OpenTheo

Should Science & Religion Mix? | Beyond the Forum Edition

August 12, 2021

The Veritas Forum

You can check out our new podcast, Beyond the Forum, wherever you listen to podcasts. • Dr. Tia Powell, Dr. Tyler VanderWeele, Dr. Richard Sloan, and Dr. Lydia Dugdale all discuss the power and peril of mixing religion and medicine at The Harvard Medical School Veritas Forum: Religion and Medicine: Should they Mix? • Please like, share, subscribe to, and review this podcast. Thanks!

Transcript

Hi, this is Carly Eshleman, the assistant producer of Beyond the Forum, a new podcast available now from the Veritas Forum and PRX. The Forum you're about to listen to is featured in Beyond the Forum's first season on The Good Life. We interviewed Dr. Tyler VanderWeele, one of the presenters you're about to listen to, for episode four of our first season.

And we talk with him about his research on how to quantify human flourishing, and more specifically, his findings that suggest that attending religious services regularly, can help you live seven years longer. You can listen to our interview with Tyler, access full show notes, and learn more about the rest of our first season by visiting beyondtheforum.org. Thanks for listening and enjoy the Forum.

[Music] Welcome to the Veritas Forum.

This is the Veritaas Forum Podcast, a place where ideas and beliefs converge. What I'm really going to be watching is which one has the resources in their worldview to be tolerant, respectful, and humble toward the people they disagree with. How do we know whether the lives that we're living are meaningful? If energy, light, gravity, and consciousness are in this street, don't be surprised if you're going to get an element of this in God.

Today we hear from Dr. Tia Powell of the Albert Einstein College of Medicine, Tyler VanderWeele of the Harvard School of Public Health, Richard Sloan, Columbia University

Medical Center, and Lydia Doug Dale of Columbia University. As they ask the question, should science and religion mix? The title of the program, let me say I'm honored to be here. Clearly this is a topic that engages many people here.

It's an honor, and it's also quite humbling to be before such a large crowd. So I will do my best. The topic is really, should there be some interaction between medicine and religion? I don't think that either can escape the other.

So I use the term frenemies, and it's a joking word, but I hope to engage some serious meaning and see if it interests you. Religion and medicine must be together. In times of crisis, people who are ill, their families, and their clinicians often rely on faith.

It's an important, long-standing source of support for many, many people. They cannot deal with people who are ill, who face threats to their life, who do, in fact, go through the process of dying without calling up crises of loss, of pain, of sorrow, and grief. So that is the proper place for religion.

It would be very odd to think that you could separate that out from what medicine does on a daily basis. What a strange notion. So they have to be friends.

They have to be entwined. You can't make that not happen. But enemies, too.

If they are siblings, they are siblings with kind of a tense relationship. There are ways in which medicine can be disrespectful to people of faith, to concepts around faith. In general, Americans tend to be a faithful country.

There are many, many believers in America and somewhat fewer within the health professions. So there is a kind of statistical imbalance that you may find there. There are also some faiths that will never be widely represented within medicine.

If you are a Christian scientist, it's unlikely that you will meet a co-religionist when you come to the hospital. I'm not saying it. It's impossible, and I certainly don't discourage it.

But because the core beliefs really discourage participation in formal medicine, you are very likely to be confronted as sort of odd man out. If you show up at a hospital. And the same might be true of quite a number of other faiths.

So there are particular faiths that are unusually excluded and treated with a certain skepticism within medicine. So I'm going to tell you about a case. I'm at the end of the day a doctor, and I think in terms of cases.

So some years ago, I heard about a woman named Mrs. Jones. She was 48. I have to tell you from my perspective today that strikes me as extremely young.

She was a Jehovah's Witness, and she unfortunately had end stage endometrial cancer. And that was she was really kind of at the end of curative options, nonetheless in the

hospital very ill. She had persistent bleeding, which is not at all uncommon for that illness, and that's not good for your blood counts.

So she had the severe anemia that you would expect with that. And famously, core to the Jehovah's Witness belief. There are many other beliefs in medicine.

We seem to focus on this one. It is actually quite a broad faith with many other aspects to it. But in medicine, we sometimes really come into tension with those who are Jehovah's Witnesses because they don't accept transfusion.

So, and we can do lots of other things, but sometimes really a transfusion is what we are backed up against. That is the thing that will address this problem. The patient refused.

Her husband was always at the bedside. A distressed colleague called me to do an ethics consultation. So, part of my ethics consultation tricks involved showing up early in the morning before the patient's husband could be there.

But backing up a little bit, I don't want in any way to undermine my colleagues. She was quite distressed. She had real moral distress.

This was a person she wanted to help and indeed was obligated to help. And who she felt was preventing her from being helped. She was rejecting that one help that the physician thought was most important.

She really thought that this woman would die sooner. She really felt that she could give better care, including better palliative care with transfusion. The physician always said that husband is always there.

He's very intimidating. He's sort of there at the bedside with his arms crossed. And the physician was very concerned that perhaps the husband was enforcing this patient's choice.

That this was in some way forced upon her. And she was particularly distressed under the circumstance to think that it was not really the woman making this choice, which really made her more likely to die sooner rather than later. So the consult process, as I said, I go there early.

I do my standard introduction, which is something like I'm Dr. Powell. They call me to come in sometimes when there's a really challenging decision to make. Not so much about the technical parts of medicine, how much of this or that to give, but what's the right thing to do here? And with these big important questions, sometimes different people really have different ideas.

And I want to know if that's happening here. And particularly I hear, and I'm very worried, that perhaps your choice is being coerced. And she said, "Yes, I am so glad you

came to ask me about that.

That lady doctor is in here all the time trying to get me to take a transfusion. I had to have my husband come in and stand by the bedside all the time so that she would stop doing that." So that was actually very educational all around. I spoke to my colleague who was quite chagrin.

This is a very reflective physician who really was trying to do the right thing. But if you unpack this issue, it's really very complicated. And there are many, many barriers here.

So who are Jehovah's Witnesses? Picture in your mind, do you know somebody who's a Jehovah's Witness? What does Jehovah's Witness look like? Any bold persons? There are largely, there's a faith largely minority, not exclusively. We were much more likely to be African American or another minority if you're Jehovah's Witness, certainly much more than if you are an attending physician. There are some of each.

You're unlikely to be an attending physician, Jehovah's Witness for sure. But there's a lot of complications here. I suspect that the patient's husband, who lived his whole life as a black man, was well aware that just by virtue of being a black man, he appeared intimidating.

I suspect further that he decided, "You're going to see me that way?" And harassed my partner, "I can go there and let me stand by the bedside and play that role. You put me in it anyway, and actually I'm okay with that right now." So there are some really complicated issues going on here about who's harassing who, how we see each other, how we engage and respect. I would say further that there are many women who are profound advocates for women, and there can be some mistaken notions about who needs rescuing.

Is this woman who as an adult has chosen her faith? I think my physician colleague felt, well clearly she needs rescue. I don't think that Mrs. Jones felt that she needed rescue. Clearly what she was saying is, "No, thank you.

I've got it. This is my choice. I need you to respect that." So intending to do right, intending to do the right thing and give and rescue this woman and give her important care, many, many things were trampled inadvertently.

It was complicated, such as, you know, in some ways, "Oh, bioethics is always talking about to who is witness and transfusion. Have we done with that?" It's actually still quite a complicated set of issues that come there. But I think profoundly the patient felt disrespected.

She felt that her religious faith-based choice, which was for her very carefully considered, long-standing, well thought out, was not respected because it was a faith-based choice. And I think that was very hurtful to her. It was not the comfort that she

hoped for, in which we might, with a better understanding, if we were all perfect, perhaps we would have started right with that and provided that for her.

So it was for me a very thought-provoking case. Mostly I've already talked about that. Now I'll give you an opposite kind of a case.

A week or so ago I was teaching the medical students in Einstein, and we did a section on pediatrics and vaccines in the bioethics section. And at the end of the course, we had a long talk about, you know, different policy options, and the students broke into groups like we always do, and each one had to debate, you know, different policy options. And at the end, as two students were leaving, they said to me, you know, I think I would support that policy option where you get a religious exemption for, you know, you don't have to vaccinate your children.

And I said, why is that? And they said, well, I'm very religious, and I really think, you know, religion is so cramped in every other respect in America. I look for places where I can support religious freedom, and I think we should do that. And I was upset.

I was upset. I didn't think they were making the right choice. These are young physicians in training.

I agree. They should support religious freedom. For me, I don't think they should support it there.

I think they're a risk. I think in part this is identity theft. I think that when you have religious exemptions, there are many people who are not part of a religion that says we're uncomfortable with vaccine.

They just say, I don't like vaccines with that autism thing. There's other stuff, which makes, is not part of any faith tradition that I'm aware of. But it's something that makes pretty people uncomfortable.

He's scoot in on a religious exemption. So it's partly I object to the identity theft issue. But I also think appropriately there are limits to parental authority.

Children are not property. And really even within, you know, the most cultures, people agree on this. Parents have a lot of authority, but it's not unlimited.

We have a sort of sliding scale for parental authority. I won't go into that now unless it's really important to you. And people can ask later.

But I think the religious exemptions for vaccines troubles me. And I feel that I understand that people of faith do feel under attack. And I think that's correct in some circumstances.

But I think a specific response is what's called for and is important. I think there is a

resurgence of childhood diseases. I think there are children dying now of measles and other things that can be addressed by vaccine.

Because we have less herd immunity and because there are exemptions to vaccines. I think we have to think about the impact on someone else's child on the immune compromised child. The child with cystic fibrosis.

The child is recovering from cancer. There are a lot of kids who are really susceptible to those diseases that we thought we had in hand that we thought we had eradicated. But that are in fact coming back now within some communities.

I think you also have to consider can you on the basis of your religion put your own child at risk. Can you make that choice? In some ways we limit that in medicine. If there's a standard treatment and your child is gravely ill.

Typically physicians do have the authority to say you cannot refuse on religious or other grounds. If this is something that is a standard treatment, high likelihood of gain. Terrible consequences if we don't do it.

We do limit parental authority there typically. The vaccine your kids not sick when you get that it's a trickier issue but still there is some increase of risk to your child. But it isn't an instantly fatal situation so it's more to remove and that makes it tricky.

But I put before you we want to respect difference in variety. This is what makes us great our diversity. But can we do it with a sort of blunt instrument should we do that everywhere? Is it possible to have some discussion between people of faith and people in medicine people were organizing public health and think about whether or not there can and should be appropriate limits in this respect.

So those religious exemptions are clearly banned in three states including California which has had recently in recent years a great uptick in some infectious childhood diseases. They are really hotly contested and all. So this is a particular issue in public policy that is right at the forefront.

There is a lot of argument on this topic. We think we are on thin ice. We are on thin ice as a nation.

This is an era of unbelievable conflict in our country and this issue of science versus faith is right there. This is where people stop talking. This is where the enmity is.

This is where we have really had a great deal of trouble in figuring out how we can continue to have a real democracy. How we can have political debate that sort of focuses on the problem and not the person. How we can have contested discussions without demonizing people who don't agree with us.

I wish that this group this enthusiastic group would really work hard on that problem and get it fixed shortly because we're really in trouble here. I'm going to wait. Okay.

So, I think it's, I propose an uneasy truce. We will never resolve all of the tensions here. However, I would like to see us really come together and see if we can do better.

I think that could be done carefully with respect and with some sort of respectful focus on if limits must be necessary. I personally think they should be, but I don't know everything. What would be appropriate context and where should limits never be imposed? Where is it wrong to do that? Mrs. Jones should never have had her faith questioned.

I mean, it's fine to say, do you really think that is anybody forcing you, but she should have immediately enjoyed the respect she deserved. So, I'll leave it at that. Religion and medicine should they mix.

As a statistician, by training, my presentation will be filled with a fair bit of data, but I will attempt to critically engage with that data to interpret and work out its implication for these, this question should that religion and medicine mix. I think any reasonable answer to that question needs to take into account the fact that for patients at least religion and medicine do mix. There have been reviews that have indicated that somewhere between 75 and 80% of American patients use religion to cope with illness for probably 35 to 40% of those.

It is the most important factor they use in their coping. Another survey of the general public indicated that about 70% of people say their religious beliefs would guide their medical decisions if they were critically injured. Yet another survey inquired about decision making and assessing the importance of various factors in decision making amongst cancer patients.

Patients listed faith in God as the second most important of these seven factors. Physicians seven out of seven. So patients at the very least are mixing religion and medicine.

The question then becomes, should these conversations take place by whom and what contexts, if so, how should they be approached, should they be encouraged, or should they be discouraged. I think in some context, at least the answers are relatively clear. An end of life care it has for some time been the case that palliative care guidelines are to inquire about religion and spirituality at the end of life as patients approach that these issues become extremely important.

And there is evidence also that when this is done, when spiritual care is provided, when these discussions take place, the experience is almost uniformly positive. This is data from one study conducted here in Boston and essentially the vast majority of nurses,

physicians and patients interacting with either physicians or nurses reported that their conversations on these matters were either moderately positive or very positive. A handful did say there were no effect of these conversations, not one experience was reported to be negative.

In spite of this fact that the guidelines are in place, that these experiences are reported to be at least neutral and often positive, these conversations still infrequently take place in practice. So end of care settings seem like a relatively clear context in which religion and medicine should mix. But there are others that are more difficult, more complicated, more controversial.

One of those, for example, would be are these discussions at all relevant, should they ever take place in, say, an annual physical exam? Why might we ever think this is appropriate? What are the objections to such conversations? And I think the objections are important. Religions are very sensitive topic, perhaps especially so in a clinical context. Clinicians and patients will often have very different religious beliefs, complicating these discussions further.

The ethical issues are complicated. There's potential for abuse of power, proselytization. And clinicians really are not trained to do so.

So the case against is potentially compelling. On the other hand, as we've seen, these issues of religion and spirituality are quite important to patients in coping with illness. Moreover, it may be good for clinicians to have at least some sense as to the patient's religious or spiritual beliefs before illness sets in.

These conversations may be facilitated by some understanding prior to illness taking place. Moreover, over the last two decades, the evidence has become stronger and stronger that participation in religious communities, powerfully shapes health and well-being. There is now evidence from rigorous longitudinal research studies that control for baseline health and social and demographic characteristics that religious service attendance is associated with about a 30% reduction in all cause mortality over 10 years of follow-up.

The same is not the case for just private practices or self-assessed spirituality, but service attendance, participation in religious communities does seem to have these powerful health effects. These are a number of national cohorts, each of which have over 10,000 participants, followed between 6 and 16 years, hazards ratios between 0.6 and 0.8, essentially suggesting a 20% to 40% reduction in all cause mortality. One of these studies that by Hummer Atoll suggested that regular attendance over the life course would be associated with approximately seven years of additional life.

As very helpfully pointed out in an early paper in 1999 by Richard Sloan and Tia Powell, much of the early research in this area was methodologically very weak. And certainly

still today, that is the case as well. What has changed in the last two decades is the number of studies that in fact are rigorous, that meet rigorous epidemiologic standards.

One of the few remaining objections is the possibility of reverse causation. Might it be the case that only those who are healthy are able to attend religious services, but increasingly as the data has gotten better and better and control for baseline health has been possible where we can look at these changes over time. That explanation has essentially almost been ruled out as well.

Perhaps there's some unknown unmeasured factor, maybe conscientious personality might affect both attending services and be associated with longer life. Maybe unmeasured confounding is an issue. About a year ago, I introduced a new measure, a statistical measure to try to address this as well.

The E value. So for example, an E value here of 2.5 would indicate that for an unmeasured variable to explain away these associations, it would have to be associated with both increased likelihood of service attendance by two and a half fold. And decreased mortality by two and a half fold above and beyond everything that's been adjusted for to explain it's way.

It does not seem particularly likely. With regard to observational evidence, the very high standards have now been met. And the same is the case now, 20 years later after that important and very reasonable methodology critique for a number of other outcomes, including the fact that religious service attendance, there is evidence associated that it is associated with lower depression, less suicide, less substance abuse, greater happiness and life satisfaction, more meaning and purpose.

Greater generosity, volunteering, civic engagement and pro-social behavior, less crime, less divorce and greater social support. Not all outcomes pulled up to this more rigorous analysis. I would say the very strongest studies suggest very little association with cardiovascular disease incidents.

Cardiovascular disease survival. Yes, but cardiovascular disease incidents. No.

Likewise to the surprise of some, I would say the very strongest studies suggest very little or no association between the religious service attendance and anxiety. But many of these outcomes, as we've seen, important outcomes to people's lives are positively affected. But is this really relevant? People certainly don't make decisions about religion based on health.

These decisions and commitments really are shaped more by experiences, by upbringing, by values, by truth claims, by evidence, by relationships. And I think it was again very rightly pointed out in a paper of Richard Sloan some two decades ago that the notion of prescribing religious activities on the grounds of these health associations

really is quite, quite ridiculous and unethical, both from religious and secular perspectives. However, for the approximately half of all Americans who do positively identify with a particular set of religious or spiritual beliefs, but do not attend services are not part of a community, it would seem reasonable in those contexts to at least raise this question of community participation as something that can be a meaningful form of community, but also powerfully promotes health and well-being.

One would, of course, want to be very careful about those who have had negative experiences in religious communities, abuse or negative interactions. So how would we really know? Well, some recommendations are to take a brief spiritual history. Many of these recommendations consist of four questions.

That may be too much in the context of modern medicine. The time is so limited. But I think sometimes these questions can be consolidated further.

So consolidating those proposed by Harold Koenig, I think they could perhaps even be reduced to two. First is faith, religion, spirituality, important to you in health and an illness, or has it been important to you at other times in your life? Second, do you have someone to talk to about spiritual matters, or would you like someone to talk to? These questions are very brief. They could be incorporated into a social history.

They're relatively neutral and unoffensive. They can be asked even if the clinician and patient have different beliefs. They can help uncover negative painful past experiences and the offer of a referral to a chaplain or a counselor could be made.

And they can also make clear someone's religious or spiritual identity, and the attendance could be raised or perhaps even encouraged as appropriate. What about atheists or agnostics? Are they somehow at a peculiar disadvantage here? Well, other forms of community could be encouraged for them. The evidence suggests that the effects on health and well-being are not quite as large as they are for a religious community, but they are still substantial and meaningful.

So I think this simple approach of taking a very brief spiritual history, if there have been negative experiences, at least offering referral, if someone does positively identify with a religious tradition, encouraging community participation. If not encouraging other forms of community participation, I think that simple approach can help address a number of the objections. The religion is too sensitive in the clinical context.

It is sensitive, and that needs to be acknowledged, but these questions again are relatively neutral. Clinicians and patients have very different religious and spiritual beliefs. That is also important, but again, these questions can be posed even if that's so.

The ethical issues are complicated. There are issues of abuse of power, proselytization. I think this is a serious concern in this setting.

I think appropriate training does need to take place. Of course, unfortunately, clinicians really are not trained to do so. Most medical schools now do offer an elective on religion, spirituality, and medicine, but the vast majority of medical students do not take those electives.

And my own view, perhaps the way forward would be to have a brief, maybe one or two lecture required module on how to take a spiritual history and respond appropriately. That might solve this issue of lack of training and also could help deal with at least some of the difficult ethical issues. Again, in favor of having such conversations, even in an annual physical exam, we've already discussed the importance of religion and spirituality in patients' lives.

And we've seen also and discussed the powerful, profound effects participation in religious community can have on health and well-being. We might also turn the question around, given the strength of the evidence relating religious community, religious service attendance to health and well-being. Are we doing harm if this information is withheld? Thank you.

So thanks very much for the organizers, just to Baratoste and I can't list the rest too many to name. I have a lot of ground to cover, but fortunately I'm from New York and I talk very fast. So the context for this presentation is the role that religion plays in the United States.

From a recent Pew Research Center poll, these are the numbers of people who attend church more than once a week in European countries. This is the number in the United States. The United States is a very different place with respect to religion.

You see it everywhere in popular newspapers, magazines, websites, it's everywhere, even with Mematos. And it is expressed in the popular media as far as the interventions can prayer really heal. A book by Dale Matthews published some 10 or so years ago.

Another book by Harold Koenig. All of these popular treatments of religion and medicine suggest that there is a beneficial effect of religion on medical outcomes. And it penetrates academic medicine as well as you know from this program.

This is North Dakota, Duke, George Washington University, here at Harvard, and it finds its way into clinical practice. Doctors recommending a dose of God for their patients. Does it belong in the clinical room in the clinical practice? Doctors recommending a dose of God, you see it everywhere.

So why has this been happening over the past 20 years, some years? There are a number of reasons I want to just touch on three very briefly. One is over the past more than 20 years, there's been a rise in irrationalism, especially in the United States, but elsewhere. As epitomized by this classic work by Dr. Doreen Virtue, which he has a

doctorate in, I have no idea.

But I don't know if you can read the, how to heal the mind and body with the help of angels. This is a sequel to how to heal the mind and body with the help of fairies and with the help of spirits, and she's got a book on all of them. Much of this is dealt with very in a wonderful tongue and cheek way by social commentator Wendy Kaminer, who wrote this great book 20 years ago called Sleeping with Extra Terrestrials.

I actually talked about this book when I gave book talks on my own. I was in San Francisco giving a talk and I cited this book and afterwards somebody came up to me and said, oh, I'll tell you what I want you to know, I'm an extraterrestrial. So as I was looking for the exit, he said, I'm Wendy Kaminer's husband.

So he was sleeping with an extraterrestrial. And another reason why this has arisen is because of the role of advocacy foundations, the John Templeton Foundation, the most significant funder of research in religion and medicine. Templeton has more recently emphasized other things, but Templeton, I think, was responsible for the rise of interest in religion and medicine and the development of some of the worst research ever published.

The physicist and Nobel Prize winner Stephen Weinberg referred to the Templeton Foundation as a hideous and evil organization and I think that was an accurate characteristic of them then, maybe not so now. And another reason is that there's a widespread dissatisfaction with contemporary technological medicine, an article in the New York Times some time ago, talking about a degrading shift from person to patient as you enter the medical realm. So what's at stake? What's at stake is, at least in the view of some of the proponents, a transformation of American medicine.

Dale Matthews and David Larson 20 years ago wrote that they want to tear down the wall of separation between religion and medicine. And Matthews wrote also that the future of medicine is going to be prayer and prozac. That's what's at stake.

And Christina Puhalski, who's been cited before, recommends a spiritual history at every new patient visit and annually thereafter. So, like so many things, HL Lincoln had something wise to say, even if it was 20 years beforehand, for every complex problem, there's a solution that's simple, neat and wrong. Nobody disputes that for many patients religion and spirituality bring comfort in times of distress, whether it's medically related or otherwise.

Nobody disputes that. The question is whether physicians have anything to add to that. That's a different question.

So, I want to address four different issues very quickly. One is, does the effort to link religion and medicine represent good science? This is Harold Koenig's handbook of

religion and medicine, religion and health, in which he claims that there are 1200 studies of religion and health with the vast majority showing a positive association. Well, where does that 1200 number come from? We decided to look at just one area, the chapters on heart disease and hypertension, in which 89 studies are cited.

So, you would think if the vast majority are associated with beneficial health outcomes, you would see that. Well, what are these 89 studies? In the first place, 33 of them were about denominational differences in religion and health. So, Jews versus Christians, Lutherans versus Episcopalians.

That's about religion and medicine has nothing to do with benefits from religious devotion. 11 were reviews of other studies. 3 were only abstract, so it's impossible to review them.

And 8 by the standards of the book showed no association whatsoever. So, that leaves 34 out of the 89. So, how good are these 34? Do they support claims of a benefit? Well, there are a number of significant problems that have already been discussed, and so I don't really need to review them.

I want to give you a couple of examples, though. This is one of the studies that is legitimately about the effects of religion on health that is cited in these chapters. It's about a church-based weight loss program for blood pressure control.

It's a weight loss program. It was held in a church. Does that make it a religious program? It's held here.

Would it be a baseball-related program? Its venue is completely immaterial. It's a standard behavioral weight loss program. But by the standards of this book, that's a positive study.

Here's another one. Buddhist meditation, the effect of Buddhist meditation on a variety of biomedical outcomes. One of the things that you always learn in graduate schools, never trust secondary sources.

Go to the original sources. This is a second. Some of the endorses that.

Maybe the only thing I say that's true. [laughter] So here's what the handbook says about this study. Fifty-two male college students were taught Buddhist meditation, thirty control students.

Meditation subjects had lower blood pressure at follow-up. Seems promising. Until you read the paper.

Turns out that the meditation students were self-selected, volunteering to be cloistered with monks for two months during their summer vacation while the control subjects were

working at McDonald's. If we put them here instead of a cloister, they probably have lower blood pressure too. So the best in the literature, and I think Dr. Vanderwheel said it well, the best studies are those that look at the relationship between church attendance or religious attendance and mortality.

And although he's very modest about it, this study in which he was the principal investigator is in my estimation the most definitive study demonstrating that there is a relationship between attendance at religious services and mortality. Very large study, very well conducted. The question is, what does it mean to attend religious services? And how accurate are measures of religious services? I don't want to get into the second question.

But the first question is best addressed by this quote from Garrison Keeler. Anyone who thinks that sitting at a church makes you a Christian must think that sitting in a garage makes you a car. People go to church and religious services for a whole variety of reasons, some of which may be religious devotion, but they may be others too.

Family history, what to do on Sunday morning, you like the cookies. So the evidence overall about connections between religious, between religion and health is at best weak and inconsistent. Is it good medicine? One of the significant issues also anticipated in previous talks is the length of the typical office visit.

This is disappeared from the slide. This, how much time do physicians actually spend with patients? This is from JAMA Internal Medicine now 10 years ago. 2.6 billion primary care patient visits in the US between 1997 and 2005.

Average time, 15 minutes. So if you're going to conduct a spiritual history and you're going to ask these questions or even a shortened version, what aren't you going to talk about? Are you not going to talk about diet? Are you not going to talk about exercise? Are you not going to talk about smoking because you've only got 15 minutes. And then there are some significant ethical issues, three significant ones.

Manipulation, coercion, privacy and causing harm. Manipulation is, well, one of the big ones. So this is from Koenig's faith, healing power of faith.

He asks, as a physician asking the reader, if you're not religious, consider attending a church or a synagogue as a visitor. Try reading religious sculpture, try to emulate the work of a truly religious person. And if that's not bad enough, here's what he recommends to those who are already religious.

Go more often, get up 30 minutes earlier and spend that time in prayer. Go to a religious scripture study group. Here is in 2002, Koenig published this case study of an elderly woman who coped with her chronic pain by strong religious belief.

And he says to her, keep it up. So here's a thought experiment. What if we change the

setting slightly? What if we change the case? Not no longer an elderly woman, but a young woman with Crohn's disease who copes by gossiping with her friends.

Does Koenig say keep it up? What about a young man with rheumatoid arthritis who copes by watching pornographic videos? Does Koenig say, no pun intended, keep it up? What about a middle-aged man undergoing chemotherapy who copes by attending meetings of Aryan nations or white supremacist groups? Is Koenig going to say keep it up? And the answer almost certainly is no. He's not going to say keep it up in any of those cases. He's only going to say keep it up in the case of religion because he favors that as an intervention.

This was us from CBS Sunday morning about ten years ago, and it's spot on about cohort. It's Sunday morning. And let's get a grasp ready too, please.

When Dr. Jordan Stoll goes into surgery, he's got the best tools man can devise at his fingertips. But he calls out for one more bit of hell-great physician, and it's pretty joy to see all we do here today, and pray for your wisdom and guidance and strength. Dr. Stoll prays with his patients.

Prays with the surgery goes smoothly without application. Now, where is he praying with his patients? Is he praying at an outpatient visit, an initial concern with the Board of Prayer? Okay. We haven't thought of becoming free today.

We just thank you for others who you do and have in concern for our well-being. Is this Colorado? Does he pray in the office? No. Does he pray when they come in for presurgical testing? No.

Where does he pray with him? When they're gowned and supine and sedated on the gurney. And he says, mind if we say a prayer, he's practically got a scalpel to their throat. And he says, mind if we say a prayer, Richard Dawkins would not say, yeah, I mind.

Hospital, we're a church that is praying to those who see all the way here today. The pulpit would be in pre-ops. That's where Dr. Jordan Stoll, an orthopedic surgeon, is praying with Peggy Martin.

He's about to operate on her shoulder. I pray for your protection over Peggy as well as Doug during the surgery. The time before surgery is just to try to pick the patient of these to see if they have any last minute questions.

And that's really when I offer to pray with them. I'm making up my pray to the fores her if that's okay with you. That's fine.

That's okay with you. [laughter] Dr. Stoll, I'll just continue. And then he goes on to say, well, I want to pray to Jesus.

Well, what if you're Jewish? What if you're Muslim? coercion is a huge issue, privacy. There are all sorts of characteristics of our lives that relate to medical outcomes. But we regard them as personal and private and out of bounds for medicine, even though they may be related to health.

marital status is one classic example. Although the literature goes back and forth, the evidence either suggests that marital status is associated with reduced mortality for men and women or only for men. And it depends upon a variety of circumstances.

Now, the cynics among you will say, it only seems like you live longer if you're married. [laughter] But we don't expect the position to say, well, Bob, this is your annual visit. You really need to lose some weight.

Next year, I'd like to see you lose 10 pounds. And you've just got to start getting exercise. You can't continue to live this sedentary lifestyle.

And by the way, I just read some interesting literature on the health benefits of marital status showing that people who are married live longer. So I think between now and next year, I'd like to see you get married. And the same is true with early childbearing.

Another problem actually causing harm. The first study I ever did involved interviewing young women who are awaiting the results of gynecologic biopsy to determine if they had cervical cancer. And the patient I was interviewing was in a semi-private room separated from the other patient by also awaiting her biopsy results separated by a curtain.

And while I was with my patient, the biopsy results came back for the other patient who was with her family. And the results were negative. And her father exclaimed, "to nobody in particular, we're good people.

We deserve this." Now, that's a perfectly reasonable thing for the father of a potentially gravely young woman to say. What was the patient I was interviewing supposed to say when her biopsy came back positive? Was she supposed to say, "I'm a bad person. That's why I got cervical cancer.

I've been insufficiently faithful, insufficiently devout. It's bad enough to be sick, worse still to be gravely ill. But to add to that, the burden of guilt or remorse over some supposed failure of devotion is simply unconscionable." So is it good religion? One of the great dangers is the possibility of actually trivializing the religious experience.

You ought to be careful what you wish for by recommending religion in the context of medicine. Is engaging in religious activities like taking an antibiotic or going on a low fat diet? This is a book written by a radiologist at Penn and a colleague called "Why God Won't Go Away." Why? Because of data like this, brain scan data showing that there are changes in the brain that are associated with meditation. Andrew Newberg, who is the

radiologist, then asks rhetorically, but it's not much of a rhetorical question, is this a photograph of God? He actually asks that.

If you're a deeply religious person, this is the sin of false idolatry. And it should be really offensive. And finally, is it really a problem? This has been raised before, but this was in yesterday's New York Times, an outbreak of measles in the areas outside of New York City where ultra-orthodox Jewish communities absorb vaccination.

The ratio is low as 60% compared to the rest of the state, 93%. This is a wonderful study by one of the most thoughtful researchers in this area, Far Curling, who's at the University of Chicago, an evangelical physician who is an extremely thoughtful ethicist who studied, I can't remember the sample size, but he determined that 14% of the survey was about what should physicians do about perfectly legal but challenging medical procedures like terminal sedation or abortion. 14% of physicians said that they believe that their personal beliefs override the concerns of their patients.

And more over 29% of them would not refer to somebody because of their own religious beliefs. So is it good science? No. Is it good medicine? Largely no.

Is it good religion? No. And is it really a problem? The answer is yes. So to conclude, as I said earlier, nobody disputes that religion is important to people in times of distress, whether it's related to medicine or other matters.

Nobody disputes that. The question is whether physicians can add anything to that, and I think the answer is largely no. Thanks.

[applause] I have that uncomfortable position of going last, which means that I have to edit my remarks on the fly, so as not to bore you with redundancies. Have you guys heard the one about wine at the wedding? You know, you give the guests the really good wine first. So you've heard the really good stuff, okay? And now you're stuck with me, the bad cheap wine.

So here we go. [laughter] I'm speaking to you tonight as a primary care doctor. And you know, for those of you who are in medicine or medical school or medical doctors, you know that primary care does not rank high in most people's esteem.

Still, if you're thinking about it, come talk to me because I'd love to persuade you to go into it. But it does give me tonight the unique perspective of actually being able to speak as someone who takes care of patients. And I spend lots of 15-minute office visits trying to figure out my patients as best as I can, as quickly as possible, so that I can take care of them well over the long term.

One piece that sort of hasn't come up yet tonight is exactly what makes primary care so special, which is that ongoing relationship between doctor and patient. So the spiritual history for better or for worse or any history for that matter does not have to be solved in

one 15-minute office visit, but can be worked out over time as the relationship between doctor and patient, or for the APRN's physician's assistance in the room, the clinician and the patient, those relationships are worked out over time. So that's sort of my preamble.

I would say that, well, let me just do this. I'm going to just skip some of the preamble and move on. I was strongly persuaded to put together slides so you'll see how simple they are.

I'm going to cover three questions tonight. First, whose religion are we talking about? I mean, when we talk about the problem of medicine and religion, whose religion is it that we're actually worried about tonight? Second question is, so what if I don't know anything about religion? What am I supposed to say to my patients? And then here's the third question. Now, the third question, Richard, I had difficulty framing, so I took it from your book.

And this is a direct quotation. It's one of the chapters from Richard's book. And here is it, is there really a demand for bringing religion into medicine? All right, so let's dive in.

This is as fancy as my slides get. No, nothing else. Okay, so first, whose religion are we concerned about tonight? And Tyler and Richard actually both touched on this, but I'm going to just flush it out a little bit as a primary care doctor.

So if we are worried about the doctor imposing her religious beliefs on her patient, then I do believe that there is a cause for concern. I take the view that the role of the doctor is not to evangelize or seek to convert her patient. No matter how much she understands her own religious beliefs to be truth.

Okay, the power to potential, I believe in the doctor-patient relationship is just too great and that that should not be the business of leveraging that unique position to make converts. And here you can just think, Constantine, and that's sort of what I'm thinking about. In fact, for those of you who are here tonight in all of the various rooms where you are, who understand part of your life's great commission to be converting the lost, I would submit to you that a powerful God does not need you to spend your 15-minute office visit on such a task.

In fact, I'm pretty sure that an omnipotent God could get along just fine without it. So the one caveat here actually would be the religious healthcare setting and the video you showed Richard was actually of an Adventist hospital. And I don't know what the implications are for that on what the patients would expect when they go to the Adventist hospital.

Maybe they would expect a certain amount of prayer. I would just say that if it's a religious institution, by all means, I think that the religious, the rituals and practices that are part of healing in that religion should certainly be incorporated into healthcare. But

still on my first question, if we are worried about religion in general and the space between doctor and patient, then I believe we do our patients a grave disservice by ignoring or seeking to sidestep their religious beliefs.

Even further, as a medical ethicist, I would say it is unethical to ignore the impact of religion on our individual patients. So for medical students in the room, even if we boil all of ethical theory down to those four principles, which you all learn every first year medical student does, beneficence, doing good, non-molephicence, not doing harm, justice and respect for patient autonomy, even if we said that's all there is to ethics, but it's not. There's so much more.

Then ignoring the impact of religion on our patients' lives fails at everything that we sort of espouse as ethical practice of medicine. Ignoring religion means we fail to recognize the full humanity of our patients, which results in harm, inequitable treatments, and a disregard for patient preferences. It means we fail at beneficence, non-molephicence, justice and respect for autonomy.

I'm going to give you some real world examples. Because I grew up in a Judeo-Christian context in the Midwest, where there were very, very few Muslims, I'm going to talk to you about my experience of sort of learning about Islam through my patients. So among my Muslim patients, I've learned over the last 13 years of practicing medicine that it is critical for me to understand how their religious beliefs affect their interaction with healthcare professionals.

So just off the top of my head when I was putting these remarks together, I thought of many ways that this has come up. And a lot of times it's come up sort of on the go, sort of at the last minute as I was trying to figure things out with them. So for example, comfort with mammography.

Many Muslim women are not comfortable with mammography at all. And then there's the question of, well, will my mammogram technician be a man or a woman? Okay. And then if I'm a female doctor taking care of a female patient, would she be willing to see one of my male colleagues if I were not available? Would her spouse be willing to see me? Would she be willing to remove her hijab or headscarf, even if she wears one or if she doesn't wear one, right? Then is she even someone who would wear one? And at what point does one remove that? Is it okay for me to shake her husband's hand if it's during Ramadan? No, right? And so, but all of this varies by patient.

Is it okay for me to invoke God as part of the healing process? Is there a place for that if this is something that she's expressed to me? And can I schedule my office visits around standard prayer times? These are all questions that I've sort of had to learn and figure out with many of my patients over the last years. Now, on some level, these questions aren't necessarily unique to Islam. And there are variations of these questions among all of the religions.

And then certainly some of this is cultural, right? But all of this is part of what it means for me to figure out an individual patient and how to care for her or him well. So, what does this always say? Okay, there we go. I get confused with this presenter view.

Okay, so now, second question. What if I don't know anything about religion? And I'm going to speed through this because we touched on it. But I'm going to just make this point to you.

It doesn't matter if you have zero knowledge about religion. In medicine, we are trained to ask about things for which we have no knowledge. When we ask our patients to open-ended questions, we are trying to understand what hurts and what helps, what makes it better, what makes it worse.

And since religion can both help and hurt, as we've heard already, it is critical to know whether and how religion is a factor. I was thinking, as I was preparing this, about the whole PQRST mnemonic. Do you med students still learn that? About pain, asking patients about, "Okay, good, I got some nods," right? So this PQRST, you know, P for palliate or provoke, what makes your pain go away, what provokes it? We have these sort of tricks that we've used to ask patients about things for which we have no knowledge.

And both Tyler and Richard actually have touched on different ways to ask about this. I sort of use a who, what, when, where, how, who do you worship, what do you worship, with whom do you worship, what is your community like, et cetera. Sort of basic questions, the sort of typical interview questions so that you could get a sense of what religion means for your patient.

And I would just clarify that inquiring after a patient's belief system in order to care better for patients does not imply, and I think this is really important. It does not imply that the doctor or other healthcare professional take on that role of clergy person, right? Just because you're asking about religion doesn't mean you're becoming the priest, okay? So, so think about this example. My patient may tell me that the best thing for his health is going to the gym.

And while I can encourage him to exercise, I'm not about to become his personal trainer, right? That's not the role for the physician, but we encourage things that bring about better health for our patients. All right. So, ask.

Third question. Is there really a demand for bringing religion into medicine? This is Richard's question. Is there really a demand for bringing religion into medicine? Why all the fuss anyway? And actually, we were talking about over dinner, you know, there's, I don't know, a thousand of you here tonight, not all in this room.

It's a holiday weekend and it's a Friday night. What are we doing? Right? I mean, think

about it, but we're all here. Here's my response.

Is there a demand? There is no way not to bring religion into medicine. And if we take a standard definition of religion as, and this is a pretty typical generic, you know, Google definition definition of religion as a particular system of faith and worship that brings coherence to a particular community, then we've all got religion, okay? We have all got frameworks, at least most of us, for making sense of the world and establishing our objects of devotion. And I would submit to you even the atheist.

So let me, let me give you an example. I know you're starting to get nervous. So recently I had dinner with a group of my colleagues, and these are colleagues I work with every day.

We don't hang out. And we certainly, we certainly don't typically dine together, but there we were. We suddenly found ourselves on the occasion of someone's departure, sitting around a dining table at one of New Haven's fine restaurants.

And what did we talk about? It's a little awkward, but we talked about our religion. That's right. We talked about our holy scripture, the New York Times.

Do you guys read that in Boston? Okay, all right, a couple people do. All right. We discussed our shared beliefs and our common morality as articulated by the editorial board of the New York Times.

We discussed our faith in human progress and our worship of career. Here we were, a particular community of people with a particular system of faith and worship. Now, perhaps this is a bit unfair, a bit too tongue-in-cheek.

So let me give one more example from the world of biomedicine. Our faith in randomized controlled clinical trials. We love our data.

We believe in it. And dare I say, we put our faith in it and allow it to dictate our shared belief system and common practices. And listen, I practice evidence-based medicine, so I believe it too.

Okay, so I'm not trying to debunk it necessarily. But then someone like Dr. John Ianides comes along. You guys know this guy from Stanford, who you should look them up if you don't.

He is a physician researcher based at Stanford, and he came out in 2005 and published a very famous article that has gotten a ton of press called, sorry, Tyler. Why most published research findings are false. And Dr. Ianides has made an entire career over debunking our holy scriptures of medical science.

So my point here is that before we dismiss religion too quickly in the practice of

medicine, it's worth considering how all of us believe in something and those beliefs affect how we understand health and illness. If this is true, and I think it is, then there's no way clinicians can avoid asking their patients about particular systems of belief and worship. If we accept the fact that we all believe something, then perhaps the better question is, when it comes to making sense of the world, which story do we find the most compelling? Thanks.

If you like this and you want to hear more, like, share, review, and subscribe to this podcast. And from all of us here at the Veritas Forum, thank you.

(gentle music)