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Avoid Stigmatizing Language About Atheist Patients



To the Editor:

In response to the article “The urgency of spiritual care: COVID-19 and the critical need for whole-person palliation” by Ferrell et al.,¹ the authors’ use of the aphorism, *No atheists in the foxhole*, insults the worldview of atheists, further stigmatizes a community of patients, families, and clinicians; undermines the role of spiritual care professionals in health care; and is not representative of the whole-person approach heralded in palliative care. The authors must recognize the danger of this aphorism used in a scholarly context, and they should remove this demeaning phrase while finding a more inclusive way to make their point about increased death anxiety during the coronavirus disease pandemic.

The authors highlight that the aphorism is in common use, yet do not address the fact that it insults atheists by portraying atheism as shallow, fragile, and insincere, teetering on the edge of collapse when confronted with the reality of death. Perpetuating these stereotypes makes it more difficult for atheists to openly discuss their own world view and spirituality, in part because of possible concerns about proselytizing or ostracism. Atheism is a concealable and stigmatized identity in the U.S., where atheists are one of the least favorably viewed groups, perceived by others as untrustworthy, immoral, and angry.² Some patients who are atheist, agnostic, or nonbelieving may have lived a life concealing this part of their identity, some may even profess faith outwardly to align with family and community pressures, whereas other atheists live more openly regarding their views. Trusted professionals should provide curious exploration of a patient’s worldview to offer individualized and expert support, but if stereotypes are perpetuated, then patients are further stigmatized.

When palliative care and spiritual care professionals give credence to the proposition that atheists cannot find meaning in death and dying without religion, those professionals undermine patients’ ability to explore life’s most important questions. Patients and families understand the subtext a phrase like this conveys and may refuse to engage with spiritual care professionals. Clinicians learning from articles like this may use the FICA tool or BELIEF tool to screen for spiritual needs but then avoid collaborating with spiritual care providers for patients who do not fit a dominant religious worldview. Administrators looking to fully support spiritual care programs may decide that

not everyone needs access to spiritual care because of reductive phrases like this.

In our experience, we have seen patients who identified as atheist, agnostic, or nonbelieving well supported through serious illness by the health care team, including spiritual care providers. We commonly see atheist patients exploring meaning in legacy making, loving relationships, the wonders of nature and the universe, and the mystery of death while still rooted in their atheist worldview. We also see atheist patients who have unfortunate experiences; made to feel less than equal based on the language and beliefs of clinicians and family members who were responsible to care for them in a potentially vulnerable state.

It is true that contemplating one’s mortality may produce death anxiety, as we have research and clinical experience to support that finding. Yet that can apply to any of us. It is the human condition, not a subgroup condition. The authors can make a strong point on potential death anxiety without perpetuating a stigma, which undermines the aim of the article: access to spiritual care is critically important during the coronavirus disease pandemic. If we seek to equitably achieve this aim, then we must strike stigmatizing, insulting, and undermining language like *no atheists in foxholes* from our scholarship.

Christian T. Sinclair, MD, FAAHPM
Division of Palliative Medicine
University of Kansas Medical Center
Kansas City, Kansas, USA
E-mail: csinclair@kumc.edu

Drew A. Rosielle, MD, FAAHPM
M Health Fairview Palliative Care Program
University of Minnesota Medical School
Minneapolis, Minnesota, USA

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