 (10.2)	31 (5.1)	.046	9 (5.5)	8 (3.6)	.357
Witnessed or been involved with one or more difficult or uncomfortable EOL experiences at my work site	412 (58.5)	59 (60.2)	353 (58.3)	.716	77 (47.0)	132 (58.7)	.022
Witnessed or been involved with one or more comfortable EOL experiences at my work site	430 (61.1)	60 (61.2)	370 (61.1)	.975	96 (58.5)	140 (62.2)	.642

Abbreviations: ACP, Advance Care Planning; EOL, End-of-Life; HCPOA, Health Care Power of Attorney

**Table 3.** Acceptability of Clergy/Ministers/Faith Leader Roles in ACP by Respondent Religious Preference

Survey item	All respondents	No religion/ prefer not to report	All religions	<i>P</i> Value	Catholic	Protestant	<i>P</i> Value
How acceptable is it for clergy/minister/faith leader to:	Mean ± SD	Mean ± SD	Mean ± SD		Mean ± SD	Mean ± SD	
Initiate ACP discussions	5.61 ± 1.63 n = 649	5.40 ± 1.77 n = 85	5.64 ± 1.59 n = 564	.379	5.54 ± 1.70 n = 152	5.78 ± 1.47 n = 208	.275
Exchange information about ACP	5.64 ± 1.61 n = 644	5.43 ± 1.71 n = 84	5.67 ± 1.59 n = 560	.317	5.39 ± 1.79 n = 152	5.90 ± 1.37 n = 206	.018
Be a decision coach for patients and/or their significant others	5.19 ± 1.80 n = 637	4.74 ± 1.99 n = 84	5.26 ± 1.76 n = 553	.030	4.99 ± 1.84 n = 151	5.42 ± 1.73 n = 204	.027
Make decisions with patients and/or their significant others	4.75 ± 1.97 n = 627	4.44 ± 2.03 n = 80	4.80 ± 1.96 n = 547	.141	4.63 ± 1.99 n = 147	4.96 ± 1.94 n = 200	.126

Abbreviations: ACP, Advance Care Planning; SD, standard deviation.