LETTERS TO THE EDITOR

RESEARCH ON SPIRITUALITY: DANGEROUS AND DECEPTIVE GROUND?

To the Editor:
Science has a way of turning the sacred into the mundane. Sometimes it is in danger of distorting the truth. Thomason and Brody[1] discuss the differences between religiosity and spirituality as though they are making significant excursions into new territory. Daaleman and Frey[2] and Ellis and colleagues[3] have scientific paradigms for research into family physicians' attitudes, beliefs, and practices. Most other researchers of physicians and religion have done the same.

However, there is a specificity of religion that is entirely ignored in these endeavors and discussions: Christianity. In the study by Daaleman and coworkers, 80.7% of family physicians and 88.5% of the general population were specifically Christian, Protestant or Catholic (more accurately, Roman Catholic).

Thus, the large majority of the religiosity and spirituality of these articles is Christian. Yet, the sterile scientific jargon in which they are discussed belies specific doctrines and tradition.

Yes, there are many Protestant churches. Yes, there are variants of thought among Catholics. However, there is much more unity than diversity within each. There is an orthodoxy by which a true Protestant church can be measured. Roman Catholic churches have an even greater specificity.

Science is treading on dangerous and deceptive ground here. Regardless of what one's desire may be for inclusion, apples and oranges exist. More than 80% of the American population and its family physicians practice Christianity, not some vague spirituality or religious experience. Almost entirely, the researched health benefits of religion have been done on Christian populations. To extrapolate these to any form of spirituality is deceptive and a misrepresentation to the belief system that fostered it.

There is no question that religion is central to health and the practice of family medicine. But it is not "religion" primarily, but Christianity. To discuss "inclusive spirituality" in general terms is also to misrepresent and to distort what is much more specific.

Although not intended, such general discussions convey the notion that whatever one believes is all right (healthful), as long as one is consistent and sincere. Christianity condemns such notions in its core beliefs. Scientists (and physicians) should be careful not to make claims for spirituality that is specifically Christian.

The avoidance of what is identifiably Christian by science in general, and medicine in particular, is a curious phenomenon. I once presented a marriage seminar that was broadly religious and highly practical to family physicians and their spouses at a national meeting. Yet, it was rejected for future inclusion solely because of its Christian content (judged by attendees' comments).

We can pat ourselves on the back and feel good about researching religion and applying it more in our practices, but our patients live in the real world of specific religious content, mostly Christianity. To ignore this reality is dishonest and detrimental to our patients and ourselves and dishonoring to the God of Christianity.

Franklin E. Payne, MD
Medical College of Georgia
Augusta

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2. Daaleman TP, Frey B. Spirituality and religious beliefs and practices. J Fam Pract 1999; 48:98-104.
3. Ellis MR, Vinson DC, Ewigman B. Addressing spiritual concerns of patients. J Fam Pract 1999; 48:105-9.

The preceding letter was referred to Drs Daaleman and Frey, who respond as follows:

Dr Payne's letter viscerally touches on many disciplines in an attempt to redact any construct of religiosity and spirituality into a specific faith tradition. Although we cannot comment on the theological perspectives offered, we can respond to many of the issues raised.

The formal study of religion by both sociologists and psychologists is a discipline that is still quite young when compared with other fields of study.[1,2] The examination of religious influences and variables on health-related outcomes is at an even earlier developmental stage.[3] In these settings, the proper use of language and exacting terminology may sound like "sterile scientific jargon," but it is the lifeblood of documenting and communicating research findings and conclusions. Dr Payne's use of the term "specificity" serves as a good example. Although he speaks of Roman Catholics as having a greater specificity, it appears that creedal assent[4] or ideologic belief[5] are preferable terms to describe his discussion of doctrinal differences between faith traditions. To an epidemiologist, specificity refers to how good a test is in rejecting samples that do not have an identified disease.[6]

We agree with Dr Payne that a patient's orientation and construction of their medical and or overall worldview are influenced by what Berger[7] calls "the sacred canopy." However, we strongly disagree that this worldview is exclusive to one specific faith tradition. His social commentary is unsubstantiated and at odds with

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ongoing research in this area. Survey data reveal that most Americans are searching for meaning in their lives, and that there is a hunger to experience God. There is also, however, a growing number of "unchurched" people who do not know what they believe or why.[8] The sociologist Wuthnow[9] describes this movement in the contemporary social scene, where a traditional spirituality of dwelling in sacred places has given way to a spirituality of seeking.

In such a climate, Dr Payne's posture raises serious ethical concerns about the nature of patient-physician interactions and the roles and responsibilities of physicians within these encounters. Medicine has always sought to cure, and when cure is not possible, to provide care to ease pain and suffering. Religion and spirituality seek to promote union with God or the transcendent. Although these distinctions are critical, they can be blurred in care providers who lack discernment, or by those who lose sight that we, as physicians, are ultimately accountable to our patients and to ourselves.

Timothy P. Daaleman, DO
School of Medicine
Bruce Frey, PhD
School of Education
University of Kansas
Medical Center
Kansas City

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Drs Ellis, Vinson, and Ewigman also respond:

We appreciate Dr Payne's letter and agree with many of his points. The recent editorial by Thomason and Brody[1] and Dr Payne's response highlight the language barriers that occur when science and religion cross what Gould[2] has characterized as "their nonoverlapping magisteria." Quantitative scientific language can never do justice to the depth of religious expression.[3] Despite these challenges, and the risk of "turning the sacred into the mundane," we believe that more dialogue between science and religion would be productive,[4] and that seeking to understand the physician's role in responding to a patient's spiritual health needs is important in caring for patients.

Our study's participants expressed a wide range of perspectives that illustrate the current state of confusion among physicians in dealing with spiritual matters. [5] Our qualitative analysis of their written comments shows the diversity of understanding about this issue (Table).

The issues are not simple. Physicians disagree even about whether spiritual issues are appropriate to address with a patient. However, many of our patients think spiritual issues are important, and we must learn how to deal with these issues. In respect of the diversity of our patients' spiritual perspectives, it is appropriate to extend the scope of research to include many religious traditions. Such research may guide physicians with diverse spiritual backgrounds in helping patients who are similarly diverse.

Addressing spirituality and medicine concurrently will inevitably stir debate, in part because the relationship between science and religion has never been settled. Instead, we have 2 cultures that peacefully co-exist, generally by avoiding serious dialogue. Some will argue that the dialogue

TABLE

Physicians' Comments About Caring for Patients' Spiritual Health Needs

Theme	Illustrations
Personal experiences shape interactions	"I've had more spiritual interaction since my own cancer."
Personal views shape interactions	"(Since) spirituality is not a part of my life, it is difficult to discuss (spiritual issues) in a way that would be helpful."
Inappropriateness to physician's role	"I don't feel that being a spiritual leader is part of my role as a physician. I don't expect spiritual leaders to be diagnosing and treating illness."
Reluctance to address issues without knowledge of patient's beliefs	"I am shy in inquiring about spiritual issues with no knowledge of the person's beliefs."
Concerns about bringing up difficult issues	"I don't know to what extent patients' beliefs play a role in their concept of health, so I usually don't ask.... It often brings up issues which are esoteric and nebulous."
Patient's degree of illness shapes interactions	"I would more often address spiritual issues if a patient (were) dealing with a terminal condition or coping with a chronic disease."

should not even be attempted, especially in a secular publication. But the evidence suggesting the importance of belief and faith in health is strong enough to warrant further investigation and discussion. As Christian physicians, we hope that our patients will discover a health that transcends the physical and psychological. Any small way that our research may help attain this goal is worth the debate that may accompany it — awkward as it may be. As long as we do it with "gentleness and reverence" (I Peter 3:16, RSV), we believe that sensitive attention to matters of the spirit in everyday practice is more likely to turn the mundane encounter into a sacred experience than to destroy the sacredness of our patients' faith.

Mark R. Ellis, MD, MSPH
Daniel Vinson, MD, MSPH
Bernard Ewigman, MD, MSPH
University of Missouri-Columbia

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5. Additional results from a study of Missouri family physicians. See Ellis MR, Vinson DC, Ewigman B. Addressing spiritual concerns of patients. J Fam Pract 1999; 48:105-9.

AUTHOR'S CORRECTION

I inadvertently omitted a vital result in our article "Rural Childhood Immunization: Rates and Demographic Characteristics" (J Fam Pract 1998; 47:221-5). The fifth sentence of the Results section should read: "In the 1991 NMIHS multivariate analysis, race differences were no longer significant at the $P<.05$ level when other factors were taken into account; however, children whose race was identified as 'other' were significantly less likely to be UTD than white non-Hispanic children at the $P<.1$ level."

N. Elaine Lowery, JD, MSPH

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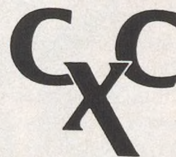

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