

Discussing Spirituality With Patients: A Rational and Ethical Approach

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Conflicts of interest: none reported

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ABSTRACT

BACKGROUND This study was undertaken to determine when patients feel that physician inquiry about spirituality or religious beliefs is appropriate, reasons why they want their physicians to know about their spiritual beliefs, and what they want physicians to do with this information.

METHODS Trained research assistants administered a questionnaire to a convenience sample of consenting patients and accompanying adults in the waiting rooms of 4 family practice residency training sites and 1 private group practice in northeastern Ohio. Demographic information, the SF-12 Health Survey, and participant ratings of appropriate situations, reasons, and expectations for physician discussions of spirituality or religious beliefs were obtained.

RESULTS Of 1,413 adults who were asked to respond, 921 completed questionnaires, and 492 refused (response rate = 65%). Eighty-three percent of respondents wanted physicians to ask about spiritual beliefs in at least some circumstances. The most acceptable scenarios for spiritual discussion were life-threatening illnesses (77%), serious medical conditions (74%) and loss of loved ones (70%). Among those who wanted to discuss spirituality, the most important reason for discussion was desire for physician-patient understanding (87%). Patients believed that information concerning their spiritual beliefs would affect physicians' ability to encourage realistic hope (67%), give medical advice (66%), and change medical treatment (62%).

CONCLUSIONS This study helps clarify the nature of patient preferences for spiritual discussion with physicians.

Ann Fam Med 2004;2:356-361. DOI: 10.1370/afm.71.

INTRODUCTION

Spiritual inquiry in health care is controversial. Patient spirituality and religiosity have been shown to be correlated with reduced morbidity and mortality, better physical and mental health, healthier lifestyles, fewer required health services, improved coping skills, enhanced well-being, reduced stress, and illness prevention.¹⁻¹⁵ Many of these studies have been criticized, yet most physicians believe spirituality has a positive effect on physical and mental well-being of patients.¹⁶⁻²⁰ Patients desire spiritual discussions with physicians, and believe spiritual health is as important as physical health, but they report spiritual discussions rarely take place.^{1,12,21} Out-patient studies have found 13% to 73% of patients want physicians to have knowledge of their spiritual or religious beliefs.²²⁻²⁵ Problematic physician issues include departing from established areas of expertise to promote non-medical agendas, lack of spirituality training, ethics of physicians acting as pastoral counselors, the possibility of doing harm, time constraints, invasion of privacy, and difficulty determining which patients want to talk.^{9,16,18,19,26,27} To help physicians develop a holistic, patient-centered assessment of spiritual and religious beliefs, this study investigated (1) acceptance of spiritual discussion in a wide range of clinical scenarios, (2) reasons why patients want

physicians to know about their beliefs, (3) what patients want physicians to do with this information, and (4) a model for predicting which patients would most likely desire spiritual discussion.

METHODS

The Office of Research of the Northeastern Ohio Universities College of Medicine (NEOUCOM) Department of Family Medicine designed the questionnaire included in Appendix 1 (available as online-only supplemental data at <http://annfammed.org/cgi/content/full/2/4/356/DC1>). Questions consisted of demographics; general health data for self and family; the SF-12 Health Survey^{®28}; personal spiritual beliefs in relation to medical care; and ratings of situations, reasons, and interventions where spiritual inquiry would be acceptable. Scores used from the SF-12 Health Survey were the overall physical and mental component scores. Questionnaire items were a mixture of nominal and Likert scale variables with 3 open-ended questions. Item content was initially developed through a literature review. Critical review and item modification was provided by 8 faculty physicians—6 research directors from affiliated residency programs, 1 private practitioner, and the family medicine director of research. Additional comments were obtained after a draft of the questionnaire was reviewed by approximately 20 interested family medicine faculty. The questionnaire was further modified after being pilot tested with family practice patients and office staff for readability, comprehension, time to complete, and whether any items important to patients were excluded. To encompass as many orientations as possible, a definition of spirituality was specifically not communicated to respondents in this study. All questions concerning spirituality were framed in terms of "spiritual or religious beliefs." For example, "Has your doctor ever asked you about your spiritual or religious beliefs"? Respondents were free to interpret the questions in a manner consistent with their particular orientation. The pilot test of the questionnaire elicited no concerns about this phrasing. Koenig uses spirituality and religion interchangeably, believing that most Americans do not distinguish between these terms.¹²

Questionnaires were administered at 4 urban family practice residency sites and 1 suburban private practice of 5 family physicians. Five trained research assistants (1 per site) administered questionnaires to both patients and adults accompanying patients to an office visit. The research assistants were first- and second-year medical students. Administration of the questionnaire took place in a private area of the waiting room set aside by the research assistant for this

purpose. The questionnaire consisted of 60 questions and took approximately 15 minutes to complete. Respondents were given the option of completing the questionnaire themselves or having it read to them to facilitate inclusion of physically disabled persons and those with low literacy skills. Eligible participants were all consenting adults 18 years of age and older who attended the physicians' offices from June 13 to July 13, 2001, on the days that the research assistant was present. Before the study began, research assistants familiarized themselves with the literature and the questionnaire. The assistants were trained by 2 of the study investigators, and they practiced with faculty and departmental staff. The assistants had daily contact with the study director to resolve questions. Research assistants collected data 3 to 4 days per week varying days of collection from week to week.

Research assistants approached the first patient to sign in at the physician's front desk at the beginning of the day. Those who consented were told that their physician and NEOUCOM were conducting a study about what people want from physicians concerning spirituality or religion. If a patient was not interested in participating, the next patient to sign in was approached. When participants chose to complete the questionnaire themselves, the next patient was approached. If no other patients were available, adults accompanying patients were asked to participate.

Research assistants entered questionnaire data in Microsoft Access. The SAS statistical package was used for data analysis.²⁹ Statistical procedures included basic descriptive statistics, chi-squares, and logistic regression. A logistic regression model was developed to determine who was most likely to desire physician inquiry about spiritual beliefs. Factors tested included respondents' sex, race, age, marital status and education; number of visits to the physician in the past year; physical and mental summary scales of the SF-12; whether respondents had ever been seriously ill, were currently suffering from a serious illness, ever had a family member who was seriously ill, or ever had to deal with the death of a family member; whether the physician had ever asked them about spirituality, and whether they had ever asked the physician about spirituality; whether there had ever been a situation in which their beliefs influenced a health care decision; whether beliefs would influence a future medical decision; whether beliefs gave them meaning to life, provided hope, provided the ability to adapt, or the ability to recover from illness; and finally, a rating between 1, not spiritual at all, to 5, extremely spiritual, on how respondents rated themselves.

The study was approved by the NEOUCOM Institutional Review Board.

Table 1. Demographic Profile of Respondents (N = 921).

Characteristic	No.	Percent
Sex		
Male	221	24.0
Female	699	76.0
Race		
White	695	76.0
Black	189	20.7
Asian/Pacific Islander	4	0.4
Hispanic	11	1.2
Mixed black/white	3	0.3
Other	12	1.3
Marital status		
Single	297	32.5
Married	434	47.4
Divorced	114	12.5
Separated	14	1.5
Widowed	54	5.9
Partner	2	0.2
Education		
Less than high school	50	5.5
High school	317	34.7
Some college	276	30.2
College grad	217	23.8
Tech school	53	5.8
Site		
Private practice	270	29.3
Residency sites	651	70.7
Respondent		
Patient	798	86.6
Adult companion	123	13.4
	Mean (SD)	Range
Age, years (median 39 y)*	41.2 (16.57)	18–90
SF-12 Physical Health Score	47.0 (10.90)	14–65
SF-12 Mental Health Score	48.0 (11.05)	14–65
Times to doctor in past year (median 3)*	5.7 (6.67)	0–52

* Medians are reported for age and times to the doctor in the past year because the distributions were not normal.

RESULTS

Nine hundred twenty-one persons (798 patients, 123 accompanying adults) completed the survey, and 492 refused, for a response rate of 65%. The demographic profile of respondents is presented in Table 1. Women were more likely to agree to participate at sites with female research assistants ($\chi^2 = 15.10$, $df = 1$, $P = .0001$). No difference in patient participation by sex occurred in sites with male assistants. The SF-12 Health Survey scores for both the physical component summary score (mean = 47.0) and mental component summary score (mean = 48.0) indicate similar health status of respondents compared with the average general US population (50.1 physical and 50.0 mental). Research assistants

estimated age of individuals who refused to participate. Based on this estimation, the percentage of refusals increased among those 60 years of age and older.

When asked what they most preferred from their physician, 17% of the respondents said they never want to be questioned about their spiritual beliefs, 63% wanted to be asked depending on the nature of the situation, and 20% always wanted their physician to know about their beliefs. Only 9% of respondents reported a previous physician inquiry, and 18% percent reported telling their physician without being asked.

Respondents who sometimes or always wanted their physician to know about their beliefs were presented with a list of medical scenarios and asked whether conversations about spirituality would be welcome. Results are displayed in Table 2. Life-threatening conditions, serious medical illness, and loss of loved ones were circumstances during which spiritual discussion was most welcome. Inquiry during physical examinations or checkups and visits for minor medical problems were the least acceptable circumstances.

The most preferred course of action among respondents and reasons they wanted their physicians to know about spiritual beliefs center around understanding (Table 3). Of those who sometimes or always wanted to discuss beliefs, 87% wanted their physician to understand how their beliefs influence how they deal with being sick, 85% wanted their physician to understand them better as a person, and 83% wanted their physician to understand their decision making. Providing compassion, encouraging realistic hope, advising how to take better care of oneself when ill, changing treatment, and referral to a spiritual counselor were all endorsed by more than 50% of those who wished to talk. Women were more likely than men (65%–55%, $P = .03$) and whites were more likely than blacks (65%–54%, $P = .01$) to desire change of treatment because of spiritual beliefs. Praying with the physician (33%) and having the physician “just listen” (22%) were the least preferred courses of action.

Results of the logistic regression modeling are presented in Table 4. Persons more likely to desire spiritual discussion were respondents 30 to 64 years of age (odds ratio [OR] = 2.1), respondents who rated that their spiritual beliefs would affect their medical decisions (OR = 3.0), respondents who said their beliefs give them hope during times of illness (OR = 4.5), and those who rated themselves more spiritual on the from scale 1 to 5 (OR = 1.3 for every 1-point increase on this scale).

Three open-ended questions were on the survey. “Can you think of an experience or situation where your religious or spiritual beliefs influenced how you dealt with a health care decision involving you or someone close to you?” was answered affirmatively by

Table 2. Ranking of Situations Where Spiritual Discussion Is Welcome

Situations	Respondents Who Wanted to Talk	
	Percent Yes*	Total Percent†
Very seriously ill with the possibility of dying	94	77
Suffering from an ongoing, long-term, serious illness	91	74
Just diagnosed with a serious illness	90	73
Suffering from grief over the loss of a loved one	87	70
Recovering from a serious illness	83	66
Admitted to hospital	75	58
Victim of sexual abuse	72	55
Addiction to drugs or alcohol	72	55
Victim of domestic violence	71	54
Suffering from chronic pain	62	45
Discuss during medical history on initial visit to doctor	60	43
Discuss during routine physical or check-up	24	7
Visit for a minor medical problem	22	5

*Percentage of respondents among those that sometimes/always wanted to discuss spirituality with their physician.

† Percentage of all respondents including the 17 that never wanted to discuss spirituality with their physician.

Table 3. What Respondents Want Physicians to Do With Spiritual/Religious Information

Reason for Wanting Discussion	Percent of Patients	
	Yes*	Total†
So that the doctor can understand how your beliefs influence how you deal with being sick	87	68
So that the doctor can understand you better	85	65
So that the doctor would understand how you make decisions	83	64
So that the doctor can provide compassion, encourage realistic hope	67	50
So that the doctor can better advise you on how to take care of yourself when sick	66	49
So that the doctor would change how you are being treated medically	62	45
So that the doctor can refer you to a spiritual advisor if you think you need it	51	34
So that the doctor would pray with you	33	16
Just so the doctor will listen	22	5

Note: Choices are not mutually exclusive. Respondents were free to mark all that apply. Eighty-eight percent of those desiring spiritual discussion marked at least 1 item.

* Percentage of respondents among those that sometimes/always wanted to discuss spirituality with their physician.

† Percentage of all respondents including the 17 that never wanted to discuss spirituality with their physician.

377 respondents and 340 (41%) gave examples. The majority of those responses dealt with some aspect of finding support from their spiritual beliefs. Comments such as "believing in God's will" or "dealing with father's death" were typical. Eighty-five respondents specifically mentioned prayer. Treatment decisions were mentioned by 22 for contraception, abortion, or prenatal testing, 8 for surgery, 5 for medication, and 5 for blood transfusion. While many remarked on the role of faith in situations of death and dying, 46 respondents specifically commented on decisions to either institute or forego life-support measures. For the second open-ended question, "Do you have any spiritual or religious beliefs

range from approximately 4% to 80% depending on the situation.^{1,21,22} The percentage of those welcoming inquiry increased with severity of illness. MacLean et al²⁴ found 33% of patients welcomed inquiry in an office visit, 40% during hospitalization, and 70% in a death and dying setting. Murgans and Wadland²² found that physicians report religious inquires 4% of the time evaluating minor illnesses, 45% of the time evaluating major illnesses, and 69% of the time counseling terminal patients. We found 5% for minor problems, 43% for medical histories, and 77% during death and dying situations. In our study, 16% of patients indicated a desire to pray with their physician, but the context was

that would influence your medical decisions?" 267 respondents answered yes and 235 (88%) gave examples. Most of the responses were general comments, such as "always seek God's direction"; however, 46 expressed antiabortion sentiments, 38 mentioned end-of life decisions, 26 mentioned prayer, and 9 said they would refuse blood transfusions. The third open-ended question finished the survey by asking for questions and comments. There were only 13 responses, none with substantial information.

No differences in spiritual preferences were found between patients and accompanying adults. There were no differences in spiritual preferences between private practice and residency respondents despite the demographic differences. Compared with the residencies, the private practice patients were more likely to be white, married, better educated, and have better overall physical health. There were no differences in spiritual preferences as a function of the research assistant.

The power of all statistical tests exceeded 0.90.

DISCUSSION

The results of our study are highly consistent with what has been found previously. Estimates of the percentage of patients who welcome spiritual inquiry

Table 4. Predictors of Respondents That Always or Sometimes Want Their Physicians to Know About Their Beliefs

Variable	Coefficient	SE	P Value	OR	95% CI
Intercept	0.405	0.375	.2810		
Beliefs give patient hope during times of illness	0.752	0.141	<.0001	4.503	2.588–7.836
Patient has spiritual beliefs that would influence a health care decision	0.553	0.151	.0002	3.025	1.676–5.461
30 to 64 years of age	0.360	0.105	.0006	2.054	1.363–3.096
Personal rating of spirituality*	0.283	0.108	.0091	1.327	1.073–1.641

OR = odds ratio; CI = confidence interval.

* On a range from 1 to 5, with 1 = not spiritual at all, to 5 = extremely spiritual.

not specified. Maclean et al found fewer than 20% of respondents wanted prayer during an office visit, but 50% welcomed this in death and dying scenarios.²⁴ Ninety-one percent of our respondents indicated their physician had never been asked about their beliefs. King and Bushwick reported 80%,¹ Ehman et al reported 85%,²¹ and a *USA Weekend* magazine poll reported 90%.³⁰ Finally, our study found 17% of patients do not want spiritual discussion of any kind compared with 16% found by Ehman et al.²¹

The major contribution of our study is helping to clarify what people want physicians to do with spiritual information and how it would influence their medical care. The most important themes that emerged involved understanding, compassion, and hope. More than 85% of respondents who wanted to discuss their spiritual beliefs and two thirds of all respondents wanted understanding from their physician. This finding is consistent with Scheurich's call for attention to patient values, Pulchalski and Romer's use of understanding in designing clinical assessments, and Koenig's theoretical perspectives concerning patient centeredness and the provision of holistic care for "someone whose being has physical, emotional and spiritual dimensions."^{12,31,32} Providing understanding, compassion, and hope are hallmarks of a good physician and are not necessarily faith dependent. A Gallup poll by the Nathan Cummings Foundation and the Fetzer Institute reported that more than one half of respondents said having a doctor who knows you well and who cares about you was very important if you were terminally ill.³³ Ellis argues that a strict scientific approach to medicine overlooks the importance of meaning of life and hope to patients' well-being.³⁴ More than one half of respondents who wished to talk about spirituality in the present study agreed that referral to a spiritual advisor was an acceptable course of action. To bridge the gap between medicine and spirituality, the physician must identify, coordinate, and utilize referral sources for patient-generated requests.^{9,11,23,35-37}

Another contribution of this study is the examination of possible predictors for those who desire discus-

sion. We found 4 predictive factors: (1) having beliefs that provide hope during times of illness, (2) having beliefs influencing a health care decision, (3) being 30 to 64 years of age, and (4) rating oneself as more spiritual. A brief questionnaire based on these factors may constitute a spiritual assessment. This study and supporting research indicate that the spiritual interview, from both patients' and physicians' perspectives, should be targeted towards those suffering from more serious illness.^{12,23,24,26,34,35,38} Future research might investigate the effect (on both patients and physicians) of instituting routine questioning during intake histories to determine its acceptability.

Our study found people aged 30 to 64 years most welcomed spiritual discussion and those aged 60 years and older were more likely to refuse participation. Observations by the research assistants indicate that persons aged 60 years and older appeared to be sicker, which was why they refused. Many of these people may be very spiritual, and if they had agreed to participate, they may have been more like the middle-aged group. A *USA Weekend* magazine poll indicated 60% of those aged 18 to 34 years and 67% of those aged 55 to 64 years wanted spiritual inquiry.³⁰ The limitations of this study include the use of a questionnaire that has not been standardized or externally validated and a sample that was overrepresentative of white, better educated women. Those who refused to participate may be less likely to desire spiritual communication with their physician. Even in the event that all 492 refusals did not want to talk about spirituality in any circumstances, more than one half of all those approached want spiritual communication of some kind.

CONCLUSIONS

Spiritual inquiry during medical care should center around understanding, compassion, and hope and should be directed toward individuals who suffer from serious illness. Physicians should identify referral sources and use them when appropriate.

To read or post commentaries in response to this article, see it online at <http://www.annfamned.org/cgi/content/full/2/4/356>.

Key words: spirituality; physician practice patterns; physician-patient relations; religion and medicine

Submitted January 15, 2003; submitted, revised, June 6, 2003; accepted July 5, 2003.

Previous presentation: McCord G, Grossman S. "The Role of Spirituality in the Family Practice Physician-Patient Relationship." Presented at the 35th Annual Society of Teachers of Family Medicine Spring Conference. San Francisco, Calif., April - May 2002.

Funding support: This study was supported by the Ohio Academy of Family Physicians Foundation and the American Academy of Family Physicians Foundation.

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