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JOURNAL DISCUSSION

Coping with Religious Coping

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Phelps AC, Maciejewski PK, Nilsson M, et al. Religious coping and use of intensive life-prolonging care near death in patients with advanced cancer. *JAMA*. 2009;301(11):1140-1147.

The Coping with Cancer Study was a multisite study based in the Dana Farber Institute's Center for Psycho-oncology and Palliative Care Research and designed to examine the relationships between psychosocial factors and end-of-life care [1, 2]. Andrea C. Phelps and colleagues used a subset of the data from this study to explore whether a statistical correlation could be found between patients' religious coping styles and the administration of intensive medical treatment during the last week of their lives. In short, Phelps et al. concluded that those patients who reported using positive religious coping methods on a survey instrument were significantly more likely than others to have undergone invasive life support at the end of their lives and to have died in intensive care units.

Readers or clinicians who wish to apply this finding to medical practice face the tasks of understanding the meaning of the prospective patients' coping styles and the significance of the outcomes being measured and then inferring why these two artifacts should be connected. In this discussion of Phelps' study, I seek this type of understanding with the goal of identifying the value that this article might have for those in graduate and postgraduate medical education.

Religious Coping

The instrument used by Phelps et al. to identify patients who relied on religious coping methods is known as the Brief RCOPE. Pargament et al., who reported on the development and validation of this tool in 2000, designed RCOPE because "coping theory represents one promising perspective from which to understand, study, and work with religious issues" in research and practice related to counseling [3]. Pargament et al. explicitly focused on the functional role of religion (especially Christian religion) in dealing with life stressors, and it is for this reason that they directed their attention to religious *coping* as opposed to religious practice, religious morality, or religious experience.

For the purposes of RCOPE, its designers narrowed the meaning of religion to religious coping. As psychology researchers, they view humans as discrete individuals who function either successfully or unsuccessfully within society; it is because of this perspective that Pargament et al. are able to make normative claims

that some religious coping is positive and some is negative [4]. For these authors, then, the question is not only how religious coping functions in the lives of people undergoing life stressors, but also how religious coping helps or hinders functioning in society [4].

But Pargament et al. are not just interested in clinical psychology; they are interested in psychological research. Although psychology has strong theoretical and empirical traditions, empiricism has come to dominate modern research. For this reason, even researchers interested in developing a theoretically based model for religious coping look for empirical evidence as the most acceptable way to pursue that endeavor. Hence, RCOPE was designed specifically to facilitate the quantitative measurement of the use of religious coping techniques among large groups of individuals.

RCOPE does not allow us to understand religious morality because it focuses on religious coping; it does not allow us to understand the ways communities experience religion because it focuses on individuals and their functioning, and it does not allow us to understand the rich and complex ways that religion affects human flourishing because it attends only to elements that can be quantified. RCOPE is not designed to serve such grand purposes, but by using such a narrow conceptualization, researchers inadvertently create the impression that we are “dealing with religion” [4]. The religious elements of the body, mind, and soul of actual humans who face a terminal disease cannot be packaged so easily.

What, then, can we say of those patients with cancer who enrolled in the Coping with Cancer Study and were categorized through a brief version of RCOPE as employing “positive religious coping methods?” Certainly, they are people who explicitly identify God as playing a role in the way they deal with their diagnosis. From this we can infer that, in general, these are persons who use God language in talking about their experience in the world, including their understanding of morality. But the method employed does not allow us to understand what religion means for each of the 178 persons who were identified by RCOPE as using high levels of positive religious coping methods. In a quantitative study of this type, attaining such understanding would be neither practical nor desired.

Use of Intensive Medical Treatment

Phelps et al. chose intensive, life-prolonging care—defined as receipt of ventilator resuscitation during the last week of life—as their primary outcome. (They also looked at hospice enrollment as a secondary outcome, but I will not address the authors’ discussion of this outcome.) Unlike the categorization of religious coping methods, ventilator resuscitation during the last week of life is an empirical and quantifiable outcome. What is less straightforward, however, is whether this outcome is viewed as desirable or undesirable. The authors state only that, “Because aggressive end-of-life cancer care has been associated with poor quality of death and caregiver bereavement adjustment, intensive end-of-life care might represent a negative outcome for religious copers” [5]. Since both “quality of death” and “caregiver bereavement adjustment” are based on retrospective recall by caregivers

for those who have recently died, we can infer that the authors believe that intensive end-of-life care is desirable or undesirable only insofar as family members (perhaps as surrogates for the deceased patient) perceive that care to have been a positive or negative experience [4].

What is the Connection?

Building from these understandings of religious coping and intensive medical treatment at the end of life, we can begin to fill in the gaps as to why these two variables might show statistical association. The authors are interested in this connection and control for several potential confounders in their statistical model—among them patient preference for heroic measures, patient acknowledgement of having a terminal illness, the assignment of a health care proxy, and the use of nonreligious coping mechanisms—in order to isolate religious coping as a causative factor. After controlling for these variables, the association between religious coping and intensive treatment remained. The authors acknowledge, however, that they are unable to discern between the effects of religious coping and other elements of religiosity, including belief in healing miracles, belief that only God knows when a person will die, and “religiously informed moral positions” [6].

In fact, scientific inquiry of this type can never prove a theory of causation, but can only fail to disprove it and thus increase our confidence that the theory is correct [7]. For this reason, we should not expect this study to provide evidence of direct causation between religious coping and intensive medical treatment at the end of life. We should, however, expect the authors to provide cogent hypotheses for a causative relationship. Instead, theories they offer present religious coping as a marker for some other religious characteristic—e.g., religious copers may decide to undergo therapies with high risks and uncertain benefits because they trust that God could heal them through the proposed treatment, or “high rates of intensive end-of-life care...may be attributable to religiously informed moral positions that place high value on prolonging life” [5]. In the end, they propose further research in order “to determine the mechanisms by which religious coping might influence end-of-life care preferences, decision making, and ultimate care outcomes” [6].

If we cannot establish a direct connection between positive religious coping and intensive medical treatment at the end of life through either empirical or theoretical means, then we must theorize an indirect connection. Such a theory might take the following form: affirmation of the role of God in coping with a terminal illness is a marker for belief in God. Those who believe in God are more likely to express a set of preferences, expectations, or moral stances that would result in explicit or implicit requests for intensive medical treatment even in the face of a lethal illness. In general, physicians are reticent to withhold intensive treatment against patient preferences. Therefore, patients who affirm positive religious coping methods are more likely to receive intensive life-prolonging care near the end of life.

Significance for Practice

Unfortunately, the above conclusions create a dilemma for medical practice. The authors imply that the administration of intensive treatment near the end of life may lead to patient and family experiences that, in retrospect, will be undesirable to those involved. On the other hand, physicians frequently administer intensive medical intervention to those who prospectively prefer such treatments for religious reasons. As a result, it is likely that, on occasion, physicians respond to patient preferences by providing interventions that are not supported by medical indications and that families will later recognize as harmful. How can we as medical providers respond to such a paradox?

One approach is to step back from a focus on survey instruments that allow us to generate aggregate data about religion and end-of-life care. There are many types of expertise and knowledge, and in this case providing care to a terminally ill patient requires understanding of a specific human and his or her needs. This understanding cannot be found in empirical study results; it can only be found at the bedside. And learning how to obtain this understanding cannot be found in a textbook on evidence-based medicine; it can only be learned by observing our mentors, talking with one another and our loved ones, and by listening to our patients. I do not disagree with Phelps and her collaborators that chaplains and mental health providers should be involved in the care of the terminally ill. But I also believe that the most important part of our role as caregivers should not be delegated. We should develop comfort and confidence in discussing religious beliefs and experiences with patients, propose only reasonable interventions that are medically indicated, and provide our presence even when we don't need to perform a procedure.

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