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Religious Coping and Life-Prolonging Care

To the Editor: The study on religious coping and use of intensive life-prolonging care near death in patients with advanced cancer by Dr Phelps and colleagues¹ showed that positive religious coping was associated with receipt of intensive life-prolonging medical care near death. The instrument used to measure positive religious coping, the Brief RCOPE,² presupposes an image of God as someone who personally interacts with people. However, empirical research in several countries outside the United States indicates that many people have a nonpersonal image of God.^{3,4}

Adherence to a nonpersonal image of God could result in a very different coping style, with more acceptance at the end of life and without life-prolonging medical care. Therefore, when discussing prognosis and treatment options with terminally ill patients, clinicians should not just examine whether patients adhere to a positive religious coping style but should explore their religious beliefs and values in a more balanced way. Because many clinicians feel uncomfortable discussing religious and spiritual issues at the end of life,⁵ well-developed training programs for clinicians are needed.

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To the Editor: In the study of the association between religious coping and receipt of mechanical ventilation by Dr Phelps and colleagues,¹ I take issue with how the end-of-life goals of care were framed. "Preferences for heroics" and "do everything possible," as used in this study, are terms

that are strongly discouraged in the communication training laboratory in which I work. These are value-loaded medical metaphors that are prone to misperception. A physician may understand that they refer to futile end-of-life treatment or cardiopulmonary resuscitation, but a patient may not have this shared perspective.

Patients may interpret the opposite of "heroic" as cowardly, and the opposite of "doing everything" as "doing nothing." Would patients prefer a physician who uses heroic measures or cowardly measures? Would patients prefer a physician who is willing to do everything for them or a physician who only goes halfway on their behalf?

I am concerned that the wording of preferences for end-of-life care may have led to confusion. It does not appear that there was any way of checking whether patients actually understood the goals of care categories as they were explained.

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1. 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.

In Reply: Dr van Laarhoven and colleagues note that the association we reported between positive religious coping and receipt of intensive life-prolonging care may not be generalizable to non-Christian populations. It is true that many items in the RCOPE¹ and Brief RCOPE² questionnaires presuppose faith in a relational God (eg, "I tried to see how God might be trying to strengthen me in this situation."). It is also correct that these surveys were validated among predominantly Christian patient samples. Because only 11.6% of participants in the Coping with Cancer study did not endorse a Christian religious affiliation, the Brief RCOPE was a well-suited measurement of religious coping in this sample. We agree that patients who adhere to nonpersonal views of God may have differing attitudes toward death and end-of-life care.

The letter from van Laarhoven et al also highlights the need for a fuller understanding of how religion or spirituality influences end-of-life medical decision making beyond the purview of positive religious coping. Religiousness per se is also significantly associated with wanting all measures to extend life.³ Additionally, belief in miracle healing is a related construct that has also been associated with preference for aggressive care.⁴ Quantitative and qualitative research is needed to assess how other domains of religion and spirituality (eg, religious beliefs and values, attainment of spiritual peace) might influence end-of-life decision making and health care outcomes.

Although we share Dr Levin's concerns about discussing "heroic measures" with terminally ill patients,⁵ he seems to have misunderstood our research methods and study aims.

Patients were asked, "Would you want the doctors here to do everything possible to keep you alive even if you were going to die in a few days anyway?" The word "heroics" was not mentioned to patients.

We do not consider this question to be confusing or difficult for patients to understand. The questions were administered in an interview format by raters trained to clarify terms in a standard and sensitive way. The validity of this particular question is supported by its significant positive associations with preference for other end-of-life care that focuses on quantity of life over quality of life, lower rates of advance care planning, and receipt of intensive life-prolonging care. Given recent attention to the ethics and legality of providing futile care, this question may prove useful in investigating determinants of patient and caregiver requests for futile treatments.⁶

We should emphasize that the Coping with Cancer study was not an intervention study that examined the effects of certain communication strategies on end-of-life outcomes. Coping with Cancer was an observational study of the associations of ethnicity, psychosocial, and religious factors with treatment preferences and end-of-life care. The wording of a treatment preferences question has little bearing on our main result: religious coping, taking into account confounding influences of preference for aggressive care, predicts receipt of intensive life-prolonging care.

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Diagnostic Errors and Patient Safety

To the Editor: In their Commentary on diagnostic errors and patient safety, Drs Newman-Toker and Pronovost¹ underemphasized the importance of physicians' diagnostic competencies—and the potential role of board certification in assessing and promoting them—in decreasing harm from

diagnostic errors. While we share the authors' enthusiasm for new systems such as checklists and computerized clinical decision support, for the foreseeable future (at least until computers replace clinicians' brains as the primary engines of diagnostic reasoning) diagnostic accuracy will continue to hinge, in large part, on individual physicians' knowledge and skills.

To minimize the probability of diagnostic error, physicians must be competent in areas such as medical interviewing, physical examination, data analysis, and clinical judgment. Although computers can enhance human performance in these areas (such as by suggesting lists of possible diagnoses or providing test characteristics such as positive predictive value), they cannot substitute for substantial gaps in foundational knowledge and clinical reasoning.^{2,3} It is likely that most patients would prefer being diagnosed by a physician highly skilled in the art and science of diagnosis rather than one with mediocre skills working in a health care system with strong computerized decision support.

For now, the process of board certification remains the most robust measure of physicians' competence in these critical areas.⁴ Enhancing the system of board certification can include creating more realistic scenarios through simulation and other modern gaming techniques, building assessment tools that permit the use of online data gathering and decision support, providing more frequent assessments (under maintenance of certification programs) coupled with meaningful feedback, and ensuring that all physicians participate in the certification process. Promoting and improving the process of board certification should be high on the agenda of those arguing for "systems solutions" to the long-neglected problem of diagnostic errors.

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To the Editor: In their Commentary on diagnostic errors in medicine, Drs Newman-Toker and Pronovost¹ highlighted the relative absence of diagnostic error conversa-