and Holick. *Critical revision of the manuscript for important intellectual content:* Pietras and Holick. *Statistical analysis:* Obayan and Cai. *Obtained funding:* Obayan and Holick. *Administrative, technical, and material support:* Holick. *Study supervision:* Pietras and Holick.
Financial Disclosure: None reported.

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Physicians' Experience and Satisfaction With Chaplains: A National Survey

Religion and spirituality (R/S) are important resources for coping with serious illnesses, but research indicates that patients' R/S needs often go unmet.[1] Professional chaplains help patients make effective use of R/S resources in the context of illness,[2] but one-third of US hospitals do not have chaplains.[3] Even hospitals with chaplaincy programs rarely have sufficient staff to address the needs of all patients. Given these constraints, physicians and other clinical staff play critical roles in directing chaplains to patients who will benefit from their services.[4] Unfortunately, little is known about physicians' experience with and impressions of chaplains.

Most physicians have little training to guide referrals to chaplains. Some evidence suggests that in the absence of such training, physicians' referral patterns are shaped by their own R/S values and experiences.[5,6] Physicians' referrals may also be shaped by their understanding, or misunderstanding, of chaplains. One study found that physicians with no experience with chaplains feared that chaplains would ignore patients' concerns and disrespect patients' beliefs.[7] Using data from a national survey, we examined physicians' self-reported experience and satisfaction with chaplains. Based on earlier findings, we focused specifically on the relationship between physicians' practice context[3] and R/S views[5,6] and their experience and satisfaction with chaplains.

Methods. The methods of this national survey have been reported elsewhere.[8] We surveyed 1144 US physicians of all specialties younger than 65 years, who were selected from the American Medical Association Physician Masterfile. We examined physicians' reports of prior experience with chaplains (yes/no) and satisfaction with chaplains (satisfied/dissatisfied). Predictor variables included physician demographics, training about R/S in medicine, practice setting, personal R/S, opinions about addressing R/S in the clinical setting, and the frequency (range, 0 "never" to 4 "always") of observing R/S to have 3 different positive and 3 different negative effects on patients.

Results. Among eligible physicians, the survey response rate was 63%. The present analysis includes the 1102 physicians actively involved in patient care. Respondents were predominantly male (74%) and came from diverse specialties, 31% worked at teaching hospitals, 12% worked at faith-based hospitals or clinics, and 64% reported caring for high numbers of critically ill patients. Of the respondents, 10% reported no religious affiliation, 59% reported being Christian, 16% reported being Jewish, and 14% reported other affiliations; 41% agreed with the statement, "My whole approach to life is based on my religion." Forty-one percent of the physicians believed it was appropriate for them to talk about their own R/S with patients when the patient asked about it. Fifty percent of the physicians believed it was appropriate for them to pray with patients when the patient requested it. The physicians reported that R/S "often" had a positive impact on their patients (mean [SD] score, 2.8 [0.5]) and "rarely" had a negative impact (mean [SD] score, 1.3 [0.5]).

Most physicians (89%) reported experience with chaplains. Among these, most (90%) reported being satisfied or very satisfied with chaplains. In a multivariate logistic regression model, experience with chaplains was associated with training about R/S in medicine, seeing large numbers of critically ill patients, practicing psychiatry or obstetrics and gynecology, endorsing positive effects of R/S on patients, and believing that it is appropriate to talk with patients about R/S whenever the physician senses it would be appropriate (**Table**). In similar models, higher levels of satisfaction were associated with practicing medical or other subspecialties, working in teaching hospitals, endorsing positive effects of R/S on patients, and believing it is appropriate to pray with patients whenever the physician senses it would be appropriate (Table). Physicians from the Northeast and those who endorsed more negative effects of R/S on patients were less likely to be satisfied with chaplains.

Comment. On the whole, physicians appear both experienced and satisfied with chaplains. Factors influencing physicians' experience and satisfaction included training in R/S, practice context, observations of positive and negative effects of R/S on patients, and beliefs about when it is appropriate to pray or talk with patients about R/S issues.

This study asked physicians about "experience with chaplains and other pastoral care professionals." In most hospitals the pastoral care professional is the chaplain, but in future research this wording should be more specific. In addition, the term *chaplain* may refer to people with diverse training and experience, from clergy who volunteer on occasion to board-certified chaplains with years of clinical experience.[2] Unfortunately, this study could not assess any chaplain-specific factors. Nor did we have information about the contexts of physician-chaplain encounters (eg, around patients who are anxious, terminally ill, or who have religious objections to treatment). Other research[4] suggests that physicians value some chaplain services, such as providing support around death, more than others. Future studies should examine the situations in which chaplains and physicians interact, the effect of physician training in R/S on such in-

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Table. Multivariate Association of Demographics, Practice, and R/S Characteristics of 1102 Physicians With Experience or Satisfaction With Chaplains[a]

Variable (Reference Group)	Odds Ratio (95% Confidence Interval): Any Experience With Chaplains vs None	Odds Ratio (95% Confidence Interval): Satisfied vs Dissatisfied
MD demographics		
Age	0.97 (0.95-1.01)	0.99 (0.95-1.02)
Female (male)	0.87 (0.47-1.59)	1.49 (0.71-3.11)
Region (Midwest)		
Northeast	0.68 (0.33-1.41)	0.44 (0.21-0.93)[c]
South	0.93 (0.46-1.87)	0.96 (0.46-2.04)
West	0.77 (0.35-1.69)	0.95 (0.41-2.21)
MD training		
Any formal training about R/S in medicine (none)	3.68 (1.58-8.60)[d]	0.67 (0.37-1.20)
MD practice		
Specialty (general medicine)		
Family practice	1.80 (0.70-4.65)	1.19 (0.50-2.83)
Med subspecialties	1.49 (0.60-3.66)	3.40 (1.20-9.67)[c]
Ob-Gyn	3.40 (1.19-9.75)[c]	2.37 (0.74-7.60)
Pediatrics	1.57 (0.59-4.18)	2.29 (0.77-6.75)
Psychiatry	3.38 (1.06-10.74)[c]	1.69 (0.67-4.23)
Surgeons	1.79 (0.65-4.91)	1.84 (0.67-5.04)
Other	0.61 (0.29-1.31)	2.98 (1.10-8.09)[c]
Work at teaching hospital	1.58 (0.90-2.74)	1.94 (1.01-3.74)[c]
Work at faith-based hospital/clinic	1.47 (0.66-3.31)	0.59 (0.27-1.31)
High critical clinical load[b] (low)	1.76 (1.07-2.90)[c]	0.81 (0.43-1.51)
MD personal R/S		
Religious affiliation (none)		
Jewish	1.15 (0.50-2.67)	1.64 (0.65-4.16)
Protestant	2.07 (0.82-5.26)	0.95 (0.41-2.20)
Catholic	1.25 (0.48-3.26)	1.27 (0.48-3.35)
Other	0.62 (0.24-1.64)	0.85 (0.31-2.35)
Life based on religion (strongly disagree)		
Disagree	1.42 (0.77-2.64)	1.82 (0.88-3.76)
Agree	1.42 (0.67-3.00)	1.80 (0.83-3.87)
Strongly agree	1.48 (0.48-4.50)	1.75 (0.69-4.43)
MD use of R/S with patients		
When appropriate to talk about R/S (never)		
When patient asks	1.31 (0.63-2.74)	2.06 (0.96-4.40)
When MD senses	2.73 (1.24-5.99)[c]	1.45 (0.67-3.15)
When appropriate to pray with patients (never)		
When patient asks	1.95 (0.99-3.85)	1.54 (0.75-3.16)
When MD senses	1.36 (0.61-3.05)	3.50 (1.40-8.77)[d]
MD experience of impact of R/S on patients		
Positive	2.30 (1.38-3.84)[e]	2.73 (1.51-4.93)[e]
Negative	1.30 (0.81-2.08)	0.36 (0.21-0.62)[e]

Abbreviations: MD, doctor of medicine; Ob-Gyn, obstetrics and gynecology; R/S, religion and spirituality.

[a] The analyses used case weights to account for the oversampling of specialties and for modest differences in response rates by sex and graduation from a US vs foreign medical school.

[b] In the past year, cared for 20 or more patients with critical and/or life-threatening illness, severe disability or chronic pain, a grave prenatal diagnosis, or an ethical quandary or who died.

[c] $P<.05$.

[d] $P<.01$.

[e] $P<.001$.

teractions, and the characteristics of interactions that each group finds most satisfying.

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Financial Disclosure: None reported.

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COMMENTS AND OPINIONS

ALLHAT Findings Revisited in the Context of Subsequent Analyses, Other Trials, and Meta-analyses

I read with interest and curiosity the recent revisitation of the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT) trial by Wright et al.[1] They concluded that current evidence confirmed that neither α-blockers, angiotensin-converting enzyme inhibitors (ACEIs), nor calcium channel blockers (CCBs), surpass thiazide-type diuretics (at an appropriate dosage) as initial therapy for reduction of cardiovascular or renal risk.[1] We cannot agree more, especially in light of recent trials including the ONTARGET trial[2] and new insights into plausible benefits of cardioprotection and renoprotection using different antihypertensive classes.[3,4]

We were surprised that the ALLHAT revisitation did not go further than just this statement[1(p834)]:

> Thus, compared with diuretic-based treatment, CCB- and ACE-inhibitor based therapies failed to demonstrate superiority in the prevention of CVD [cardiovascular disease] or ESRD [end-stage renal disease] in participants with DM [diabetes mellitus].

Indeed, the ALLHAT data showed that among those with diabetes, more patients in the lisinopril group progressed to ESRD compared with the chlorthalidone group (25 of 1563 vs 26 of 2755 [relative risk, 1.74; 95% confidence interval (CI), 1.00-3.01; $P=.05$]).[4] Besides, Suissa et al,[5] in a population-based historical cohort analysis of 6102 Canadian patients with diabetes, demonstrated an increased rate ratio of ESRD of 4.2 (95% CI, 2.0-9.0) after 3 years or longer of ACEI therapy compared with diuretics, β-blockers, and CCBs. The Ongoing Telmisartan Alone and in Combination with Ramipril Global Endpoint Trial (ONTARGET) report has raised further doubts of renoprotection with ACEIs and/or ARBs, more so with combination ACEI/ARB.[2] Also, the ONTARGET authors, in a post hoc analysis published in *The Lancet*, concluded that proteinuria reduction by itself cannot be taken as a definitive marker of improved renal function and that the benefits of any treatment, including combination renin-angiotensin-aldosterone system blockade on major renal outcomes, remain to be demonstrated.[6]

In 2008, we reported on the previously unreported syndrome of late-onset renal failure from angiotensin blockade.[3,4] We submit that the potential for iatrogenic renal failure from ACEI and/or ARB use remains underestimated, especially in older patients.[3,4] A recent review of the literature has unearthed a growing list of reports implicating iatrogenic renal failure from ACEI and/or ARB use, such as following cardiothoracic surgery, after oral phosphate sodium, and following contrast administration.[4]

We support the use of the various antihypertensive drug classes for hypertension. Chlorthalidone is an effective and safe first-line agent.[1] It is less expensive, and sometimes this and other diuretics are the only available antihypertensive agents available in some third-world settings. For ACEIs and ARBs, we suggest more caution in their use, especially in patients older than 65 years.

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In reply

We appreciate the favorable comments by Dr Onuigbo on this latest ALLHAT publication.[1] We were also impressed by the very positive findings in thiazide-treated patients. ALLHAT was designed to determine whether α-blockers, ACEIs, or CCBs were superior to thiazide-type diuretics (prescribed at an appropriate dosage) as initial therapy for reduction of cardiovascular or renal outcomes.[1] While potentially understated, we believe that our overall conclusion that the thiazide-type diuretic was not surpassed is consistent with the data and trial objectives.

Regarding kidney failure, Dr Onuigbo is correct that the ACEI was not more effective than the diuretic in preventing ESRD in any ALLHAT subgroup, even in patients with diabetes (and in nonblacks, in whom the blood pressure difference between treatment groups was <1 mm Hg). Owing to lack of space, renal outcomes were not discussed in detail, but they have been published.[2] In fact, diabetic participants with an estimated glomerular filtration rate of 60 to 89 mL/min per 1.73 m^2, showed borderline higher risk of ESRD with the ACEI use (relative risk [RR], 1.74; 95% CI, 1.00-3.01). However, this was not seen in all diabetic participants (RR,

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