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JOHN W. RAWLINGS SCHOOL OF DIVINITY

Promoting Health Literacy to Aging Christians: To Combat the Scourge of Euthanasia through the Church

A Thesis Project Submitted to

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Doctor of Ministry

by

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THE DOCTOR OF MINISTRY THESIS PROJECT ABSTRACT
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The many dilemmas that occur in the medical care of chronically ill seniors raise the question of whether senior populations have become the new black. The research seeks to provide an evidence-based review of limited health literacy among elderly African American Christians regarding diagnoses and medical treatments, which has resulted in unethical Christian practices becoming a norm. The researcher adapted the health literacy framework of PaascheOrlow and Wolf's view of three distinct causes that influence health literacy: the access and utilization of health care, the patient-provider relationship, and self-care. The problem is that Victory Church members may not understand the chaplain's role in addressing the need for health literacy for aging members to combat the rise of euthanasia through the church. The purpose of this thesis is to bring awareness to chaplains that clinical training can benefit pastors and ministers in their capacity as caretakers by shaping end-of-life choices consistent with Christian ethics. The study aims to research the positive benefits that health literacy may produce in elderly African Americans' decision-making and ability to implement advance directives in the event of a health crisis. The form of the survey will be the Likert scale. The specific tools used to measure and analyze the intervention processes are focus group discussions, interviews, and action research. Through interviews and surveys of participants and literature reviews by scholars in medicine and issues associated with death and dying, a conceptual framework underscores what is learned and promising areas of future interventions.

Keywords: health literacy, Christian ethics, spiritual care, chaplains, end-of-life decision-making

Contents

Tables

Illustrations

Abbreviations

AD *advance directives*

AS *assisted suicide*

DMIN   *Doctor of Ministry*

DNR   *do not resuscitate*

EOL   *end of life*

PAS   *physician-assisted suicide*

PE   *passive euthanasia*

QOL   *quality of life*

RTL   *right-to-life*

CHAPTER 1: INTRODUCTION

Introduction

Modernity brings with it many of the social ills people are experiencing in the world today. Health care abuses abound because people live longer with an increasing number of incurable and chronic illnesses. As a volunteer at a hospice facility and training chaplain in health care, the researcher has seen firsthand that exposure to chronic long-term conditions is abundant among the elderly and that decisions on end-of-life care are often made in haste and unadvised by patients and family members. The health care chaplain is an asset to the church in this area, although some pastors fail to support the office of chaplaincy.

Death and dying is an everyday occurrence in health care, and many face death with fear and uncertainty. Peter Berger acknowledges that "every human society is in the last resort, men bunched together in the face of death. The power of religion depends, in the last resort, upon the credibility of the banners it puts in the hands of men as they stand before death, or more accurately as they walk inevitably towards it."[1] Death is not something people face privately. Death is a social experience affecting loved ones and others closely associated with the dying person. Death is the one thing the living rarely discuss, although the Scriptures attest that "everything alive will die" (Eccl 9:5).[2]

No one looks forward to passing, and fewer make final preparations for death, especially African Americans exposed to many health disparities. A significant gap in research on right-to die choices is apparent among African Americans. Yet there is a growing need for ministering to

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[1] Peter Berger, *The Sacred Canopy: Elements of a Sociological Theory of Religion* (Oxford: Oxford University Press, 1967), 51.

[2] Unless otherwise noted, all biblical passages referenced employ the *English Standard Version* (Wheaton, IL: Crossway, 2008).

the emotional complexities associated with health care and coping with death and suffering. There is a discrepancy in Christian beliefs about death and dying. This study examines the spirituality of elderly African American Christians' belief systems regarding making end-of-life decisions. There is a significant gap in knowledge on the dying's religious commitment and what should be considered theologically as a "good death." This study hopes to be an essential tool for examining the religious perspectives of aging Christians and those who influence their end-of-life decisions (e.g., pastors, medical providers, caretakers, chaplains, clergy, and family).

Ministry Context

Background / Call to Ministry

The researcher was called into the gospel ministry in 1984 and publicly acknowledged the call in 1986. She was licensed on August 10, 1986, to preach the gospel by Mount Gilead Missionary Baptist in Nashville, Tennessee, under the late Reverend Foster G. Young's pastorate. She served in the service of the Lord for thirty-eight years. The researcher's various positions at Mount Gilead included being the young adult Sunday school teacher for twelve years. She founded the Woman-to-Woman outreach program, working with single parents, domestic abuse victims, and the homeless. To support the foundations, the researcher began a nonprofit business, Be-a-Witness Ministry, organized in 1997. The nonprofit company ran out of the researchers' basement. The main products sold were CDs, Christian T-shirts, Christian devotionals, and other faith-centered paraphernalia.

Call to Service

Currently, the researcher is a member of the Victory Church in Nashville, Tennessee, founded by her pastor, Bishop Kenneth Dupree. The researcher serves the church pastor in

community outreach services, including prison ministry and care ministry to the sick and shut-in members, along with visitations at nursing homes and assisted-living facilities. The researcher serves in the biblical context: "Whatever you did for one of the least of these brothers and sisters of mine; you did for me" (Matt 25:40, New International Version [NIV]). Under Bishop Dupree's encouragement and direction, the researcher began volunteering first as a hospice aid, which developed into providing spiritual care as a training chaplain to the church's families and other patients experiencing spiritual distress brought on by painful, humiliating death and grief.

Bishop Dupree retired in 2019, after which the church experienced a split, and now the executive pastor at Victory is Derick Faison. The latter previously served as an associate pastor at the Potter's House in Dallas, Texas. The researcher's recent health decline and diagnosis with cancer and early stages of dementia warrant health literacy concern among African American seniors. The researcher worked in health care as a licensed cook for dietary services for over eighteen years. The researcher developed a ministry of presence after listening to the patients. They shared philosophical and psychological concerns associated with finding meaning in life when independence is lost or limited. Debilitating health and chronic illness cause conflict with faith, and the absence of support from family or church negatively influence health decisions.

<div align="center">Vision of Vocation</div>

Alive Hospice

Being a hospice volunteer ministering to patients with a life expectancy of six months or less is spiritually rewarding. The work is stressful; volunteers need to be grounded in their faith to nurture the dying's spiritual needs. Volunteering at Alive Hospice in Nashville, Tennessee, is humbling and challenging. Alive is a 501(c)(3) charitable nonprofit organization established in Middle Tennessee in November 1975. The three core goals of hospice are to provide

comprehensive care for terminally ill patients and their families, offer support for grieving adults and children, and serve the community as a center for research and education.[3] Before COVID19, the researcher volunteered three days a week for eight hours at hospice, working primarily with in-housed congregation members.

Alive Hospice in Nashville continues to maintain the same principles as the vision of its founder, Cicely Saunders. Janet Soskice describes Saunders's viewpoint as a colleague and pioneer of the hospice movement in Britain. Robert Twycross explained that the hospice's role is not to "help people die but to live well while dying."[4] Saunders, however, was a trained nurse, social worker, and medical doctor; the hospice movement developed from her Christian beliefs. Yet the benefit was much broader than religious affiliation, and she believed the dying should be allowed to die in peace and with dignity. Saunders offered three fundamental principles that motivate this study. According to Coward, "Saunders developed a program of care for the dying based on pain control; a family or community environment; and an engagement with the dying person's most deeply rooted spirituality."[5] The connection with faith in sickness and dying is not characterized by an institutional affiliation but inspired by the death, burial, and resurrection of Jesus Christ. The gospel parallels the core values of what constitutes the biblical context of dying with dignity. As a volunteer chaplain, the researcher has noticed that this concept is often missing in the experiences shared with some terminally ill African American Christians.

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[3] "About Alive," Alive Hospice, accessed August 28, 2020, https://www.alivehospice.org/about/about-alive.

[4] Janet Soskice, "Dying Well in Christianity," in *Religious Understandings of a Good Death in Hospice Palliative Care*, eds. Harold Coward and Kelli I. Stajduhar (Albany: State University of New York Press, 2012), 141, ProQuest Ebook Central.

[5] Harold Coward and Kelli I. Stajduhar, introduction to *Religious Understandings of a Good Death in Hospice Palliative Care*, 1.

Volunteer Chaplain

As an associate minister at Victory Church, the researcher is the only chaplain at the church, and serving at Victory has its challenges. Victory Church is a predominately African American congregation. It is a nondenominational church with a majority of middle- and upper-class members. The community consists of about four hundred active members, 40 percent of whom are seniors. As more and more members became patients, the Care Outreach work consisted of visiting Alive Hospice. Other health care facilities (e.g., nursing homes, hospitals, rehabilitation centers, and assisted-living care centers) became daily tasks. In this light, chaplaincy encompasses and answers the question the rich ruler asks Jesus: "Who is my neighbor?" (Luke 10:29). In this context, neighbors include visiting church members as well as a chaplain in training ministering to others of different faiths and some with no faith affiliation.

There is so much uncertainty in some elderly members suffering from chronic illness or caring for a spouse disabled or with Alzheimer's. Christians' faith is tested continuously in the present culture. God is pushed out of the equation when questions about medical treatments conflict with the Word of God. Christians may be wavering in faith, "but God's firm foundation stands, bearing this seal: The Lord knows those who are his" (2 Tim 2:19). Ministering to terminally ill patients suffering from unbearable pain and near death is difficult for the chaplain when fear and doubt take over. The impact of health literacy, as Ferrell et al. postulate, "hinders individuals' ability to access and navigate the healthcare system, make appropriate health decisions, and act on health information."[6] Health literacy coupled with incoherent Christian belief is a phenomenon on the rise among elderly African American Christians.

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[6] Betty Ferrell, Jay Goldsmith, Thomas Smith, Myra Glajehen, George Handzo, and Sandra L. Ragan, *Textbook of Palliative Care Communication* (Oxford: Oxford University Press, 2015), 90. ProQuest Ebook Central.

Aging Christians are among the most likely to desire a quick fix to end their pain. Other Christians lose hope when diagnosed with a debilitating disease, and their quality of life and independence are stripped away. Several in the congregation have made hastening death decisions in compliance with a chronically ill loved one. However, Paul reminds us that "if in Christ we have hope in this life only, we are of all people most to be pitied" (1 Cor 15:19); another translation reads, "We are of all men most miserable" (1 Cor 15:19, King James Version [KJV]). Chaplains experience this miserable condition, and this study seeks to bring this reality to the black church. The fear of death and the avoidance of suffering are unwarranted, present a breakdown in communication, and threaten to result in health decisions inconsistent with a Christian worldview.

Problem Presented

The problem is that Victory Church members may not understand the chaplain's role in addressing the need for health literacy for aging members to combat the rise of euthanasia through the church. There is a need for the church to provide a venue to educate members and leaders concerning the ethical decisions made by elderly and terminally ill patients before undergoing medical treatments. An earnest discussion must occur worldwide, especially among congregants in the black church in America. An intense debate is needed to support and educate members on the legality and morality of medical treatments and end-of-life procedures.

Pulmonologist Dee W. Ford estimates that "the 19th and 20th centuries saw a scientific revolution and the establishment of 'modern medicine.' The explosion in medical knowledge, therapies, and technologies is largely attributable to an increased focus on the scientific method

and empirically demonstrable outcomes."[7] In other words, the blending of faith and science

becomes more compatible as new opportunities for health-related quality of life measured by the

value of a patient's life, which often is contrary to religious conviction. Bülow et al. report that

"the human condition is complex and not easily reduced to mere empiric decision-making. This

is particularly true in the context of life-altering decisions about end-of-life care or value-laden

concepts such as patient autonomy."[8]

     There are other alternatives available in long-term care for the chronically ill, the

disabled, the elderly, and those in vegetative states who cannot make end-of-life decisions for

themselves. Technical advances preserve life at all costs, but is there any value in the life they

are maintaining? Rowland and Isaac-Savage convincingly argue that "one of the avenues least

researched within the Black Church is the pastor's perception of its educational role in health

and wellness and its efforts to reduce health discrimination and health disparities."[9]

     The missing element in the church that is central to research are the humanitarian efforts

of activism around health conditions and interventions on health disparities that exist among

African Americans. Between these two junctures, the problem exists in finding measures to

combat preventable diseases, and pastoral support on health decisions is a must with their aging

members. The researcher's interest in the project encapsulates the necessity for collaboration

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[7] Dee W. Ford, "Religion and End-of-Life Decisions in Critical Care: Where the Word Meets Deed," *Intensive Care Medicine* 38, no. 7 (2012): 1089–91, accessed January 29, 2021, https://doi.org/10.1007/s00134-0122557-5.

[8] Hans-Henrik Bülow, Charles L. Sprung, Mario Baras, Sara Carmel, Mia Svantesson, Julie Benbenishty, Paulo A. Maia, Albertus Beishuizen, Simon Cohen, and Daniel Nalos, "Are Religion and Religiosity Important to End-of-Life Decisions and Patient Autonomy in the ICU? The Ethicatt Study," *Intensive Care Medicine* 38 (2012): 1126–33*,* accessed January 29, 2021, https://doi.org/10.1007/s00134-012-2554-8.

[9] Michael L. Rowland and E. Paulette Isaac-Savage, "As I See It: A Study of African American Pastors' Views on Health and Health Education in the Black Church," *Journal of Religion and Health* 53, no. 4 (2014): 1091–101, accessed July 7, 2020, https://doi.org/10.1007/s10943-013-9705-2.

between health care chaplains, pastors, and black church leaders. The problem with health literacy can be eliminated when Victory leadership receives training that will equip them in ministering to the terminally ill, the disabled, caretakers, and surrogates to make informed Christian decisions on long-term care and advanced medical treatments.

Purpose Statement

The purpose of this DMIN action research thesis is to bring awareness to the role of the health care chaplain and how their clinical pastoral training can benefit pastors and ministers in their administration of holistic patient care to aging members. The researcher hopes that integrating educational workshops for more senior adult members, their families, and caretakers may enhance their ability to make healthy lifestyle changes and informed end-of-life choices that dispel fears. The lack of pastoral support in times of medical crisis is a problem and demonstrates the need for research on patients' rights and autonomy related to end-of-life care. Pentaris and Thomsen highlight the relationship with religion and the experiences of death and dying, stating that "religion and belief have received increasing attention in death policies, end-of-life care, and research over the last 20 years."[10] They suggest a concept of religious literacy, referring to implying "a set of skills and abilities necessary to better respond to needs related to religion and belief."[11]

An intricate central issue for many religious traditions is the reverence for human life. In the euthanasia debate, the slippery slope is that by removing the sanctity of life from the

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[10] Panagiotis Pentaris and Louise L. Thomsen, "Cultural and Religious Diversity in Hospice and Palliative Care: A Qualitative Cross-Country Comparative Analysis of the Challenges of Health-Care Professionals," *Omega Journal of Death and Dying* 81, no. 4 (2020): 648–69, accessed January 29, 2021, https://doi.org/10.1177/0030222818795282.

[11] Ibid.

equation, a rapid progression toward the legalization of one or more forms of euthanasia throughout America will become inevitable. Health literacy will lead to making the essential end-of-life preparations shaped from a Christian worldview. With the opening of a dialogue on death and dying issues, members may not continue to avoid the conversation. If seniors learn of life's meaningfulness at all stages of existence, their lives are valued.

In following Jesus' example of caring for the sick, disabled, and disenfranchised, the health care chaplain and the church are commanded "to go and do likewise" (Luke 10:37). The church so often neglects this mandate as more senior members' health declines that often so does the members' faith, a decline caused by their experiencing feelings of abandonment, loneliness, and isolation. The Victory Church pastor and leaders must comply with the spiritual needs of elderly Christians experiencing social and health crises. Trull and Creech identify this spiritual interaction with "pastors administering pastoral care with people facing some life event as bringing God's presence and a reminder of God's care to the hurting and displaced families."[12] The researcher contends that by being provided health literacy education with some form of Christian counseling, the seniors can maintain a biblical understanding of sickness, suffering a terminal illness, and death that will inform decision-making over health consistent with Christian ethics.

Basic Assumptions

The biblical principles foundational to the study thesis begin with the Christian declaration *sola scriptura*, Latin for "by Scripture alone." Scripture alone is the sole authority for Christian faith and practice. Through a sound exegesis of the critical biblical passages that form

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[12] Joe E. Trull and R. Robert Creech, *Ethics for Christian Ministry: Moral Formation for Twenty-FirstCentury Leaders* (Grand Rapids, MI: BakerAcademic, 2017), 79.

the basis of this research, adherence to the Holy Bible as the primary source of study (2 Tim

3:16–17) also substantiates the educational training aspect of pastors, ministers, and members in

the church. The "all Scripture" refers to both the Old and New Testament as referenced by Paul's

writings in verse 16. "The unique placement of this passage, situated during a time of

persecution by evil imposters of the faith, paints the background for the passage."[13] Another

assumption presumes that the participants will abide by the principles of the Word of God.

The project assumes participants will benefit from the study's relevancy, assuming they

agree that every Christian should want a dignified death for themselves and their loved ones. The

hope is that all participants believe that life's sacredness is due to human life being God's gift.

The study considers the participants' religious affirmation on the death, burial, and resurrection

of Jesus Christ. Therefore, as Christians, the assumption is that participants will own the fact that

Christians make sense of life through the lens of Christian theology.

The hope is that respondents in the study will provide honest answers. There is the

assumption that Alive Hospice volunteer chaplains will participate in the study. There is the

hope that the pastor of Victory Church and its board of trustees will approve the project and

financially support and provide the facility's use to conduct the study. The study considers that

all participants are Victory Church members, family members, or caregivers to a member. The

researcher assumes all staff, team leaders, volunteer workers, and facilitators will not seek

compensation.

The assumption is that all members will participate voluntarily with no influence of

intimidation or coercion. Working in the medical field, the researcher expects staff, families, and

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[13] Walter L. Liefeld, *1 & 2 Timothy, Titus,* The NIV Application Commentary (Grand Rapids, MI: Zondervan Publishing House, 1999), 281.

caretakers to abide by institutional policy and HIPAA privacy rules. Additionally, the researcher assumes 100 percent participation of qualifying members for the study. The researcher's assumption is that some participants may choose to drop out of the research and may do so without pressure or influence from recruiters. A written summary explaining why will be requested but not required if a participant chooses to drop out. Anticipated estimations for some unforeseen causes resulting in the attrition of participants have been calculated and adjusted by the number of proposed subjects in the recruiting stage of the study. The hope is that participants will allow documentation of their responses to be preserved for data processing. However, if participants choose otherwise, their responses will be destroyed.

The study is contingent on providing a clear purpose for the research and assumes that the retainment of participants' engagement will not decrease. The facilitator believes that the responses to questions will provide insights from which interventions may lead to practical solutions to the problem at the center of the research. The study acknowledges that integrating health literacy workshops for more senior adult members may enhance their ability to make healthy lifestyle changes and more ethically informed end-of-life choices. The assumption is that the study will generate continuing research that will extend beyond African American Christian seniors and become beneficial for other demographics.

Definitions

Below is a list of terms used throughout this research project to help the reader understand the study's context and direction. The black church, which Pollard and Duncan define as "consisting of multiple racial-ethnic communities of Christian faith, united by African

heritage and the shared historical and present-day experiences of people of African descent,"[14]

postulates that the meaning of pastor and pastoral care is understood from the biblical mandate

for a pastor as defined in Scripture, closely linked with the pastors' function or duties as

recorded in 1 Peter 5:2–4.

In the book of Jeremiah, "God gave us pastors according to his heart, which shall feed

you with knowledge and understanding" (Jer 3:15, KJV). According to Stansbury et al., whose

qualitative study distinguishes between pastor and pastoral care by their functions, "The

theological view of a pastor as shepherding a flock and the pastoral role of counseling with

implications for social work, psychology, and psychiatry."[15] The ministry of chaplaincy closely

relates to pastoral work. The professional health care chaplain requirements distinguish it.

Chaplains are "clinically and theologically trained and educated members of the

healthcare team accredited by a certified professional chaplaincy organization."[16] There are

distinct functions that health care chaplains perform within that support the project's thesis.

VandeCreek and Burton describe these activities thusly:

> When religious beliefs and practices are tightly interwoven with cultural contexts,
> chaplains constitute a powerful reminder of the healing, sustaining, guiding, and
> reconciling the power of religious faith; and healthcare chaplains educate the healthcare
> team and community regarding the interrelationship between religious and spiritual
> issues. Professional chaplains serve as a mediator serving as contact persons to arrange
> complementary therapies and encouragement and support for research.[17]

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[14] Alton B. Pollard III and Carol B. Duncan, introduction to *The Black Church Studies Reader*, ed. Alton B. Pollard III and Carol B. Duncan (New York: Palgrave Macmillan, 2016), 6, e-book.

[15] Kim L. Stansbury, Debra A. Harley, Lois King, Nancy Nelson, and Gillian Speight, "African American Clergy: What Are Their Perceptions of Pastoral Care and Pastoral Counseling?," *Journal of Religion and Health* 51, no. 3 (2012): 961–69, accessed July 6, 2020, https://doi.org/10.1007/s10943-010-9413-0.

[16] "What Is a Chaplain?," Healthcare Chaplains Ministry Association, accessed September 2, 2020, https://www.hcmachaplains.org/what-is-a-chaplain/.

[17] Larry VandeCreek and Laurel Burton, "Professional Chaplaincy: Its Role and Importance in Healthcare," *Journal of Pastoral Care* 55, no. 1 (2001): 86–88, accessed January 29, 2020, https://doi.org/10.1177/002234090105500109.

The chaplain's ministry fluctuates within the medical health system, where the various forms of euthanasia prevail. "The word euthanasia comes from two words in the Greek language *eu* means 'well' or 'good,' and *Thanatos* means 'death.'"[18] "Today it has come to mean the intentional end of a person's life to end suffering."[19]

A medical specialty "focuses on diseases and disabilities associated with aging and later life and on the health and long-term care needs of older adults termed geriatrics. The scientific study on aging and old age is defined as gerontology."[20] Sasser and Moody explain aging as a "multi-faceted (bio-psycho-social) and contextual process intertwined with development throughout the entire span of a human being's time on earth."[21] The study focuses on the final lifespan of aging African American Christians unprepared to mitigate the various secular worldviews in the medical field.

The definition of *worldview* that resonates with this study comes from James W. Sire, who describes it as a "fundamental orientation of the heart that can be expressed as a story or in a set of presuppositions (assumptions which may be true, partially true, or entirely false) that we hold (consciously or subconsciously, consistently, or inconsistently) about the basic constitution of reality and that provides the foundation on which we live and move and have our being."[22]By Sire's definition the Christian, worldview comprises the biblical narrative of God as the giver and sustainer of life as found in Scripture. God said of himself, "See now that I, even I, am he, and there is no god beside me; I kill, and I make alive; I wound, and I heal; and there is none that

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[18] Steve Wise, *Euthanasia* (Philadelphia: Natural Highlights, 2016), 9, ProQuest Ebook Central.

[19] Ibid., 10.

[20] Jennifer R. Sasser and Harry R. Moody, *Gerontology: The Basics* (London: Routledge, 2018), 2.

[21] Ibid., 14.

[22] James W. Sire, *The Universe Next Door*, 5th ed. (Downers Grove, IL: IVP Academic, 2009), 20.

can deliver out of my hand" (Deut 32:39). The study contends when defining the various types

of euthanasia proponents who argue it depends mainly on the context of the situation in

distinguishing its legality are not beholden to the declarations made in the Deuteronomy

discourse. Several categories of euthanasia are more frequently discussed that are crucial in the

ethical debates on legalization. Keown identified active euthanasia as occurring "when a lethal

injection or some other drug is given to end a person's life."[23]

Keown's research demonstrated that proponents argued that "intentionally shortening a

patient's life by withholding food, water, or warmth is no less wrong than injecting a lethal

poison, this act of omission defines passive euthanasia."[24] Passive euthanasia is performed by

withholding food and water or neglecting to provide necessary medical care. Voluntary

euthanasia is performed on those who specifically request death, whereas involuntary euthanasia

describes killing a person who has not clearly expressed a wish to die. The most highlighted

form of euthanasia is physician-assisted suicide (PAS). The term, coined by the bizarre actions

of "Dr. Jack Kevorkian (Dr. Death), a retired pathologist who assisted more than forty people in

committing suicide by providing the patient with a lethal drug and encouraging others to end

their lives. Kevorkian escaped conviction for his medical practices until he recorded himself

administering a lethal injection, shifting from assistance in suicide to euthanasia, securing his

murder conviction."[25]

Today, a great deal of stress placed on seniors' successful aging, measured by

maintaining independence, raises the ethical premise of human life's intrinsic dignity apart from

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[23] John Keown, *Euthanasia, Ethics, and Public Policy: An Argument against Legislation*, 2nd ed. (Cambridge: Cambridge University Press, 2002), 9.

[24] Ibid., 10.

[25] See "Dr. Jack Kevorkian's *60 Minutes* Interview," CBS News, June 4, 2011, accessed August 1, 2020, https://www.cbsnews.com/news/dr-jack-kevorkians-60-minutes-interview/.

life quality. Karimi and Brazier define this as "over-all well-being, personal development, purposeful activity, and personal values."[26] Aging is stigmatized by the term *geriatrics*, a medical specialty that focuses on the diseases and disabilities associated with aging and later life and the health and long-term care needs of older adults. "The study of aging and old age defines gerontology."[27] The research focuses on communicating health information clearly and understanding it correctly in the continuum of care, disease prevention, diagnosis, decision-making treatment, and self-care coined by Osborne as defining g health literacy.[28]

The concern for the underuse of hospice and palliative care among ethnic minorities research shows it centers around religious beliefs and practices. To manage anxieties associated with the two programs, defining their role and rules may alleviate many misconceptions. Hospice seeks to provide total comfort and care to patients as well as support to families. "The practice of hospice care avoids attempts to cure the patient's illness. Hospice focuses on providing care instead of seeking a cure."[29] The same kind of care is available with palliative care, which is medical care provided to patients with life-limiting illnesses. "Palliative care, referred to as "comfort care," focuses on pain relief and other symptoms by addressing the patient's physical, emotional, social, and spiritual needs."[30] There are two primary types of palliative medications administered to relieve pain and suffering attributed to the underuse of

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[26] Milad Karimi and John Brazier, "Health and Health Related Quality of Life, and Quality of Life: What Is the Difference?," *PharmacoEconomics* 34, no.7 (2016): 645–49, accessed September 2, 2020, https://doi.org/10.1007/s40273-016-0389-9.

[27] Sasser and Moody, *Gerontology*, 2.

[28] Helen Osborne, *Health Literacy from A-to-Z*, 2nd ed. (Burlington, MA: Jones & Bartlett Learning, 2013), 2.

[29] Lisa S. Wagner, *Aging and Diversity: An Active Learning Experience*, 3rd ed. (London: Routledge, 2019), 520.

[30] Ibid.

hospice and palliative care by ethnic groups: psychotropic drugs and narcotics. The way to ensure your final wishes are honored in the event you are unable to speak for yourself is by implementing advance care planning before the need arises. Advance care planning is about ensuring that health care treatments and care preferences are legally documented and updated as circumstances of life changes.[31]

Limitations

The research is limited by a large gap in the literature specific to black church pastors and health care chaplains' association and collaboration. The study is limited by gaps in the application that exist in the broad range of disparities in the health of at-risk groups (e.g., elderly adults and African Americans). The gaps in application limit the research in lacking a means for measuring health literacy among African American Christians and other minority ethnic groups. The study is limited to Christian participants as defined by a Christian worldview—a worldview that takes on, as Eckman postulates, "an entire way of thinking, covering not only theology but how to think about ethics, history, science, literature, about everything."[32]

The study is limited to recruitment selection from members of the Victory Church. The study may use other faith groups only for comparison of biblical worldviews. The restraints in place at Alive Hospice on policies and patient eligibility of hospice services limit the research to administration approval. Patient confidentiality laws limit the study of recipients. Participation is voluntary, and some may opt out for reasons of choice, fear, death, or chronic situations that impede further involvement in the study.

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[31] "Give Peace of Mind: Advance Care Planning," Alzheimer's Disease and Healthy Aging Program, CDC, accessed July 20, 2020, https://www.cdc.gov/aging/advancecareplanning/index.htm.

[32] James P. Eckman, *The Truth about Worldviews: A Biblical Understanding of Worldview Alternatives* (Wheaton, IL: Crossway, 2004), 119.

The research is limited in scope and does not presume to have all the solutions to fully address all the issues associated with health disparities among African Americans or all the problems related to medical providers' demands and expectations. The researcher recognizes the study is not perfect and that more research is needed. Presently, the COVID-19 pandemic has placed unprecedented restraints on access to patients and limited access to regular congregational accessibility. Limitations on participants providing honest answers to questionnaires and group class discussions can pose problems with accurate data reports.

Delimitations

Some delimitations to study include the age restrictions of participants, limited to seniors sixty-five years old and over. Participants will be recruited from the congregation at Victory Church and its members at hospice. The research is restricted to African Americans because they are the people who mostly make up those who experience health disparities. The study will exclude all health care facilities other than residents and outpatients at Alive Hospice. The recruitment is limited to members only living in assisted living and retirement communities. The study delimits patients who lack coherency (e.g., moderately severe dementia patients, Alzheimer's patients, family members with patients in vegetative states, or participants who lack cognitive aptitude). The research delimits the specific sites for the study to Victory Church, hospice, and participants' homes. The scope of the study delimitation is on existing legislation related to right to life and all forms of euthanasia. Data were collected by pen and pencil survey. All participants in the study were in a middle to upper-class income range.

To the researcher's knowledge, this study is the first evaluation of participation between the black church pastor in concert with the health care chaplain on the impact that training in health literacy has on the decision-making process of older African Americans' preservation of

faith in crisis. The research delimits the use of results from the data analysis to be shared without anonymity of participants, and the researchers expressed consent. A further delimitation is the open-ended survey responses. The philosophical framework protocol used action research that followed a qualitative research methodology, including triangulation of multiple perspectives, focus group discussions, and research literature.

Thesis Statement

If the Victory Church in Goodlettsville, Tennessee, pastors and ministers assist the chaplain with promoting health literacy, together they may combat the scourge of euthanasia among senior members through the church. Suppose the congregation gets training on the ways that the health care chaplain promotes whole-person health and spirituality. In that case, they may support ways of achieving a continuum of spiritual care and educate families on end-of-life decisions for chronically ill members.

With the growing concern over problematic medical practices, escalating medical services costs, inequality in health care and an ever-increasing chronically ill aging population, the researcher asks if seniors have become the new black. What value do the church and community place on the sacredness of human life? Where should training and education on health care concerns take place for aging Christians? Do pastors fear having the death and dying conversation with terminally ill and disabled members? A greater concern the researcher hopes to address is the importance of advanced care planning among Christians in the black church. Do faith and beliefs conflict with the utilization of hospice and palliative care for African Americans? How much does religion play in beliefs concerning sickness, suffering, life, and death?

The research seeks to find the answer to these questions as an aging population of Christians faces making complex decisions as they approach the end of life. The study highlights that to better adhere to Christian ethics amid ever-developing medical technologies and advances to prolong life at all costs or resort to assisted suicide for those suffering from a terminal condition, health literacy will educate patients and caretakers with alternatives that correlate with faith convictions. The church is the right platform for the conversation to begin, and the black church must take the lead. The health disparity among aging African Americans, as Smith argues, "results in more than 60,000 excess deaths from preventable disease in this country"[33]

Today, the church is immersed with many challenges, but the church must not let down its guard on its responsibility. An effective pastor needs to know and understand their members' wishes before they face a health crisis. Moral failures in decision-making are often traced to the absence of discourse, which plays a vital role in shaping Christian principles that conflict with end-of-life decisions. It is, therefore, a vital imperative to surmount the obstacles that impede sound and ethical choices. Werhane contends that "to be our most effective, efficient, and ethical best, we must perform the apparent and essential functions of our positions with the aim to meet bottom-line objectives and to guard against any ethical risk or vulnerability that might threaten those objectives at all times."[34]

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[33] Selina Smith, "Closing the Academic-Ecclesiastical Gap: Black Church Studies' Role in Eliminating Health Disparities," in *The Black Church Studies Reader*, 291.

[34] Patricia H. Werhane, *Obstacles to Ethical Decision-Making: Mental Models, Milgram, and the Problem of Obedience* (Cambridge: Cambridge University Press, 2013), 5.

CHAPTER 2: CONCEPTUAL FRAMEWORK

This action research will review the issues confronting the health care chaplain and the spiritual dynamic their roles have in the lives of parishioners facing end-of-life care. Pastors need to be in conversation with aging members and their families concerning quality-of-life decisionmaking. The health care chaplain understands that religion and spirituality are fundamental to patient care; that's why the absence of pastors and minister's voices in conversation with their members facing end-of-life treatments is alarming. This project aims to promote awareness to the severe epidemic of health disparities associated with chronic diseases among African Americans. The disadvantages in health care result in inadequate care and presumptions in quality treatment and hasten end-of-life decisions that conflict with Christian ethics.

Therefore, the study proposes that if Victory Church in Goodlettsville, Tennessee, pastors and ministers receive health education training, they may appreciate the role of health care chaplains and provide a venue for being in conversation with their members on decisions on the right to life that may combat the scourge of euthanasia through the church. In the modern world, right and wrong are weighed in the pluralistic balances of justice for all rather than governed by Christian ethics' exclusivist creeds. "Politicians, scientists, physicians, business leaders, everyday citizens, and our clergy increasingly find themselves in situations where they really do not know what to do. As a result, ethics has become a boom industry, and moral failure a regular front-page phenomenon."[35] The ministers of God must live and operate under a strict ethical

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[35] Trull and Creech, *Ethics for Christian Ministry*, 1.

discipline that encourages and helps them maintain a higher standard that reflects Christ in motion (1 Timothy 3:1–7), fully committed to an ethical ministry.

Literature Review

Christian Ethics

The primary measures Christians must consider when making ethical decisions are embedded in their biblical view of God. The Christians' relationship with God is covenantal (Heb 8:6–13), founded on the acceptance of three imperatives: God's control (Eph 1:11), God's authority (Dan 2:20–22), and God's presence (Deut 31:8; Heb 13:5). A definition of Christian ethics is attributed to Frame's definition "ethics is theology, viewed as a means of determining which persons, acts, and attributes receive God's blessing, and which do not."[36] From this formulation, the research concurs with the definition of Christian ethics. Almost opposite this view is the divine command theory cliché that because "God said it, I believe it and that settles it." Wilkens expounds on this theory: "At its core is the belief that God is the source of moral truth and communicates his will to humanity via commands. Our choice is to go our own way or to follow."[37]

According to Wilkens's view, what is left is determining Pilate's question to Jesus: "What is truth?" (John 18:38). Wilkens's perspective on ethics as a discipline helps to shed light on the subject. "The shift from the traditional view as questions about right and wrong are replaced with ought."[38] Wilkens poses that "in ethics, right means something different that

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[36] John M. Frame, *The Doctrine of the Christian Life* (Phillipsburg, NJ: P&R Publishing, 2008), 10.

[37] Steve Wilkens, *Beyond Bumper Sticker Ethics: An Introduction to Theories of Right and Wrong*, 2nd ed. (Downers Grove, IL: IVP Academic, 2011), 197.

[38] Wilkens, *Beyond Bumper Sticker Ethics*, 16.

correct. Correct is the label we attach to factually true information. While right is oriented to moral truth."[39] The conclusion to the matter rests in "God's rightful authority," which, Wilkens deduces, "is the foundation of ethics."[40]

It is beyond the scope of this to fully embrace the ethical dilemmas that continue to plague society in general and the Christian church in particular concerning what constitutes religious tradition and the various trajectories of religious movements that have spurned from our differences and disagreements. The political response to our differences compelled the Christian response to African Americans' realities and lived experiences, birthing a movement characterized by disfunction more than by unity. It is through the facets of these changes that the black church emerged as a social justice institution for African Americans in pursuit of their allegiance to identify with Christ and their African heritage.

The Protestant Church

Early Beginnings

The significant acclimation attributed to Jesus in the Gospel of Matthew reads, "Thou art Peter, and upon this rock, I build my church: and the gates of hell shall not prevail against it" (Matt 16:18, KJV). The misinterpretation of this Scripture is reflected in the play on words Jesus uses referring to the declaration by Peter in Matthew 16:16. *The Bible Knowledge Commentary* provides clarity on the issue:

> Peter's declaration about the Messiah's person led to a declaration of the Messiah's program. **Peter** (*Petros*, masc.) was strong like a rock, but Jesus added that **on this rock** (*Petra*, fem.), He would build His church. Because of this change in Greek words, many conservative scholars believe that Jesus is now building His church on Himself. Others hold that the church is built on Peter and the other apostles as the building's foundation

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[39] Ibid.

[40] Ibid., 199.

stones (Eph. 2:20; Rev. 21:14). Still, other scholars say that the church is built on Peter's testimony. It seems best to understand that Jesus was praising Peter for his accurate statement about him and was introducing His work of building the church on *Himself* (1 Cor. 3:11).[41]

On these two passages of Scripture hangs the church's institutional framework today, just as one of the great forces in religion occurred in the sixteenth-century Reformation, which became the basis for Protestantism. Americans were shaped and groomed by this movement as it gave rebirth to Christianity with all its variations in America, especially among the white middle class. Inazu stipulates how, as recently as half a century ago, public and cultural norms in America were underwritten by a distinct white middle-class Protestant church. These teachings contributed mainly to monolithic thinking about religion and morality in the white middle class.[42] However, Catholic scholar and writer Joseph Bottum highlights the single most significant factor in America over the past few decades: "The extraordinary explanatory event that follows nearly everything in our social and political history is the crumbling of the mainline Protestant Church as the central institution in our national experience."[43]

The Black Church

As the literature is somewhat vague about the role the church plays in today's culture for the black family, this is an area for future research. "Flemings proposes three great forces that became the cornerstones for African Americans' spiritual, academic, and social development: the African American church, historically black colleges and universities, and African American

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[41] Louis A. Barbieri Jr., "Matthew," in *The Bible Knowledge Commentary: An Exposition of the Scriptures*, vol. 2, *New Testament*, ed. John F. Walvoord and Roy B. Zuck (Colorado Springs: David C. Cook, 1983), 57.

[42] John Inazu, "Evening Conversation with John Inazu in Nashville, TN," Trinity Forum, Nashville, March 2017, video, 1:21:39, April 3, 2017, accessed July 27, 2020, https://www.youtube.com/watch?v=XX3eBcwyCaA.

[43] Joseph Bottum, *An Anxious Age: The Post-Protestant Ethic and the Spirit of America* (New York: Image, 2014), Kindle.

media. Each continues to contribute to the growth of African Americans today."[44] The black church, born out of struggle, continues to be challenged by racism, discrimination, and inequality. Flemings concludes that "the formation of the African American Church was out of necessity to maintain faith while enduring the most severe challenges, ones that often led to forced hardship and premature death."[45]

Rowland and Isaac-Savage postulate that the only consistent norm among African Americans is their relationship with the black church: "The church has served the spiritual needs, provided social support, and remains the primary institution looking out for African Americans' well-being."[46] However, according to the authors, in these African American institutions of justice, "a road less traveled in research within the Black Church is leadership (pastors) perspectives on their role in answering the call-in response to health disparities and health discrimination."[47]

In contrast, Smith agrees with Rowland and Isaac-Savage, asserting that "the Black Church must take on the challenge of combating African Americans' health concerns through education."[48] However, Smith highlights a significant difference: "The Black Church must become the change agent for the growing gaps in health as it reaches the masses through sacred speech and social movements among African American communities."[49] There is a gap in the literature on the black church's relationship to the ministry of chaplaincy. The researcher

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[44] John T. Flemings, "Three Forces That Shaped African-American History," *Diverse Issues in Higher Education* 32, no. 1 (2015): 31, accessed November 28, 2020, https://diverseeducation.com/article/69623/.

[45] Ibid.

[46] Rowland and Isaac-Savage, "As I See It."

[47] Ibid.

[48] Smith, "Closing the Academic-Ecclesiastical Gap," 292.

[49] Ibid.

hypothesizes that most ministers in the black church prefer the grandeur of pastoring a congregation above a calling into chaplaincy.

African American Pastors

Pastoral Care

While the church's traditions have changed over time, many black pastors, as Swift et al. contend, have abandoned a religious presence at the expense of modern-day evangelistic practices. There are some black church pastors who are practicing inclusivism and are maintaining a "low-key pastoral presence and care for ailing members in favor of a stance based on clear commitment, active membership and mission."[50] Whereas in comparison to the absence of the pastor, Thomas maintains, "chaplains in healthcare who before offered a purely religious ministry to members and adherents of their own denominations now devote most of their working times to patients, caregivers and staff who have no link with any faith community."[51] Swift agrees with Thomas on the value of the chaplain in their "dual role of offering spiritual and pastoral care within a Christian, secular, multifaith, pastoral, and theological tradition. Herein is where the importance of understanding the meaning of the healthcare chaplain and their inherent spirituality of presence connects with the patients experience of illness."[52]

Spiritual growth and direction are reasons many turn to the church, as suggested by Anderson, who echoes the sentiment of Smith that the church is the proper environment where

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[50] Stephen Pattison, "Kingdom: The Acceptable Face of 'Religion'?," in *A Handbook of Chaplaincy Studies: Understanding Spiritual Care in Public Places*, ed. Christopher Swift, Mark Cobb, and Andrew Todd (London: Routledge, 2016), 13.

[51] Jacqueline M. Thomas, "Voicing the Spiritual: A Dynamic Exploration and Analysis of the Role of the Chaplain in English Hospices" (PhD diss., St. Mary's University, 2016),51 ProQuest Dissertations & Theses Global.

[52] Swift et al., *A Handbook of Chaplaincy Studies*, 176.

training can begin as pastors unite to combat these health crises: "An open-ended framework for spiritual care practice is an invaluable way of defending the work of chaplains in healthcare."[53] According to Anderson, "certification of professional caretakers contributes an enormous value in health care ministering from within a pluralistic society and on a global scale."[54] Roland and Isaac-Savage concur with Anderson's position that "life finds meaning through the coming together of three dimensions of cultural, religious, and spirituality that make up our lives and shape our worldviews."[55] Anderson concludes, "Caretakers often miss these components as it coincides with healthcare."[56] In light of this view, spirituality is synonymous in health care with pastoral care.

In contrast with Thomas's views, pastoral care and pastoral counseling, as Stansbury et al. argue, was "once synonymous views in theological circles relative with their role as caretakers of the soul. The divergence of psychology, social work, and psychiatry after the first World War changed the pastoral field in making a distinction in how the two entities functioned and the skills they embraced."[57] Theologians defined pastoral care homogenously and pastoral counseling heterogeneously. The authors further associate "pastoral care with chaplaincy serving and ministering to congregations, and pastoral counseling therapeutically requiring special training. The chaplains contribute a spiritual/cultural dynamic which involves the use of clinical sensitivity."[58]

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[53] Robert G. Anderson, "The Search for Spiritual/Cultural Competency in Chaplaincy Practice: Five Steps That Mark the Path," in *Ministry in the Spiritual and Cultural Diversity of Health Care: Increasing the Competency of Chaplains*, ed. Robert G. Anderson and Mary A. Fukuyama (New York: Routledge, 2004), 4.

[54] Ibid., 6.

[55] Ibid.

[56] Ibid.

[57] Stansbury et al., "African American Clergy."

[58] Stansbury et al., "African American Clergy," 961–69.

However, the ministry is all about providing a pastoral presence of caring and an understanding that "pastoral care is more an art, not a science,"[59] says VandeCreek. From a slightly different perspective in distinguishing the role of the pastor and the chaplain than Anderson, VandeCreek argues that

> a significant breakthrough is possible in the 21st century by blending sensitive spiritual care and state of the art medicine. As physician's research to examine effectiveness in treatment, so do chaplains in providing spiritual care to patients and their families are proven to be essential workers. One distinction between science and religion is understanding one as a belief; the other a process.[60]

Skeptics, as with those in science, "identify friction with science and religious faith as they also find CPE challenging. Nevertheless, they each are a process for information on how to help those in need of their professional care."[61] The African American pastor must aspire to a higher level of knowledge to combat the challenges confronting the black church in today's pluralistic culture (e.g., euthanasia). Hollinger defines pastoral care as "the attempt to express grace, love, forgiveness, empathy, compassion, holistic healing, and accountability in the context of the Christian church. Historically, it has included such things as counseling, rites of penance and forgiveness, prayers for healing and general care for hurting people."[61]

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[59] Larry VandeCreek, "Chaplain No: Should Clinical Pastoral Education and Professional Chaplaincy Become More Scientific in Response to Health Care Reform?," in *Professional Chaplaincy and Clinical Pastoral Education Should Become More Scientific: Yes and No*, ed. Larry VandeCreek (New York: Routledge, 2012), xv, ProQuest Ebook Central.

[60] Ibid.

[61] Ibid.

[61] Dennis P. Hollinger, *Choosing the Good: Christian Ethics in a Complex World* (Grand Rapids, MI: BakerAcademic, 2002), 21.

Chaplains

Chaplaincy

Chaplaincy is a sacred calling. Chaplains are sent into restricted situations where only the

Holy Spirit can minister. The chaplain is no respecter of persons; the chaplain makes no

difference between the Jew, the Muslim, the atheist, or any other religious faith or lack thereof.

Several positive effects of chaplaincy are noted by Sullivan, who confirms that "the chaplain's

work reifies an ongoing indeterminacy about where to locate religious work on the late modern

period. Secondly, the chaplain fills the gap between the individual conscience or religious

sensibility and the no longer stable possibility of religious community."[62]

There is an overwhelming presence of chaplains in the field of health care. A growing

awareness of patients' spirituality comes into play in the context of health care. "Spirituality was

before an overlooked concept as a need for patient care. Many, however, believe faith and

spirituality greatly influence healthcare outcomes,"[63] Timmins and Pujol propose. The chaplain

is the chosen candidate in health care, suggesting a slight difference from VandeCreek's position

on the chaplains' providing professional care. More holistically, Timmins and Pujol ascertain

that chaplains in many countries are aimed and equipped to provide spiritual and pastoral care in

addressing patients' needs and ensuring adequate patient care during their health care stay.

Chaplains offer support to patients and families in challenging illness experiences. In confirming

the scientific role today, the authors agree with VandeCreek that "chaplaincy has developed into

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[62] Winnifred Fallers Sullivan, *A Ministry of Presence: Chaplaincy, Spiritual Care, and the Law* (Chicago: University of Chicago Press, 2014), 54.

[63] Fiona Timmins and Nicolas Pujol, "The Role of Health Care Chaplains in Resuscitation: A Rapid Literature Review," *Journal of Religion and Health* 57, no. 3 (2018): 1183–95, accessed July 7, 2020, https://doi.org/10.1007/s10943-018-0604-4.

a responsive relationship-oriented multifaith service who are among the few in healthcare prepared to minister in diverse religious traditions. Ministering to all faiths and the nonreligious, as Timmins and Pujol state.[64]

Cadge defends the position of VandeCreek, stating that "many healthcare organizations have become more religiously and spiritually inclusive by dropping the term chaplain and pastoral care, replacing it with the word spiritual, because it is more welcoming and inclusive,"[65] a view also embraced by Stansbury et al. Although medical personnel in intensive care units personnel welcome spirituality into the patient's healing process, this is only when families and patients see no biomedical way out of their condition. Often, Cadge explains, "religion, spirituality, and faith were sources of conflict in medical care where families insist on medical treatments against the advice of medical teams."[66]

According to Turner, the conflict in care and treatment evolves "when existential questions that revolve around death that all faith seeks answers for and find ways to better prepare for death. In so doing, the *Dying Matters Awareness Week* was established to provide a platform for conversations on death and dying."[67] When talking about death, one considers own and the deaths of their loved ones; therefore, staff and chaplains also enter into the conversation. Chaplains, although having numerous roles in health care, are often associated with death. Turner opines that part of the chaplain's purpose is to listen to the patients as they grapple with processing life-changing diagnosis. The role of chaplains may include religious and or spiritual

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[64] Timmins and Pujol, "The Role of Health Care Chaplains in Resuscitation," 1186.

[65] Wendy Cadge, *Paging God: Religion in the Halls of Medicine* (Chicago: University of Chicago Press, 2012), 17, 88.

[66] Ibid., 131, 144, 148.

[67] Susan Turner, "Dying Matters, Faith Matters: The Role of Chaplains at the End of Life," *Journal of Palliative Nursing* 17, no. 4 (2011): 161–62, accessed July 17, 2020, https://doi.org/10.12968/ijpn.2011.17.4.161.

care for patients: "Chaplains equipped to deal with the Why Me? Questions asked by patients prepare them for what's next? The National Health Services (NHS), incorporated since 1948, employs chaplains, and faith communities sanction others on behalf of NHS to care for the spiritual and religious needs of patients."[68]

Chaplains do what is necessary in whatever setting they find themselves working according to Jacobs, whose perspective agrees with the policy of the National Health Services that the chaplain's role is to ensure attentive care on patients' emotional and spiritual needs. Chaplaincy, Jacobs claims, was "once thought of as a default job. The danger this view imposed on the healthcare chaplain reflects in religious institutions that failed to understand the chaplain's role as a vocation."[69] Chaplaincy, however, as Jacob states, concurring with VandeCreek's position, "is a specialized ministry distinguished by an academic training at a masters-degree level and 1600 hours of clinical pastoral education in an accredited hospital-based training program."[70] The two significant changes in chaplaincy are reflected in the claims by Jacob, as Cohen argues that "the need for the training of chaplains and the ordination of women in the 20th century who chose chaplaincy as an alternative to standard pulpit appointments."[71]

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[68] Turner, "Dying Matters, Faith Matters: The Role of Chaplains at the End of Life," 161–62.

[69] Martha R. Jacobs, "What Are We Doing Here? Chaplains in Contemporary Health Care," *Hastings Report* 38, no. 6 (2018): 15–18, accessed June 30, 2020, https://doi.org/10.1353/hcr.0.0079.

[70] Ibid.

[71] Jeffrey Cohen, "How Is Chaplaincy Marginalized—by Our Faith Communities and by Our Institutions and Can We Change It?," *Religion* 9, no. 1 (2018): 24, accessed July 24, 2020, https://doi.org/10.3390/rel9010024.

Euthanasia

Assisted Suicide

Feifel writes, "It has been said that we learn looking backward, we live looking forward, a person's thinking and behavior may be influenced more than we recognize by his/her views, hopes, and fears, concerning the nature and meaning of death."[72]

Crick and Miller offer a prelude for the previous statement in their estimation that "the great task before Christian workers, chaplains in particular, is to find a way to work within the systems of this world in order to redeem and sanctify those systems in the authority of our Lord Jesus Christ, who sends them."[73] A chaplain's role is magnified in decisions on end-of-life care. Despite the many medical advances as well as palliative and hospice care, people are agonizing in pain, requesting that their doctors put an end to their suffering. The specialization alluded to is visible in the chaplain's ministry, who daily deals with death and dying. Today, people want to avoid suffering at all costs, and a "vast number of people in the United States and the United Kingdom, are requesting, as estimated by opinion polls, legalization of physician-assisted suicide through lethal injection or some other means of assisting the patient suicide."[74] Keown outlines the assisted-suicide stipulations; they include "a patients competence in making such a request, information made available about prognosis and alternatives such as palliative care, and patients who previously asked for physician-assisted suicide or patients who prefer the means to do it themselves."[75]

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[72] Herman Feifel, *The Meaning of Death* (New York: McGraw-Hill, 1959), 116.

[73] Robert D. Crick, *Outside the Gates: Theology, History, and Practice of Chaplaincy Ministry*, 2nd ed. (Oviedo, FL: HigherLife Development Services, 2011), e-book.

[74] Keown, *Euthanasia, Ethics, and Public Policy*, 1, 9.

[75] Ibid., 10, 11, 14.

The confusion, according to Keown, centers on defining *euthanasia*. One definition of *euthanasia*, a word derived from Greek, is "a gentle and natural death." Keown outlines three distinct ways *euthanasia* is defined:

> First, the most common one explains euthanasia as connoting active, the intentional termination of life by a doctor who believes death is beneficial for his/ or her patient called active euthanasia (AE). Secondly, euthanasia, including the intentional termination of life by the omission of the continuation of feeding-tubes, ventilators, called passive euthanasia (PE). Thirdly, a common practice used in hospitals and hospice the administration of palliative drugs known by voluntary assisted suicide (VAE).[76]

No one looks forward to dying or wants to part with surmounting difficulty; that is why Smith and Himmel suggest "that hospice care offers a better option for dying well and living well until the end. Hospice promotes the best medicine and most comfortable conditions, as evidenced by their appeal and rapid growth."[77] Those opposing euthanasia do so on the principle that legalizing any form of euthanasia opens the door to selective killings, known as the slippery slope argument. Cokeram suggests that allowing "euthanasia will slide down to killing those in a persistent vegetative state, the terminally ill, elderly patients, dementia patients, and Alzheimer's patients against their will."[78] The idea of killing chronically ill people and allowing patients to choose their time of death raises many ethical and social questions. Cokeram claims that "to die with assistance in secret is not regulated; there are no safeguards in place to prevent abuse."[79]

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[76] Keown, *Euthanasia, Ethics, and Public Policy*, 10, 11, 14.

[77] Fran Smith and Shelia Himmel, *Changing the Way We Die: Compassionate End-of-Life Care and the Hospice Movement* (Berkeley, CA: Viva Editions, 2013), 5.

[78] Paul Cokeram, introduction to Cokeram, *Euthanasia* (Farmington Hills, MI: Greenhaven Press, 2007), 9, e-book.

[79] Ibid., 14.

Australian philosopher Peter Stringer opposes the view, arguing that "euthanasia is morally justified on the grounds that it relieves a person of suffering and misery."[80]

God, the Bible, and opposing views on voluntary euthanasia are concepts highly promoted among Protestants who believe people should not be allowed to ask for painless, hastened death because of incurable disease. Women and blacks are more likely than white men to have a negative view of voluntary euthanasia. Quantitative analysis suggests people who associate God as Father, Master, and King have negative attitudes about euthanasia. Other sociodemographic factors that influence voluntary euthanasia include race, political affiliation, national citizenship, education levels, belief in patient autonomy, and personal experiences with other family members' illness and subsequent deaths. The most significant influence is religion. Sharp reveals that several states have legalized some forms of physician-assisted suicide and voluntary euthanasia in Washington, Vermont, and California."[81]

According to Sikora, today there are more pluralistic, urban, and industrialized societies that have disassociated themselves from religion and have become more idiosyncratic and private. The impact religion once had on matters of morality has shifted. Secularity, confusion on the issues related to death, and the extent of the impact of validation of scientific knowledge and sacred knowledge now relegate moral attitudes. Sikora seeks to disentangle the effect of faith, God talk, denominational impact, and church attendance as paralleled with the evolutionist and scientific worldviews that have become typical for modern rationality.[82]

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[80] Peter Stringer, *Should the Baby Live? The Problem of Handicapped Infants* (New York: Oxford University Press, 1985), e-book.

[81] Shane Sharp, "Traditional God Images and Attitudes towards Voluntary Euthanasia," *Religious Research Association* 59 (2017): 529–45, accessed July 23, 2020, https://doi.org/10.1007/s13644-017-0304-7.

[82] Joanna Sikora, "Religion and Attitudes concerning Euthanasia," *Journal of Sociology* 45, no. 1 (2009): 31–54, accessed July 21, 2020, https://doi.org/10.1177/1440783308099985.

Gorsuch extrapolates that the earliest Christian history of Scripture does not explicitly forbid suicide. Later, in the fifth century, Augustine argued against intentional suicide based on the sixth commandment, "You shall not murder" (Deut 5:17, NIV). The first push for assisted suicide in America dates back to the nineteenth century, in response to Darwin's *On the Origin of Species* and *Descent of Man*. Degeneracy in America is considered a health crisis, and the remedy was the sterilization and killing of the least desirables and the unfits in society. Over the last thirty years, arguments from fairness and equal protection to refuse treatment and assisted suicide are grounded on the principle of informed consent. Living wills and advance directives instructing family in the event of the patient's becoming incompetent are the arguments for euthanasia and assisted suicide.[83]

Today eight states in America have death-with-dignity laws: California, approved in 2015 and in effect from 2016; Colorado, 2016; the District of Columbia, 2016, 2017; Hawaii, 2018, 2019; Maine, 2019; New Jersey, 2019; Oregon 1994, 1997; Vermont, 2013; and Washington, 2008. Montana does not have a statute safeguarding physician-assisted death. In 2009, courts ruled that nothing in the law prevented physicians from honoring a patient's request to hasten their death by prescribed medication.[84]

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[83] Neil M. Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton, NJ: Princeton University Press, 2006), 25, 33, 48.

[84] "States That Allow Assisted Death," Death with Dignity, accessed July 23, 2020, https://www.deathwithdignity.org/learn/death-with-dignity-acts/.

Quality of Life

Aging

The psalter pronounced the biblical time line for human destiny: "The years of our life are seventy, or even by reason of strength eighty; yet their span is but toil and trouble; they are soon gone, and we fly away" (Ps 90:10). Today, the question is whether this is a blessing or a curse. The US census report on aging estimates the most up-to-date count of the baby boom generation; those born between 1946 and 1964, sixty-five and older, total seventy-three million. The impact of seniors on the US population is referred to as a "gray tsunami."[85] The aging population wave increases the need for caretakers and health services that will have implications in the coming decades. Older Americans outnumber their children, and many still support and house their children, or vice versa, showing the need for interventions in the planning of health care directives.

New approaches to promote adequate patient care in the final stages of life are long overdue. Life-sustaining medicine, advances in technology and science, medication treatments, and end-of-life decisions raise ethical concerns related to the patients' quality of life on lifesustaining therapies. According to Calabro et al., some argue in favor of withholding treatments from vegetative-state individuals. The hopeless state of the patient, from the surrogate or patient's perspective, means that hastening death through euthanasia or physician-assisted suicide presents a way of dying with dignity.[86] However, the authors conclude that religious and

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[85] America Counts Staff, "2020 Census Will Help Policymakers Prepare for the Incoming Wave of Aging Boomers," US Census Bureau, December 10, 2019, accessed July 17, 2020, https://www.census.gov/library/stories/2019/12/by-2030-all-baby-boomers-will-be-age-65-or-older.html.

[86] Rocco Salvatore Calabrò, Antonino Naro, Rosaria De Luca, Margherita Russo, Lory Caccamo, Alfredo Manuli, Bernardo Alagna, Angelo Aliquò, and Placido Bramanti, "End-of-Life Decisions in Chronic Disorders of Consciousness: Sacrality and Dignity as Factors," Review Paper, *Neuroethics* 9, no. 1 (2016): 85–102, accessed July 23, 2020, https://doi.org/10.1007/s12152-016-9257-8.

secular opponents argue against the right to die based on the sacredness of life regardless of age, disability, or irreversible loss of consciousness and prefer end-of-life and palliative care. Living, in this view, should be preserved at all cost. The dignity aspect Calabro et al. claim as an innate right to be valued.[87]

Life's journey brings with it important questions of meaning, justice, and quality of life. Many more people are living longer, for which a crisis is forming on the horizon in the twentyfirst century triggered by longevity and lower birth rates. Australians' ethical landscape is influenced by conversations on aging, postmodernity, pluralism, and secularity. Pluralism grounded in human autonomy is the moral choice brought on by secularity. The danger, McNamara explains, is a culture structured on feelings and a dominating secularization that can marginalize people free of consciousness toward God. The culprit that evokes this cultural milieu is market-driven values.[88] According to McNamara, the "dichotomy between much and more maximizes an ethic of achievement against an ethic of being. The concept is dangerous for aging. De-value for the elderly is due to non-productivity measured by independence. The aging decline is a dependency, but one meaningful up the aging has on society, is that death is a reality and life is finite."[89]

Kimble contends that the time has come for a new understanding of aging: "The quality in aging equates to successful aging, looking ten years younger, athletic, good health, which leads to longevity. The glorification of youthfulness can result in gerontophobia. The ultimate

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[87] Ibid.

[88] Laurence J. McNamara, "Ethics and Ageing in the 21st Century," in *Aging, Spirituality, and Pastoral Care: A Multi-national Perspective*, ed. Elizabeth MacKinlay, James W. Ellor, and Stephen Pickard (New York: Routledge, 2010), 31.

[89] Ibid., 32–40.

fear in aging is death and loss of quality of life."[90] No doubt that is why in today's secular culture, forty is said to be the new twenty and fifty the new thirty. A new paradigm of aging requires broadening the horizon for older adulthood that embraces spirituality and has meaning making at its core. Kimble explains that the gospel is good news for aging and dying. Kimble aligns with Victor Frankl's observation that "because the struggle for survival has subsided, people question life's meaning. Aging provokes the question of meaning. Importance somehow has become of spiritual value for the aging as it relates to wholeness. The spiritual dimension come together with the physical and social equating to human existence and how people value life."[91] There is a possibility that religious principles may lead to asserting the sacredness of life. However, the fact is that advancements in technology require people to make choices when it comes to death. The aging Christian must not lose faith; life's preservation is not in the hands of medical technology but in God's hands.

Orr observed that "clinical controversy concerning patients in Vegetative States (VS) is due to uncertainty, families are optimistic, and the primary ethical dilemma surrounding the continuation of nutritional support is that it is keeping the patient alive."[92] According to a 2003 study published in *Pediatrics*, over 90 percent of deaths in adult intensive care units promote prolonging life-sustaining treatments. Belief in the sanctity of life for Christians obligates some degree of choice, but conviction should never preclude all decisions. Orr reminds the reader that all

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[90] Melvin A. Kimble, "Beyond the Biomedical Paradigm: Generating a Spiritual Vision of Ageing," *Journal of Religious Gerontology* 12, no. 3–4 (2008): 12–41, accessed July 20, 2020, https://doi.org/10.1300/J078v12n03_03.

[91] Kimble, "Beyond the Biomedical Paradigm," 12–41.

[92] Robert D. Orr, "People in a Vegetative State Should Be Allowed to Die," in Cokeram, *Euthanasia*, 57.

life is finite, and carefully choosing end-of-life care treatments should be spiritually guided and wisely decided for oneself and their loved ones. Judeo-Christian ethics value human beings and suffering in life is preferred over termination to eliminate pain. Scriptural principles and traditions must maintain some degree of discretion. Lifesustaining treatments in some stipulations can be proper and, in others, morally wrong.[93]

The twenty-first century has revealed the inadequacy of many pastors' positions in their unbiblical approach to combating illness, disease, and death. The desolation in the pastors' goal of enhancing wellness in the present life is ambiguous with seeing God's hand in their suffering. Bogosh identifies two perspectives emerging from science and Christian tradition: "The naturalistic approach to medicine assumes illness, disease, and death are the results of various mutations. Christianity believes in God's deliberative act of creation (Ge.1:31). The choice of the first man and woman to disobey. The Christian paradigm is all suffering is a result of humanity's rebellion."[94]

Morin counters by arguing that although CPE and chaplaincy may first rely on spiritual and religious approaches in ministry, they also know that interpretations of God's word are limited.[95] Smith proposes a harmful effect that religiosity is associated with fewer negative health behaviors. However, it has not been until recently that this has become a priority for the church in general and, more specifically, for the black church.[96] Puchalski acknowledges that dying is healthy yet treated as an illness. Today, many avoid dying, striving to live forever at any cost. Insecurities on dying prevent the patients, family, and physicians from having the death

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[93] Ibid.

[94] Christopher Bogosh, "Pastoral Counseling in the Twenty-First Century for Illness, Disease, and Death," *Puritan Reformed Journal* 1, no. 1 (January 2009): 192–210, accessed July 21, 2020, https://prts.edu/wpcontent /uploads/2019/04/PRJ_Vol-1_No1_2009.pdf.

[95] Marie-Line Morin, "Respecting the Dual Sided Identity of Clinical Pastoral Education and Professional Chaplaincy: The Phenomenological Research Model," in VandeCreek, *Professional Chaplaincy and Clinical Pastoral Education Should Become More Scientific*, 177.

[96] Ibid.

conversation.[97] To combat the problem, we must confront the awareness that death is a reality

for everyone.

In the struggle with loss, suffering, meaning, purpose, and death lies a commonality; as

Puchalski indicates, all are in the process of dying. However, because of advances in medicine

and technology, the end of life can last an unestimated time, raising the question of how to live

with dying unavoidable.[98] Ellor and Pickard propose, from a Christian perspective, that human

life is a fundamental good underlying all other values. However, human existence is not the

highest value and is not absolute. Christians' sanctity of life is grounded in God as Creator and

humankind's creation in God's image. Therefore, the gift of life is precious, and the right to life

has divine origins and reinforces all other human rights, natural and or legal.[99] A concern for the

quality of life flows out of this understanding. It allows us to weigh the values of life-prolonging

therapies articular to each situation.

The criteria for quality of life for aging adults are ever changing and will remain a much-

debated issue. There are three problematic issues that Ellor and Pickard identity for future

debates. The first is the reality of some elderly acceptance of death. Reality is proof that all pain

will never be controlled adequately; therefore, persons should be allowed to choose how they

want to die. Secondly, medical research reveals the quality-of-life principles that will pose

challenges for medical and health care concerns on prolonging life. Finally, the fear of elderly

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[97] Smith, "Closing the Academic-Ecclesiastical Gap," 299.

[98] Christina M. Puchalski, *A Time for Listening and Caring: Spirituality and the Care of the Chronically Ill and Dying* (Oxford: Oxford University Press, 2006), 5.

[99] Laurence J. McNamara, "Ethics and Ageing in the 21st Century," 19.

persons kept alive by artificial mechanisms creates fear. These three issues are foundational for framing the issues relating to aging and ethics in the twenty-first century.[100]

Autonomy

Autonomy derives from the Greek word *auto*, meaning "self," and *nomos,* meaning "law" or "rule." Sproul states that "to be autonomous means to be a law unto oneself."[101] However, for the Christian, there is no theological basis for being a law unto oneself. Jesus' instruction to his disciples, as well as to the Christian, is that "if anyone would come after me, let him deny himself and take up his cross daily and follow me" (Luke 9:23). The extreme meaning in Jesus' words is to be "obedient even unto death" (Phil 2:8). Becoming so committed to Christ is the opposite of self-law. The tensions with the Christian's autonomy argument are enigmatic to following Christ.

Theological Foundations

Redemptive History

Redemptive history for the Christian means the death, burial, resurrection, and ascension of Jesus Christ distinctively presented in John's Gospel. The Fourth Gospel writer provides the meaning for the preamble of redemptive history, defining it as the unfolding of God's plan of salvation. The themes in John's book encompass the divine revelation of God's love, coupled with the exaltation and obedience of suffering servant and Jesus' self-designated title, the Son of Man. Carson extrapolates:

> Titles like the "King of Israel" and "the King of the Jews," while appropriate at a certain level, were so loaded with political messianism that they could not be adopted without

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[100] Ibid., 20.

[101] Robert C. Sproul, *Chosen by God* (Wheaton, IL Tyndale House Publishers,1986), 42.

restraint and appropriate caveats. "Son of Man," on the other hand, lay ready to hand as an expression that could be filled with precisely the right content. In the New Testament, the title refers only to Jesus and occurs almost always on lips. He himself shapes its content, and under its rubric, fuses the authoritative figure of Daniel 78 with the righteous sufferer motif from the Old Testament, a motif that reached its high point in the "servant songs" of Isaiah 42:1–53:12.[102]

It is precisely the context of this discourse on the "Suffering Servant" that forms the subject matter pastors and ministers must engage in with aging members before being faced with end-of-life decisions. Christians face having to make decisions while in health crisis mode. Interpretive abilities are shrouded in anxiety, fear, and intimidation. Support from spouses, children, and other family members or caretakers may or may not reflect Christian values. Christians must maintain a Christian worldview in a complex world, trusting in the stability of God's promises.

Christian Worldview

The research is founded on the biblical metanarrative tracing the overall storyline of the Bible, from Genesis to Revelation, which forms the Christian worldview, the essence of which is incurred from God as King and the ultimate authority having all power in the heavens and earth. Bush notes that "the most fundamental questions are whether God is the ultimate reality of the universe, his relationship with the creation, in particular his relationship with humanity and whether he has revealed anything to us. This would, of necessity, also include the existence and nature of truth and how one evaluates what is good or bad, right or wrong."[103]

The estimation of the Christian worldview of ethics is built on God's commands (Exod 20:1–17; Matt 22:36–40). The general revelations of God (Rom 1:19–20, 2:12–15) and special

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[102] D. A. Carson, *The Gospel According to John*, The Pillar New Testament Commentary (Grand Rapids, MI: William B. Eerdmans, 1991), 164.

[103] Kenneth Bush, "Shaping the Future: The Role of the Local Church in Nurturing a Christian Worldview" (DMin diss., Reformed Theological Seminary, 2007).

revelations (Rom 2:18, 3:2) reflect God's divine revelations in nature and holy writ (the Bible),

which shape Christian identity and outlay humans' ethical responsibility to God and one another.

The study concurs with Birch and Rasmussen's observation:

> The question of biblical authority is not properly focused on the inherent character of the Bible itself. The question is more fruitfully focused on God, who is acute in the world and whose will is disclosed to persons in and through this activity. Biblical texts such as the Ten Commandments, the Sermon on the Mount, or the Pauline exhortations are not comprehensive instructions but exemplary guidance.[104]

For kingdom children, Jesus' prayer in John, chapter 17, reinforces God's will, as disclosed in

Jesus' words. Christians are "in the world but not of the world" (John 17:16), and Jesus has

given to the Christian the Holy Spirit, the primary source that will "lead them and guide them

into all truths" (John 16:13a). The "Christians' task, then, is not to withdraw from the world, nor

to be confused with the world, but to remain in the world, maintaining witness to the truth by the

help of the Paraclete (15:26–27), and protected by the Father himself, in response, to the prayer

of Jesus."[105] These promises stand sure; therefore, the Christian fallibility lies in a lack of faith or

hope during adversity.

It is apparent that terminal diagnosis, age-related disability, suffering, and sickness al test

Christian faith. Under these circumstances it may become impossible for Christians to know

every variable and nuance in trying to choose what course of action to take. Brunner reminds the

Christian that

> the antidote to a troubled Church spirit or heart (Jn 14:1b) is a freshly trusting relationship with God and his Son, who know how to calm storms and to reach ports. This trust is impossible for us to stir up on our own, but this trust is enabled by this creative Word of Hope from the Lord of the Church, constantly proclaimed in the Church

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[104] Bruce C. Birch and Larry L. Rasmussen, *Bible and Ethics in the Christian Life* (Minneapolis: Augsburg Press, 1989), 1, 32.

[105] Carson, *The Gospel According to John*, 565.

that is faithful to this One who knows our situation and knows our good reasons for depression.[106]

Job, the poster child for suffering, resonates with the human experience. The message of Job concerns the wisdom in agony: "But those who suffer he delivers in their suffering; he speaks to them in their affliction" (Job 36:15, NIV). Longman asserts that "true wisdom is with God, and a correct understanding of God's wisdom and power will cultivate a proper perspective on life as well as a disposition of trust in suffering."[107] There is a level of trust between patients and the health care chaplain as they are sometimes the only support in times of health crises.

Thinking Biblically

The health care chaplain's work discloses God's activity in the clinical setting in the medical world. The Bible is replete with charitable, compassionate, and watchful actions, attributes of the chaplains who offer a ministry of presence in a complex world. Although chaplaincy has no implicit designation in the Bible, chaplaincy reflects a significant holistic value outside the gates. Throughout Jesus' life, He modeled a ministry of presence in a servant role, as does the chaplain. Jesus' parable of the Good Samaritan in Luke 10:30–37 expresses the heart and soul of a health care chaplain's ministry: "I was sick, and you visited me" (Matthew 25:36). The Great Commission in Matthew 28:19–20 clarifies that discipleship involves teaching others to obey Christ's commands. Christ's commission is not limited to baptizing, preaching, and training. Obedience is a central part of the Great Commission. This parable does seem to express an order of Christ, and one could reasonably argue to the extent that this parable

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[106] Frederick Dale Bruner, *The Gospel of John: A Commentary* (Grand Rapids, MI: William B. Eerdmans, 2012), 784.

[107] Tremper Longman III, *Job*, Baker Commentary on the Old Testament Wisdom and Psalms (Grand Rapids, MI: BakerAcademic, 2012), 439.

represents the heart and soul of a health care chaplain's ministry chosen to be a conduit of God's love and care in a way that fulfills the Great Commission.

Chaplains symbolize love and compassion in action. The uniqueness of the chaplain's role is similar to the critical aim of Jesus' parable. Barker and Kohlenberger's exposition on the particulars of the text states:

> The NT parables aim to lead one to a decision; Jesus' question in v36 forces the "expert in the law" to voice his decision. In his question, Jesus focuses on the person who loved, the Samaritan who made himself a neighbor. This reversal of the "expert's" question (v29) provides in itself the key to the meaning of the parable and Jesus' teaching on love. Love should not be limited by its object, its extent and quality care in the control of its subject. Furthermore, love is demonstrated in action, in this case, in the act of mercy, and it may be costly.[108]

The chaplain operates within a dual dynamic, as Bovon and Koester propose: "The gospel writer connects love and community in a framework of allegiance to God through the authorized commentary by Jesus' interjection of Deuteronomy 6:5, love of God and Leviticus 19:18, love of one's neighbor."[109] The chaplain demonstrates through practice the double love standard without compromise.

Further examining the biblical and theological basis for the project, the research will integrate a critical exegesis of scriptural passages that offer a sound theological foundation for the researcher's thesis in supporting the sacredness of life—the broader theological section in the study centers around the *Imago Dei* doctrine. The following passages are the "first mention of bearing the image of God and the only places in the Old Testament where the image of God is

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[108] "Teachings and Travel towards Jerusalem (9:51–19:44)," in *The Expositor's Bible Commentary*, vol. 2, *New Testament*, ed. Kenneth L. Barker and John R. Kohlenberger III, abridged ed. (Grand Rapids, MI: Zondervan, 2017), e-book.

[109] Francois Bovon, *Luke*, vol. 2, *A Commentary on the Gospel of Luke 9:51–19:27*, ed. Helmut Koester, trans. Donald S. Deer (Minneapolis: Fortress Press, 2013), 49–65.

mentioned. Genesis 1:26–27; 5:1–3; and 9:6."[110] Many religious debates on human worth and the sacredness of life focus on these texts. To establish a biblical foundation for the prohibition of mercy killings and murder for Christians is to honor God in our bodies as part of our bearing God's image.

The emphasis on bearing God's image purports the godlike similarity. Image emphasizes God's close similarity, while likeness distinguishes that the parallel is not equal with or exact.[111] Hamilton goes on to emphasize that the human dignity concept "stands as a basic guide to human dignity with the foundational statement made in God's image (Genesis 1:26–27) that not only connotes divinity but echoes of royalty as well."[112] The proeuthanasia advocates carelessly dismiss the arguments for humanity's sacredness in supporting an individual's quality of life. A person's usefulness is what provides a quality of life. Proponents argue that when a person is no longer socially active, nonproductive professionally, and dependent on others for support medically, financially, and physically, the quality of that person's life is diminished.

Clark et al. note that the "health-related quality of life refers to aspects of a person's self-concept of well-being that negatively impacts the health-related quality of life of patients as well as family caregivers."[113] When the ability to communicate with others is lost due to unconsciousness, or when the patient becomes nonresponsive to natural surroundings and is supported by cardiopulmonary resuscitation devices, life becomes devoid of value, and it is

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[110] Claudia Weiz, "Imago Dei: References to the Invisible," *Studia Theologica* 65, no. 1 (2011): 74–91, accessed September 6, 2020, https://doi.org/10.1080/0039338X.2011.578372.

[111] Victor P. Hamilton, "Genesis," in *The Baker Illustrated Bible Commentary*, ed. Gary M. Burge and Andrew E. Hill (Grand Rapids, MI: Baker Books, 2012), 10. E-book.

[112] Thomas L. Brodie, *Genesis as Dialogue: A Literary, Historical, and Theological Commentary* (Oxford: Oxford University Press, 2011), e-book.

[113] Matthew M. Clark, J. Michael Bostwick, and Teresa A. Rummans, "Group and Individual Treatment Strategies for Distress in Cancer Patients," *Mayo Clinic Proceedings* 78, no. 12 (2003): 1538–43, accessed December 4, 2020, https://doi.org/10.4065/78.12.1538.

unnecessary to prolong that person's life. The *Imago Dei* doctrine serves as the estimation of the value of human life made in God's image. Crick and Miller substantiate the intrinsic value, stating, "God is the life source that dwells within all life. This mystery gave rise to an understanding of God's people that all life is sacred."[114] God's image in humanity is intrinsically tied to the biblical principles that shape Christians' life and ministry. The creation of humanity serves as the pinnacle of God's creation. Some of the main strands in the history of understanding humanity's creation in *Imago Dei* must be placed within the context of the meaning for the original audience.

Three themes emerged from the traditions of Israel. The first is how humanity was fashioned: "And the Lord God formed man of the dust of the ground and breathed into his nostrils the breath of life" (Gen 2:7). Second is the relationship established between humanity and God distinct from all that preceded humankind: "And God said, let us make man in our image, after our likeness. And let them have dominion over the fish of the sea and over the birds of the heavens and over the livestock, and overall the earth and over every creeping thing that creeps on the earth" (Gen 1:26); "So, God created man in his own image, in the image of God, he created him, male and female he created them" (Gen 1:27); "And God blessed them" (Gen 1:28a). Third is the duty or purpose for humanity: "And God said to them, 'be fruitful and multiply and fill the earth and subdue it and have dominion over the fish of the sea and over the sea and over the birds of the heavens and over every living thing that moves on the earth'" (Gen 1:28b).

The *Imago Dei* explanation of the conclusion of Genesis 1:26–27 comes from the catechism of the Catholic Church, which taught that "the first man was not only created good but

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[114] Crick and Miller, *Outside the Gates*.

was also established in friendship with his Creator and harmony with himself and with the creation around him."[115]

Erickson presents his own three general views of God's "image," the substantive, relational, and functional views. Namely, the substantive argument identifies the image as a definite quality or characteristic in humanity's makeup—the relational theory that the image is experienced through humans' relationship with God and other humans. The functional view is related to something the human does, as expressed in Genesis 1:28.[116] Erickson aligns with the theory that God's image is primarily substantive or structural. The image, Erickson notes, "refers to the elements in the human makeup that enable the fulfillment of human destiny."[117] To say a person is better off dead than to live any longer in pain or suffering because it degrades life's sanctity leads to poor decision-making. Life's value is in life itself, which leads to a second hot debate issue based on autonomy: What and whose responsibility is it to protect the most vulnerable because of age, disability, sickness, or risk of abuse or neglect?

<div align="center">Whose House Is It?</div>

The Autonomy Debates

Autonomy implies an individual's freedom to choose, the ability to be free to choose without outside coercion. Pakhu describes the pro-euthanasia movement's assertion that "human persons are free and autonomous, and therefore may choose a peaceful death rather than bearing

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[115] *Catechism of the Catholic Church*, rev. ed. (London: Geoffrey Chapman, 1999), 374.

[116] Millard J. Erickson, *Christian Theology*, 3rd ed. (Grand Rapids, MI: BakerAcademic, 2013), 463.

[117] Erickson, *Christian Theology*, 470.

the indignity of a life no longer worth living."[118] The autonomous argument contradicts the nonnegotiable instruction given in Paul's message to the Christians at Corinth and Christians in our own time: "Do you not know that your body is a temple of the Holy Spirit within you, whom you have from God? You are not your own, for you were bought with a price. So, glorify God in your body" (1 Cor 6:19–20).

Promoters in the euthanasia debate argue that a patient's wishes should be respected if they choose to have their life terminated. The autonomy-based arguments are the strongest ones in favor of administering voluntary acts of euthanasia compared to active, passive, indirect, and physician assisted). Christian freedom, however, is not synonymous with ownership. Autonomy may be a sobering truth that the original Christian hearers had to come to terms with just as Christians do today. Corinth was a flagrantly immoral culture where religious prostitutes conducted the worship scene in the Temple of Aphrodite. Today, believers live amid sexual immorality; it is a time when everyone is again "doing what seems right in their own eyes" (Judg 17:6).

The autonomous mentality of anything goes crept into the church of Christ today as it did in Corinth. In this section of Scripture, Paul provides strategic instructions on whose house it is. Paul clarifies the letters' valuable content to Corinth, explicitly dealing with the volatile nature of life in the church at Corinth. In response to the autonomy argument, Davis surmises that "our bodies are a temple of the Holy Spirit, who dwells within each of us, and we are, as a result, no longer free to use our bodies apart from a recognition of the presence of the Spirit within us.

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[118] Joseph Pakhu, "Debate on Euthanasia (Pros and Cons)" (MTh thesis, Universidade Católica Portuguesa, 2015), 16.

'Bought at a price,' which God did not hesitate to pay in and through his Son, we must respond in gratitude by giving 'honor' to God with our whole being."[119]

Appointed Time to Die

"And just as it is appointed for man to die once, and after that comes judgment," reads Hebrews 9:27.

There is a great deal of narrative in the Bible that cannot be proven. However, the one guarantee prominent for this research is the pronouncement that death is imminent for every living creature: "For the living know that they will die" (Eccl 9:15a). The questions that humanity ponders are when and how. Ecclesiastes' writer attests that "to everything, there is a season and a time to every purpose under the heaven. A time to be born and a time to die" (Eccl 3:1:1–2, KJV). Jamieson, Fausset, and Brown's exposition on this passage places the appointed cycle of life and death under God's sovereignty as the designated time for humanity to fulfill God's purposes: "A man can no more reverse the times and order of 'planting,' and of 'digging up,' and transplanting, than he can alter the times fixed for his 'birth' and 'death.'"[120]

The appointed time to die is relevant to the study as much as the blessings of old age. People live longer globally, and those who are aging and suffering from terminal illness and disease have become the most vulnerable population requesting a right to die. The rationale of euthanasia arguments among the elderly rests on escaping pain, suffering, disability, and loneliness and quality of life. Another reason the right to die has gained popularity in today's culture is the false freewill assumption. "To whomever you yield yourself, servant, to obey, they

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[119] James A. Davis, "1–2 Corinthians," in Burge and Hill, *The Baker Illustrated Bible Commentary*, 1288.

[120] Robert Jamieson, A. R. Fausset, and David Brown, *A Commentary, Critical and Explanatory, on the Old and New Testaments* (Hartford: S. S. Scranton, 1871), 2:405, accessed September 11, 2020, https://www.google.com/books/edition/A_Commentary_Critical_and_Explanatory_on/jhFMAQAAMAAJ.

become your driving force" (Rom 6:16). The freedom of choice to make decisions for oneself is

absorbed into our culture's moral fabric. In the book of Acts, a similar parallel with today's

culture motivates Paul's address to the Areopagus council (Acts 17:28). "The battle between

science and religion continues in a world where worldviews collide. Paul challenged his

listener's views on the most pertinent issues of the Christian faith creation, providence, and life

after death from a biblical perspective."[121]

Here is where the author in Hebrews connects with the many challenges of one's

conception of morality, mainly whether Christians truly possess a right to die: "Many people in

contemporary society avoid the topic of death at all costs. In a context in which naturalism

governs the worldview, death represents termination, the end of one's existence, the ultimate

enemy."[122] The opposite of what is implanted in the text lies more beyond death than cessation

of life, not only for Christians but all of humanity. The Hebrew writer moves beyond physical

existence into a realm where, once crossed, there is no reentry. The insight into the Epistle to the

Hebrews challenges Christians to persevere. Cockerill's exegetical understanding of Hebrews

9:27 promotes the challenge:

> Since Christ's "once for all" finished work has provided for both the present condition
> and future destiny of humanity, it is the perfect antidote for the universal human
> predicament. The way in which his finished work is described in v28 shows that it
> corresponds appropriately to human need as described in v.27. The pastor has already
> exhibited the common condition of [humankind] as living under the pall of death (2:14–
> 15). Human beings fear death and especially the judgment that follows. There is a
> disturbing finality to both.[123]

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[121] David E. Garland, *Acts*, Teach the Text Commentary Series (Grand Rapids, MI: Baker Books, 2017), 189.

[122] George H. Guthrie, *Hebrews*, The NIV Application Commentary (Grand Rapids, MI: Zondervan Publishing House, 1999), 319.

[123] Gareth Lee Cockerill, *The Epistle to the Hebrews*, The New International Commentary on the New Testament (Grand Rapids, MI: William B. Eerdmans, 2012), 425.

God determines the length of days, as Job came to learn. Patterson notes that "the book of Job demonstrates that a sovereign, righteous God is sufficient and trustworthy for every situation in life, even in the most difficult of circumstances."[124] Christians must not lose sight of their hope but trust in the promises of God. The writer of Lamentations declares, "The Lord will not cast off forever, but though he causes grief, he will have compassion according to the abundance of his steadfast love" (Lam 3:31–32). Even the psalter finds pleasure in being afflicted, for it is how he learned God's statutes (Ps 119:71).

The quality of life should never overrule the sacredness of life created in God's image. Suffering, sickness, pain, disability, or even old age does not give a person the right to die. God is the giver of life and the sustainer of life, and it is God and God alone who sets the limits of human longevity. Therefore, the theological implications as presented are appropriate in determining that regardless of the circumstances, the Word of God should inform the Christian's decision-making process in making end-of-life decisions commensurate with a Christian worldview. Connecting to God in obedience and love, new insights for living life in Christ emerge from the theological principles whereby we carry out those convictions at the Victory Church, prayer, community, and support that make up the theories that shape the theoretical foundations of the study.

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[124] Richard D. Patterson, "Job," in *The Holman Illustrated Bible Commentary*, ed. E. Ray Clendenen and Jeremy Royal Howard (Nashville: Holman Reference, 2015), 511.

Theoretical Foundations

The Kingdom of God

This study seeks to promote health literacy for older adults on the premise that most elderly African Americans who confess hope in Christ see their faith waver during times of health crises and do not make end-of-life decisions consistent with Christian ethics. Blind obedience to any authority other than God goes against the theoretical foundations promoted by Victory Church and the Scripture. The theoretical basis for the study and its correlation to humanity's theological position bearing God's image *Imago Dei* founded on the Kingdom of God, demonstrative in the practices of prayer, community, and support. Matthew's Gospel writer left on record Jesus' command "to seek first the kingdom of God and his righteousness" (Matthew 6:33). Benner elucidates, "These words addressed to those who are seeking the way into the Kingdom of God-the Kingdom where a Great Love and Wisdom, the serving and the inspiring of others, and the utter forgetfulness of self, are the natural life of everyone who dwells therein."[125] God's redemptive rule and reign in Christians' hearts through and by Jesus Christ personifies the healthcare chaplain's practical practices and the spiritual presence they bring in the dire of situations.

Preceding the command to seek first the kingdom of God (Matt 6:33), the disciples received instructions on what it takes for faithful discipleship. The discipline of prayer is an active practice and tradition at Victory Church. The church's scheduled times of corporate prayer alone are not enough. However, as did Jesus during his earthly life, prayer must be performed in Victory members' private lives. The disciples asked Jesus a fundamental question significant in

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[125] Joseph Sieber Benner, *The Way to the Kingdom* (Chicago: Barakaldo Books, 2020), ProQuest Ebook Central.

discipleship: "Lord teach us how to pray" (Luke 11:1). Christians are expected to pray, as the Word of God makes clear: "Continue steadfast in prayer" (Col 4:2). As Whitney explains, "People who continue steadfastly in prayer have devoted themselves to pursuing a Christlike life where prayer is an ongoing priority."[126] The study confirms that prayer is the comfort, strength, and hope that leads to making a godly coherent end-of-life decision. To "pray without ceasing" (1Thess 5:17), Whitney notes, "emphasizes prayer as an activity" and "reminds us that prayer is a relationship. Prayer is in one sense, an expression of an unbroken Christian relationship with the Father."[127]

The Providence of God

The theoretical basis for the research results from the researcher's hands-on-experiences, from voluntary work in a hospice facility, serving as an associate minister at the Victory Church, and reviewing relevant research on health care chaplains, euthanasia / assisted suicide, and literature on aging and gerontology. The missing element in the church central to the study is are the humanitarian efforts of activism around health conditions and interventions on health disparities that exist among African Americans. Between these two junctures, the problem exists. Finding measures to combat preventative diseases and pastoral support on uninformed health decisions is a must with aging members to curb the rise in euthanasia in the church. A recent event in the researcher's ministry context brought awareness of physician-assisted suicide (PAS) and passive euthanasia (PE) and the secular views on dying and answers to whether these

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[126] Donald S. Whitney, *Spiritual Discipline for the Christian Life*, rev. and updated (Colorado Springs: NavPress, 2014), 81.

[127] Ibid.

practices conflict with Christian ethics. This study's position is that life and death are in God's providence.

Proverbs 16:33 (NIV) states, "The lot is cast into the lap, but every decision is from the Lord." This means that it is God, not individuals themselves, who makes the decision regarding how long one lives and the timing of one's death. Job 14:5 (NIV) states, "A person's days are determined; You [God] have decreed the number of his months and have set limits he cannot exceed," and Ecclesiastes 8:8 (NIV) reads, "As no one has power over the wind to contain it, so no one has power over the time of their death." Some interpret these verses to mean that one should not hasten one's death through medical means because doing so usurps God's authority in regard to the length of one's life and the timing of one's death.[128]

The best way to connect with the researcher's ultimate goal is to provide a context that enables participants to work toward collaborative solutions with medical providers. Making health decisions consistent with their faith is based on the precedence that there is in Scripture.

<div align="center">The Word of God</div>

Understanding the church's theological traditions enables Victory Church members to approach end-of-life decisions from God's law in community with other believers who faithfully commit to the church's Scripture and principles. An individual's view of the Bible and surrender to its authority have a more significant effect on making decisions consistent with their religious convictions. The next step toward accomplishing the outcomes desired is building a community around the most vulnerable aging family. The mandate was given by God that those who are sick

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[128] Shane Sharp, "The Bible and Attitudes towards Euthanasia," *Death Studies* 43, no. 4 (2018): 240–47, accessed December 7, 2020, https://doi.org/10.1080/07481187.2018.1450793.

or caring for elderly sick parents must take the initiative to call for the elders of the church to pray over them, anointing them with oil in the name of the Lord (Jas 5:14).

There is an element of pressure placed on patients when they are faced with making decisions on health treatments and procedures to prolong or hasten death out of lack of information on alternatives, fear, social isolation, and financial deprivation. Incorporating a Christian community is necessary in times of crisis in combating loneliness or feeling that their decline in health creates a burden to the family. Stringer points out that "the heart of action research is not the techniques and procedures that guide action but the sense of unity that holds people to a collective vision of their world and inspires them to work together for the common good."[129] The Word of God speaks to these concerns, stating that "we should have the same care one for another. And whether one member suffers, all members suffer with it" (1 Cor 12:25–26, KJV); the research seeks to integrate these principles into the ministry context that participants may gain greater clarity and understanding on the role of the health care chaplain and support they provide.

Qualitative analysis reveals that those who follow the tradition of bearing God's image (Gen 1:27) view all euthanasia forms negatively. Christians' faith and worldview made in God's image places an innate value on humanity, dispelling all forms of suicide. According to Sharp, "One set of religious beliefs that social scientists say predicts people's social attitudes and behaviors is their image of God."[130] However, the researcher has witnessed that in the clutches of suffering and death, when fear so often replaces faith, death with dignity takes priority over sacred life with patients seeking a way of escape.

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[129] Ernest T. Stringer, *Action Research* (Thousand Oaks, CA: Sage Publications, 2014), 173.

[130] Sharp, "Traditional God Images and Attitudes towards Voluntary Euthanasia."

There is the need for the pastor and chaplain to collaborate to ensure members' faith is grounded and strengthened, holding to the promises in the Word of God. During these times, individuals must rely on Isaiah's words concerning the coming Messiah and Redeemer, who, according to Isaiah, "bore our griefs and carried our sorrows" (Isa 53:3–4). The psalter concludes that God "sent out His Word and healed them, snatching them from the door of death" (Ps 107:20, NLT). The spectrum of views on life and death reflects whether it is permissible for Christians to choose to hasten death practices to escape suffering, disability, or loss of life quality. The researcher concurs with Lanier's perception on medical interventions at the end of life:

> For centuries, practitioners of medicine have sought to lessen pain, restore physiologic homeostasis, preserve anatomical function, and prolong life. With many of these goals realized as we enter the 21st century, it is ironic that public discussion of medical care often focuses on definitions of *inappropriate death vs. unnatural longevity* related to the most critically ill patients.[131]

Unfortunately, activities connected with this research are everyday concerns between family members, the patient, and the medical care team on dealing with the chronically ill's death and dying. Several questions abound on the correct approach to choose. What course of action is supported by family members regarding their loved ones' final wishes for the patient? When does the patient's autonomy become paramount against caretakers' decisions when the medical team suggests that there is nothing more medical science can do? The questions are intense, and the issue is who can offer the most satisfying answer.

The health care chaplain's environment is complex, operating between culturally and religiously diverse beliefs and attitudes concerning end-of-life care. However, this issue of

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[131] William L. Lanier, "Medical Interventions at the End of Life: What Is Appropriate and Who Is Responsible?," *Mayo Clinic Proceedings* 80, no. 11 (2005): 1411–13, accessed December 6, 2020, https://doi.org/10.4065/80.11.1411.

finding the correct answer to questions on voluntary euthanasia or assisted suicide for Christians should not be. Paul speaks against any definition of an inappropriate death on the theological basis, asking, "Do you not know that you are God's temple and that God's Spirit dwells in you?" (1 Cor 3:16). Paul resisted the urge to hasten death in his letter to the Philippian church, confessing, "I'm torn between two desires: I long to go and be with Christ, which would be far better for me. But for your sakes, it is better that I continue to live" (Phil 1:23–24, NLT). What greater witness is there than to live for God even amid chronic illness, pain, and suffering? The Bible teaches the Christian that God suffers alongside and on behalf of His people (Phil 2:5–8; Heb 4:14–15). God may not always miraculously heal or deliver, but Christians can remain confident that God can keep His promises: "For it is God which worketh in you both to will and do of His good pleasure" (Phil 1:29). "No person suffers alone; Christians are to bear one another's burdens, and so fulfill the law of Christ" (Gal 6:2).

<div align="center">"Forsake Not the Fellowship"[132]</div>

"There is strength in numbers." *Merriam-Webster* defines this idiom as meaning "that a group of people has more influence or power than one person."[133] Community and fellowship are essential for building stronger bonds between real life and church life. Living today in a world where there is so much uncertainty, the Christian's perception of truth matters. The question of theodicy asks how a good God can allow so much evil and suffering in the world. Although some agnostics may disagree that evil and suffering are a human dilemma, Christians believe that they entered the world because of rebellion; Romans 5:12–17 makes this claim

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[132] Heb 10:25.

[133] *Merriam-Webster*, s.v. "there is strength in numbers (*idiom*)," accessed December 11, 2020, https://www.merriam-webster.com/dictionary/there%20is%20strength%20in%20numbers.

abundantly clear. The way of truth is developed in fellowship bonds with other Christians. The research purports it is the health care chaplain and pastors' service to incorporate a sense of community around the patients and families of those who need their care.

The chaplain provides a light of hope, love, and spiritual transcendence of God in times of darkness for the patient and family. The chaplain must draw on clinical sensitivity alongside spiritual awareness within diverse cultural and religious traditions. Christians' traditions must not be isolated from their emotional and spiritual care during a despairing health crisis. The church must unite in the process of the healing care of its brothers and sisters in love, prayer, and community. Each is encouraged to esteem others better than themselves (Phil 2:3). This is similar to how clinical pastoral training equips the chaplain with engaging multiple spirituality expressions, unlike the pastor. The pastor, ministers, and congregation must not remain dormant to engage in health literacy education to combat the complex health care issues about end-of-life treatments. "No matter how great your faith in God, pain and grief are a part of life."[134]

The research revealed some pastors' assumption is that the chaplain is equivalent to the pastor. However, chaplains daily witness patients who die alone, afraid, and confused, a significant distinction from the pastor. The chaplain's role is twofold because they also provide pastoral care. Not enough can be done by the health care chaplain and medical staff and providers in the care of Christians facing a life-threatening diagnosis or disabilities or undergoing chronic pain and suffering. The social isolation from the spiritual advisers at Victory Church is alarming. The matter reflects that it is also disheartening and shows evidence of a decrease in compassionate care at the end of life.

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[134] Charles Stanley, *The Blessings of Brokenness: Why God Allows Us to Go through Hard Times* (Grand Rapids, MI: Zondervan, 1997), p. 4 of cover.

CHAPTER 3: METHODOLOGY

Brief Overview

The Black Church

There is a direct correlation between five shared themes that surfaced from the research to structure and support the thesis. First, looking at the black church will provide a context for the Victory problem. The goal here is to compare elderly members' process for promoting good health practices and their prudence in decision-making and desire for chaplain educational training on end-of-life care. The black church is the right platform because of its long history in fighting for social issues. "Since social justice appears as a theme and concern in many churches, it is only appropriate that, among other things, the Black Church should address the issue of health education and health interventions."[135] In the first stage of the methodology, the project will be conducted at the Victory Church, a predominately African American congregation affiliated with the researcher's ministry context, located at 705 Rivergate Parkway, Goodlettsville, Tennessee.

Chaplains, Pastors, and Pastoral Care

Pastors and pastoral care are relevant because the pastors are the souls' doorkeepers. Shepherds are accountable for the sheep of God. The Victory Church may learn to appreciate the chaplain as they become acquainted through collaboration with the health care chaplain's resourcefulness. The chaplain and pastors/ministers are not in competition. Pastors and chaplains operate in two distinct professions, but each offers spiritual and pastoral care from an operational

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[135] Rowland and Isaac-Savage, "As I See It."

context that involves some of the same people they minister. Today, "as technology becomes more dominant and business perspectives manage health care, clinical pastoral education and chaplaincy are called to support those experiencing illness, despair, and death by presenting the message of the great religious traditions."[136] A committee was devised using the ministerial staff at Victory Church. Brief surveys were distributed to team members and staff for a qualitative analysis of how well they understand the health care chaplain's role.

Assisted Suicide / Euthanasia

Next are debates on euthanasia and assisted suicide; as the concepts move closer and closer to legalization across America, clergy's competency in health matters is necessary. For Christians, every decision has an antecedent, and in the case of euthanasia, the ends do not justify the means. Anderson resounds the sentiment of the paper's thesis statement: "Those who provide spiritual care and counseling in hospitals and other settings, especially certified health care chaplains, have a responsibility. A responsibility to develop competencies that respond to the concerns and distresses expressed in uniquely spiritual and cultural ways by the person, family, and kin in life transitions and crisis."[137] To their credit, research has shown that collaboration between pastors and ministers in counsel with health care chaplains and their congregations can bring awareness to adequate health care procedures that satisfy spiritual needs.

The overview extrapolates the interpretive process suggesting key areas that need to be dealt with to incorporate an action plan. "Certain Christian beliefs encourage terminally ill Christians

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[136] Larry VandeCreek, "Chaplain Yes: Should Clinical Pastoral Education and Professional Chaplaincy Become More Scientific in Response to Health Care Reform?," in VandeCreek, *Professional Chaplaincy and Clinical Pastoral Education Should Become More Scientific*, xvii.

[137] Anderson, "The Search for Spiritual/Cultural Competency in Chaplaincy Practice," 2.

to live a morally responsible life until their death and cultivate a moral prejudice against taking the life of any human being. This moral prejudice can, however, in exceptional cases outweighed by moral considerations in favor of medically-assisted suicide or voluntary euthanasia."[138]

Action Plan

The specific tools used to measure and analyze the intervention processes are focus group discussions, interviews, and action research. Qualitative and quantitative methods are the chosen evaluation designs. The qualitative action approach will consist of a questionnaire provided by the recruiters to evaluate the number of participants willing to participate in the study. Interviews were conducted with church administrators, community leaders, volunteers, and focus group discussions. The qualitative process will measure the intervention's effects by observing the study's goals and outcomes. The research study will use mixed methods triangulation, consisting of interviews with participants, focus group discussions, and multiple information sources. The survey form will ask respondents to rank questions on a four-point Likert scale ("very well," "well," "somewhat," and "not at all"). The purpose is to integrate changes in participants' lives, monitor progress, and inform stakeholders of ongoing developments. This research project required Institutional Review Board approval and informed written consent for participation.

On February 8, 2021, the project was approved, and the initiating phase began on February 13, 2021; the phase included planning, implementing, and reviewing. Team leaders were recruited and selected on February 14, 2021, from the ministry staff, church administrators, and members at Victory Church. All research staff underwent a two-day training session in the study protocol. After the selection of team leaders, clients, and stakeholders, the framework is to

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[138] D. Etienne de Villers, "May Christians Request Medically Assisted Suicide and Euthanasia?," *HTS Teologiese Studies* 72, no. 4 (2016): a3397, accessed July 20, 2020, http://dx.doi.org/10.4102/hts.v72i4.3397.

establish the goals for the project and identify the objectives and tasks. Next, the team leaders are responsible for facilitating lessons and activities, setting up meeting rooms for focus group discussions, making a list of resources needed and material costs, and securing a timetable for a start date on March 19, 2021, and a finish date of March 26, 2021. Recruitment flyers were posted on the church website and in church announcements on February 14, 2021.

This study is designed to examine the health literacy of aging Christians who are members at Victory Church on the role spirituality plays in making health care decisions and end-of-life priorities on critical care, alternative medicine, and advance directives. There is a need for the church to provide a venue to educate select members and church leaders concerning the ethical decisions made by elderly and terminally ill patients before undergoing medical treatments to combat the scourge of euthanasia in the church. By assisting older adults with making conductive health care decisions that constitute Christian ethics, the study's intervention activities will be designed from the perspective of aging Christians' views regarding long-term health care and end-of-life decision making. Descriptive qualitative research is consisting of five focus group discussions with six participants. The researcher plans to conduct interviews at hospice facilities, including in-home consultations with seniors suffering from a terminal illness or caring for a terminally ill family member.

Participants will be recruited from the membership at the Victory Church, a predominately African American congregation of middle- and upper-class families. Forty percent of Victory's members are sixty-five and over, of which five percent are nonactive due to hospitalization, living in assisted-living facilities, or sick and shut in because of declining health or caring for a loved one with a disability or debilitating health. The researcher plans to include the three church family members currently housed at Alive Hospice. The researcher experiences volunteering at a hospice facility, where emotions are intense and health decisions are made in

haste rather than from a faith position, especially among senior Christian adults. The study will focus on and design questions associated with assisted suicide and euthanasia to gauge participants' rationale when faced with making right-to-life decisions.

Since religion and spirituality in environmental settings of advanced illness rank high among ethnic minorities, collaboration with the black church pastor becomes an essential first step. After the pastor and advisory committee at the Victory Church are presented with the proposal, group leaders for workshops will be selected and literature designed to promote health literacy will be collected. The researcher will ask the pastor of Victory Church to allow the use of the facility, classrooms, and fellowship hall for meetings and to finance the costs for activities, resources, and nutritional needs. The researcher will schedule the first meeting two weeks after IRB approval. The conference will begin the training process and selection of church administration, staff members, clergy, and hospitality committee workers to participate in their primary roles to volunteer aid in the study.

Participants will be recruited by a random selection of volunteers from the membership; interviews with participants, caretakers, and family members who may serve as surrogates will be conducted by email/mail and other social media platforms. Focus discussion groups will meet from noon to 2:00 p.m. for one week. A meeting with Alive Hospice Patient Affairs will be administered by phone to request permission for interviewing members of Victory Church housed at the facility. Recruitment flyers, survey questions, authorization, and consent forms will be mailed/emailed and handed out at Victory Church upon IRB approval.

Participation is 100 percent voluntary. The study will be limited to participants sixty-five years old and up. The study restricts recruitment to Victory Church members and their families. The plan is to conduct five in-depth interviews, audiotaped after consent forms are signed with homebound members. The tapings will last approximately fifteen to thirty minutes. A

questionnaire will be distributed in person and by mail, focusing on participants' and caretakers' views on long-term care, thoughts on end-of-life choices, and a brief reflection on what constitutes quality of life. The researcher's responses to questions will be anonymously collected and evaluated using the data analysis processes of categorizing and coding information. After unitizing the data, the experiences and preferences will be used to define the problem in terms that make sense to them, and interventions will be formed from the basis of the participant's subjective experiences. Statistical information identifying the various themes held in common and opposing viewpoints will provide a clearer picture of the research's status. The data will be incorporated and analyzed against evidence-based information derived from the research literature.

The study is open to all members aged sixty-five and up, with a maximum of fifty participants. However, no more than thirty-six members are expected to participate in the study. The focus groups will comprise active attendees of the church. The demographics consist of single, widowed, and married couples as well as nonactive elderly members who may live alone, with family members, or with in-home care providers. Furthermore, participants will include those with chronic illnesses, who are disabled, and who are in relatively good health and those with or without advance directives in place. The study will provide adequate monitoring and the saving of collected data to protect subjects' privacy. The researcher will ensure the confidentiality of data maintained. The series of questions to be addressed is as follows: (1) What is age's effect in making life-and-death decisions about a terminal illness? (2) How does the utilization of living wills and durable powers of attorney ease senior adults' and family members' minds? (3) Can Christians request assisted suicide or euthanasia medically? (4) What are older adults' views on what constitutes successful aging? (5) What spiritual issues have you experienced while dealing with illness or a spouse of a family member's condition? The

questions were designed to ensure that the interviews will remain time framed and consistent with the study's goals.

The themes emerged from the study coming from the participants' experiences and meaning-making process. There is a severe issue in America among its aging citizens, which causes those suffering from chronic illness and disability to submit to medical technology demands for health care whose focus is no longer on care but more on treatments. Modern medicine opens the door for reconsidering long-held beliefs and the Christian tradition on human life's sacredness. The spiritual question on what gives meaning to life is replaced with life quality. The medical dilemmas and the aging population crisis of acutely ill seniors beg whether senior populations have become the new black. A questionnaire developed by the researcher based on a review of literature will enable participants to construct informed accounts of their situations, allowing them to examine the complex issues in health treatments to make health decisions consistent with spiritual convictions proactively. The researcher will ensure all future developments that incorporate changed procedures may not be short lived.

Intervention Design

The study aims to research the positive benefits health literacy may produce in elderly African Americans' decision-making process. The time line for the survey is one week. Participants were recruited through personal communication (word of mouth), letters, phone, email, social media platforms (church website, Facebook), recruitment flyers, and church announcements. After receiving all approvals and funding and securing the venue, distribution of consent and permission forms will take place. Questionnaires and health assessment profiles will be typed and printed. Notifications to guest speakers, medical professionals, and volunteer health care chaplains will be affirmed. With more and more elderly Christians having spiritual concerns

associated with a life-threatening illness or caring for a loved one with advanced disease, questions on coping with death and dying are magnified during the transitional stages leading up to the end. "The importance of religion to many patients and families confronted with end-of-life decisions is irrefutable."[139] Medical interventions to hasten death or prolong life impact spiritual concerns in end-of-life decisions centered on playing God. Whose right is it to make the call on whether one lives or chooses to die?

The problem addressed in the study is that Victory Church members in Goodlettsville, Tennessee, may not understand the health care chaplain's role in addressing the need for competent and spiritually sensitive end-of-life care and treatment alternatives affecting aging members. "Older adults bear a heavier suffering burden than most other segments of the population because of the greater presence of chronic conditions and functional limitations among older populations."[140] The researcher will conduct a qualitative action research study to catalyze and impart information to other pastors and members in the black church to dispel fears and anxieties associated with end-of-life care and treatments and stop the surge of euthanasia in the church.

The study is framed on the three fundamental phases of "action research look, think, and act."[141] The fieldwork will involve a kickoff meeting with leadership in the look phase. At this stage, invitations are sent out to participants to secure interests and commitment. From the information gathered, the researcher's understanding of stakeholders' experiences enables the committee to work toward viable solutions that will cause participants to invest their time and

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[139] Ford, "Religion and End-of-Life Decisions in Critical Care."

[140] Mary Beth Quaranta Morrissey, Melissa Lang, and Barney Newman, *A Public Heath Strategy for Living, Aging, and Dying in Solidarity: Designing Elder-Centered and Palliative Systems of Care, Environments, Services, and Supporters* (London: Routledge, 2019), 38.

[141] Stringer, *Action Research*, 7.

interests. The study defines the problem investigated from a Christian worldview set in the health care systems' secular context during this phase. The facilitator will form an advisory group that will assist and work with advising and evaluating legal requirements, budgeting, and develop time lines. Those who make up the advisory group are the pastor, assistant pastor, elders, deacons, and the legal staff at Victory Church.

In the second phase of the field research, the task will involve coming together with key personnel at Victory Church. Their professional expertise includes physicians, attorneys, teachers, and community organizers. Together the group will analyze and interpret the situation, agree on a course of action, and receive training to extend understanding of the problem's nature and context. The researcher will lead the ministerial staff, who will schedule and conduct visits to hospitalized participants, sick and shut-in home visits, and visits to members housed in assisted living facilities. Volunteer chaplains will schedule the study's visits to hospice participants. The team leader's roles and responsibilities will include recruiting, teaching, transporting, and various administrative tasks to generate interests and willingness among participants to serve as research subjects.

Also, part of the intervention plan will include distributing materials on the study's nature, establishing criteria of ethical considerations such as respect for privacy, prohibiting undue pressure or influencing participation, avoiding unbiased presentation, and ensuring the signing and collection of consent forms and permission slips. Once the preparatory work is complete, the third and final intervention is the active phase. The researcher seeks to formulate practical solutions to the research problem by assessing the information received from group leaders detailing participants' experiences and perspectives. The researcher will chart the outcome statements with the goal in mind of what the study hopes to achieve, promoting health

literacy to the aging community members, which may prevent their making ill-advised hastening death decisions and curb the rise of euthanasia in the church.

Field intervention will be conducive to outcome statements:

- Obtain permission from the pastor and church advisory board to utilize the church as a venue for activities, training, and meetings

- Facilitate the selection of volunteers to help run the program

- Obtain funding for supplies and materials

- Seek to elicit support from other volunteer chaplains at the hospice facility, doctors, and social workers to formulate a complementary coalition between family, caregivers, and medical providers

- Link participants to outside supportive networks for further consultations

- Assess the study's worth and effectiveness against research literature specific to the Victory Church problem

A final intervention will be to conduct a follow-up with members and their families to identify what measures participants plan to make in decisions concerning end-of-life care. The researcher will use the data from focus groups and interviews to code areas of success, evaluate issues, and identify program deficiencies and other concerns that may have surfaced during direct observation of workshops. The final approach will include thanking all participants, membership, and leaders at Victory Church. The researcher will send invitations to all volunteers, guest speakers, and members for a future celebrative buffet or luncheon held at the Victory Church and hosted by the Care Ministry.

Implementation of the Intervention Design

The observation for the study is qualitative, using the concept of triangulation. The data collection methods were derived from interviews, focus group discussions, field observation, and the research literature. The research began with gaining approval from the International Review Board to start the field research, after which the researcher gained permission from the pastor and trustee board at Victory to establish the research site, budgeted, and received financing to obtain resources for tasks and activities. Volunteers, recruiters, and team leaders trained according to the positions maintained.

The study will be presented during the announcements each Sunday for a month. Letters will be sent to every member age sixty-five and upward, inviting them to participate in the study. Consent form documents and questionnaires will be mailed/emailed and returned during the focus group discussion and/or when interviews are conducted. All consultations will be audiotaped with the interviewee's permission. Participants will divide into groups: group A, married participants; group B, single, divorced, or widowed participants; and group C, homebound and institutionalized participants.

All participants will be asked to complete a series of questionnaires, including a health assessment and spiritual aspects of care (duration: five to ten minutes). Group A (married participants) and group B (single, divorced, or widowed participants) will be asked to participate in a focus group (thirty to forty-five minutes) and an optional advance directive workshop (ten to fifteen minutes). Group C (homebound and institutional participants) will be asked to complete a recorded phone or in-person interview lasting a minimal of thirty minutes. The records of this study will be kept private. Published reports will not include any information that would make it possible to identify participants. Research records will be stored securely, and only the researcher will have access to the records. Data collected from may be shared for use in future

research studies or with other researchers. If data collected from are shared, any information that could identify participants, if applicable, would be removed before the data are shared.

The researcher will organize and codify data by emergent themes. A detailed interpretive research process is conducted to interpret the data's meaning after reviewing audiotapes and information gained from participants' ideas. The data provide the basis for action relative to the problem investigated and establish a positive environment that engages the participants. The study allowed seniors to attend workshops or receive home visits on health literacy that may prepare them for making health care decisions commensurate with a Christian worldview. The group activities are designed to create empathetic listening, including the stakeholders in the process of investigation, and planning that relates and is effective with each participant's social context. The participants can understand the issues from their experiences as the intervention design formulates solutions to how they perceive the problem.

The evidence-based strategies to address health literacy interventions will come from the materials participants receive to improve communication between patients and health providers. Health professionals will be encouraged to provide the information for their patients to help them make informed decisions in preparing for health challenges. The workshops will provide the participants with relevant support systems that will promote preventive health options based on their health care needs. Taking part in the study breaks down potential health disparities stemming from poor communication and understanding of diagnosis and treatment options. The access to and utilization of health services and health information offer the skills to deal with management of serious illness and diseases that also promote self-care and caregiver support.

The benefits from the study connect participants to federal programs and health support systems that offer home health care services, assisted living, and retirement communities for seniors. Other services provide transportation to and from medical appointments, information on

long-term-care options, chaplain service, hospice, and palliative care services. Free legal assistance is offered to participants if needed, such as help with completing living wills and durable powers of attorney and assigning surrogates to speak for them and carry out their wishes if the participant becomes incapacitated or unable to speak or make health decisions for themselves. Do-not-resuscitate forms were made available upon request.

Families became more proactive in taking responsibility and committing to assisting their loved ones' health care needs by attending workshops and doctor appointments with them. The main form of intervention was spiritual advisement and in-person communication. However, other forms of interaction were computer-based processes through Zoom and Skype. Video presentations and written materials were made available through a link to government websites. Positive results are reflected by reducing health-related barriers, learning the consent process for treatments, and changing lifestyles and mind-sets on "committing everything to God and allowing Him to direct one's decisions" (Prov 16:3). Training in self-management improved decision-making errors. After participants learn about health policy and receive information on long-term care and end-of-life procedures, they will understand and identify health risks. The members' quality of life is accentuated according to the participants' spiritual health needs.

The goal for providing health literacy to participants from a Christian worldview promotes health decisions consistent with Christian ethics and spiritual convictions. The study shows that senior adults facing health challenges can begin to prepare ahead in the event of disability or terminal diagnosis. The problem at Victory Church will decrease when pastors, church leaders, and ministry staff commit to educational training on health alternatives and advance care directives that may benefit its senior members. Victory Church has the resources, ability, professional staff, and desire to develop intervention plans designed to improve its aging

members' health awareness. The measurement instrument will include direct observations of participants, interviews, and a review of literature.

Multiple factors evolved from data showing that there is an association between health care and spiritual care. Participants identified the consequences of limited health knowledge, chose alternatives, and facilitated their individual needs by attending workshops to learn how to develop an action plan. Meetings will focus on presentations, testimonials, and centered discussions about combating health disparities among aging African Americans. The interventions will seek to provide literacy improvements and create collaboration among the pastor, chaplain, health providers, and aging members. Old age at one time represented those members of society who had matured to becoming independent. Currently, old age among many senior African Americans is signified by those in poor health, those with a lack of adequate health insurance, and those who overload health care institutions and are told that medical science can do nothing more for their condition. The pastor, chaplain, and leadership training improved communication, fellowship, and accountability for those who were weak physically, mentally, and spiritually.

The personalized touch of meeting people created trust, built partnerships, and developed guidance and security. Through prioritizing health care decisions before failing health, participants will be trained to push health providers to explain diagnoses so patients can better decide on treatments, including preventive health measures proven to minimize health risks and equip participants with support services. The study's outcome was successful by providing information, skills training, support systems, and recommendations of resources; modifying access and health disparities barriers; offering continuous monitoring; and listening to participants' feedback.

Several elderly members in hospice care who failed to make advance care directives will be provided an opportunity. The study seeks to rectify this problem by teaching family members how to talk with their loved ones before advanced stages of chronic diseases and also by permitting patients to express their medical preferences before failing health leads to their making urgent decisions on preserving life in fear and haste. The data collected will reflect the topics explored with team leaders, including questions on patients' current living conditions and circumstances that family members and other support systems provide for members unable to participate because of disability or final life stages.

The coding process will show the number of those who experienced critical illness or cared for a loved one who found it difficult to talk about death. The role faith plays in accepting hospice care or palliative measures how the study will estimate patients' social and psychological meanings of life and validate the premise that there is a loss of faith during these times among African Americans undergoing this care. The broader subject on ways faith beliefs influence decisions on health practices are ignored, specifically with assisted suicide, euthanasia, and physician-assisted suicide when families are isolated from the church and loved ones will be documented from research literature and family testimonials. Many older adults express a desire not to be resuscitated or kept alive on a machine when brain activity is lost. However, no one has taken legal steps. Having this knowledge is vital for caretakers, family members, and trusted clergy to share with aging members in the study and will be beneficial for final wishes to be carried out. When it came to making health decisions for terminally ill loved ones or family members, medical intervention will significantly impact faith alone. The impact and significance of these conversations and documentation will influence future discussions as preferences in health care wishes, formulated in light of faith and Christian values.

CHAPTER 4: RESULTS

Objectives

The study's purpose was to explore aging African American Christians' spiritual perspectives on the rapid influence assisted suicide and euthanasia play in making health care decisions in a critical state of suffering, chronic illness, and terminal disease. At the Victory Church, a dominant ideological tradition takes precedence in the practices and attitudes of elderly members faced with making life-threatening medical decisions consistent with the Word of God. This research aims to meet this gap in application.

The results of the research revealed three striking findings: (1) the attitude of Christians is shifting positively in favor of euthanasia; (2) there is a need to understand advanced medical technology that seeks to prolong rather than preserve life when making end-of-life care decisions consistent with Christian convictions; and (3) the availability of family, care providers, physicians, and clergy as a support team for the patient experiencing a health crisis is paramount in determining a biblical framework for health decision-making. It is apparent that our feelings impair our decision-making, resulting in the need for seniors to articulate their wishes and prayerfully consider God's will on issues of euthanasia and physician-assisted suicide.

The Positive Shift toward Euthanasia

The issues surrounding euthanasia are not directly addressed in Scripture; however, the teachings and example of Jesus' life, death, and resurrection support the position of the research against the practice of euthanasia in the church, as evidenced by the results of the research. The results show that the positive shift toward euthanasia is due to a fear of death and a denial of dying. There is no escape from death as death is the state of fallen humanity. Paul reflects on this fact, stating, "The wages of sin is death" (Rom 6:23a). Losing sight of God's gift of eternal life,

as in the second part of that verse, is what happens to those who fear dying by clinging to life.

Froggatt contends that "the process of individualism that characterizes modernity, and the lack of

the religious structures and practices which formerly shaped society, means that people cannot

easily incorporate the inevitability of death."[142]

Life Prolonging versus Life Preservation

The downward trajectory from the intrinsic value of life made in God's image to quality

of life, defined by the World Health Organization as "individuals perception of their position in

life in the context of the culture and value systems in which they live, and in relation to their

goals, expectations, standards and concerns,"[143] demonstrates the researcher's position on the

ways that euthanasia is creeping into the church. The data reflect the need for reinforcement of

biblical principles in general but specifically about sanctity of life, God's sovereign authority

over life and death, and the display of mercy, compassion, and hope in Christ.

The focus group debate concerning euthanasia was approached from the perspectives on

personal autonomy, quality of life, medical costs, burden to family, and ending suffering.

Research literature confirms that "there is a shift in attitudes regarding physician-assisted suicide

and euthanasia. Public opinion polls, for instance, conducted from 1936 to 2002 found that

Americans radically changed their attitudes regarding both physician-assisted suicide and

euthanasia."[144] The shift is irrefutable from the participant data collected among the age group of

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[142] Katherine Froggatt, "Life and Death in English Nursing Homes: Sequestration or Transition?," *Aging and Society* 13, no. 9 (2001): 319–32, accessed April 15, 2021, https://doi.org/10.7748/nop.13.9.8.s9.

[143] "WHOQOL: Measuring Quality of Life," Tools and Toolkits, World Health Organization, accessed April 15, 2021, https://www.who.int/tools/whoqol.

[144] Maureen V. Himchak, "A Social Justice Value Approach Regarding Physician-Assisted Suicide and Euthanasia among the Elderly," *Journal of Social Work Values and Ethics* 8, no. 1 (2011), accessed April 15, 2021, https://jswve.org/download/2011-1/spr11-himchak-Social-justice-approach-to-physician-assisted-suicide-inelderly.pdf.

sixty-five to seventy-five. The shift is mainly due to self-determination on the right to die to when death is imminent and severe suffering. The change that resulted from the project's implementation was that 13 percent of the participants expressed that they were unaware that their position went against biblical principles or church doctrines. Combating the breakdown in health literacy and establishing communication and support from spiritual advisers to council participants was part of the research implementation strategy.

Promoting health literacy as outlined in the research highlighted the aggressive medical treatments that fall outside the scope of Christian doctrine but are heavily relied upon by most participants in the study. These life-prolonging treatments rob us of a peaceful death and from honoring God in dying as well as in living. Paul encourages the Christian to "do everything for the glory of God" (1 Cor 10:31). The overwhelming purpose in life for Christians is to glorify God: "For if we live, we live to the Lord, and if we die, we die to the Lord. So then whether we live or whether we die, we are the Lord's" (Rom 14:8). For arguments on the quality of life, the research asked, "What is the value in the life that is prolonged?" In response, 20 percent of the respondents stressed that "there is no value in suffering."

Overview of Study Results

The intervention design depicted how health literacy educates patients and caretakers with alternatives that correlate with faith convictions. The study shows that the church is the right platform for the conversation to begin, and the black church must take the lead in dispelling health disparities among aging African Americans. Multiple factors evolved from data information showing that there is an association between health care and spiritual needs. Participants identified the consequences of limited health literacy and discovered alternatives

and created an action plan through attending the workshops. The observation for the study was qualitative, using the concept of triangulation.

The data collection methods are derived from interviews, focus group discussions, field observation, and research literature. The participants' engagement in the research was evident by the developmental change that occurred with their acknowledgment of the need to make changes in how they manage end-of-life decisions. At the start of the research, a proportionate number of participants had no clear understanding of euthanasia or awareness of physician-assisted suicide.

At the start of the project, for the thirty-two members who participated, the research achieved the goal of promoting health literacy to combat the scourge of euthanasia in the church. After being made aware of advanced medical technology and implementation of advance care directives and living wills, 28 percent of participants drafted an advance care plan that describes in detail what is important to the patient and what type of care they prefer.
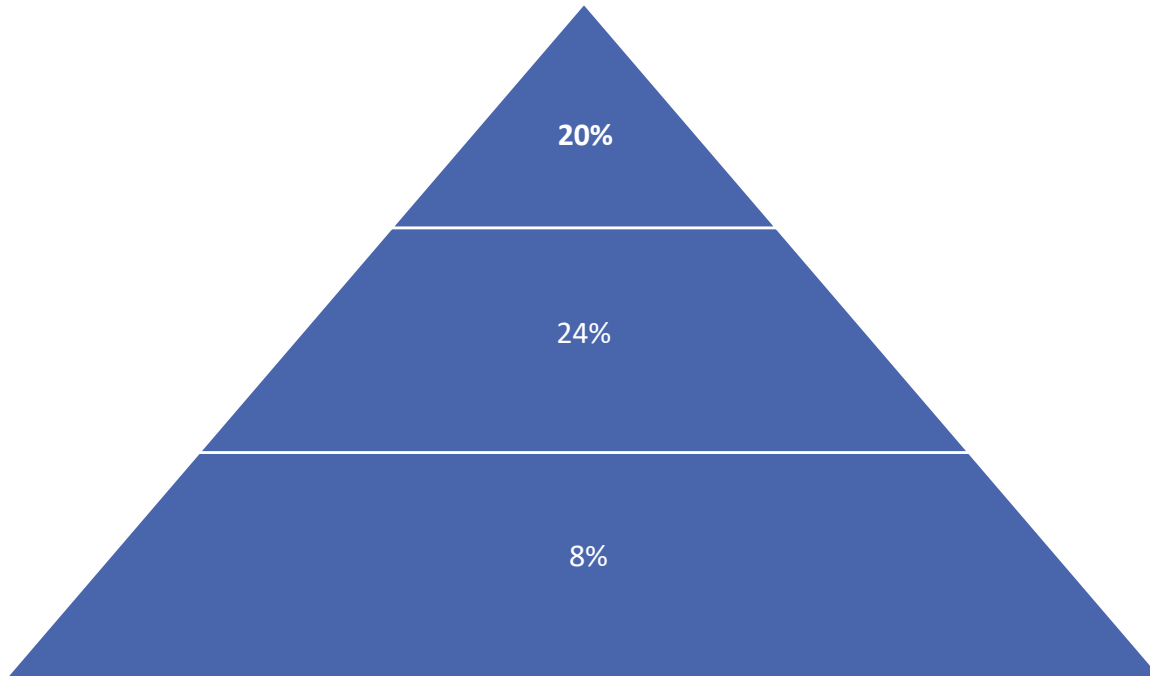
Figure 1. Developmental changes. The top tier represents the ratio who participated in making end-of-life care changes. The center tier represents those who implemented some changes in end-of-life care. The bottom tier represents the ratio of those who showed little or no interest in making end-of-life care changes.
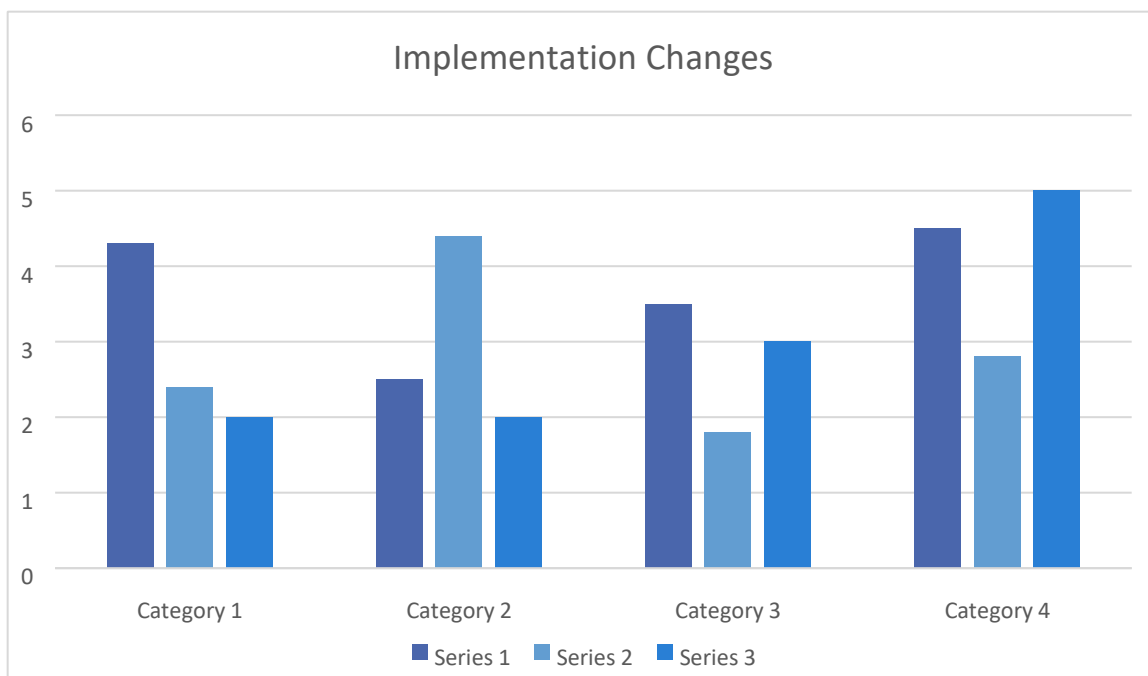
Figure 2. Transitional changes.

In figure 2, category 1, series 1 displays the 4.3 percent range of participants in the age group sixty-five to sixty-nine who attended advance care planning workshops. The second bar reflects 2.4 percent, the range of participants who drafted the standard forms for filing living wills and durable power of attorney, assisted by the volunteer health care professionals. The third bar represents the 2 percent range of persons who preferred that the health care team caring for them make end-of-life decisions for treatments without an advance directive or living will.

Category 2, series 2 displays that 2.5 percent of the participants aged seventy to seventy-five who attended advance care planning workshops. The second bar reflects the 4.4 percent of participants who went on to file advance directives assisted by the volunteer health care team. The third bar represents the 2 percent of participants who were undecided.

Category 3, series 3 displays the 3.5 percent of participants aged seventy-five to eighty and above who attended advance care workshops. The second bar presents the 1.8 percent of

participants who relied on health care personnel to draft advance care directives on medical procedures, treatments they will benefit from regarding quantity of life. The third bar shows the 3 percent of participants who were undecided and chose not to take part in drafting advance directives or living wills.

Category 4 shows the total changes that resulted from the project's implementation. Of participants who appointed an enduring power of attorney for personal care and welfare, the range was 5 percent. The level of participants who designated a family member, health provider, or solicitor to be involved in decisions about end-of-life care on their behalf when they are unable value was 4.5 percent. The value of participants who needed more time to consider making advance health care decisions was 2.8 percent. A participant identified as Paula shared that when her

> father was in the advanced stage of lung cancer, his physical appearance had changed dramatically. Dad could barely hold himself up; the endless coughing left him weak and breathless. Dad could no longer tolerate food. His sense of taste and smell was gone and [he was] nauseous most of the time. Father complained of pain and just wanting to die. The emotional toil this placed on the wife was devastating. Father no longer had value in his life. There was no value in lying daily in chronic pain, barely alive, suffering, and other family members suffering, unable to help him get relief. If euthanasia was an option for Father, we all would support him in his choice to die to end his suffering.

The research supports palliative care as a compassionate way to ease suffering and end-of-life despair. Palliative care places the spiritual concerns of the patient as an integral part of dealing with their illness. Chaplains are often part of the palliative care initiative. A physician who volunteered in the study conducted a lecture on palliative medicine. The participants wrote down questions for the physician to answer. Most participants reported that they had no knowledge of palliative care and embraced it as a compassionate alternative; they were encouraged to discuss it with their loved ones.

A central premise was to understand the benefits of alternative treatments for a peaceful and natural passage to dying. Katy Butler explains, "There is a way to a peaceful, empowered death, even in an era of high technology medicine. It begins long before the final panicked trip to the emergency room. It requires navigating over years not days in a medical system poorly structured to meet the needs of aging people, and of anyone coping with a prolonged or incurable illness."[145] The research put forward the need to understand more about putting in place advance care directives to eliminate the suffering endured by patients and their family during prolonged illness.

> Interviewee 1 stated:
>
> Isn't it too late? This program should be for the young, who have more time to plan. We are all old, and our health is what it is, and it's too late to change now. Medicine and machines [e.g., oxygen machines, pacemakers, CPAP machines, hearing aids] are all that's holding us together. So when doctors offer hope through life-prolonging technology, how does this go against Christian ethics?[146]

The research contends that preservation of life is only possible through Christ. The ventilators, respirators, feeding tubes, and battery-powered resuscitation machines are no match in preserving life compared to the love of God through Christ Jesus our Lord. Medical technology can only sustain life for as long as the battery-powered machines have current running to the body. Medical technology does not reveal the dangers witnessed by the chaplains and ICU nurses and doctors who wrestle with family decisions to keep the machines going instead of reconciling with the wishes of the loved one. The family members fight so hard to let go. In these situations, the conciliatory chaplain in the ICU many times provides the only presence of God in a distressful situation.

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[145] Katy Butler, *The Art of Dying Well: A Practical Guide to a Good End of Life* (New York: Scribner, 2019), loc. 219, e-book.

[146] Focus group conversation with the researcher, Victory Church, March 22, 2021.

Interviewee 1 question provided an excellent example of clinging to hope for a cure in the absence of care in the halls of medicine. Often the elderly succumb to cultural trends even amid end-of-life care. Evidence shows that those of faith strongly request aggressive treatments without understanding the consequences of their actions. This research showed that participants became better equipped for death, seeing God's goodness as extending our golden moments when we allow God to guide our decisions.

As the apostle Paul says, the immaculate hope brings into perspective the assurances of God and the frailty of humankind. Our natural bodies cannot escape suffering or death. However, as Paul wrote, "Therefore we do not lose heart. Though outwardly we are wasting away, inwardly we are being renewed day by day. For our light and momentary troubles are achieving for us an eternal glory that far outweighs them all. So we fix our eyes not on what is seen, but on what is unseen, since what is seen is temporary, but what is unseen is eternal" (2 Cor 4:16–18, NIV).

Similar to the lost art of dying in peace, security, and comfort that our ancestors in Christ experienced, so have the sermons on the death and resurrection of Jesus Christ been missing, replaced with a watered-down, culture-based version of quick-fix health care that offers organ supporting methods that in the end only prolong the inevitable and offer no hope of a cure. The community we have in fellowshipping with one another must not stop at the church door but extend into the institutions where many Christians are isolated, alone, and confused.

<div align="center">Securing a Strong Support Team</div>

Empirical results outlined a major complaint among respondents between the age range of seventy-five and above from group B, consisting of single, divorced, and widowed participants. The primary complaint was isolation and a breakdown in social support of any type.

Interviewee 2 said, "When your health fails and you are not actively attending church as you once could, the visits from friends and neighbors die out and church support becomes nonexistent."[147]

Interviewee 3 said:

> After losing my wife to cancer, the toil it took caring for her prevented me from returning to my position as deacon. It did not take long after her passing that my own health declined. The children were angered because of decisions concerning my wife's possessions, and we have not spoken for two years. Social support comes from home health aides, doctors, and a few church members who frequently stop by to visit. I participated in this research hoping to regain a connection with my children, which taking part in the advance care planning workshops have enabled me to do. The gratitude in my heart seeing and talking with my children after two years of not speaking— because of each of us, unbeknown to the other, who took part in the study—was reward enough that it was a God-sent event. Now with an advance directive and living will in place, I can rest in peace knowing the family will know and honor the final wishes.[148]

Interviewee 4, a participant in group B, said that when a stroke changed his life, for the first time the reality of death and dying plagued his mind and hindered recovery. The doctors asked if he had advance directives or a living will, and he answered no. He continued:

> That was four months ago. After receiving the email inviting me to take part in the study, it was as though God was sending a reminder to make this a priority. A social network does not always consist with those who love you, but as the Word of God says, "Some have entertained angels without knowing it" [Heb 13:2]. The workshop and church family are God's attending angels.[149]

The list would be too numerous to record the positive outcomes from testimonials of participants who needed to be guided in making health decisions consistent with faith and to become health literate concerning medical procedures, life-sustaining technology, and how to deal with end-of-life dilemmas before a catastrophe. The finality in the hearts of many in the

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[147] Focus group conversation with the researcher, Victory Church, March 22, 2021.

[148] Focus group conversation with the researcher, Victory Church, March 23, 2021.

[149] Focus group conversation with the researcher, Victory Church, March 23, 2021.

research who had received some diagnosis, especially cancer or Alzheimer's or dementia, reinforced the need for the black church—its pastors, and clergy—to take an active part in safeguarding against assisted suicide and active euthanasia. The data revealed that members prefer to have a safety net consisting of pastors, health providers, family, and friends offering social support before, during, and after a prolonged or incurable illness.

The interplay between respondents against any form of euthanasia on religious convictions based on God's sovereignty over life and death and those with a more supportive attitude toward assisted suicide and voluntary euthanasia on the premise of patient autonomy was intensely debated. The recordings were transcribed and anonymized. For those against euthanasia, three case studies were openly discussed, guided from research questions.

Case 1: Palliative Care

A terminally ill patient at home with only a few months to live is in chronic pain and has refused palliative treatments. The doctor is unable to prescribe any medicines that will reduce his physical pain. Does the utilization of living wills and durable power of attorney ease senior adults and family members' minds?

In focus group A, a respondent identified as Mary, a married sixty-seven-year-old woman caretaker to her seventy-three-year-old husband with stage 4 cancer, said she felt uncomfortable when her husband requested assistance with ending his life. She believed that the taking of life was in direct contrast with the commandment "Thou shall not kill" (Deut 5:17, KJV).

But, she said, it became hard to care for him at home, having rejected hospice care. Mary had to watch him agonize in pain, constantly asking her to kill him. Mary could not do it. One day her son came by to visit and shared how some doctors provide a lethal drug in terminal cases, similar to taking an overdose of slipping pills. Mary's son asked, "Why don't you help

Dad end his suffering?" Mary told him that God would end his suffering when God was ready;

that was not her job to do. Three days later, Mary went into the bedroom to reposition him in the

bed, which Mary did every two hours; her husband had passed away in his sleep. Mary said,

"This assured her she did the right thing by waiting on God."

The research posits that although Mary's religious convictions were strong, her husband's

suffering could have been avoided.

Case 2: Quality of Life

A patient with Alzheimer's is in the final stages of the disease, with decreased independence,

severe cognitive difficulties, and lack of physical control. She no longer knows her family and

demonstrates personality and behavioral changes such as distrust, wandering, aggressiveness,

delusions, and mood swings. She suffers from acute malnutrition, infections, and dehydration

and has no chance of recovery. What are older adults' views on what constitutes successful

aging?

In group A, a participant identified as Frank, eighty-four, who had been married for forty-

six years and formerly opposed all forms of euthanasia, shared the story of his eighty-year-old

wife with Alzheimer's. Frank's failing health had prevented him from continuing to care for her.

According to Frank, "Regardless of a person's health condition, their life was still precious to

God." Frank believed the quality of life should not be the basis for ending life because "life is

sacred." Frank went on to say that his wife and he had enjoyed each other for over fifty years.

Sometimes she would nurse him back to health, and at other times it would be her health that had

begun to decline.

The choice was hard to place her in the nursing home, but it was what was best for her.

Before her memory failed, she would say to Frank, "Honey, when the time comes, will you

please do what you think is best and let me go? That's what God wants." Frank had said that he would never let her go. It would be better if God took him first because he could never do anything to cause her harm. Frank did not keep that promise. His wife had fallen three times; the third time resulted in two broken ribs and a laceration to her face. Frank's wife wandered off while in the care of a nurse, during a doctor's appointment off the facility. When they found her, she was sitting at a bus stop three blocks away in the pouring rain.

Frank went on to say that today, if he had it to do all over again, he believed he would have assisted in his wife's death. Frank stated, "The quality of a person's life should be taken into consideration when there is no obvious cure or provision of comfort. We put an animal out of their misery; why not those whose life is forever changed because of a disease?" Frank does not visit the nursing home anymore. His wife does not recognize him, and he has found it too hard to see her in that condition. He believes that his wife would be better off dead, in the arms of Jesus, instead of tied down to a wheelchair all day. Frank's position on euthanasia has changed. Frank today supports physician-assisted suicide in cases such as his wife's.

Case 3: Active Euthanasia

An example in favor of assisted suicide comes from a sixty-eight-year-old respondent from group B, identified as Nancy. Nancy was not ashamed to admit assisting in the death of her mother. The mother's suffering was inhumane. Nancy's mother had requested assisted suicide, so Nancy complied. Nancy moved here to Nashville from a state where assisted suicide and voluntary euthanasia were legal. Before that time, Nancy had been a caretaker to her mother. The mother's health took a turn for the worse, and in answer to the question of whether Christians can request medically assisted suicide or euthanasia, Nancy answered yes.

At the time, Nancy and the mother were devout Christians. When physicians were unable to adequately relieve the mothers pain and her prognosis was less than six months, her mother was still mentally competent and therefore qualified under Oregon's Death with Dignity Act to die a good death. It was comforting, Nancy said, to have a compassionate health care chaplain assist with spiritual guidance. Her mother held to the belief that "nothing can separate us from the love of God in Christ Jesus our Lord" (Rom 8:38–39), and this to her included her choice of euthanasia. The comfort of God's Word and the absence of guilt in the face of medical decision-making, is what guided Nancy in following her mother's request.

Case 4: Voluntary Euthanasia

Very recently a family split over removing their father from life support when the eldest daughter requested that a minister come and perform the last rites. A participant from group C (in-home and institutionalized participants), identified as Sara, is a member at Victory Church. Sara, sitting at the bedside, holding gently her father's hand, shared that her father would not want life support. He had once been a vibrant, active, and enthusiastic man. He was strong willed, loving, and kind and was a dedicated Christian man.

Although the father never verbally said it, his lifestyle and Christian convictions showed a man ready to face death when the time came. Sara's family created a scene in the ICU after the doctor said there were no more medical treatments they could give the father. The catheters, ventilators, respirators, and feeding tubes worked against him more than for him, causing infections, pneumonia, and fever. The father's condition became severe. He required dialysis because of kidney failure, and CPR was twice performed when his heart stopped. Yet Sara's brothers refused to agree with stopping life support. Sara said that when considering the spiritual issues experienced while dealing with her father's illness, fear, uncertainty, anger, remorse, and

rage, she felt her brothers lacked compassion. She said, "Despite the doctors explaining my dad would not survive, the machines are not keeping him alive but only prolonging the inevitable." Sara explained that there was no spiritual support from family, friends, or the church where her father had served for most of his adult life. The stress plagued her into bitterness and depression, until her own health began to take a turn for the worse. When she heard about the research, it seemed that God had answered her prayer. Sara learned about advance directives and received spiritual support from the health care chaplains in the critical care unit. Her two brothers who were not active church attendees and the one brother who was an active member at Victory all had reservations on what they believed to be taking part in the active termination of their father's life. The family was split down the middle until one of the ICU nurses requested that a chaplain come, which allowed the siblings to come to agreement.

Sara indicated that the delicacy with which Chaplain Francis dealt with the ethical dilemmas, the ideological differences, and religious convictions created a sense of peace and forgiveness. "We concluded it was not what was best for us but what was best for our dad." After all life support stopped, their father's eyes opened, and after fifteen minutes they closed again. Their father's life had ended, but there was a sense of connection and peace with the father and among the siblings.

Although examples fluctuated between those who were strongly against any form of euthanasia and those in favor, attitudes shifted toward favoring euthanasia when family members expressed their struggle with the unbearable suffering of a loved one. The autonomy of the patient was the most outstanding component in decisions on end-of-life. The family members' self-determination on what was meaningful for their loved ones reflected that quality of life was indecisively intertwined with their right to die. Therefore, most of the participants were in favor of voluntary euthanasia. The other interviewees' strong disapproval of euthanasia correlated with

religious convictions that termination of life is an affront to God and that suffering is part of life and a direct result of the Fall.

Most interviewees believed that active euthanasia without the patient's approval is forbidden. Respondents who were indecisive on voluntary euthanasia agreed that the patients had the final word on decisions to end life. Peter Singer expounds on this view, stating, "Killing a person who does not choose to die fails to respect that person's autonomy; and as the choice of living or dying is about the most fundamental choice anyone can make, the choice on which all other choices depend, killing a person who does not choose to die is the gravest possible violation of that person's autonomy."[150]

Thirty-six participants were selected to be in the study, of which thirty-two participated. Health literacy workshops proved successful among the aging Christians at Victory Church. The data showed that most participants were implementing advance care initiatives before needing treatment, which aligned closely with the study's goals. A wavering faith in God during times of health crisis was prevalent in the data, at a higher rate among men than women. However, the data reflected that more women than men fail to have their final wishes documented; the primary reason is that women in most cases are the caretaker, putting their needs after another's.

Women more than men questioned the power of God. Hospice patients felt a high level of church abandonment, and those spiritually struggling with a cancer diagnosis felt abandoned by God. The study reinforced collaboration among the pastors and chaplains working toward the common goal of strengthening the faith of those who waver during a health crisis. Fear and anxiety among participants making end-of-life decisions were eliminated through spiritual guidance, health information, and church support. New approaches in patient care led to

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[150] Peter Singer, *Practical Ethics*, 2nd ed. (New York: Cambridge University Press, 1999), 99.

improved relationships with health providers, particularly at the last stages of life, avoiding euthanasia as an option.

Health literacy workshops opened a dialogue on death and dying, which combated the undue stress and spiritual clashes participants encountered with concerns about dignity and quality of life and the right to die peaceably. To evaluate whether God and Scripture's traditional beliefs influenced attitudes toward the different forms of euthanasia, the data collected represent an overview of the end-of-life decisions based on the question of what gives meaning to life. Participants were asked to rate each topic using the five-point Likert scale.

Table 1 presents the results of the participant demographics. Descriptive statistics were used to characterize the health disparities prevalent among senior African Americans. Data were collected from thirty-two participants. Seventeen in-depth interviews of approximately fifteen to thirty minutes were conducted with ten married couples, four single assisted living patients, six widows, eight divorced people, and four singles who had never married and were living at home. The three members in hospice died before the start of the study. Data collection methods included questionnaires, interviews, and an ethnographic descriptive study observing the everyday lives of nineteen focus group participants.

Table 2 explores the demographics of participants, beginning with gender. There were thirty-two participants, fifteen male and seventeen female. The ages of participants ranged from sixty-five to sixty-seven (thirteen), sixty-seven to sixty-nine (ten), seventy to seventy-five (five), and seventy-five to eighty (three) and above (one). The oldest participant in the study was ninety-two. There were ten married couples, three widows, nine divorced people, and ten singles.

Regarding living arrangements, five participants lived with their spouse, three lived with a biological family member, nine lived in a health care facility, zero lived with friends, eleven

lived alone, and four lived in an assisted living self-care facility (two in a retirement community and two in a nursing home).

The study shows the types of health disparities consistent with African Americans, especially diabetes, hypertension, depression, chronic pain, and heart disease. Respiratory diseases were higher among men than women in the study. Three cancer patients and two other participants were diagnosed with early signs of dementia. Arthritis in all three categories was higher among women in the study, while heart disease and depression were higher among men. Balance issues, chronic pain, and vision and hearing loss were prevalent among all thirty-two participants.

Table 1. End-of-life discussions

Prompt	Strongly agree (*n*)	Agree (*n*)	Neutral (*n*)	Disagree (*n*)	Strongly disagree (*n*)
Withdraw life sustaining therapies while in a vegetative state	8	12	7	3	2
Life is a gift from God and should be protected at all costs	32	0	0	0	0
Prefer end-of-life counseling with pastor/clergy	12	15	5	0	0
Accept hospice / palliative care to alleviate pain and suffering	8	7	4	5	8
Prefer assistance with dying with respect to maintaining quality of life	5	7	7	6	7
Maintain choice to die naturally and at home with family	18	9	3	0	2

Revive, including by use of breathing machine and feeding tubes	9	4	6	8	4
Allow natural death without the use of breathing machines	7	8	4	8	5
Support voluntary euthanasia	8	0	8	12	4
Support involuntary euthanasia	0	0	4	2	26
Support active euthanasia	3	3	4	5	17
Support physician assisted suicide	9	6	4	8	5
Time to begin conversation with loved ones on advance care directives is before intensive care is needed	32	0	0	0	0

Table 2. Research demographics

Gender	*n*
Male	15
Female	17
Age	
65–67	13
67–69	10
70–75	5
75–80	3
80+	1
Marital status	
Single	8
Married	10
Divorced	8
Widowed	6
Living arrangements	

Spouse	5
Biological children	3
Home health aide / sitter	1
Friend	0
Alone	10
Assisted living	4
Medical facility	9

Medical history

Balance issues	32
Cancer	12
Chronic pain	30
Cognitive health	
Dementia	2
Alzheimer's	1
Depression	5
Diabetes	18
Heart disease	20
Orthopedics/rheumatology	
Osteoarthritis	7
Osteoporosis	7
Rheumatoid arthritis	4
Lupus	0
Muscular dystrophy	0
Respiratory disease	
Asthma	3
Emphysema	5
Chronic obstructive pulmonary disease	3
Sinusitis	15
Vision	13
Hearing loss	4

The results confirm the importance of health literacy among African Americans at Victory Church, who wish to avoid efforts to prolong life at any cost. The most important insights on health literacy are linked to health outcomes, which relate to the high levels of health disparities that exist among elderly African Americans. There is an apparent lack of an appreciation for engaging in preventive health measures among Victory members in the study.

The research results elucidate the likelihood that 9 percent of participants would request life sustaining technology to prolong life at any cost. Although not implicitly stated, the factor that guides this percentage is a fear of death, isolation, and lack of support.

The results showed that collaboration between the pastors and chaplains working toward the common goal of strengthening the faith of those who waver during a health crisis was essential in providing spiritual guidance, health information, and church support participants required in making end-of-life decisions. New approaches in patient care lead to improved relationships with health providers, particularly at the last stages of life.

The themes that emerged from the study came from the participants' experiences and meaning-making process. The evidence shows that there is a severe issue in America among its aging citizens, which causes those suffering from chronic illness and disability to submit to medical technology demands for health care whose focus is no longer on care but more on treatments and hastening-death practices. The dilemmas in medical care and the aging population crisis of chronically ill seniors are not isolated to Victory Church membership, but the rise in euthanasia is apparent at Victory. The research fits within multiple religious denominations where attitudes surrounding treatment and end-of-life decisions are polarizing among aging Christians. While informative, the results of these analyses do not account for trends among other faith groups or ethnicities; these are concerns that require additional investigation in the future.

When looking at the implications of the findings, the researcher first argued that it is vitally essential for the church to support its aging members through health knowledge, preventative care, and other health literacy initiatives that may aid in making health decisions consistent with spiritual convictions to combat the scourge of euthanasia in the church. Second is the need for starting a death conversation with aging members, counseling them on the reality

that neither God nor the church has abandoned them in their medical crisis, but they must continue in prayer and trust that God is "working all things according to the counsel of his will" (Eph 1:11).

Third, a reorganization of care is needed, which requires advance care planning to ensure that final wishes and health decisions are honored. A certain level of care must be taken to ensure that limited health literacy is overcome at the Victory Church. This is a priority. Pastors and health care chaplains working together can empower rather than disempower health and wellbeing by providing health information that improves not only quality of life but dignity in dying.

Physicians who volunteered in the study provided information on quality of life and the rights of the patient as set out in the state's dignity laws and the right to refuse treatments, which is not the same as assisted suicide. The four primary ethical needs of the patient that the physician spoke about responding to during end of life are as follows: (1) the physician must continue to respond to the medical needs of the patient until there is no possible cure; (2) the physician must respect the patients' rights and autonomy to refuse treatment or continue care; (3) the physician must keep the lines of communication open and take into consideration the emotional support that the patient may need; (4) the physician is bound by their profession to offer comfort care and appropriate pain control for their patients and in no way facilitate the death of their patients. Rarely if at all are the spiritual needs of the patient addressed by physicians.

The greatest challenges the research sought to expose are the same as the central argument for euthanasia: (1) to help the patient escape suffering, and (2) to alleviate chronic pain. The researcher argues that the greatest challenge in combating euthanasia is lack of knowledge of medical alternatives and spiritual support to assist with the fears associated with

dying, as proposed by Elizabeth Kubler-Ross in her book *On Death and Dying*, which models

the five stages of grief: denial, anger, bargaining, depression, and acceptance.[151] Kubler-Ross

asserts that the decline of religion is closely associated with the fears and denial of death

experienced by terminally ill patients, which have today grown to catastrophic levels. The data

show that by participating in a dialogue on death and dying and by training on the benefits of

advance care directives, elderly Christians do not have to fear or face death alone or unprepared.

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[151] Elisabeth Kübler-Ross, *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy, and Their Own Family* (New York: Scribner, 1969), 26, 32, 48, 65, 78.

CHAPTER 5: CONCLUSION

Purpose of Study

The premise of this research study is that if the pastors and ministers of Victory Church in Goodlettsville, Tennessee, assist the chaplain with promoting health literacy, together they may combat the scourge of euthanasia among senior members through the church. Suppose the congregation receives training on ways the health care chaplain promotes whole-person health and spirituality. In that case, they may support ways of achieving a continuum of spiritual care and educate families on the end-of-life decisions that not only advance the Gospel but also testify to God's sovereignty over life and death.

In helping the population of aging Christians make complex decisions as they approach the end of life, the study highlights the importance of pastoral intervention with members, which permits them to better adhere to Christians ethics. Chaplaincy exists amid ever-developing medical technologies and advances to prolong life at all costs. The health care chaplain witnessed patients' experiencing resorting to some forms of assisted suicide to avoid suffering from a terminal condition. Cancer is vicious, and so are many other chronic diseases that destroy the body, the mind, and spirit. The church is missing during these times of decision-making for its Christian members.

As Hatcher states, "Terminal illness removes the suddenness that often comes with death and gives people the time and opportunity to be intentional about their last days."[152] This intentionality is far removed in ICUs and other medical facilities, which promote medical advances to prolong life or permit practices that hasten death. What matters for this study is that

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[152] Lori Hatcher, *Refresh Your Faith: Uncommon Devotions from Every Book of the Bible* (Grand Rapids, MI: Our Daily Bread Publishers, 2020), 165.

dying gracefully according to the Word of God is far removed when the patient is impaired,

under the influence of psychotic drugs, or offered the choice of euthanasia, what John Paul

taught as "a false mercy."[153] The God of mercy can be glorified through suffering, as eighteenth

century theologian Oswald Chambers wrote:

> As a saint of God, my attitude toward sorrow and difficulty should not be to ask that they be prevented, but to ask that God protect me so that I may remain what He created me to be, in spite of all my fires of sorrow. Our Lord received Himself, accepting His position and realizing His purpose, in the midst of the fire of sorrow. He was saved not from the hour, but out of the hour.[154]

Chambers's sentiment pulls at the heart of this research, as there continues to be an

extraordinary number of African American Christians considering a right to die with dignity

over a natural dying process. Being administered prescribed medication to end life is termed

active euthanasia. An alarming number of Victory members shared their personal testimonies of

making the decision to let a loved one die by omission of artificial life support. The catalyst that

draws enormous attention is physician-assisted suicide. Physician-assisted suicide occurs when

the patient's physician facilitates in their death. In the state of Tennessee, technically illegal.

During the study, however, it became apparent that the practice is being performed in the state.

The alternative position this research offers is to promote dialogue within the black church and

community on the benefits of hospice and palliative care; advance care directives should be the

first step in preparing the patient at the end of life.

People are losing hope in Christian values as the modern-day spirituality of Christians is

viewed through the lens of cultural diversity and change. The influence of negative religious

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[153] John Paul II, *Evangelium Vitae: On the Value and Inviolability of Human Life* (Washington, DC: United States Bishops Conference, 1995), 66.

[154] Oswald Chambers, *My Utmost for His Highest: An Updated Edition in Today's Language* (Grand Rapids, MI: Discovery House, 1992).

perspectives challenges end-of-life decisions on treatments and care. The anything-goes approach pushes against the disciplines of the rigid Judeo-Christian "thou shalt not." The Gospel message is replaced with an all-inclusive conformity to an intellectualized disdaining of the "one" way to any way or multiple ways of finding completeness. No longer is there sharing of faith that their name is written in the Lamb's book of life but how many likes they got on a Facebook post or TikTok video. Prayer is reduced to a "chat," and the once-experienced tranquility of a peaceful and natural death is synonymous with the noisy corridors of hospitals and ICU units beeping, mechanical ventilators, respirators, and other organ support technology. It is no wonder that the voice of God is silenced under such complex technology.

The researcher is close to many of the participants as well as to the subject, as her health care experiences and perspectives have greatly influenced the interpretation of the data. Her medical diagnosis and experiences as a training chaplain in hospice were the reasons for this research, to bring awareness to the number of Christians who fear death and the choice of being subjected to a nursing home for long-term medical care. The importance of drafting advance care directives became paramount when a diagnosis of lymphoma, rheumatoid arthritis, and the dreadful reality of signs of early dementia caused the researcher to respond, "How long, O Lord?" (Ps 13:1). Immediately, the bucket list was filled with things you wish to experience before you die instead of planning on how you want your final wishes to be carried out.

When the doctors are unable to communicate with you, and the family has no idea of whether you would want your life prolonged by resuscitation, artificial feeding tubes, ventilators, and respirators once the doctors have affirmed there is no more that medical technology can do but to prolong the life, not cure it, that is not the time to think about talking with your loved ones about death and how you want your final wishes carried out. The importance of talking with family before the need arises is the greatest challenge in the black family. Another challenge is

with the amazing number of African American seniors with a terminal diagnosis who have a preference for euthanasia to avoid suffering or excruciating pain (the reasons expressed to the researcher while working as a chaplain at hospice).

The evidence-based strategies to address health literacy interventions came from the materials participants received to improve communication between patients and health providers. Health professionals were encouraged to provide the information for their patients to help them make informed decisions in preparing for health challenges. The workshops provided the participants with relevant support systems to promote preventive health options based on their health care needs. Taking part in the study was a way for participants to break down potential health disparities stemming from poor communication and understanding of diagnosis and treatment options. The access to and utilization of health services and health information offered the skills to deal with management of serious illness and diseases while also promoting self-care initiatives and caregiver support.

The benefits from the study is that participants were connected to federal programs and health support systems that offer home health care services, assisted living, and retirement communities for seniors. Other services provide transportation to and from medical appointments, information on long-term-care options, chaplain service, hospice, and palliative care services. Families became more proactive in taking responsibility and committing to assisting their loved ones' health care needs by attending workshops and doctor appointments with them. The main form of intervention was spiritual advisement and in-person communication.

 Free legal assistance was offered to participants by volunteer solicitors upon request, as was help with completing living wills and do-not-resuscitate forms, durable powers of attorney, and assigning surrogates to speak for them. If a participant became incapacitated or unable to

speak or make health decisions for themselves, their wishes were carried out. The pastor and clergy dialogue created a confident path for members to begin the spiritual conversation of how they deal with the deaths of loved ones and caring for loved ones experiencing a terminal crisis in health.

The idea of death as a loss was upended for the Christian by the Word of God, especially from Jesus' death and Resurrection, because "death is swallowed up in victory" (1 Cor 5:54). The reassurance and reconnections of aging Christians with the promises of God will eliminate fear and anxiety with disconcerting medical diagnoses and open the way to making in advance end-of-life decisions consistent with Christian convictions. This study examined the health literacy of aging Christians who are members of Victory Church on the role spirituality plays in making health care decisions and end-of-life priorities on critical care, alternative medicine, and advance directives. From the research it was determined that many elderly Christians at the Victory Church need reassurance on the promises of God through Christ in combating the scourge of euthanasia in the church.

The members were reminded that the last enemy to be destroyed is death. Therefore, death is a reality that if in Christ Christians do not have to fear. Death should not decrease faith or relinquish the blessed hope of the Christian in their dying hour. Christ triumphed over death, as Paul confirms: "Death is swallowed up in victory" (1 Cor 15:54). The black church must act now as euthanasia lies at the door as the preferred option for aging Christians. During the time of this research, among the 40 percent of Christians aged sixty-five and above, 12 percent of families admitted to helping relieve their dying loved one's pain by hastening-death practices. Discourses on health and the dying person in dialogue with professional volunteers in the study seeking alternate management to their illness and dying interests made the final total 24 percent.

The church is responsible for teaching or attempting to implement in practice alternative ways of coping with life-threatening illness and dying by offering a holistic framework that seeks to enlighten and empower elderly Christians against the choice of hastening death options. The first step to beginning this dialogue with aging Christians experiencing a health crisis or threatening death is to listen. Many times the only comfort for those suffering is to be present with them. The active listening used in this study built trust, restored faith and reduced fears of dying, which were positive results.

The biblical teachings on death and dying are against euthanasia but not medical technology. Still, the researcher argues that prolongation of life as an escape from dying is unchristian. Humanity's boundary is set; there is no going beyond what God has ordained. Living longer does not come with the promise that your life will be free of pain or suffering. Who would choose to live longer in a chronic health state only to have to one day still face the inevitable? The Psalter emphasizes that "the years of our life are seventy, or even by reason of strength eighty; yet their span is but toil and trouble; they are soon gone, and we fly away" (Ps 90:10). These were a few of the concerns addressed in the research.

The participants all agreed that conversations on end-of-life decisions are some of the most important conversations to have with health providers, family, and spiritual advisers. The themes that emerged from the open dialogue were designed to strengthen the aging on how to live well while experiencing a terminal diagnosis or faced with impending death. The pastors who led the intervention conversations detailed that the Christians position is to always glorify God in whatever state one finds themselves in. There was evident confusion on what God's will is and how bioethics align within the word of God.

The premise of the paper argues for hospice or palliative medicine to control pain and reduce suffering as a substitute to euthanasia. Connor says that "the psychological and spiritual

aspects of coping with impending death are intertwined. It is an arena where psychology and religion overlap. How people cope emotionally is affected by their spiritual belief system, and their capacity for spiritual growth is influenced by psychological health."[155]

Maintaining the mind of Christ on every area of life enables the Christian to submit everything to God, for it is "in him that we live and move and have our being" (Acts 17:28). By stirring up the gift of God in those who participated in the study, hearts and minds were committed to making health decisions in harmony with the Word of God. Hospice and palliative medicine align with God's plan for Christians, which was the vision of hospice from its inception. It is meant to provide comfort to reduce suffering. The uniqueness of hospice and palliative care is in providing a network of community: "Team meetings enhance a sense of community within hospice. Each member of the team is valued as an essential contributor to the process of helping patients and their families achieve a good death."[156]

Another major theme in the study was prevention. Volunteers from hospice explained that their main goal is its focus on prevention. Those without advance care directives in place can still benefit from hospice and palliative care over the finality of euthanasia. Connors explains:

> Palliative caregivers help patients and their families to face difficult decisions about care. They educate about the different treatments available and the benefits and burdens of each. Hospice team members help the patient formulate goals for care at the end of life. These goals will determine how the patient is treated. Areas addressed include use of antibiotics, blood transfusions, oxygen, respirators, cardiopulmonary resuscitation, dialysis, chemotherapy, radiation therapy, ambulance transport, IV therapies, tube feedings, and hospitalization.[157]

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[155] Stephen R. Conner, *Hospice and Palliative Care: The Essential Guide*, 3rd ed. (New York: Routledge, 2017), 60.

[156] Ibid., 171.

[157] Conner, *Hospice and Palliative Care*, 172.

The downside of senior illness today that results in a terminal diagnosis is that patients rarely get to receive medical care in the comfort of their own surroundings, which for most is in their homes. Elderly people often are admitted into medical institutions for care, where most respondents in the study said is where their social and psychological breakdowns occur. During these times is when 12 percent of participants explained that they should have the right to die or choose to hasten death by suicide. A concept used by some physicians, as discussed by one participant concerning her loved one, is the gradual medicating of the patient until death occurs. This procedure is a form of an illegal practice of physician-assisted suicide, unlike hospice and palliative care. A major difference with institutional care and hospice or palliative care is that palliative or hospice care can be administered in the privacy of the patient's home.

The assessment process of hospice and palliative care is tailored to the needs of the patient's wishes and their family. The interdisciplinary team members assigned to the patients include a hospice physician, a registered nurse, a social worker, a spiritual counselor, and a dietary counselor. "The end-of-life process is a momentous experience for a patient and family, and it can be challenging for the interdisciplinary group (IDG) to individualize care related to the cultural and religious beliefs of today's diverse populations."[158] The researcher acknowledges that at this juncture it is important for the spiritual community of the church to support aging members if possible. The pastor and church leaders who participated in the study suggested assigning clergy to every medical facility or home where a senior member had no family or other social support to combat this problem.

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[158] Tina M. Marrelli, *Hospice & Palliative Care Handbook: Quality, Compliance, and Reimbursement*, 3rd ed. (Indianapolis: Sigma Theta Tau International, 2018), 98.

The problem is not unique to the Victory Church. Black church leaders everywhere can benefit from replicating a similar type of research among their senior members. Elderly people are listed as one of the most vulnerable populations in America: "Even if an individual elderly person is physically able to care for him/herself and is in full possession of their mental capacity. They are considered a vulnerable group because in the event of disaster, seniors like children, are particularly likely to suffer disproportionately compared to their younger neighbors."[159]

The health disparities among African Americans were another reason to increase health literacy among aging Christians in the black church is to stop the scourge of euthanasia in the church. Through promoting health literacy, a medical care plan can be initiated in advance before the need arises. Elderly members can have the opportunity to draft living wills and assign a surrogate to carry out the health decisions of patients in the event they are unable to speak for themselves. Advance care directives can be established to manage the patient's wishes on how they want terminal treatment to be carried out to maintain the quality of life that the patient and family desire.

The positive impact participants gained from the study through the promotion of health literacy is beneficial to future research, from which several interventions can develop that incorporated Christian values. First, forming a social network between health providers, family, and the church exposed the pitfalls that hindered an individual's ability to access and navigate the health care system, Second, participants were motivated to make appropriate health decisions with spiritual guidance in line with Christian convictions. Third, preventive health measures

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[159] "What Is a Vulnerable Population in Healthcare?," Blog, CareCentrix, September 7, 2017, accessed April 20, 2021, https://www.carecentrix.com/blog/what-is-a-vulnerable-population.

were put in place that influenced participants to act on the information they received through planning and the preparation of health directives.

The researcher seeks to add to the research and current literature on euthanasia by staying well informed on the laws in this state and through scheduling annual health fairs at Victory to measure the attitudes of members about hastening-death choices. The future vision is to improve health literacy by getting members' perspectives on what they think about health and end-of-life care. By becoming health literate, members can maintain better health outcomes for themselves and their long-term care, which can effectively aid in the proper use of medical information to combat the growth of euthanasia in the church.

In Tennessee talk among non-faith-based groups advocating for euthanasia and physician-assisted suicide is on the rise. Advances in medicine and medical technology's development of life-prolonging devices have come to the surface as sustainers of life without the consideration of the side effects, suffering, and degenerative conditions that the patient and family must undergo. Today more than ever, seniors are faced with decisions that challenge what was once an unimaginable concept. People's faith is also challenged with scientific explanations of changing the course of death by defining it using altering standards, such as a person who may only be brain dead or comatose, those whose breathing has stopped, and people being kept alive by ventilators or respiratory devices, questioning traditional moral standards to equate life to a quality desired rather than a gift from God.

When considering the issues surrounding the debates on euthanasia and physician assisted suicide, autonomy is the number one argument used to end suffering and hasten death. The problem with this argument is choice. A patient may choose to end their life by suicide, but it must be understood this is their choice, not their right. To say a person has a right to die is to make oneself equal with God, the giver of life. Jesus' words to Pilate substantiate this claim

when Pilate says to Jesus: "'Do you not know that I have authority to release you and authority to crucify you?' Then Jesus said, 'You would have no power over me at all unless it had been given to you from above'" (John 19:10–11). For the Christian God must be the source and force behind all we do. Therefore, electing to die to be free of suffering or imminent death is unethical because your right to die infringes on the physician or family member assisting in your death.

Another argument examined in the study in the debate on the right to euthanasia and physician-assisted suicide is the mercy argument. The study rebuts this argument on the grounds of the slippery slope argument. Think back on genocide and the Holocaust, where individuals because of disability and national heritage were euthanized. This is similar to when a physician in the 1900s, William Duncan McKim, asked for "a gentle, painless death" for the less desirables in society, "for America's drunkards, criminals, and people with disabilities. The only thing that stood in the way, McKim explained, was the unreasonable dogma that all human life is intrinsically sacred. The march of science, he concluded, dictated that Americans give up this long standing belief."[160] It does not take but a glance to see how close Victory's seniors have come to giving up the long-standing truth that the intrinsic value of man lies in humanity's origin. The study argues that "made in God's image" is where humankind's sacredness lies.

As a chaplain in training at a hospice facility listening to the stories of patients and family members who wrestle with deciding on matters of life and death, the researcher noticed two extremes surface: those family members who want to delay the inevitable by whatever means necessary and those who just want to get it over with, electing to hasten death rather than linger on in suffering and pain. Then, pressed with medical concerns of progressive dementia, the

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[160] Ian Dowbiggin, *A Merciful End: The Euthanasia Movement in Modern America* (New York: Oxford University Press, 2003), 1.

researcher's faith, too, was shaken to a degree that placed her in a similar plight as the apostle Paul: "I am torn between the two: I desire to depart and be with Christ, which is far better, but it is more necessary for you that I remain in the body" (Phil 1:23–24, NIV). However, the choice to "fall in the hands of a merciful God than in human hands" (2 Sam 24:14) far outweighs seeking a hastening way of escape. There are other alternatives, and the study promotes hospice and palliative care as a more ethical and godly option.

The researcher's being at the beside of dementia patients in the final stages of life made advance directives an obvious way to reflect Paul's thoughts on the necessity of remaining in the body: this is how to glorify God. The final witness to the world should not be met with fear but faith that the one who started the work will finish it. The decision to remain in the body although the mind is visibly departed will be the final witness to my family and loved ones on how valuable and precious life is and to cherish it while you have your being." The researcher was inspired by this declaration as well as from the problem that has become apparent at the Victory Church among African American seniors.

This study is designed to examine the health literacy of aging Christians who are members at Victory Church on the role spirituality plays in making health care decisions and end-of-life priorities on critical care, alternative medicine, and advance directives. There is a need for the church to provide a venue to educate select members and church leaders concerning the ethical decisions made by elderly and terminally ill patients before undergoing medical treatments to combat the scourge of euthanasia in the church. By assisting older adults with making conductive health care decisions that constitute Christian ethics, the study's intervention activities will be designed from the perspective of aging Christian views regarding long-term health care and end-of-life decision-making.

The evidence-based strategies that addressed health literacy interventions came from the materials participants received to improve communication between patients and health providers. Health professionals provided the information for their patients to help them make informed decisions in preparing for health challenges. The workshops provided participants with relevant support systems that promote preventive health options based on health care needs. Taking part in the study helped to break down potential health disparities stemming from poor communication and understanding of diagnosis and treatment options. The access to and utilization of health services and health information offers the skills to deal with management of serious illness and diseases and also promotes self-care and caregiver support.

A series of questions framed the study: (1) What is the effect of one's age's in making life and death decisions about a terminal illness? (2) How does the utilization of living wills and durable powers of attorney ease senior adults' and family members' minds? (3) Can Christians request assisted suicide or euthanasia medically? (4) What are older adults' views on what constitutes successful aging? (5) What spiritual issues have you experienced while dealing with illness or a spouse of a family member's condition? The questions addressed the problem at the Victory Church that members may not understand the chaplain's role in addressing the need for health literacy for aging members to combat the rise of euthanasia through the church. An alarming number of senior members with chronic illness or who are caring for a family member voiced their preference toward assisted suicide and euthanasia to avoid long-term care in a nursing facility, enduring uncontrolled pain and suffering, and lingering imminent death.

The researcher's interest in the project encapsulates the necessity for collaboration between health care chaplains, pastors, and black church leaders. The problem with health literacy can be eliminated when Victory leadership receives training that will help them minister to the terminally ill, the disabled, caretakers, and surrogates to make health decisions

commensurate with Christian ethics. Bringing awareness through the action-research approach on the fundamentals of look, think, and act was used to engage all stakeholders. In the look phase, the problem was presented to the leadership at the Victory Church and the reality of the chaplains' experiences with terminally ill members were shared, raising the need for the pastor and clergy to build a community around aging members and their families.

The accumulation of data made up the think phase. In this phase, ideas were reflected upon as well as concepts for interpreting and developing an understanding of how to proceed with interventions that would make sense to the participants and speak to their individual and collective experiences. In this phase, the participants shared through testimonials how their behavior, not facts, guided their decision-making process. The final stage 'act' put legs under the study as participants took part in implementing and utilizing resources to bring about positive change.

By continuing to build on the principles and doctrines at the Victory Church and connecting to God in obedience and love, new insights for living life in Christ emerged. The theological principles whereby we carry out those convictions at the Victory Church is through prayer, community, and support, which make up the theories that shape the theoretical foundations of the study.

The researcher does not presume to have all the solutions to fully address all the issues associated with health disparities among African Americans or fully address all the problems related to medical providers' demands and expectations. The researcher recognizes that the study is not perfect and that more research is needed to combat the scourge of euthanasia in the church. The study has pulled back the curtain, and hopefully it will lead to more research on the end-of life medical decisions of aging African American Christians.

APPENDIX A

RAPID ESTIMATE OF ADULT LITERACY IN MEDICINE

—— Patient Education Workshop

Assessing the Literacy Skills of Your Adult Patients

You can quickly determine your patient's literacy with this oral reading and recognition test, known as the Rapid Estimate of Adult Literacy in Medicine (REALM). It measures a patient's ability to pronounce 66 common medical words and lay terms for body parts and illnesses. To use the REALM, follow these five steps:

1. Give the patient a copy of the following lists of words. (Keep a copy for yourself.)

List 1		List 2		List 3	
Fat	Cancer	Fatigue	Miscarriage	Allergic	Gonorrhea
Flu	Caffeine	Pelvic	Pregnancy	Menstrual	Inflammatory
Pill	Attack	Jaundice	Arthritis	Testicle	Diabetes
Dose	Kidney	Infection	Nutrition	Colitis	Hepatitis
Eye	Hormones	Exercise	Menopause	Emergency	Antibiotics
Stress	Herpes	Behavior	Appendix	Medication	Diagnosis
Smear	Seizure	Prescription	Abnormal	Occupation	Potassium
Nerves	Bowel	Notify	Syphilis	Sexually	Anemia
Germs	Asthma	Gallbladder	Hemorrhoids	Alcoholism	Obesity
Meals	Rectal	Calories	Nausea	Irritation	Osteoporosis
Disease	Incest	Depression	Directed	Constipation	Impetigo

2. Ask the patient to read aloud as many words as she can, beginning with the first word on List 1. When she comes to a word she cannot read, tell her to do the best she can or say, "blank," and then go on to the next word on the list.

    If the patient takes longer than five seconds to read a word, prompt her to move on by saying, "blank," and pointing to the next word on the list. If the patient begins to miss every word, ask her to pronounce only those words she knows.

APPENDIX B

PARTICIPANT SURVEY[161]

Personal Health Assessment Questions

Health View

Complete the following statements by circling the choice that best fits your response:

1. **In general, my overall health is**

a) **excellent**

b) **good**

c) **fair**

d) **poor**

Preventive Health

2. **How often do you get immunization shots?**

a) **yearly**

b) **rarely**

c) **never**

Social Activity

3. **During the past four weeks, to what extent has your physical health interfered with routine activities with family, friends, neighbors, or church attendance a) none at all**

b) **slightly**

c) **moderately**

d) **quite a bit**

e) **extremely**

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[161] "Sample Personal Health Assessment Questions," Benefits, Washington County, Oregon, accessed November 17, 2020, https://www.co.washington.or.us/support_services/hr/benefits/upload/sample-phaquestions.pdf.

Emotional/Stress Coping Skills

4. **How well do you feel you are coping with current stress or emotional problems**

a) **coping very well**

b) **coping fairly well**

c) **having trouble coping at times**

d) **often have trouble coping**

e) **feel unable to cope**

Health Literacy Assessment Questions

Health literacy is the degree to which people understand and process health information and health services, which enable them to make informed decisions relative to their healthcare needs.

Self-Advocacy

On a scale from 1-4, choose the number that best answers the following questions

A. **How well do you process necessary health information provided by healthcare providers?**

1) **always**

2) **most of the time**

3) **less than half the time**

4) **seldom or never**

B. **What is your level of confidence in filling out medical and or insurance forms**

1) **extremely confident**

2) **moderately confident**

3) **slightly confident**

4) **lack confidence**

C. **One's level of health literacy directly influences their ability or lack thereof in assuming responsibility for self-care and fostering preventive health practices**

1) **strongly agree**

2) **agree**

3) **somewhat agree**

4) **disagree**

Advance Care Planning

Advance care planning ensures your wishes are known and honored if you become unable to speak for yourself.

Barriers To Health Directives

Whether we succumb to physical or mental impairment, chronic disease, or sickness, the one thing none can escape is death.

Denial

Describe your position with the following statements 1.

Drawing up a living will is a sign of

hopelessness

a) **strongly agree**

b) **somewhat agree**

c) **disagree**

Confusion

2. **By designating a durable power of attorney, I forfeit control over myself and my possessions**

a) **strongly agree**

b) **somewhat agree**

c) **disagree**

Lack of Awareness

3. **Advance care directives can be changed and updated as my health needs and life circumstances change**

a) **strongly agree**

b) **somewhat agree**

c) **disagree**

Advances to Health Care Directives

4. **Seniors need a plan in place for making difficult choices about health care**

a) **strongly agree**

b) **somewhat agree**

c) **disagree**

5. **Planning for end-of-life care prevents unnecessary suffering and lessens the burden imposed on family members having to make final decisions**

a) **strongly agree**

b) **somewhat agree**

c) **disagree**

6. **Health directives ensure my choice for unwanted or desired resuscitation protocols a)**

strongly agree

b) **somewhat agree**

c) **disagree**

APPENDIX C

CONSENT REQUEST TO PARTICIPATE IN RESEARCH

Title of the Project: Healthcare Chaplain's Intervention Plan: Promoting Health Literacy to Aging Christian's in the Black Church

Principal Investigator: Willie M. Corley, associate minister/volunteer chaplain, Victory Church Goodlettsville, TN.

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be a senior adult. The study is limited to participants sixty-five years old and upwards and restricted to members at the Victory Church. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why is it being done?

The purpose of the study is to bring awareness to the role of the healthcare chaplain and how their clinical pastoral training can benefit pastors and ministers. The chaplain hopes that by integrating educational workshops for older adult members, their families, and caretakers, it may enhance their ability to make healthy lifestyle changes and informed end of life choices.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Arrive at the church by 11.00am

2. Sessions will last 30-45minutes

3. Three groups of participants with 4-5 per class

4. In-home and phone interviews will be recorded

5. Transportation will be provided

6. Refreshments/lunch will be served at the end of each focus group

How could you or others benefit from this study?

I.   The direct benefits participants should expect to receive from taking part in this study are opened dialogue on death and dying, which can combat the undue stress and spiritual clashes seniors may encounter with concerns about the dignity and quality of life and the right to die peaceably.

II.   Fear and anxiety is eliminated through the spiritual guidance, health information, and church support participants required in making end-of-life decisions. New approaches in patient care will lead to improved relationships with health providers, particularly at the last stages of life.

III.   Participants should not expect to receive a direct benefit /compensation from taking part in this study.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

Liberty University will not provide medical treatment or financial compensation if you are injured or become ill as a result of participating in this research project. This does not waive any of your legal rights nor release any claim you might have based on negligence

The mandatory reporting of elder abuse, or intent to harm self or others will be disclosed to the proper authorities.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify participants. Research records will be stored securely, and only the researcher will have access to the records.

Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data is shared.

- Participant responses will be anonymous./ Participant responses will be kept confidential through the use of [pseudonyms/codes]./ Interviews will be conducted in a location where others will not easily overhear the conversation.

- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted

- Interviews/focus groups] will be recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher[s] will have access to these recordings.

- Limits to confidentiality cannot be guaranteed in focus group settings. While discouraged, other members of the focus group may share what was discussed with persons outside of the group.

How will you be compensated for being part of the study?

Participants will not be compensated for participating in this study

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University or the Victory Church. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you, apart from focus group data, will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Willie M. Corley. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted] or email

wmcorley@liberty.edu.You may also contact the researcher's faculty sponsor, Dr. Jeff Brawner at jwbrawner@liberty.edu.

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio record me as part of my participation in this study.

_____

Printed Subject Name

_____

Signature & Date
Legally Authorized Representative Permission

By signing this document, you are agreeing to the person named below participating in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records.

If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I agree for the person named below to take part in this study.

☐ The researcher has my permission to audio record the person named below as part of their participation in this study.

_____

Printed Subject Name

_____

Printed LAR Name and Relationship to Subject

_____

LAR Signature   Date

APPENDIX D

SAMPLE ADVANCE CARE PLAN[162]

MY ADVANCED CARE PLAN & GUIDE

Plan the healthcare you want in the future and for the end of your life

This is my advance care plan and contains my choices. Please follow this plan if I am unable to tell you what I want.

Name

Date

Address

Phone

What Matters to Me

My cultural religious and spiritual values, rituals, and beliefs

This is what I want family and healthcare team to know about what worries me.

I worry about how my health might affect my future plans.

---

[162] "My Advance Care Plan & Guide," Advance Care Planning, Health Quality & Safety Commission, New Zealand, https://www.hqsc.govt.nz/assets/ACP/PR/ACP_Plan_forms_.pdf.

I worry about how my health might affect my loved ones.
I worry about where I will be cared for.
I worry about how my pain will be managed if it occurs?
I worry about being able to communicate.
I worry about being a burden.
I worry about going into long-term care.
I worry about dying alone.
I worry about how my family and loved ones will manage without me.
I worry about being confined to a bed.
I worry about my family and loved ones overriding my wishes.
I worry about a clash between traditional and modern cultural medical technology.
I worry about finances.

Why I'm Making an Advance Care Plan

This is why I am making my advance care plan:

How I make Decisions: **Scale 1-5**

I like to know only the basics	1-------2------3--------4------5	All the details about my condition and treatment
As doctors treat me,	1-------2------3--------4------5	
I would like my doctors to do what they think best		to have a say in every decision

If I had an illness that was going to shorten my life, I would prefer to know my doctor's best estimate for how long I have to live	1-------2------3--------4------5	Not how quickly my illness is likely to progress
How involved do you want your loved ones to be? I want them to do exactly as I have said, even if it makes them uncomfortable	1-------2------3--------4------5	I want them to do what brings them peace, even if it goes against what I have said
When it comes to sharing information… I don't want my loved ones to know anything about my health	1-------2------3--------4------5	I am comfortable with my loved ones knowing everything about my health

If I am unable to make decisions, I would prefer them to be made like this:

o I want my enduring power of attorney for personal care and welfare to make decisions using the information in this advance care plan.
My EPOA's name is
Relationship to me: **Phone:**

Or

o I don't have an enduring power of attorney. Using the information in this advance care plan, the following person will help my healthcare team make the best decision for me.
Name:
Relationship to me: **Phone:**

In addition the following people know me well and understand what is important to me. I would like them included in discussions about my care and treatment.

Name:
Relationship to me: **Phone:**
Name:
Relationship to me: **Phone:**
Name:
Relationship to me: **Phone:**

When I am dying my quality of life means:

- **Being aware and thinking for myself**
- **Communicating with the people who are important to me**

- **To be made comfortable**

When I am dying I understand that my comfort and dignity will always be looked after:

This will include food and drink if I am able to have them.

In addition, I would like you to:

- o Let the people who are important to me be with me o Take out things, like tubes, that don't add to my comfort.
- o Stop medications and treatments that don't add to my comfort and recovery. o Attend to my religious, cultural and/or spiritual needs.

The place I die is important to me:

- o **Yes.**   o **No.**

When I am dying I would prefer to be cared for:

- o **At home**
- o **In a hospital level care facility (**residential care) o **In hospice** o **I don't mind where**

My treatment and care choices

1. I would like my treatment to be aimed at keeping me alive as long as possible. I wish to receive all treatments that the healthcare team think are appropriate to my situation. The exception to this would be:
If required and appropriate I would want CPR to be attempted: o Yes.   o No o I will let my doctor decide at the time.

<table>
<tr><td>2.</td><td>I would like my treatment to focus on quality of life.
If my health deteriorated I would like to be assessed and given any tests and treatments that may help me to recover and regain my quality of life, but I DO NOT WANT TO BE RESUSCITATED.
For me quality of life is:

</td></tr>
<tr><td>3.</td><td>I would like to receive only those treatments which look after my comfort and dignity rather than treatments which try to prolong my life. I DO NOT WANT TO BE RESUSCITATED.</td></tr>
<tr><td>4.</td><td>I cannot decide at this point. I would like the healthcare team caring for me to make decisions on my behalf at the time, considering what matters to me and in close consultation with my family and loved ones.</td></tr>
<tr><td>5.</td><td>None of these represent t my wishes. What I want is recorded in my Advance Directive.</td></tr>
</table>

> **I choose option number:**

Signatures: By signing below, I confirm:

- I understand this is a record of my preferences to guide my healthcare team in providing appropriate care for me when I am unable to speak for myself.
- I understand treatments that would not benefit me will not be provided even if I have specifically asked for them.
- I agree that this advance care plan can be in electronic format and will be made available to all healthcare providers caring for me.

Name

_____

Address

_____

| **Phone** | **Signature** | **Date** |

_____

Healthcare professionals who assisted me

By signing below the healthcare professionals confirms that:

- I am competent at the time I created this advance care plan.
- We discussed my health and the care choices I might face.
- I have made my advance care plan with adequate information.
- I made the choices in my advance care plan voluntarily.

Healthcare Practitioner

Facility/Organization/ Designation

Phone   Signature   Date

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IRB Approval Letter

Willie Corley
Jeff Brawner

Re: IRB Approval - IRB-FY20-21-317 Healthcare Chaplain's Intervention Plan: Promoting Health Literacy

to Aging Christians in the Black Church Dear Willie Corley, Jeff Brawner:

We are pleased to inform you that your study has been approved by the Liberty University Institutional Review Board (IRB). This approval is extended to you for one year from the date of the IRB meeting at which the protocol was approved: February 8, 2021. If data collection proceeds past one year, or if you make modifications in the methodology as it pertains to human subjects, you must submit an appropriate update submission to the IRB.
These submissions can be completed through your Cayuse IRB account.

Your study falls under the expedited review category (45 CFR 46.110), which is applicable to specific, minimal risk studies and minor changes to approved studies for the following reason(s):

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your stamped consent form can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. This form should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document should be made available without alteration.

Thank you for your cooperation with the IRB, and we wish you well with your research project.

Sincerely,

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office