Better Together: A Critical Survey of Conceptions of Religious Literacy, and Analysis of Their Implications for Application to Healthcare Settings in the United States

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Abstract

Healthcare and religion are deeply intertwined facets of human experience. Each has existed as long as the other in human history, and influences between them are accordingly protean. This is true globally and especially in the United States, which is one of the most religiously diverse industrialized nations but, ironically, also one plagued by religious illiteracy. This thesis will argue that United States healthcare settings are particularly treacherous areas regarding the lack of religious literacy. Although recent decades have witnessed an increased awareness among scholars and some healthcare providers of the importance of religion/spirituality for patients in these settings, the ability of healthcare providers to incorporate religion/spirituality in the care of their patients is lacking, due in large part to a lack of religious literacy. This thesis will examine how work in this area has been limited by a lack of agreement on how to define religious literacy, by several barriers to the religiously literate provision of spiritual care, and by the lack of a quantitative instrument with which to measure religious literacy. Reviewing four prominent notions of religious literacy – based on 1) knowledge, 2) understanding, 3) faith, and 4) practice – this thesis will further argue that an understanding-based notion of religious literacy is most amenable to application to healthcare but is informed in important ways by the other three, which function better together with the one.

Frontispiece

This frontispiece image is modified, with permission, from the cover of Cunningham, Steven Clark, *It's Considerate to Be Literate about Religion: Poetry and Prose about Religion, Conflict, and Peace in Our World.* Orange Hat Publishing, 2022.

Author's Biographical Sketch

Born in Denver, CO, Dr. Steven Cunningham received his B.S.Chem. from Creighton University in Omaha, NE, where he majored in Chemistry and Spanish and was active in the arts, earning Best of Show for his sculpture in the annual juried art show and publishing his poetry in a university magazine. After a postbaccalaureate research fellowship in neuroscience at the National Institute of Aging in Baltimore, MD, he completed medical school at George Washington University and residency in general surgery at the University of Maryland, during which he also completed an oncology research fellowship at Johns Hopkins University. Following residency, he graduated from a clinical fellowship in pancreato-hepato-biliary surgery, also at Johns Hopkins, after which he joined what is now Ascension Saint Agnes Hospital, where he currently serves as Director of Pancreatic and Hepatobiliary Surgery and Director of Research.

During his time at Harvard Extension School, culminating in the present thesis, he has served as teaching assistant for HarvardX's MOOC (massive open online course), "Religion, Conflict and Peace," become an active member of the American Academy of Religion, earned an Interfaith Leadership certification from Interfaith America, and published a book for lay audiences on religious literacy. For all ages 12 and up, this book, *It's Considerate to Be Literate about Religion: Poetry and Prose about Religion, Conflict, and Peace in Our World* (Orange Hat Press, 2022), is his third book of poetry and prose and has received the Benjamin Franklin Award as well as the first place in the "Social Change" category of the Next Generation Indie Book Awards. He is also the

author of two prior award-winning books of poetry and prose for children: *Your Body Sick and Well: How Do You Know?* (Three Conditions Press, 2019) and the bilingual (English/Spanish) *Dinosaur Name Poems / Poemas de Nombres de Diosaurios* (Three Conditions Press, 2009).

Passionate about incorporating the principles of religious literacy into healthcare, he has availed himself of his certificate in Interfaith Leadership at Interfaith America, as well as the Interprofessional Spiritual Care Education Curriculum at George Washington University's Institute for Spirituality & Health, to now lead programs and workshops on religious literacy for healthcare providers locally and nationally.

Dedication

To my fellow humans, patient and provider alike, with sober recognition of how fluidly those roles reverse.

Acknowledgments

There are, of course, more people to whom I am indebted than I can name, including: all my professors and teaching assistants at Harvard Extension School and Harvard Divinity School, who stimulated a generative learning environment; all my classmates, whose many different perspectives so deeply enriched discussions inside and outside of class; all my friends, family, and colleagues, whose support was invaluable; and all my patients, who have taught me things that no one else could teach me. In particular, I would like to thank my excellent prethesis advisor, Dr. Ricky Martin, and my excellent thesis advisor, Dr. Stephen Shoemaker. Most of all, I would like to thank my best friend, confidant, and wife, Myriam, for her support of me and my work, for her patience and astonishing strength during a long and sometimes painful course through medical school, residency, fellowship, early career, and now graduate school again, for her forgiveness for my many errors, and for her infectious laugh. This thesis would not be possible without her.

Table of Contents

Frontispiece iv

Author's Biographical Sketch v

Dedication vii

Acknowledgments viii

Chapter I. Introduction 1

Background 1

Definition of Terms 6

Chapter II Notions of Religious Literacy 8

Understanding – Moore 8

Knowledge – Prothero 10

Faith – Ford and Higton 13

Practice – Ennis 16

Chapter III. Interactions between Healthcare and Religion/Spirituality 21

Religious Influences on Healthcare – Negative 23

Religious Influences on Healthcare – Positive 26

Healthcare Influences on Religion – Negative 28

Healthcare Influences on Religion – Positive 29

Additional Caveats Regarding "Positive" and "Negative" 30

Chapter IV: Comparison and Contrast of Religious Literacy vis-à-vis Healthcare 33

What Is Special about Healthcare? 33

Religious Literacy in Healthcare 35

Chapter V. The Big Picture 47

Future Directions: Designing a Quantitative Measure of Religious Literacy for Application to Healthcare 47

Proposed Methodology of Future Work 52

Conclusion 53

References 59

Chapter I.

Introduction

Background

One of the great ironies of living in the United States is that, although Americans are far more religious than citizens of other wealthy, industrialized nations (Fahmy), and although there is great religious diversity in the United States (Pew Research Center), religious illiteracy in the United States is rampant (Moore 3; Prothero 1). Like most forms of illiteracy, religious illiteracy hampers communication in a vast array of interpersonal and interprofessional relationships. We in these United States could certainly tolerate, in short, living a little better together regarding religious understanding. Examples of religious illiteracy are, unfortunately, not difficult to find: As will be explored in this thesis, one key aspect of religious literacy is recognizing that religions, unlike the people who interpret them, are not actors with agency. Yet, following the 9/11 terrorist attacks and especially during the 2016 presidential campaign in the United States, agency was frequently ascribed to religion in the commonly heard, religiously illiterate utterance "Islam hates us" (Johnson and Hauslohner). This is a manifestation of religious illiteracy because religions do not *do* anything; people do, sometimes violently and sometimes peacefully. Accordingly (and as a second example), most of the widely respected notions of religious literacy, including those described in Chapter II, understand religions as requiring interpretation by people. Religions, in other words, do not speak for themselves, and there is not one "true" interpretation of any religion or

worldview – there are, rather, multiple legitimate interpretations. Yet, appeals to “true Christianity” (Schofield), “true Islam” ("How I Accepted Ahmadiyyat – the True Islam"; "Indonesia Radio Denies Singapore's Radical Preaching Claim"; Fibiger), “true Buddhism” (SGI), etc, are commonly observed manifestations of religious illiteracy. Finally, and relatedly, as will be elaborated in Chapter II, most notions of religious literacy stress the interconnectedness of religion and public life and underscore the importance of understanding the diverse ways in which religion is inextricably interconnected with social, political, and economic aspects of public life. Just as we individuals are each situated in a particular context – each with a unique “situatedness” – and we experience the world and its religions from a particular embedded perspective, so too religions are deeply embedded in most or all parts of public life. Yet, calls are commonly heard for the separation of religion and public life (Meyerson), or, even more extremely, for the eradication of religion from public and private life (Dawkins; Harris; Hitchens).[1]

Given that one of these common tenets of religious literacy is that religion is deeply embedded in many if not all aspects of public and private life, and given that all humans in all societies fall ill, the healthcare arena is no exception to this tenet. Although there is no a priori reason to think that religion would be any less embedded in patient populations nor that patients would report any less religiosity/spirituality than the general

[1] The religiously literate stance that religion is deeply embedded in most or all aspects of public life is a descriptive observation, not a prescriptive imperative. Although Meyerson, Dawkins, Harris, and Hitchens do not make claims to the contrary, i.e., that religion is *not* deeply embedded in public life – indeed the fact that some of them (e.g., Dawkins, Harris, Hitchens), so strenuously argue for its removal evidences their keen awareness of its embeddedness – still, their resistance to it, and in particular their belief that it *can* be eradicated, qualifies, in my view, as a manifestation of religious illiteracy. Religion can no more be eradicated from human society than roots can be eradicated from a tree, or pavement from a highway – the tree, the route, the society will all still exist for a time, but without something essential to being a tree, a highway, a human society, respectively.

population, still, surveys of patients do indeed show that they report a high level of religion/spirituality: in a recent study of 116 cancer patients from The Ohio State University, nearly 90% of participants reported having important religious/spiritual beliefs (Merath et al.); similarly, of 230 patients surveyed in cancer centers in New York, Connecticut, and Texas, most (88%) considered religion to be important (Balboni et al. "Religiousness and Spiritual Support"); and in a survey of 100 patients at MD Anderson Cancer Center, almost all (98%) patients considered themselves both spiritual and religious (Delgado-Guay et al.). However, it is not only cancer patients who, because of their often-particularly-poignant situation of facing a new diagnosis of cancer or the need for a potentially life-threatening operation, report high levels of spirituality and religiosity: when 272 outpatient, primary-care patients were surveyed using the Duke University Religion Index (DUREL) instrument during routine healthcare to measure intrinsic spirituality and religiosity, 87% were found to be intrinsically religious,[2] and 60% were "significantly" or "completely" in agreement with relevant questions about their spirituality/religiosity, rates that tracked with the local general population in North Carolina (Henderson et al.).

Furthermore, consideration of patient religion/spirituality is an important part of patient-centered care, which is one of the six Institute of Medicine goals for the future of healthcare systems (Savel and Munro). Unsurprisingly perhaps, patients who are in

[2] The DUREL instrument addresses three dimensions of religiosity: organizational religious activity, nonorganizational religious activity, and intrinsic religiosity (or subjective religiosity), which assesses the extent to which an individual has a personal religious motivation or commitment, as opposed to *extrinsic* religiosity, a religiosity that is a part of one's persona, or, in Koenig and Büssing's words, "mainly 'for show'" (80), or used as a means to financial, social, psychological, or other ends, rather than for the sake of religion itself. A person with high intrinsic religiosity, by contrast, pursues "religion as an ultimate end in itself" (80) (Koenig, Harold G. and Arndt Büssing. "The Duke University Religion Index (Durel): A Five-Item Measure for Use in Epidemiological Studies." *Religions*, vol. 1, 2010, pp. 78-85, doi:10.3390/rel1010078.).

potentially life-threatening situations, such as those facing a new cancer diagnosis, or need for a major operation, report lower overall religious/spiritual well-being than population norms (Merath et al.), likely due to the experience of personal and spiritual distress or crisis.

Patients' desire to have their religion/spirituality incorporated into their care plan, although common, is not without exception. Some studies show that patients are not in favor of their providers participating in religion/spirituality, even if it is believed to be important or beneficial. In one study, for example, open-ended interviews with patients who underwent craniotomy at one North American hospital suggested that patients may not be in favor of their physician being the one to engage in religion/spirituality with the patients and loved ones (Ravishankar and Bernstein). Nevertheless, more-exhaustive reviews of the literature suggest that patients do favor provider participation – even if not always by their physician – in discussions of religion/spirituality: systematic, literature-review analyses have shown that many patients have a strong interest in discussing religion/spirituality during the medical consultation, and therefore doctors and other healthcare providers should be better equipped with religious literacy to assist patients in having these conversations (Best et al.).

Unfortunately, the healthcare providers for these patients are often unable to meet this need due to lack of religious literacy. In the United States, providers perceive several specific barriers to discussing religion/spirituality, including potentially offending patients, thinking that it is someone else's job, time limitations, and perhaps most importantly (since it affects the other barriers), lack of training (M. J. Balboni et al.; Best et al.; Palmer Kelly et al.). Furthermore, Dinham has observed that the relationship

between religion/spirituality and healthcare has been poorly addressed, and that public professionals lack religious literacy, are precarious regarding religion/spirituality, and are therefore largely unable to engage well with religion/spirituality (83). Although certainly not universal, the belief among healthcare providers that they need religious-literacy training as part of their professional development is widespread (Chan and Sitek). This sentiment is common in but not unique to the United States. Indeed, doctors in diverse countries around the world think that they should discuss religion/spirituality but lack the religious-literacy training to be able to do so well. For instance, in the "Spirituality in Brazilian Medical Residents" study involving seven Brazilian university centers, residents who perceived that religion/spirituality can influence health thought that they should discuss religion/spirituality but acknowledged a lack of training in religious literacy as an obstacle to addressing patients' religion/spirituality in their clinical practice (Vasconcelos et al.).

Unfortunately, one of the most fundamental unresolved issues in this area is that religious literacy, however important it may be to patients at the intersection of healthcare and religion, is difficult to study. There are two main, distinct but related reasons why this is the case. First, while there is a plethora of good, widely used, well-validated instruments to measure religiosity/spirituality (Austin et al.), there is no such instrument available to measure religious literacy (see Chapter V). Second, there is no universally agreed-upon definition of what exactly constitutes religious literacy (Shaw 150). In fact, there are several diverse conceptions of religious literacy (four of which are considered in detail in Chapter II) that, while overlapping in some ways, are discordant in others.

This thesis, therefore, aims to lay the groundwork for the design and validation of a quantitative instrument to measure religious literacy. In particular, this thesis will critically review four salient conceptions of religious literacy published in the literature and analyze them to show their implications for application to the education and training of providers in the healthcare setting.

Once these implications are better understood, future directions will be suggested using such a quantitative instrument, including addressing the relatively unexplored issue of whether the level of religious literacy among providers working with patients facing a life-threatening diagnosis or operation can be measurably increased by a short-term intervention, and if it can be, how this increase may affect patients regarding their overall experience with the healthcare setting and their experience of their own religion/spirituality. Similarly, a case will be made for also investigating the effects of increased religious literacy on provider experience and well-being.

Definition of Terms

"Religious literacy"

In this work, the term religious literacy will generally refer to a knowledge and/or understanding of religion as deeply embedded in public life and constituting a competency to navigate and engage with, in a well-versed and self-reflective manner, the religious landscape of our world.

"Religion" versus "Spirituality"

Religion and spirituality, although related, are distinct but difficult-to-define concepts. For the purposes of this thesis, religion is a construct made by people in the

context of a culture and a society, generally institutionalized in a set of beliefs about the transcendent shared by a community, often including worship of God or gods, and typically stressing a distinction between the sacred and the commonplace (Cunningham *It's Considerate to Be Literate About Religion*… 15). Spirituality, a broader but related concept that is traditionally and historically rooted in religion, is an intrinsic and dynamic part of being human and is characterized by an individual's relationship to and experience of the transcendent, often involving a search for the sacred, whether through religion or other paths (Balboni et al. "Provision of spiritual care"; Koenig *Medicine, Religion, and Health*; Puchalski "Improving the Quality of Spiritual Care" 887; Sulmasy).

"Healthcare setting"

This term will be used as defined by the Centers for Disease Control and Prevention, meaning: "a broad array of services and places where healthcare occurs, including acute care hospitals, urgent care centers, rehabilitation centers, nursing homes and other long-term care facilities, specialized outpatient services … and outpatient surgery centers" (Christensen and Fagan).

Chapter II

Notions of Religious Literacy

Although religious-literacy scholars largely agree that religion is deeply embedded in society and that religious literacy is accordingly an essential part of being a member of society, they differ in their conception of what exactly constitutes religious literacy. This chapter will compare and contrast four salient notions of religious literacy – based on understanding, on knowledge, on faith, and on practice – and will consider them here in general individually, and then Chapter IV will consider them more in particular through the lens of healthcare.

Understanding – Moore

The notion of religious literacy adopted by the American Academy of Religion (AAR Board of Directors), arose in large part from the work of Diane Moore (*Overcoming Religious Illiteracy*), who has observed that manifestations of religious illiteracy include the beliefs that: 1) religions are defined by their rites, rituals, ceremonies, or scripture; 2) religions are internally uniform and stable over time; 3) religion is limited to the private sphere; 4) religions are actors with agency to act in and on the world; 5) a religion or a religious community is responsible for the actions of particular individuals who self-identify with that religious tradition (in other words, seeing the actions of individuals or communities merely through the lens of their religion). By contrast, she argues that: 1) religions are more than the sum of their rites,

rituals, ceremonies, and scriptures; 2) religions are dynamic over time, place, and person; 3) religion is deeply embedded in most if not all aspects of public life; 4) people, not religions, are actors with agency, and people interpret religions in vastly diverse ways, leading them in turn to act in similarly diverse ways according to their interpretations; 5) people are not defined or motivated entirely by their religion, but rather also by cultural, social, economic, and political factors (in other words, the particular people who commit violence [or promote peace] in the name of their religion – and not their countless and peaceful coreligionists – are to be blamed for those violent acts [or appreciated for promoting peace]).

The distilled version of this notion of religious literacy adopted by the AAR's steering group on religious literacy, co-led by Eugene V. Gallagher of Connecticut College and Diane Moore of Harvard Divinity School, was published online as the "AAR Religious Literacy Guidelines: What United States College Graduates Need to Understand about Religion." These Guidelines include the abilities to:

- Discern accurate and credible knowledge about diverse religious traditions and expressions
- Recognize the internal diversity within religious traditions
- Understand how religions have shaped—and are shaped by—the experiences and histories of individuals, communities, nations, and regions
- Interpret how religious expressions make use of cultural symbols and artistic representations of their times and contexts
- Distinguish confessional or prescriptive statements made by religions from descriptive or analytical statements (AAR Board of Directors)

Although these Guidelines were designed for college students, building on Moore's earlier work on religious literacy in secondary education (*Overcoming Religious Illiteracy*), many of them apply as well, as we shall examine in Chapter IV, to the

healthcare setting, which includes not only secondary-education and college students, but any human engaging with a healthcare setting in the United States.

According to this notion of religious literacy, *understanding* what *religion* is as a thing in and shaping our world is prioritized over *knowing* facts about *a particular* religion or about particular religions. Although one of the arguments of this thesis is that this understanding-based approach is better than a knowledge-based approach, one caveat is that a person can be religiously literate according to this understanding-based notion of religious literacy while knowing very little about any particular religion, since the only reference to knowledge is to be able to discern which knowledge is accurate and credible, a point that we will return to later as we review the ways in which these four notions of religious literacy complement each other. For now, however, we turn to the second notion of religious literacy, in which this relative depreciation of knowledge in favor of understanding is reversed.

Knowledge – Prothero

Stephen Prothero's book for lay audiences, *Religious Literacy: What Every American Needs to Know—And Doesn't*, articulates a notion of religious literacy that I will term "knowledge-based." Perhaps due to the popularity of this 2007 *New York Times* bestseller, Prothero's definition of religious literacy is one of the most common: "the ability to understand and use the religious terms, symbols, images, beliefs, practices, scriptures, heroes, themes, and stories that are employed in American public life" (13). Although Prothero uses the verb 'to understand' here and not 'to know' – and indeed, to his credit, he specifically notes that religious literacy is "not just the accumulation of facts" (14) – he nevertheless does strongly stress the importance of knowing specific

facts about religions, and about Protestant Christianity in particular, since that religious tradition is the dominant one in the United States. In Chapter IV, however, we will consider the implications of the fact that many diversely international patients in American healthcare, all of whom need and deserve their providers to be religiously literate in a patient-centered manner, may not care whether or not their providers "understand and use the religious terms, symbols, images, beliefs, practices, scriptures, heroes, themes, and stories that are employed in *American* public life" (my emphasis).

Prothero uses a helpful analogy between linguistic and religious literacy to describe his sense of religious literacy: just as with a language, the grammar and linguistic building-blocks of which one must know to be literate in the use of the language, so too with a religion one must be able to employ in daily life religious building blocks: a religion's "key terms, symbols, doctrines, practices, sayings, characters, metaphors, and narratives" (11-12). And just as one speaks of being literate and fluent in *a particular* language or in particular languages, and one refers to speaking *a language*, not to *speaking language* in general, similarly, Prothero writes, "religious literacy in the abstract is an impossibility," since one cannot be literate in every religion, and there is no "one generic religion to 'speak'" (12). Instead, he writes, it would be best "to refer to specific religious literacies," and

> in the United States today the most important of these particular literacies is Christian literacy. Inside the academic study of religion, it is decidedly out of fashion to emphasize Christianity over other religions … But the United States is also the world's most Christian country. With a Christian population of about 250 million, there are more Christians in the United States today than there have been in any other country in the history of the world. Christianity's dominance, moreover, swells as you enter the corridors of power. Of all the members of the 109th Congress, 92 percent were Christians, as were 100 percent of fifty state governors in 2000. Among this elite group of state and national politicians, there were zero

> Muslims, zero Buddhists, and zero Hindus.[21] So it should be obvious that Christian literacy is more important than other religious literacies when it comes to understanding US politics. (12-13)[3]

Whereas for Moore religious literacy is more conceptual, less fact-based, and more concerned with understanding religion than with having knowledge about religions, for Prothero, religious literacy is largely content-based. According to him, a religiously illiterate person typically fails to know basic facts about particular religions (viz. Protestantism). Indeed, pace Prothero's aforementioned nod to understanding, this difference is plainly seen in the titles of their each of their writings: Prothero's subtitle is *What every American needs to* know—*and doesn't*, while the Guidelines published by the American Academy of Religion (AAR Board of Directors), which was co-authored by Moore, is subtitled *What United States College Graduates Need to* Understand *about Religion* (my emphases).

One key aspect of religious literacy embraced by both Moore and Prothero (and, as discussed below, Ennis, who builds on Moore's work) is that religion, while certainly a private affair, is not merely private, but rather is deeply embedded in most or all aspects of public life, even though this embeddedness is not always obvious. One possible reason why, especially in the United States, the public embeddedness of religion so easily escapes notice is illustrated by Scott Appleby, who, during a guest lecture to an audience of 200 armed-forces officers whom he was addressing on the topic of international relations and religious militance, asked, "'How many of you have prayed today?' Reluctantly, it seemed, slightly more than half the audience raised their hands."

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[3] Prothero's superscripted citation #21 is from "Religious Affiliation of U.S. Congress," http://www.adherents.com/adh_congress.html#109. In 2006, he writes in the end notes, 494 out of 535 members of Congress and 47 out of 50 governors self-identified as Christians.

However, when he asked the follow-up question, "'Whether or not you raised your hand, how many think your prayer life is none of my business?' [w]ith what seemed greater enthusiasm, more than 150 hands shot into the air" (1). This impromptu poll illustrates, as Appleby has noted,

> the striking legacy of the United States and the modern West in general: the development and institutionalization of the 'public' and 'private' realms of life as separate cultural and social spaces [whereby the] public-private distinction informs the way many Americans understand and practice religion" (1).

The belief that religion is and should remain private, that the wall of separation between church and state that Jefferson saw in the First Amendment ("Thomas Jefferson to Danbury…") should exist and be maintained, obscures just how deeply embedded religion is in public life. While Moore's and Prothero's notions of religious literacy embrace this embeddedness of religion, the third notion that we will now consider goes even further, taking Prothero's keen insight that religious literacy should not be limited to merely abstract concepts, but rather needs traction. Two sources of such traction – faith and practice – are the focus, in fact, of the next two notions of religious literacy.

Faith – Ford and Higton

Our third conception of religious literacy has its basis in theology. Starting with commonly understood distinctions between *theology* and *religious studies* – the former often assuming the faith of the person doing the studying, while the latter might be said to bracket one's faith or lack thereof; or the former being more of an internal discourse within an individual privately or among a community of coreligionists, while the latter is more public; or the former being about God, while the latter is more about the practices and beliefs of religious people – David Ford and Mike Higton have argued that religious

literacy requires not only religious studies but also theology. This is a requirement inherent in neither the notion of religious literacy described by Prothero nor that by Moore. Furthermore, not only does their faith-based notion of religious literacy require an in-depth engagement with theology, but in their account of religious literacy, that engagement is exclusively Christian.

Their justification of a Christian-only approach to religious literacy rests on their observation that while

> Religious Studies might typically be defined in a similar way regardless of the religious community or tradition being studied, the nature of 'Theology' is harder to generalise. There are discourses whose relationship to other religious traditions is analogous to Christian Theology's relationship to Christianity, but the analogies can't be assumed without further investigation to be drawn tightly enough to allow our arguments to walk lightly across them. The practices of reasoning, the social location of those practices, the materials on which they draw, and the effects that they might have differ markedly from case to case. We therefore talk about Christianity, about Christian Theology, about Religious Studies insofar as it takes Christianity as its subject matter, and about 'the churches' as a way of naming a range of Christian communities and traditions that might be the focus of such study. (40)

Although at first glance this notion of religious literacy seems rather exclusive, allowing only faithful Christians to participate, Ford and Highton would not agree that their notion of religious literacy lacks broad inclusivity. Indeed, they unsurprisingly anticipate this criticism and describe as the first step in their argument the fact that Christian theology, like religious studies, is an academic discipline that may be – and, in fact, is – undertaken both by Christian and by non-Christian students and scholars, both by those who self-identify as believers in or practitioners of Christianity and by those who do not.

For Ford and Higton, "students can, in other words, learn about Christian reasoning by learning to reason Christianly" (41). To put it another way, they argue that their notion of religious literacy is inclusive because it does not require believing

everything that Christians believe, or even having any Christian faith, but rather merely believing that Christians believe the things they do, and that these things matter: it requires, essentially, belief "in the existence of Christianity … a rich and complex weave of [Christian] communities, traditions and identities" (41) that orders the lives of Christians through sustained and disciplined deliberation about Christian beliefs and implications; it requires believing that within these practices of deliberation it is possible to reason, to argue, to consider evidence, and to question; and it requires a belief that these practices of deliberation cannot be entirely reduced to other discourses.

Religious literacy, by their account, is available to and inclusive of any person willing to engage in a Christian theological discourse, even if that person lacks faith or personal belief in God or other Christian beliefs. Rather, they explain, people of various religious traditions may and should learn each other's theological languages well enough "to experiment in them, to speak recognisably in them – becoming *literate* in them" (44-45; original emphasis). And while Ford and Higton argue that religious literacy properly includes Christian theology, they also argue a similar case could conceivably be made regarding other religious traditions.

While this approach may provide excellent religious literacy when working with Christians, the limitations that patients face in various healthcare settings, whereby they cannot always choose whom to see in a dependent patient-provider relationship, largely limit the applicability of this approach to healthcare, as will be discussed in detail in Chapter IV, "What is Special about Healthcare?"

Practice – Ennis

The fourth notion of religious literacy, one that combines elements from all the above three notions, is one that I am terming practice-based religious literacy. Developed at by Global Spiritual Life at New York University (NYU) and described by Ariel Ennis in *Teaching Religious Literacy: A Guide to Religious and Spiritual Diversity in Higher Education*, this conception of religious literacy, like the prior three, includes knowledge, but is more practice-based insofar as it more explicitly distinguishes academic knowledge and experiential knowledge, calls for allyship and action from religiously literate people, and stresses the importance of active self-reflection for religious literacy, all three of which aspects seem at first glance to be applicable to healthcare. Before discussing this application further in Chapter IV, a more detailed description of their practice-based religious literacy is warranted.

Ennis frames his notion of religious literacy in four pillars: 1) knowledge, 2) ecumenical orientation, 3) self-reflection, and 4) application. The first pillar he describes is knowledge, based largely on Moore's emphasis on the interconnectedness of religion and public life, including an essential awareness and understanding of the diverse historic and contemporary interconnections between religion and social, political, and economic aspects of public life, in both local and global communities, cultures, and hierarchies (10).

For the second pillar, Ennis borrows the term "ecumenism" and uses it to mean "pluralism," but without, he hopes, the problematic associations that "pluralism" has had with religious beliefs relying on claims of exclusive truth, since some have understood "pluralism" to imply that all claims must be equally true. Ravi Zacharias, for example, a

prominent Christian apologist and author, when interviewed by Richard Schoonover, associate editor of *Enrichment* journal, and asked about "what is destroying the moral and spiritual foundation of today's society," responded that

> in pluralism you have a competing number of worldviews that are available, and no worldview is dominant. *But smuggled in with pluralization was the absolutization of relativism.* The only thing we could be sure of was that all moral choices were relative and there was no point of reference to right and wrong. This resulted in the death of reason (my emphasis).[4]

Numerous scholars have provided good responses to this worry, and because pluralism is so essential to religious literacy, a closer look at these responses is warranted. One can hardly disagree with Zacharias that an extreme, reductive relativism is altogether unhelpful, but conflating an anything-goes relativism with pluralism obscures the essential aspect of *engagement with diverse others* that pluralism entails, and toward which Ennis in this second pillar (and in the fourth pillar below) is aiming in this fourth notion of religious literacy. The mid-twentieth-century American Jesuit John Courtney Murray described pluralism as just such a vigorous engagement:

> By pluralism here I mean [not only] coexistence [of those] who hold divergent and incompatible views with regard to religious questions … [but pluralism also] implies disagreement and dissension within the community [and] implies a community within which there must be agreement and consensus. There is no small political problem here. If society is to be at all a rational process, some set of principles must motivate the general participation of all religious groups, despite their dissensions, in the oneness of the community. (x)

Murray's conception of pluralism, with its concomitant embracing of the reality of disagreement and dissension within a community *and* of its calling for engagement with

[4] In "Defending Christianity in a Secular Culture," *RZI*, the link to which fails, but which is excerpted by the Greater Rochester Medical Community Christian Fellowship, accessed July 28, 2023, http://grmccf.org/outreach/conf15/food-for-thought/).

such differences toward a "oneness of the community" would, if Zacharias had it more in view, perhaps assuage the latter's concerns about an absolute moral relativism. Zacharias rightly worries that absolute relativism is a totalizing stance, as is the idea of absolute objectivism. But as historian of science Donna Haraway has importantly highlighted in her landmark article on feminism, the alternative to relativism is

> not totalization[, but rather] is partial, locatable, critical knowledges sustaining the possibility of webs of connections called solidarity in politics and shared conversations in epistemology … Relativism is the perfect mirror twin of totalization in the ideologies of objectivity; both deny the stakes in location, embodiment, and partial perspective; both make it impossible to see well. Relativism and totalization are both "god tricks" promising vision from everywhere and nowhere equally and fully. (584)

Unlike relativism, pluralism, by contrast, rests on precisely such partial knowledges that we all must needs have, limited as we are in fully understanding and knowing each other in a religiously diverse[5] society. As Diana Eck more plainly states, echoing Murray's emphasis on engagement, pluralism

> is not simply relativism. It does not displace or eliminate deep religious commitments, or secular commitments for that matter. It is, rather, the *encounter* of commitments. Some critics have persisted in linking pluralism with a kind of valueless relativism, in which all cats are gray, all perspectives equally viable and, as a result, equally uncompelling. Pluralism, they contend, undermines commitment to one's own particular faith with its own particular language, watering down particularity in the interests of universality. I consider that view a distortion of the process of pluralism. I would argue that pluralism is *engagement with*, not abdication of, differences and particularities. While the encounter with people of other faiths in a pluralist society may lead one to a less myopic view of one's own faith, pluralism is premised not on a reductive relativism but on the significance of and engagement with real differences. (71; my emphases)

[5] And, of course, diverse socioeconomically, culturally, politically, sexually, etc.

Given the contested nature of the meaning of the term "pluralism," therefore, Ennis and colleagues at NYU have used instead the word "ecumenism," which, they argue, "avoids implications of subjective truths" (10), and which, they point out, "despite its Christian roots, can be used in to refer to all religions" (11).

This second pillar, ecumenical orientation, borrows also from the practice of *appreciative knowledge*, which is described by Interfaith America's Eboo Patel (113) and used in Interfaith America's training modules for interfaith leaders. Built upon the work of Eck and others, appreciative knowledge has three parts: a recognizing of the contributions of other traditions, a sympathetic understanding of the distinctive history and commitments of other traditions, and a third and active part of developing ways of working with and serving other communities. For Patel, the point of appreciative knowledge is going beyond mere awareness – even intimate awareness – of facts about different religious traditions to reaching out to people of those traditions to experience and *engage* with some aspects of the facts (111). Accordingly, this second pillar, ecumenical orientation, is of interest not only in traversing religio-cultural boundaries, but also in developing firsthand experience within different religious traditions.

The third pillar in Ennis's practice-based notion of religious literacy, self-awareness and reflection, builds on the second pillar insofar as it requires one not only to have ecumenical appreciative knowledge, but also to articulate and display an awareness of how such an appreciative knowledge interacts with one's own religious identity. This pillar is one's "insight into the intersection of personal religio-spiritual identity and larger global forces" (9).

Finally, the fourth pillar, largely the crux of this practice-based notion of religious literacy, is application: *using* religious literacy to inform the actual *work* of bridging intercultural divides. This pillar is essentially the ability to *apply* in daily life the first three pillars and is the pillar that most distinguishes this notion of religious literacy from the prior three, and the one that most significantly adds something new from these four notions of religious literacy to the application of an optimal religious literacy to healthcare.

It is, after all, the *engagement* between patients and the healthcare system that is under consideration here. Since all humans, according to the most widely accepted definitions of spirituality, are intrinsically spiritual,[6] and since, as discussed in Chapter I above, patients want and need the healthcare system to pay attention to their religion/spirituality, and since the unique characteristics of healthcare engagement increase the stakes for a diverse population of patients, a keen sense of and appreciation for religious pluralism in healthcare is essential. These unique characteristics of engagement between patients and healthcare will be explored in greater depth in Chapter IV, but first a contextualizing consideration is needed of the ways that healthcare and religion/spirituality interact with each other.

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[6] It is understood that "intrinsically spiritual" looks different for different people, both religious people and those who self-identify as nonreligious. For definitions highlighting that spirituality is an intrinsic part of being human, see: Koenig, Harold G. *Medicine, Religion, and Health: Where Science and Spirituality Meet.* Templeton Foundation Press, 2008, Puchalski, C. M. et al. "Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus." *Journal of Palliative Medicine*, vol. 17, no. 6, 2014, pp. 642-56, Medline, doi:10.1089/jpm.2014.9427, and Sulmasy, D. P. *The Rebirth of the Clinic: An Introduction to Spirituality in Health Care.* Georgetown University Press, 2006.

Chapter III.

Interactions between Healthcare and Religion/Spirituality

As countless writers have pointed out, human health and illness are deeply intertwined with religion/spirituality; they have been since the beginning of recorded human history, and continue, despite descriptive and prescriptive comments of some to the contrary,[7] to be so today. From the time of the earliest known medical text, Ferngren explains – a text written in Sumerian cuneiform c. 2100 BCE during the third dynasty of Ur (19) – a time when little was known about anatomy, physiology, or pathophysiology, the very close association between healthcare and religion was manifest in the common ascription of the causes of disease "to vague or malignant spirits or to demons or divine beings" (1). Experienced healers, likely aware of their limitations, "treated [merely the symptoms of] many conditions for which there were no cures and turned more quickly than do moderns to supernatural forces for help" (2). And in the United States, despite Thomas Jefferson's famous calling for a wall of separation, Americans have always been and continue to be deeply and broadly religious and have, since the American "City on a Hill" was first uttered, similarly appealed to a higher power, to God, to Providence, to endorse each victory and each healthy day, and to punish each failure with sorely felt consequences, often injury or illness (Cunningham "Manifest Destiny" 8).

[7] Sam Harris, Daniel Dennett, Richard Dawkins, and Christopher Hitchens, for example, sometimes called "the Four Horsemen" in a biblical reference to the book of Revelation (6:1–8), take stances beyond personal atheism, moving instead toward an antireligion position and have, to varying degrees, called for an end of religion, due to what they perceive as an unfavorable cost/benefit analysis of religion on the human stage. The position taken is this thesis contradicts their stance as, again to varying degrees, a religiously illiterate stance.

Yet, the intimate relationship between religion and health, although as old as each partner in the relationship, has faltered at times. Even though humans have always been religious/spiritual, healthcare has not always been very effective at taking this essential aspect of whole-patient care into account. In particular, as Astrow et al. explain, during the Renaissance, science and religion grew increasingly in opposition to each other, and accordingly medicine "came to see religion as a barrier to progress" (284) as it began to leave behind the supernatural in favor of the scientific, until medicine and religion had largely separated from each other. This separation increased through the Enlightenment, which, for all its beautiful boons, threatened to seal the divorce. Indeed, many experts in the field could see that healthcare was broken and that the idea of the whole bio-psycho-social-spiritual patient had become all but lost in the rubble (Puchalski and Ferrell). Doctors during this time were largely focused on the biologic patient, on the pathophysiology, on treating *disease*. But after 1948, when the World Health Organization (WHO) redefined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO), subsequent generations of medical students (this author included) began to learn the bio-psycho-social model. But as Puchalski and Ferrell note, an entire component of the whole person – the spiritual aspect – was still missing (Puchalski and Ferrell). By the 1980s, the bio-psycho-social model of health and disease was increasingly yielding to the now-truly-whole model of the bio-psycho-social-*spiritual* person (Saunders).

Since religion is so deeply embedded in human society, including and especially our United States society – indeed, the recognition and understanding of this embeddedness is a tenant of most notions of religious literacy, including those reviewed

in Chapter II – and given that all humans need healthcare, it comes as no surprise that religion and healthcare influence each other, nor that these influences are so numerous and protean: they are sometimes obvious, though often subtle, and may be on occasion negative, while other times they are clearly positive, but they are always present insofar as the healthcare arena is a large part of human societies, all of which are religious to a greater or lesser extent. Not only can the influences be either positive or negative, but they are bidirectional, as exemplified in the below sections, in which we see religion and healthcare both positively and negatively influencing each other.

A caveat warrants mention before further examining these influences. It is understood in the sections that follow, of course, that association does not equal causation and that, although there are many associations, causation, and even sometimes the direction of effect, is harder to determine. Nevertheless, a brief review of some salient influences between religion and healthcare will serve to contextualize the discussion that follows.

In the first set of influences, religious influences on healthcare, the locus of influence within religion varies and may be constituted in religious leaders and their teachings/utterances/behavior, in scripture and its interpretation, in religious doctrine, in the individual's own spirituality informed by their religion, or, most commonly, in some combination of these loci.

Religious Influences on Healthcare – Negative

One salient example of various loci of influence within religion interacting to impact healthcare is vaccination. And given that the WHO has identified vaccine

hesitancy as one of the ten greatest threats to human health (Akbar), vaccines serve[8] as a particularly salient example in the current thesis. In one of the largest global surveys ever performed on vaccine confidence, Larson et al. found that rates of religious incompatibility with vaccine recommendations were highest in the WHO-defined regions of South-East Asia and the Western Pacific at 25.7% and 24.3% respectively (297). Although Muslims surveyed in that study had only moderate rates of religious objections to vaccines – 3%, 12%, and 14% in Afghanistan, Nigeria, and Pakistan, respectively (300) – Muslim fundamentalism has been cited by others as a major factor in polio-vaccine refusal in these three countries (Ahmad; Ahmed et al.; Alsuwaidi et al.; Warraich), which are the three principle remaining polio-endemic areas in the world.

Some data suggest, however, that it is not simply the religion of Islam per se that is linked with vaccine hesitancy or refusal. Saudi Arabia, for instance, has a Muslim population of nearly 100% but a very low (2%) religious objection rate (Larson 300). Indeed, other studies have found no association between vaccine confidence and religious affiliation (de Figueiredo et al. 3). However, methodologic differences may explain this discrepancy, since, unlike the Larson survey, in which participants were asked about religion, per se, the de Figueiredo survey asked only about vaccine issues, not specifically about religion, and these responses about vaccine opinions were simply correlated with known rates of religious affiliation. In particular, while Larson et al. specifically asked

[8] Although there is currently a popular anti-vaccine movement in the United States, widely propagated through various media expressing distrust of organizations such as the Centers for Disease Control and the World Health Organization, vaccines been widely demonstrated to have a favorable risk/benefit balance as a health intervention. The evidence for this – that vaccines cause more benefit than harm – is overwhelming but beyond the scope of this thesis and so will be accepted as definitively convincing in the discussion that follows, even without exhaustive review of the medical literature. Readers who remain unconvinced are encouraged to seek out the advice of a medical professional well versed in critical analysis of the scientific literature.

participants to rate on a Likert scale their degree of agreement with the statement, "vaccines are compatible with my religious beliefs" (296), de Figueiredo et al., by contrast, asked only about vaccine importance, safety, and effectiveness and then correlated these responses with social and demographic factors, such as sex, age, education, employment status, and religious affiliation. But given that 97% of people in sub-Saharan Africa are religious,[9] it is not surprising that there was no significant correlation with response to questions about vaccine attitudes and beliefs.

Observations in polio-endemic areas suggest that local religious leaders have been influential in spreading anti-vaccine sentiment, both for explicitly religious-doctrine reasons and for reasons that are not obviously religious. Religious reasons for vaccine refusal include the determination via a *fatwa*, or a ruling in Islamic law, that vaccines are *haram*, or forbidden, under Islamic law (Rochmyaningsih 628), and reasons that are not obviously religious, but are communicated by a religious leader, include the belief that vaccines are ineffective or will make children sterile (Walsh; Sheikh).

Vaccines, of course, are not the only example of effective medical therapies repudiated for religious reasons. Unfortunately, examples of the negative influence of religion on health are plentiful and well-known in the United States, including devastating outcomes following the refusal of antibiotics and other standard Western medical therapies in favor of therapeutic prayer (Fraser) and the refusal of blood products by Jehovah's Witnesses (Biscoe and Kidson-Gerber). Unsurprisingly and reassuringly,

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[9] The breakdown is as follows: 62% Christian, 31.4% Muslim, 3.2% folk religions, and 1% each for Buddhist, Jewish, and other, with only 3% unaffiliated. https://www.statista.com/statistics/1282636/distribution-of-religions-in-sub-saharan-africa.

however, although the religious leaders are effective in swaying followers for negative change, they are also able to effect positive change.

Religious Influences on Healthcare – Positive

Although at the immediately post-COVID time of this writing, religious arguments against vaccines are still commonly seen in the United States news media (Gerson; Singh), there is also ample evidence of religious arguments in favor of vaccines. One of the most powerful sources of the influence that religion exerts – both positively and negatively, as illustrated above – seems to be trusted religious leaders, who, much more so than nonreligious leaders, are able to motivate their coreligionists towards behavior with health benefits that they may well not otherwise accrue when similarly urged by lay leaders. For example, political scientists at South Dakota State University (Viskupič and Wiltse) conducted an online survey to evaluate the ability of various sources of information to motivate undervaccinated populations to receive the COVID-19 vaccine. They presented 709 unvaccinated registered voters with messages that were identical in endorsing vaccination but were attributed either to a political, medical, or trusted religious leader (506), finding that only the religious leader's message had a positive and statistically significant effect increasing interest in receiving the vaccine, whereas the same message from political or medical leaders had no statistically significant effect on reported inclination to receive the recommended vaccine. Similarly, in several Muslim-majority populations, religious leaders have been effective in lowering vaccine hesitancy and helping to eradicate poliomyelitis in Afghanistan and Pakistan (Jabbar). Interestingly, Jabbar points out, after involving religious leaders, increased acceptance of vaccination occurred not only for those families initially refusing for

religious reasons but also those family refusing due to misconceptions – e.g., that vaccines are ineffective at preventing disease, that they cause infertility, etc. ("Ten Threats to Global Health in 2019"; Alsuwaidi et al.) – strongly suggesting that religion, which is deeply embedded in all human societies, is deeply relevant for the choices people make, even when they appear at first glance to be nonreligious choices.

Although many Christians in the United States and elsewhere have cited Bible verses (e.g., Isaiah 53:5, Luke 17:11-19, Psalm 30:2, 1 Corinthians 6:19, Leviticus 17:11) during the COVID-19 pandemic in opposition to COVID-19 vaccine (Jain), many other Christians have also cited bible verses – interestingly, sometimes very similar verses – in support of getting the vaccine (Hopler). Verses that have commonly been interpreted in support of vaccination include those teaching followers to take good care of their bodies by preventing disease (e.g., Psalm 139:13-14, Romans 12:1, 1 Corinthians 3:16-17, 1 Timothy 5:24) and to love and to care for other people (e.g., Matthew 22:37-40, Matthew 25:40, Romans 12:10).

Similar concepts about the preservation of life and the prevention of disease as a religious imperative also exist in Islam. Alsuwaidi et al., for example, reviewed interpretations of *sharia*, or Islamic-law, concepts pertaining to vaccination in the context of destiny and fate and noted that both the International Islamic Fiqh Academy in 1992 and the Fatwa Committee of Perlis in Malaysia in 2016, among others, have issued statements indicating a religious obligation for Muslims to get vaccinated to prevent disease in themselves and others (3).

Beneficial religious influences on healthcare are not limited to reducing vaccine hesitancy, however. In a systematic review of the literature, Cavalcanti et al. have

reported that spirituality and religiosity confer better pain control and decreased anxiety and stress in cancer patients (2003-2005). Additionally, Balboni et al. very recently performed a systematic literature review of the relationship of religion/spirituality with both serious illness and with health outcomes and then convened a Delphi panel evaluating the data, first qualitatively to generate initial evidence statements and to suggest implications for healthcare, and then quantitatively to evaluate the strength of the data supporting evidence statements and to rank suggested implications ("Spirituality in Serious Illness and Health" 186). Data that they reviewed strongly suggested that active participation in religion/spirituality was positively associated with several health benefits, including less cognitive decline among older adults, healthier diet, more exercise, fewer depressive symptoms, and lower mortality, among others (193).

Healthcare Influences on Religion – Negative

During the COVID-19 pandemic, although many people relied on their faith as a source of positive coping experienced a strengthening of faith (vide infra), many others experienced a progressive loss of faith over the course of the pandemic. Büssing et al., for example, evaluating 4,693 participants recruited from June 2020 to November 2021 via snowball sampling in various social networks in Germany, performed a continuous cross-sectional survey and found a decrease in prayer and meditation, decreased trust in a transcendent power, and a continuing loss of faith (Bussing et al.). Specific survey items in this study included "I lost my faith due to the corona pandemic" and "I have confidence in a higher power / source that supports me" (744), and these negative influences of the COVID-19 healthcare crisis on religion/spirituality were observed in both Catholics and Protestants, and in both younger and older persons. Indeed, it is an

everyday observation available to any healthcare provider paying attention that illness, complications, bad experiences with the healthcare system, etc. can precipitate a spiritual crisis.

Healthcare Influences on Religion – Positive

While it is true that illness, the need for medical or surgical care, and even routine health maintenance sought through what sadly is often a difficult-to-navigate healthcare system can lead to spiritual distress and religious struggles, such struggles are not, of course, always fruitless. Indeed, a health crisis leading to a religious or spiritual crisis often eventually leads to personal growth and religious renewal, which in turn can lead to improved wellness and quality of life. As physician Richard Moss has noted, it is in moments of crisis, health crisis in particular, that the door of transformation may be opened to us (xii).

In their discussion of a quantitative review of 34 controlled studies testing the effects of providing psychological support in addition to standard medical and surgical care of patients facing surgery or recovering from heart attack, Mumford et al. note that such health crises as serve as a "dangerous opportunity" because they can allow the patient to "change direction and assume new and potentially better patterns of adaptation" (144). Given that the analyzed studies (published 1955-1978) predated much recent attention to holistic care, including the now-more-common incorporation of religion/spirituality issues into care plans, Mumford et al. do not use the term "religion," but certainly many of the patients interpreted the "dangerous opportunity" in light of their personal religion/spirituality. In a more recent study of patients newly diagnosed with cancer, patients were asked more explicitly about religion, and the majority of surveyed

patients reported increased in their prayer and their faith following their diagnosis (Moschella et al.).

Additional Caveats Regarding "Positive" and "Negative"

The above, very brief review of interactions between religion and healthcare sets the stage for a discussion comparing and contrasting the four aforementioned notions of religious literacy vis-à-via healthcare. First, however, in addition to the above caveats regarding causation and direction of effect, some additional comments on those interactions between healthcare and religion are needed.

For example, a question that immediately arises regarding these interactions is about the assignment of "positive" and "negative" to the interactions. Loathe to claim what Moore has called "the pretense of neutrality" (56), I want to acknowledge and embrace my biases and normative positions associated with the terms "positive" and "negative." For example, one point of departure for the above sections on religious influences on healthcare is that vaccines are good and beneficial, not bad or harmful, as some have argued (cf. footnote #8), and therefore religious influences that interrupt vaccine administration are taken in turn to be harmful. While this is not, in my estimation, a particularly controversial or complicated position, despite a relatively very few but very vocal antivaccine healthcare providers, the discussion of the reverse interactions, viz. those of healthcare on religion, are more controversial and complicated and therefore require a more nuanced consideration.

A negative for one person may, of course, be seen as a positive by another. At first glance, for instance, a "negative" influence of healthcare on religion might be precipitating a spiritual crisis, but yet, as mentioned above (Moss), crises can, as people

struggle through them, lead eventually to increased personal growth. Similarly, for those who think, as do the antireligion writers referred to in footnote #7 as the Four Horsemen, that religion has a net-negative effect on society and human flourishing, a finding such as that in the Moschella study, viz. that a new diagnosis of cancer led a majority of patients to have a greater faith or more church attendance or to engage in more prayer – essentially, to be more *religious* – may be considered a harmful outcome.

This thesis, by contrast, takes as a point of departure that religion is best considered not to be itself inherently good or bad, but rather simply something that exists embedded deeply in the world. In this sense, religion bears some similarity to other omnipresent facets of our physical and social worlds. The ground upon which we walk, for example, as illustrated in a recent poem on religious literacy, is akin to religion insofar as "Wherever you go, to the pews or to skid row // Religion paves the road; it surrounds us from head to toe" (Cunningham *It's Considerate to Be Literate About Religion…* 16). That ground may be interpreted as sacred by a Native American, as ripe for lucrative development by an investor, or as merely a way to get from point A to point B by a person who is ground-agnostic, but the ground, qua ground, is neither objectively good nor bad. Like grounds, religions are interpreted and employed by humans in manifold ways, sometimes positively or peacefully and sometimes negatively or violently, sometimes leading to human flourishing, and other times impeding it.

Such diverse ways of interpreting religions are keenly seen in the world at large and of course also in the healthcare area. Although the general population and the healthcare population are similar in their need to live better together, there are some key differences between these populations that are highly relevant. A brief consideration of

how these populations differ will set the stage for our analysis of religious literacy vis-à-vis healthcare.

Chapter IV:

Comparison and Contrast of Religious Literacy vis-à-vis Healthcare

What Is Special about Healthcare?

The experience of patients within the healthcare system is different in some important ways from the experience of people in the general population regarding their respective religion(s)/spirituality. The vast diversity of different faith traditions and spiritual identities that exists in the general population is generally mirrored in the patient population, so what primarily makes the healthcare experience different is not necessarily a greater religious or spiritual diversity, but rather the social constraints and the power differentials that exist in healthcare.

In the general population, people tend to self-select into like groups, often according to the preferences of people moving about in the population. It is a widely accepted fact about human psychology and cultural evolution that humans tend to self-select in this way, to be tribalistic (Henrich 200); we generally prefer to be with those others who look, dress, eat, smell, pray, etc. as we do. In a healthcare setting, however, especially in the confines of an inpatient setting such as a hospital, it is often a call schedule – not one's personal, culturally evolved preferences – that determines whom one will be with when seeking and/or receiving care.

In addition to these constraints, in the healthcare area there is also an important power differential between patient and provider, whereby one person in need of care is beholden to another person in a position of power to provide the care – a relational

inequality that does not generally exist among peers, colleagues, co-workers, neighbors in the larger, less restricted community of society at large. Clearly, religious literacy is important in the daily lives of people in the general population, but what really separates the healthcare arena, imbuing religious literacy with much higher stakes there, are this power differential and the loss of freedom to choose whom to care for and from whom to receive care.

A third, somewhat obvious difference is that the patient population is an at-risk population. They are, as discussed below, generally of lower socioeconomic status and are often in a vulnerable state due to illness or injury. Even people free of current illness or injury, however, such as those seeking routine health maintenance in a healthcare setting, are still very often subject to the power differential and the socioreligious confinement.

Healthcare work, then, is a kind of interfaith work, and healthcare providers and their administrators should be well versed in interfaith leadership in healthcare, which includes spiritual care, both of which rely on religious literacy, as argued in Chapter I. Because the work of healthcare happens in and to a patient population that is not only diverse but is also constrained by call schedules, and because there is a power differential, the resultant high stakes require moving beyond mere diversity to pluralism in healthcare.

Though the difference between diversity and pluralism is sometimes overlooked, it is essential. As discussed above, while diversity is only a demographic fact, pluralism "goes beyond mere plurality or diversity to active engagement with that plurality" (Eck 70), and it is that active engagement which is needed in (and partly *defines*, I would

argue) healthcare. Interfaith leadership, perhaps best described by Patel, building upon the writings of Eck, is the work of leading individuals and communities that orient around religion differently toward increased understanding and cooperation (4). And in healthcare, the *individuals* in this interfaith setting are the patient and the provider; the *community* of the provider is comprised of colleagues, office and hospital staff, trainees, etc., while that of the patient is their family, friends, advocates, and other members of their support community (all of whom may be religious, but often do not self-identify as such). And the *work* at hand is the healthcare of the patient which requires from all these diverse people precisely that understanding and cooperation through active engagement with diversity that Patel and Eck describe.

Religious Literacy in Healthcare

The four notions of religious literacy discussed above are neither the first expressions of religious literacy nor are siloed expressions isolated unto themselves. Jackson, for example, despite not using the term "religious literacy," described already in 1997 what he termed an "interpretive approach" to religion in general and religious education in particular (*Religious Education*). Several elements of Moore's notion of an understanding-based religious literacy are recognizable in Jackson's earlier work, including an appreciation for the internal diversity of religions, an understanding that religions do not speak for themselves as actors with agency in the world but rather require interpretation, and an embracing of the need for all people to recognize their own situatedness in relation to religion(s).

Even though Moore's notion of religious literacy privileges understanding over knowledge while Prothero's reverses this hierarchy, Moore and Prothero both recognize

the value of knowledge *and* understanding. However, I am arguing that knowledge, while necessary and certainly helpful, is not sufficient for a religious literacy that is optimized for the healthcare arena. While Prothero is spot-on that living and participating fully in the United States – a democracy historically governed by White, straight, male Protestants – requires having a good working knowledge of that perspective and faith tradition, in healthcare, by contrast, most patients are not White, straight, male, and Protestant, so it is essential that the foundation of religious literacy upon which to build relationships with diverse patients be one that allows broader understanding of religion, especially given the high-stakes power differential and social confinement that characterize healthcare and its vulnerable patients.

Both Moore's understanding-based religious literacy and Ford and Higton's faith-based religious literacy stress the important difference between what I have called religious engagement *from the inside* versus *from the outside* (Cunningham *It's Considerate to Be Literate About Religion…* 6). The phrasing used in the American Academy of Religion's executive summary for this *inside* engagement with religion is "confessional or prescriptive," or theological, whereas engagement with religion from the *outside*, by contrast, is termed "descriptive or analytical," a cultural-studies engagement (AAR Board of Directors). Very similarly, Ford and Higton describe the difference between the from-the-inside *theology* that characterizes the crux of their faith-based notion of religious literacy and from-the-outside *religious-studies* approach. For them, studying religion from the inside, but not studying from the outside, often assumes a faith of the person doing the studying, and religious literacy, they argue, requires not only religious studies but also theology.

When applied to the healthcare setting, however, Ford and Higton's notion of religious literacy falters. Given the social constraints and the power differential that patients are exposed to within healthcare, an optimal religious literacy would be one applicable to a broad diversity of religious traditions and spiritual identities. As Dinham and Francis note in their consideration of Ford and Higton's faith-based notion of religious literacy, even though they, Ford and Higton,

> are clear that Theology and Religious Studies are not the same as religious literacy[, they] want them to be used as tools to achieve it[, but t]his renders it a necessarily intellectual and therefore somewhat elite endeavour, likely to appeal to and work for a limited number of participants. (16)

Although Ford and Higton seem to want their approach to be broadly applicable, even they themselves acknowledge the impracticability of expanding their uniquely Christian endeavor:

> Far more space would be needed to do justice to other traditions, but we are confident, based on experience of what happens in settings where a Theology and Religious Studies approach has had time to mature, that analogous positions to that we propose in relation to Christian Theology can be maintained convincingly with regard to other religions. This chapter might be seen as an invitation to develop such positions in relation to religious literacy. (40-41)

There are some problems, however, with this optimistic perspective, the most formidable of which is practicality. How such an approach could be operationalized in the healthcare setting is entirely unclear. Given that their notion of religious literacy requires in-depth engagement with theology and that religious diversity is high and markedly increasing in the United States,[10] it is not practical to reach such a detailed

[10] Although religious diversity itself is often overestimated by citizens in their Western countries (cf. Ipsos MORI. "Perils of Perception Study." Ipsos MORI https://www.ipsos.com/sites/default/files/publication/2014-11/6656-ppt.pdf. Accessed July 12, 2023.), the *rate of increase* of religious diversity is nevertheless impressive, as the number of people self-identifying as non-Christian has increase four- to nine-fold since the 1960s (Smith, Tom. "Religious Diversity in

understanding of each particular theology of each particular patient's particular religion. While the approach of Ford and Higton is admirable in taking seriously a deep engagement with the formal Christian theology that has developed over centuries and is the most common theology in the United States (Pew Research Center "Religious Landscape Study"), their notion of religious literacy is not only unfeasible practically, but also it essentially omits consideration of less formal and systematic belief systems and worldviews that are nonreligious and/or nontraditional. In the increasingly diverse general and patient populations in the United States, the examples of such belief systems and worldviews are numerous: including religions that cannot be accurately characterized as generally even having a theology to speak of, such as Buddhism, adherents of which there are nearly 4 million in North America, the global region with the second highest number of Buddhists in the world (Pew Research Center "The Global Religious Landscape: Buddhists"); including the so-called "nones" who respond to surveys claiming no particular religious affiliation, and whose proportion in the general population has swelled in recent decades according to several surveys, such as General Social Survey from the University of Chicago, from 5% in 1972 to nearly 25% in 2018 (Burge 14), but who are increasingly recognized to be quite spiritual and even religious, despite their responses to surveys (Cadge; Grose; Stark);[11] and including the truly

America: The Emergence of Muslims, Buddhists, Hindus, and Others." *Journal for the Scientific Study of Religion*, vol. 41, no. 3, 2002, pp. 577–85.).

[11] Wendy Cadge (Cadge, Wendy. "Interfaith Lecture Series S2023:E - Wendy Cadge." Chautauqua Institution, July 10, 2023 2023. https://assembly.chq.org/m/ndqvTM0M/wendy-cadge?r=aK0mw24f&play=1&seriesId=f0KgKfBy.) in particular notes that religion in United States is currently in a transitional time, similar to what sociologist Ann Swidler called an "unsettled time," which is a cultural period in which ideologies govern action, as opposed to settled periods in which culture independently influences action (Swidler, Ann. "Culture in Action: Symbols and Strategies." *American Sociological Review*, vol. 51, no. 2, 1986, pp. 273-28.), and in this unsettled period, Cadge explains, the delivery systems for spirituality and religion are changing. Replacing the delivery systems of traditional churches and congregations, there are now many new delivery systems, what Cadge calls the "spiritual

nonreligious who self-identify as atheist or agnostic but who, by virtue of being human (cf. footnote #6) are spiritual, such as this writer. People from all three of these categories are not well accounted for by Ford and Higton but are just as likely as anyone to find themselves patients in a healthcare setting, even though their intrinsic spirituality may manifest in ways not recognized by Ford and Higton's notion of religious literacy.[12]

One good point that Ford and Higton do make, however, about practical application will segue nicely to consideration of Ennis's practice-based notion of religious literacy: When Ford and Higton argue that students should learn about Christian reasoning by "learning to reason Christianly" (41), they are describing an essential aspect of religious literacy, especially as it applies to healthcare, viz. the importance of a practical, hands-on approach. If we think back to Prothero's comments that "religious literacy *in the abstract* is an impossibility" (12; my emphasis), it is clear that he too embraces the importance of concrete engagement with religion. Ironically, however, Ford and Higton are describing religious literacy in an exclusively Christian context, and that exclusivity essentially precludes their approach from being applicable to the healthcare setting. But the idea that a practical, hands-on approach is sometimes the most effective one is nevertheless precisely the idea upon which we now pivot to the fourth notion of religious literacy applied to healthcare.

There are several aspects of Ariel's practice-based approach to religious literacy that warrant further discussion regarding applicability to healthcare. These include: an

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infrastructure" of the future (a major key to which, she argues, are and will be chaplains and spiritual-care providers, as well as nontraditional or nonchurch modes of gathering in meaningful ways, both in person and online), which is largely replacing churches and congregations but nevertheless serving the very similar spiritual and religious needs.

[12] Religious literacy being, as discussed above, something that undergirds, shores up, provides a necessary foundation for spiritual care, which all patients, even those who self-identify as nonreligious, need and deserve.

understanding of the embeddedness of religion in human life, especially the social, political, and economic aspects of public life; a recognition of the situated perspective that each person brings to religion and healthcare; and a call for religious allyship. Several of these are similar to aspects in Moore's understanding-based notion of religious literacy in their applicability to healthcare. Prior to examining these in more detail and assessing their application to healthcare, however, additional consideration is needed of what an ideal notion of religious literacy in healthcare would look like.

The healthcare arena is unlike many aspects of human society. Not only is there, as discussed above, a diversity of patients subject to social restrictions that prevent the normal self-selection into social groups and a power differential that subjects patients to a position in which they are dependent on their providers, but the healthcare population – especially the hospitalized population – is characterized by the presence of an illness or injury that precipitates the encounter with the healthcare system, an encounter often experienced as a personal crisis in the lifetime of the patient (Balboni et al. "Spirituality in Serious Illness and Health"). The healthcare population is further characterized by a lower socioeconomic status, which itself has been associated with increased rates of hospitalization (Abdel-Rahman), with more readmissions to the hospital (Gershon et al.), and with greater utilization of and reliance on the emergency department (Schlichting et al.). Indeed, apropos of socioeconomic status, there is increasing evidence and appropriate attention in the media (Abutaleb) and in the medical literature (Koch; LaVeist and Pierre; Schillinger) paid to such social determinants of health, of which religion – in

particular being discriminated against as a religious minority – is an often overlooked one.[13]

However, it is not only patients, but also their providers who warrant closer examination regarding considerations of an ideal notion of religious literacy applied to healthcare. Although healthcare-worker burnout was particularly fierce during the COVID-19 pandemic, during the surges of which "exhaustion and moral distress became nearly universal among workers" (Wu et al. 711), even prior to the pandemic, burnout was highly prevalent among healthcare workers. In a systematic review published the year before the COVID-19 pandemic, for example, prevalence estimates of overall burnout and burnout subtypes among physicians were 67.0% for overall burnout, 72.0% for emotional exhaustion, and 68.1% for depersonalization (Rotenstein et al.). And burnout is not, of course, limited to physicians; other types of healthcare workers experience high rates of burnout, especially nurses (Lopez-Lopez et al.) and social workers (Parola et al.).

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[13] As discussed in Chapter III, religion is *not* a particularly overlooked social determinant of health regarding the case of *being religious*, but my point here is that much or most of the literature on social determinants of health and health-disparities research has traditionally focused on social parameters such as race, socioeconomic status, gender, etc., and not on religion. For example, an unfiltered PubMed search for "social determinants of health" at the time of this writing returns 42,659 results, a similar search for "social determinants of health socioeconomic status" returns 7,952, and one for "social determinants of health race" returns 3,998 results, whereas a search for "social determinants of health *religion*" returns only 591. When the searches are filtered to include only systematic reviews of the literature, "social determinants of health" returns 1,741, whereas "social determinants of health religion" returns 22 results, many of which only mention religion in the introduction, but do not actually include it in the analyses. When filtered by reviews and with results sorted by relevance, in a search for "social determinant," none of the top three results even mention the term "religion" (Alegria, M. et al. "Social Determinants of Mental Health: Where We Are and Where We Need to Go." *Current Psychiatry Reports*, vol. 20, no. 11, 2018, p. 95, Medline, doi:10.1007/s11920-018-0969-9, Braveman, P. and L. Gottlieb. "The Social Determinants of Health: It's Time to Consider the Causes of the Causes." *Public Health Rep*, vol. 129 Suppl 2, no. Suppl 2, 2014, pp. 19-31, Medline, doi:10.1177/00333549141291S206, Thornton, R. L. et al. "Evaluating Strategies for Reducing Health Disparities by Addressing the Social Determinants of Health." *Health Affairs (Millwood)*, vol. 35, no. 8, 2016, pp. 1416-23, Medline, doi:10.1377/hlthaff.2015.1357.) It is because of this deficit of consideration of religious discrimination in the health-disparities literature that I refer here to religious discrimination – which, like racial and other forms of discrimination, in frequently implicit and unrecognized – as an often-overlooked social determinant of health.

And sadly, but unsurprisingly, healthcare-worker burnout is associated with poorer-quality care. In a systematic review and meta-analysis of the literature, Tawfik et al. examined 123 publications including 241,553 healthcare providers to examine the relationship between quality of care and burnout. Studying five quality-of-care outcomes – best practices, communication, medical errors, patient outcomes, and quality and safety – they found among the 74 studies in the quality-and-safety category a highly statistically significant ($p < 0.001$) association between burnout and quality of healthcare (560), underscoring the important relevance of provider burnout to the current thesis.

Therefore, given all these aforementioned unique aspects of healthcare compared to the general population, and given that religious illiteracy, as discussed in Chapter I, is at least as, if not more, prevalent in healthcare than in the general population, and given that patients want and need the religion/spirituality to be a part of their care plan but that providers lack the religious literacy to do so, the important question persists: what would an ideal notion of religious literacy for healthcare providers looks like? The high degree of diversity in healthcare demands that it be one able to be readily applied to a religiously diverse population, a demand which largely excludes the (exclusively Christian) faith-based notion of religious literacy described by Ford and Higton. Pace their claim that their approach as applied by them to Christianity could be similarly applied to other religions (Ford and Higton 41), it is not all clear that this is feasible in the educational setting for which they propose it, much less the more time-restricted and unpredictable healthcare setting. And because nobody – especially not overworked, burnout-prone healthcare providers – can know every fact about every religious tradition and worldview, a more fact- or knowledge-based notion of religious literacy such as that

proposed by Prothero is also inadequate – at least on its own – for application to healthcare settings.

The understanding-based notion of religious literacy by Moore and the practice-based notion of religious literacy described by Ennis, however, bear a closer look. Both of these approaches hold promise for applicability to healthcare, and indeed, as discussed above, share significant overlap: both stress an *understanding* of religion as deeply embedded in public life, both therefore do not rely solely on the knowledge of facts that limit Prothero's approach, and both are readily employed in a diverse population without the requirement of Ford and Higton to engage deeply with theology, to "reason Christianly." Indeed, the stress on bridging divides described by Ennis as a key aspect of practice-based religious literacy, as "a commitment to using religious literacy to inform one's work to bridge intercultural divides" (18), is particularly relevant for healthcare providers, who need to be what Ennis terms "allies":

> [our] definition [of religious literacy] is heavily influenced by Dianne [sic] Moore and her articulation of the interconnection of religion with other global forces. And yet, we have also created a definition of religious literacy that requires action as well as knowledge. In our definition, being religiously literate necessitates putting knowledge into practical use as an ally and by creating space for conversations about religious diversity to flourish. At first glance, allyship and dialogue may seem to be identical manifestations of religious literacy, but there is actually a critical distinction between showing up as an ally and discussing religious differences openly and productively in day-to-day settings. In the first instance, one utilizes religious literacy to attend a rally in support of a colleague who experiences a form of religious discrimination. In the second, one utilizes her position as a manager in her unit to create an environment where people feel comfortable expressing religious identity and asking for religious accommodations as they need. These two manifestations complement each other, but are both equally important to manifesting religious literacy in daily life. (9-10)

The use of "her position as a manager" in this passage exemplifies the appropriateness of this notion of religious literacy in healthcare, where, as discussed above, there is always

such a power differential between the healthcare provider and the patient who is beholden to the provider for care.

Although, as discussed in Chapter I, there is no universally agreed upon quantitative measure of religious literacy, Ennis and colleagues at NYU's Global Spiritual Life have developed a qualitative-semiquantitative measure of religious literacy for use in higher education. In what they have termed "Faith Zones," Ennis and colleagues have developed at NYU

> a new way of thinking, teaching, and talking about religion and spirituality that was also paying homage to the phenomenal work of the LGBTQ "Safe Zone" programs. I imagined this introductory diversity education training as a place to begin finding shared language for talking about complex issues related to belief systems and religious tenets, experiences of identifying as atheist or agnostic, or even a "none," and learning to be comfortable having these conversations with classmates, colleagues, and other community members. (vi-vii)

Their Faith Zone project of measuring religious literacy relies on the development of a rubric for analyzing the progress of participants along their four aforementioned pillars of religious literacy (14). For each of these pillars, students may be scored 0-3 after participation in one of the three-hour Faith Zone workshops led by Global Spiritual Life staff. Ennis acknowledges that attaining level 3 "is something we do not expect to see as a result of our 3-hour workshops, but it is a goal for how a senior who has been involved in our office for several years might articulate these concepts" (14), which is a rather high bar to be applied to the busy workaday lives of healthcare providers. Moore's approach, by contrast, and as exemplified below in actual experience, is amenable to a more practical, shorter-term intervention that is manageable within the restrictions of healthcare settings.

Regarding the several reasonable points that Prothero makes about his knowledge-based religious literacy – e.g., that the fact that "Christianity's dominance swells as you enter the corridors of [United States] power" (12) necessitates knowing the facts of this particular religious tradition well – his approach clearly allows the disconcerting possibility of being factually "literate" regarding the content of Christianity despite being religiously illiterate in Moore's conceptual sense, as delineated above. Indeed, it is not difficult to imaging a perfectly "Bible-literate" or knowledge-literate individual, well-versed in Prothero's or Ford and Higton's Christian literacy, but who is religiously illiterate by Moore's or Ennis's definition, e.g., who sees religions as monolithic and stable over time, who thinks that a religion is simply its rites, rituals, and ceremonies or is defined merely by its scripture, who thinks of religions as actors with agency, who blames a religion at large for the actions of individuals within that religious tradition, and who fails to see a difference between the devotional expression religion, with all the particular, normative, theological assertions that accompany such expressions and interpretations of devotional religion on one hand, and, on the other hand, the nonsectarian, nontheological, academic, descriptive, cultural-studies approach to religion.

Another good reason, therefore, to privilege Moore's notion of religious literacy is that it allows and indeed facilitates the kind of content literacy that Prothero and Ford and Higton advocate, while the inverse is not necessarily true. While Prothero is correct that utter ignorance of Christianity (and other religions) severely impairs a citizen's ability to function well in our sociopolitical world, Moore's religious literacy allows one to navigate that world with an understanding of all the myriad manifestation of religion

and to avoid the common pitfalls that Moore, Prothero, Ford and Higton, and Ennis all know commonly occur from a lack of religious literacy.

Chapter V.

The Big Picture

Future Directions: Designing a Quantitative Measure of Religious Literacy for Application to Healthcare

Although there are scores of instruments available in the literature to measure religiosity/spirituality – DUREL being one of the most common (Koenig and Büssing) – no widely used, validated, quantitative instrument exists to measure religious literacy (Fitchett; Hill; Muehlhausen). Thus far, four published conceptions of religious literacy have been evaluated and their applicability to healthcare considered, none with such an instrument available, leaving Moore's (AAR Board of Directors) understanding-based notion the most appropriate and practical for use is scale development. The concepts contained therein are: 1) that religions are internally diverse & dynamic; 2) that confessional, prescriptive, or theological statements made (from "the inside") by and about religions differ in important ways from descriptive, analytical, or cultural-studies assessments made (from "the outside"); 3) that religions have influenced – and are influenced by – the experiences and histories of individuals, communities, nations, and regions; 4) that one can discern knowledge that is accurate and credible about religions and their various expressions (including both basic, general facts about religious traditions and the fact that religions are not actors with agency); and 5) that multifarious religious expressions employ and reflect the culture and contexts in which the religions exist (that they, like all the humans who interpret the religions, are situated in a particular time and context). All of these five key concepts are readily amenable to being communicated with teams of healthcare providers, as evidenced by my experience

communicating them in a variety of invited presentations in various forums, including to chaplains (Cunningham "It's Considerate to Be Literate About Religion: Chaplains and Religious Literacy"; Cunningham "Su1.05 Religious Literacy for Chaplains"), to social workers and case managers (Cunningham "A Discussion of Religious Literacy for Case Managers"), to palliative-care providers (Cunningham "The Spiritual Care of Patients: A Discussion of Religious Literacy for Palliative-Care Providers"), and to other allied healthcare professionals, including nurses, pharmacists, other physicians, and technicians (Cunningham "Religious Literacy for Healthcare Providers"). Audience responses were overwhelmingly positive, with presentations often engendering requests for future presentations. For example, of 26 evaluation responses following the presentation to allied healthcare professionals, the evaluation of the "program as a whole" was 96.2% favorable (42.3% very good, 34.6% excellent, 19.2% good, and 3.85% fair).

Future directions include the development, validation, and use of such a scale. Given my role as a cancer surgeon, given the aforementioned observations that hospitalized patients are often facing a life-crisis situation, especially those facing a potentially life-threatening situation, such as a cancer diagnosis or a major (>2-h) operation, given that all patients and especially these patients with serious illness (Balboni et al. "Spirituality in Serious Illness and Health") are in need of spiritual care, and given that such care relies on good religious literacy of their providers (vide supra), these patients would constitute an appropriate cohort for future development of a novel, quantitative measure of religious literacy. And my place of employment, Ascension Saint Agnes, a private, religious, community, teaching hospital in Baltimore with a religiously and socially diverse patient and provider population, would accordingly be an

appropriate venue for the development and validation of a quantitative scale of religious literacy.

The level of religiosity/spirituality of a population is obviously relevant to any inquiry into the religious literacy of that population, and therefore future study of religious literacy in the healthcare setting should include a measure, using an established, validated scale of religion/spirituality such as DUREL. This assessment would ideally be applied both to patients and to their providers for baseline comparisons.

Having a general understanding of the religiosity/spirituality of this population of patients and providers, a next direction for future work about religious literacy would consider venue and audience. Given that Moore first described her religious literacy approach in secondary education (*Overcoming Religious Illiteracy*), the question arises about whether her religious literacy program for secondary education can be adapted to assessing religious literacy in an adult, hospital setting. In other words, can a new, quantitative, religious-literacy instrument be designed, formally validated, and used to measure religious literacy in this Ascension Saint Agnes population?

If so, a next step would be to assess religious literacy among providers working with patients facing a life-threatening situation, such as a cancer diagnosis or a major operation and to assess if the baseline level of religious literacy among providers can be increased by a short-term intervention teaching religious literacy, such as the presentations to healthcare personnel cited above.

Still further future directions include assessing the generalizability from a single Ascension institution to include other Ascension hospitals of the same type, followed by

a comparison of the Ascension experiences to that of a secular, quaternary-care, state-university-hospital setting.

And perhaps the most important direction would ask the question of whether there are benefits accrued by patients regarding their overall experience. Although, as discussed above, data are lacking (hence the need for the instrument proposed herein), there is ample reason to think that patients will benefit from their providers having increased religious literacy. In his 1963 *Man's Search for Meaning*, Viktor Frankl popularized the idea that, in light of the unavoidability of suffering, the human problem is not so much suffering, per se – since we all do and will suffer – but rather suffering without meaning, and that one's religiosity/spirituality is what provides the essential meaning (87) – meaning which is so badly needed to accompany the inevitable suffering that accompanies the illness and injury that brings people to engage with the healthcare system.

Finally, given the above discussion of provider burnout in Chapter IV, an appraisal of the impact of such an intervention on providers and *their* experiences working with these patients would be omitted from this work only remissly. The risk of suicide is five to seven times higher for physicians than for the general population (Ventriglio et al.), and surgeons, who comprise one of the main provider groups of interest for this work, are in one of the highest-risk specialties (Dutheil et al.), a fact consistent with the high rates of burnout discussed in Chapter IV. It is probably not merely coincident to this fact that surgeons score high among other physicians in measures of verbal aggressiveness (Lazarus et al.). Yet, surgeons, who literally and figuratively touch patients more intimately than many or all other specialties, may be

uniquely poised to leverage this intimacy in the service of patients. As surgeon writer Richard Selzer has poetically put it, "The flesh is the spirit thickened" (Selzer *Letters to a Young Doctor* 14), and although this perspective has been taught to some surgeons-in-training (Cunningham and Sutton), much work remains to be done. Surgery, due to its ability to present patients with a crisis situation, and to the role of surgeon as priest (Selzer *Mortal Lessons* 24-36), may, ironically therefore, be particularly suited to addressing the spiritual needs of not only the patient, but also the themselves and their discipline. As Judith Petry has pointed out in her apropos-titled article "Surgery and Meaning," "by approaching surgery as a potential catalyst for healing and helping patients to explore the meaning of their surgery in their lives, we can heal the patient and the specialty" (365).

Before all of that can happen, however, surgeons – indeed all healthcare providers – need to be more religiously literate. As reviewed above, lack of religious literacy is very commonly cited by healthcare providers as a barrier to the provision of spiritual care that patients want and need. However, because religion, like politics, is often considered something that one simply knows not to talk about at the Thanksgiving table, that same culturally acquired reticence unfortunately spills over into the professional lives of providers, to the detriment of patients (Balboni et al. "Spirituality in Serious Illness and Health"). But when providers are more religiously literate, they are more comfortable addressing the religious and spiritual needs of their patients. And because, as the adage goes, "you can't manage what you can't measure," a scale for religious literacy is a necessary tool, not only for the clinical application described here, but for research use as well.

A reasonable hypothesis for this future work, therefore, is that healthcare providers who become more religiously literate will be better able to provide the spiritual care that addresses the meaning that patients ascribe to their illness or injury, and that this religiously literate provision will meaningfully improve both patient and provider experience.

Proposed Methodology of Future Work

Given that the crux of this future work would be the design and validation of a novel, quantitative scale, the methodology of that work would be focused on the technical aspects of the task. As helpfully outlined by Boateng in his review of best practices in scale development, there are nine discrete steps, which he divides into three phases: Phase I focuses on the development of questionnaire items, which first requires the identification of the domain(s) or construct(s) to be measured, which in the present case would be the concept of religious literacy as defined by Moore and the AAR. Once the domain is defined, then items are generated. Given that later steps will eliminate many question items, a broad net should be cast in this first phase to generate about twice as many items as the anticipated final number of items. After the identification of domain(s) and generation of items that characterize step 1, step 2 generally convenes a group of content experts to assess the content validity of the items. Phase II, scale development, then proceeds to step 3, which pretests the questions individually, prior to their inclusion in the survey, to ensure that they are meaningful as intended and to minimize misunderstandings. In step 4, the format for survey administration is determined, along with the sample size of the test population for assessing the quality of the initial set of survey items (10 people per survey item is a general guideline, but as

Boateng points out higher ratios of test population to item number are always better). Step 5 is item reduction, based on the results of the work in prior steps, and in step 6 – factor extraction – the optimal number of factors (a.k.a. domains) for the survey is determined using factor analysis, which is a regression model of unobserved (latent) factors and observed standardized variables that are taken to stand for the latent factors. Phase 3 then evaluates the scale with several tests. These include: tests of dimensionality in step 7, which is sometimes omitted; tests of reliability in step 8, which typically includes testing for internal consistency of items and for consistency over time when the same population takes and then later retakes the survey; and finally tests of validity in step 9.

Such future work, despite its promises, will have several potential limitations, including all those delineated by Morgado et al., who have described in a systematic review the limitations of scale development, as reported by the authors of 105 relevant publications included in their analysis (9). By far the most common limitation observed by investigators during scale development was problems with sample characteristics, noted by 81% of studies. The next two most-common limitations were those attributable to methodology and to psychometrics, each noted in about one third of the studies evaluated. Less common limitations to expect in this future work include missing data, social-desirability bias, item limitations, difficulty controlling for all potentially confounding variables (each noted in <3% of the studies evaluated) (Morgado 9).

Conclusion

In this thesis, I have argued that healthcare and religion are deeply related, each influencing the other both positively and negatively, that healthcare and religion, which

were born and raised together and underwent a transient parting of ways during the Renaissance and the Enlightenment, have in recent decades begun a reconciliation accompanied by an increasing awareness in healthcare of the importance of religion/spirituality for patients. Yet, at the same time, healthcare workers are suffering increasing levels of burnout and, of course, due to this and other reasons reviewed here, often therefore feel unable to provide the spiritual care that the literature and abundant experience shows that patients clearly want and need. Part of the problem is time constraints, certainly, but perhaps a bigger problem is providers lacking the religious literacy to meet this need. There is often a misplaced but entrenched fear among healthcare providers that religion is too deeply private an issue to discuss. An increased religious literacy is clearly needed to make patients and their providers better together, but what kind?

Of the four salient notions of religious literacy examined here – Moore's based on understanding, Prothero's on knowledge, Ford and Higton's on faith, and Ennis's on practice – Moore's understanding-based notion is most appropriate for application to healthcare settings. Its concepts are easily communicated in a standard, one-hour, small-group, in-service, healthcare workshop, or in a large-audience, lecture format; it avoids the pitfalls both of being exclusively Christian and of requiring a working familiarity with the intricacies of any one religion's theology (or lack thereof); and it is amenable to use in scale development and deployment in support of future research on religious literacy in healthcare.

Such an endeavor, however, is helpfully informed by the other three notions: it is not only patients and providers who can be aptly described as working better together

with religious literacy, but also the four notions of religious literacy reviewed in this thesis are also better together. In other words, although Moore's notion is the most appropriate for application to healthcare and for use in quantitative scale development, the other three provide useful aspects that one would be wise to incorporate, or at least to keep in view, especially the hands-on, practical approach of Ennis, which stresses recruitment of religious-literacy allies, of which there are many potential options in both the inpatient and outpatient healthcare settings. Similarly, Prothero's focus on knowledge, while incomplete, informs us that more knowledge of the religious traditions that providers are likely to encounter in their daily work can only make better an understanding-based religious literacy. Providers who wish to broaden and deepen their fund of such knowledge may avail themselves of any of several good references on religious traditions (Cobb et al.; Fisher; Weber and Walter). Finally, and similarly, the taking seriously of theology, despite the limitations of Ford and Higton's notion of religious literacy as broadly applied to healthcare, underscores the value of a deeper versus a merely superficial engagement.

What is clear is that the stakes are high regarding religious literacy in general and particularly high regarding religious literacy in the healthcare setting. The stakes are higher in healthcare not only because of the increased demands of pluralism in a setting that subjects patients to a power differential and restricted social choices, but also because religious diversity, much like racial diversity, presents an opportunity religiously based discrimination to occur, leading to all three levels (cultural, structural, and direct) of Galtungian violence to occur (Galtung). Just as embedded racism is one of the many social determinants of health, so too embedded assumptions, biases, and uncertainties

about religion put already-at-risk patients at further risk in a religiously diverse healthcare setting where they are beholden to providers to whom they are socioreligiously restricted, and therefore at risk of poorer care.

It is not only patients, however, who stand to benefit from increased religious literacy in healthcare. Burnout of physicians and other healthcare providers is an increasing problem, and when presented with the charge to do one more thing that they do not have time to do, such as provide the spiritual care that the landmark 2022 paper by Balboni et al. (184) calls for – spiritual care that is greatly facilitated by increased religious literacy – those providers may well reply that they are too simply busy to be able to afford to spend the time. However, mounting evidence and experience about benefits accrued by providers who do tend to spiritual care suggests that those tables should turn: it is not that providers cannot afford to spend the time, but rather that they cannot afford *not* to, given the ability of tending to spiritual care, undergirded by religious literacy, to improve provider well-being and decrease burnout.

The juxtaposition of these two ways of perceiving the healthcare provider's spending of time on increasing religious literacy and thereby facilitating the provision of good spiritual care – 1) as something that one cannot afford to do or 2) as something one cannot afford not to do – presents an ambivalence of time and other resources and how we should spend them. In part because healthcare is sacred work, I am borrowing Scott Appleby's term here: "the ambivalence of the sacred" (Appleby *Ambivalence of the Sacred*), whereby he means "the pre-moral, pre-interpreted, 'raw' (if always mediated) experience of the radical mystery of the numinous" (Appleby "Religious Violence" 36). In the field of religious peacebuilding, Appleby's ambivalence of the sacred has served as

a useful lens through which to see many, different, diversely troubled situations, including in Rwanda (Clark), the United States (Cunningham "Manifest Destiny"), and, most recently, the Ukraine (Hanna). When surgeons or any healthcare providers are presented with an apparent duality – such as between what I referred to above as an *inner* versus an *outer* engagement with religion, or between not having enough time to attend to religious literacy in the service of the spiritual care of patients versus not being able to afford not to make the time – this concept of ambivalence becomes relevant.

When Jakelić discussed a particular aspect of Appleby's work, viz. that it "links in important ways the analytic and normative components of the study of religion" (99), she also highlighted the ambivalence between the aforementioned outer, analytic, descriptive versus the inner, confessional, prescriptive engagement with religion. There is an ambivalence in such instances because the apparent duality is false; neither of the two options need be the sole case: just as one can engage with religion both from the inside and from the outside, so too can the busy healthcare provider both not have the time but yet not afford not to have the time. It is the acquisition of religious literacy that melds the two and resolves the duality. In other words, religious literacy is a tool for navigating the ambivalence of time, as well as the ambivalence of the sacred.

One of Appleby's greatest contributions to the study of religion was to underscore that religion is not only the problem, but very often an essential part of the solution in conflicts that have historically revolved around religion (and in the religious influences on healthcare discussed in Chapter III). In the same vein, a patient's religion/spirituality, which is often associated with spiritual distress in the face of illness or injury may also be precisely what paves the path to spiritual healing, and the more religiously literate the

provider, the better this path is navigated. Even among the four notions of religious literacy analyzed here, there also exists an ambivalence insofar as there are elements of each that inform the religiously literate healthcare provider – Moore's stress on understanding, Prothero's focus on the importance of having knowledge about religious traditions and his clear acknowledgement that religions are not merely private affairs but are deeply embedded in public life, Ford and Higton's important insight that the way to best know a religious tradition is to learn a facility with its worldview or theological arguments, and Ennis's essential addition of moving beyond academic religious literacy to a praxis of religious literacy that engages not only diverse others pluralistically but also engages allyship.

The religiously literate healthcare provider can, armed with the understanding-based religious literacy of Moore make use of the insights of the other three, better together. Given, however, that the goal of my future directions is the design and validation of a novel, quantitative-scale instrument, and that Moore's is easily taught to healthcare providers and is most amenable to scale development in application in healthcare, her understanding-based notion of religious literacy is preferred.

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