jfp online

What Do Family Physicians Think About Spirituality In Clinical Practice?

MARK R. ELLIS, MD, MSPH; JAMES D. CAMPBELL, PHD;
ANN DETWILER-BREIDENBACH, MA; AND DENA K. HUBBARD
Springfield and Columbia, Missouri

■ OBJECTIVES To describe the context in which physicians address patients' spiritual concerns, including their attitudes toward this task, cues to discussion, practice patterns, and barriers and facilitators.

■ STUDY DESIGN This was a qualitative study using semistructured interviews of 13 family physicians.

■ POPULATION We selected board-certified Missouri family physicians in a nonrandom fashion to represent a range of demographic factors (age, sex, religious background), practice types (academic/community practice; urban/rural), and opinions and practice regarding physicians' roles in addressing patients' spiritual issues.

■ OUTCOMES MEASURED We coded and evaluated transcribed interviews for themes.

■ RESULTS Physicians who reported regularly addressing spiritual issues do so because of the primacy of spirituality in their lives and because of the scientific evidence associating spirituality with health. Respondents noted that patients' spiritual questions arise from their unique responses to chronic illness, terminal illness, and life stressors. Physicians reported varying approaches to spiritual assessment; affirmed that spiritual discussions should be approached with sensitivity and integrity; and reported physician, patient, mutual physician–patient, and situational barriers. Facilitators of spiritual discussions included physicians' modeling a life that includes a spiritual focus.

■ CONCLUSIONS These physicians differ in their comfort and practice of addressing spiritual issues with patients but affirm a role for family physicians in responding to patients' spiritual concerns. Factors that form a context for discussions of spiritual issues with patients include perceived barriers, physicians' role definition, familiarity with factors likely to prompt spiritual questions, and recognition of principles guiding spiritual discussions.

■ KEY WORDS Spirituality [non-MeSH]; family medicine; medicine and religion. (*J Fam Pract 2002; 51:249-254*)

see the SPECIAL ARTICLE *on this subject by Mark R. Ellis, MD, MSPH*
"Challenges Posed by a Scientific Approach to Spiritual Issues"
ON PAGE 259

KEY POINTS FOR CLINICIANS

- Family physicians differ in their views regarding the appropriateness of addressing patients' spiritual issues, but they widely support a patient-centered approach to any spiritual assessment that is performed.
- Physician barriers to spiritual assessment may include upbringing and culture, lack of spiritual inclination or awareness, resistance to exposing personal beliefs, and belief that spiritual discussions will not have an impact on patients' illnesses or lives.
- Facilitators to spiritual assessment may include communicating a willingness to have these discussions and the physician's modeling a life of balance and spiritual maturity.

An emerging body of research supports the inclusion of spiritual issues in healthcare. Studies have correlated religious commitment with health.[1-3] Many patients affirm the importance of spiritual factors in their lives.[4-5] Recent studies demonstrate that many patients wish to have spirituality considered in their health care, especially during grave illness or emotional crisis.[4-6] How to accomplish this objective

From Cox Health Systems, Family Practice Residency Program, Springfield, Missouri (M.R.E.), Department of Family and Community Medicine, University of Missouri–Columbia (J.D.C., D.K.H.), and the Department of Rural Sociology, University of Missouri–Columbia (A.D.-B.). This article includes material presented at the Society of Teachers of Family Medicine Annual Conference, May 2000, Orlando, Florida. The authors report no competing interest. Reprint requests should be addressed to Mark R. Ellis, MD, MSPH, 1423 N. Jefferson Ave., Suite A-100, Springfield, MO 65802. E-mail: mellis@coxnet.org.

TABLE 1

SELECTED SPIRITUAL QUESTIONS OF PATIENTS AND PHYSICIANS

Questions PATIENTS' QUESTIONS	Spiritual Dimension*
How do others cope with this?	Coping with illness
What do you think death is like?	Death and dying
I just wonder what my life is supposed to be about now.	Life's meaning and purpose
What did I do to deserve this? God must be angry with me.	Role of God in illness
PHYSICIANS' SCREENING QUESTIONS	
Have you had stress or changes in your life recently?	Screening
What is important to you?	Belief system
Has faith been important to you?	Beliefs
How have you dealt with difficult times in the past?	
From what do you draw your strength?	Resources
Do you hold any spiritual beliefs that might help you at this time?	

*With the exception of "screening" and "resources," items under the Spiritual Dimension heading are found in Kuhn CC.[9]
For the complete table, see Table W1 at www.jfponline.com.

is less clear. Although physicians possess spiritual assessment tools,[7-11] broader issues such as physician attitudes, roles, and varied ways of dealing with spirituality have not been widely studied. Understanding this context is crucial if physicians are to include spiritual assessment in patient care.

Two studies of Midwestern family physicians found strong support for addressing patients' spiritual concerns. In one survey, family physicians in Illinois (n = 210) believed that strong religious convictions positively affect older patients' mental health (68%) and physical health (42%).[12] These doctors supported physicians' pursuing spiritual issues at patients' request (88%) and when patients faced bereavement or impending death (66%). Similarly, Missouri family physicians (n = 231) affirmed that spiritual well-being is an important health component (96%) and that hospitalized patients with spiritual concerns should be referred to chaplains (86%).[13] A far smaller percentage of these physicians, however, felt they should personally address patients' spiritual questions (58%).

Despite acknowledging the importance of spiritual issues, the Missouri physicians seldom engaged patients in conversations about death and dying, meditation or quiet reflection, prayer, forgiveness, giving and receiving love, the role of a deity in illness, and the meaning or purpose of illness. They reported such barriers to spiritual discussions as lack of time (71%), inadequate training for taking spiritual histories (59%), and difficulty in identifying patients who want to discuss spiritual issues (56%). The gulf between physicians' attitudes and practice of spiritual assessment suggests an incomplete understanding of their role in spiritual health.

A study by Craigie and Hobbs[14] of 12 family physicians who are themselves deeply spiritual represents early progress toward understanding this role. These physicians perceived that their spirituality enabled them to experience sacredness in patient encounters, to view medicine as a mission, to maintain centeredness, and to serve as instruments of healing. They described themselves as facilitators and encouragers of patients' spiritual values and resources. We reasoned that unlike the deeply spiritual respondents in the Craigie and Hobbs study, family physicians in general are likely to have a broad range of attitudes and practices regarding spiritual assessment. We sought to better understand the spectrum of views about the physician's role in spiritual encounters, to describe family physicians' approaches to addressing spiritual issues, and to further explore barriers to spiritual discussions and facilitators of these discussions.

METHODS

We conducted semistructured interviews[15] with 13 family physicians. Participants assessed their frequency of addressing patients' spiritual issues and provided demographic information and practice characteristics. Interview topics included spirituality in the doctor-patient relationship, the practice of addressing spiritual issues, and perceived facilitators and barriers to discussing spiritual issues. Interviews were conducted by one of the authors (either A.D.B. or D.H.) or by a research assistant trained in qualitative investigation techniques. Interviews averaged 45 minutes in duration.

To guard against bias in advocating a particular stance toward spiritual assessment, we stressed to respondents that we wanted their honest observations and confirmed their statements throughout the interview. Before analyzing the data, we noted our preconceptions toward spiritual assessment. We consciously sought to avoid these biases while reviewing the data.[16] To further reduce the likelihood of bias, we selected a research team whose members represented multiple academic disciplines and religious backgrounds.

Qualitative research aims to uncover new information and perspectives rather than to draw definitive conclusions from a representative study sample.[17] Study participants were deliberately selected[18] to represent a range of demographic factors (sex,

TABLE 2

PHYSICIANS' APPROACHES TO ADDRESSING SPIRITUAL ISSUES

Techniques
Spiritual discussion in context of broad issues
Asking spiritual questions at onset of relationship and again during crises
Assessing and affirming patients' spiritual resources

Diagnostic Approach
Active attention to patient cues or questions
Consideration of questions in context of patient's known spiritual background
Processing of questions to look for deeper spiritual questions or issues
Asking clarifying questions to assure accurate identification of spiritual issues
Offering therapies (answers, suggestions, or exercises) related to patient's questions and appropriate to patient's beliefs and values

Principles
Sitting and listening has value
Use patient-centered reflection rather than providing answers to spiritual questions
Approach spiritual discussions with gentleness and reverence
Do not impose spiritual or religious views on patients

For the complete table, see Table W2 at www.jfponline.com.

age, religious background), practice types (academic or community practice; urban and rural), and practice regarding physicians' role in addressing patients' spiritual issues.

All study participants were board-certified family physicians in Missouri. Three participants were white women; 10 were white men. They ranged in age from 37 to 63 years. Three were in full-time community practice; all others were medical school or residency faculty. All but 1 faculty member reported previous community practice experience. Two participants practice in rural locations; 2 in community health centers; 1 in a metropolitan community practice; 4 in metropolitan community-based residency clinics; and 4 in a metropolitan university-based residency clinic. Subjects' religious affiliations were Jewish (1), Christian (6), "Unitarian Universalist with Muslim leanings" (1), "Unitarian Universalist with Buddhist leanings" (1), "Unitarian" (2), "none" (1), and agnostic (1).

Interviews took place in participants' offices. We informed them of the use of audiotapes during the telephone recruitment and obtained verbal consent before audiotaping. An Institutional Review Board approved our study.

Study staff transcribed the interviews verbatim. Investigators verified interview content through comparison with interviewers' notes and entered the text into Ethnograph,[19] a computer database program designed to organize textual material. Investigators used an iterative process to make an initial template for organizing and coding data.[20] Our multiple readings of interviews led to further code revisions until consensus was reached regarding salient issues or themes.[21,22] We solicited respondents' views of the validity of the final codes and themes and of the accuracy of illustrative quotations.

RESULTS

Six respondents reported regularly addressing spiritual issues with patients. One respondent reported an intermediate level of involvement; 6 reported that they do not regularly address spiritual issues. One physician was opposed to physicians' addressing spiritual issues with patients.

The themes that emerged from the coded interviews were associated with 5 issues: (1) the appropriate role for physicians in addressing spiritual concerns; (2) situations in which physicians focus on spiritual issues (the nature and setting of these discussions); (3) how physicians address spiritual issues; (4) barriers to addressing spiritual issues; and (5) facilitators of spiritual assessment.

Physician's Role

Physicians who regularly discussed spirituality believed that the scientific evidence linking spirituality and positive health outcomes justified their actions. One study participant stated, "Every physician ought to be dealing with [patients'] spiritual issues. [For example,] how can you justify not talking about spirituality to a patient with depression when you can prove scientifically that strengthening faith commitment helps them? It really comes down to a quality of care issue."

Some respondents believed that the primacy of spirituality in life provided a justification for addressing spiritual issues with patients. As one stated, "These values . . . get at the core of who you are. I would hope that I would be respectful and supportive" [whether or not I was a physician].

The respondents universally viewed themselves as supportive resources for patients through listening, validating spiritual beliefs, and remaining with patients during times of need. One expressed that healing occurs as physicians and patients connect as people, stating, "I don't have to be a spiritual master. I can be a human being, trying to connect with another human being. That is a healing experience."

Although several participants seldom addressed spiritual matters, only one strongly opposed the initiation of such discussions, out of concern about role definition and invasion of patients' privacy. This participant felt that spiritual matters were "no more in the physician's domain than questions regarding patients' finances or their most evil thoughts."

Nature and Setting of Discussions

Respondents reported specific patient illnesses and stressors that are likely to prompt spiritual discussions. These included terminal illness; chronic illness; specific conditions, such as heart disease, cancer, or miscarriage; depression, anxiety, or other psychiatric illness; pregnancy; and life stressors, including traumatic illness in the family. Other patient situations associated with spiritual discussions included the presence of symptoms without an explanation (eg, pain, insomnia, anorexia), loss of a bodily function, role change within the family, or an illness that erodes one's self-concept.

Physician respondents also reported factors that often prompt them to ask spiritual questions. These included intensive care unit admission, new diagnosis of terminal illness, treatment failures, patients' dissatisfaction with progress of treatment, and discussion of advanced care directives. The respondents who regularly address spiritual issues use screening questions that they tend to ask in response to a patient's cues or crisis (Table 1).

Some respondents asserted that patients' spiritual questions arise from their unique reactions to life stress and illness. One physician stated that patients' questions have "more to do with their view of their illness than what the illness really is." Spiritual questions commonly asked by patients covered a wide range of spiritual themes (Table 1).

TABLE 3

SELECTED BARRIERS TO SPIRITUAL DISCUSSIONS AND FACILITATORS OF THEM

Barriers
Physician Barriers
Lack of comfort or training
Lack of spiritual awareness or inclination
Fear of inappropriately influencing patients
Mutual Physician–Patient Barriers
Discomfort with initiating discussions
Lack of concordance between physician and patient spiritual or cultural positions
No common "spiritual language"
Physician-Perceived Patient Barriers
Fear that it's wrong to ask doctor spiritual questions
Belief that spiritual views are private
Perception of physician time pressure
Situational Barriers
Time
Setting (examination room)
Lack of continuity or managed care
Facilitators
Actions
Expressing interest over time in person's life to develop rapport
Reinforcing importance of spiritual coping mechanisms
Use of similar approach as in discussions of sexuality, other sensitive issues
Situational Factors
Visiting patients at bedside or home
Resources
Coworkers (reinforce physician's role)
Physician Qualities
Inner strength, balance, and spiritual centeredness
Openness, assurance of "helper" role

For the complete table, see Table W3 at www.jfponline.com.

Manner of Addressing Spiritual Health Issues

The physicians in our study believed that in most circumstances, patients should initiate spiritual discussions. One said, "It's one of those areas where you need a small amount of the patient's permission to get started and a lot more of the patient's permission to finish."

Those who regularly address spiritual issues reported using a variety of techniques and approaches (Table 2). These physicians allow for an inclusive definition of spirituality; they try to normalize spiritual discussions and to integrate spiritual discussions into the ongoing doctor–patient relationship. One said that "bringing [spirituality] to the table" along with other potentially sensitive issues helps patients know "what you're interested in and gives them the option of deciding to pursue it or not."

The physicians who address spiritual issues follow principles of spiritual assessment (Table 2). All respondents affirmed that spiritual discussions should be approached with sensitivity and integrity to avoid imposing their own belief systems on their patients. One said, "I can't even describe how negative it [would be] for me to impose my spiritual beliefs on [my] patients." Another respondent agreed, but also described a tension between faith-based and profession-based thoughts: "[Discussing one's faith with a patient risks being] an abuse of power; yet if a patient dies tonight and I haven't shared the Good News that I have . . . I'm neglecting something that's very important. . . . How do we do this . . . with both gentleness toward the patient and reverence toward God?"

Respondents expressed divergent viewpoints concerning routine spiritual history taking. Although some considered this to be an essential skill, those who seldom addressed spiritual issues found it less pressing and more time consuming than medical concerns. None reported the routine use of currently available spiritual assessment tools. A respondent opposed to initiating spiritual discussions noted a Judeo-Christian bias in these tools, calling their use "cultural imperialism."

Barriers to Spiritual Assessment

Our respondents noted significant barriers, including

physician barriers, mutual physician–patient barriers, physician-perceived patient barriers, and situational barriers (Table 3). An example of a physician–patient barrier is the mutual feeling that neither wants to raise issues of spirituality for fear of alienating or causing discomfort in the other.

Facilitators of Spiritual Discussions

Respondents noted that characteristics facilitating patients' discussions of sexuality and other sensitive issues also facilitate conversations about spirituality. These characteristics include communicating a willingness to engage in (and having the time for) such discussions and assuring patients that spiritual confidences will be received in a nonjudgmental fashion.

Physicians who are more spiritually inclined may be more likely to address spiritual issues with patients. As one respondent stated, "When I have conversations about spiritual issues, it's [sic] usually been at my initiation . . . because I'm more concerned about religious sorts of things than many physicians."

A final theme expressed by respondents is that physicians who model a life characterized by balance and spiritual maturity can facilitate patients' spiritual growth. One stated, "My patients perceive something about my balance and spiritual strength that makes them believe they can do anything. It allows me to move to the next level with them . . . [by showing them how to foster] that strength in themselves with the help of family, community, and God." Other facilitators are listed in Table 3.

DISCUSSION

The relationship between religiosity and positive health outcomes does much to justify spiritual assessment.[1-3] Other justifications include enhanced coping in chronic illness states,[23] providing patients with hope in illness-coping and recovery;[24,25] the possibility that neglect of spiritual needs may drive patients away from medical treatment,[24] and evidence that some patients desire physicians to raise spiritual issues.[6,25,26]

We sought to explore the context of spiritual assessment rather than to further justify such assessments. The context of spiritual assessment refers to the philosophical question of whether physicians should address spiritual questions and to practical questions of how spiritual matters arise, how physicians approach them, and what barriers and facilitators they perceive with regard to discussing spirituality. Our study adds to knowledge about this context in several important ways.

We found variance of opinion concerning the physician's role in spiritual assessment. Respondents reporting infrequent spiritual assessment expressed the view that spiritual issues have lower priority than other medical concerns. Yet those who regularly address spiritual issues justified this with scientific evidence associating spirituality and health. They also proposed a justification not found in previous studies: that spirituality is central to life and therefore important for its own sake rather than simply as a means to a medical end. These findings support and augment previously cited justifications for physicians assisting patients with spiritual health issues.[1-3,6,24-26]

Our study results add to the list of categories that prompt discussions of spiritual issues. Respondents affirmed a role for physicians in discussing end-of-life issues and advanced care directives, as in previous studies.[27-29] In addition, they observed that patients' spiritual questions arise from their unique responses to chronic illness, terminal illness, and life stressors. They identified 2 new categories prompting spiritual discussions: unexplained symptoms and treatment failure.

All respondents affirmed a role for physicians in supporting patients who initiate spiritual discussions. As in a previous study,[14] they viewed themselves as facilitators and encouragers of patients' spiritual values and as resources rather than as spiritual counselors. The most reticent physicians believed in responding to patients' questions rather than initiating discussions, an approach that may fail to identify spiritual issues. All respondents supported a patient-centered approach to spiritual assessment in which physicians act with integrity and take care not to abuse their position.

Many physicians saw value in spiritual history taking, though none reported routine use of spiritual assessment tools. The potential Judeo-Christian bias in assessment questions noted by one respondent highlights the need to use culturally sensitive, generic assessment tools[30] and to work toward further development of such tools.

We identified new barriers to spiritual assessment, including a physician's upbringing and culture, lack of spiritual inclination or awareness, resistance to exposing personal beliefs, and belief that spiritual discussions will not influence patients' illnesses or lives. Respondents also postulated patient barriers, including fears that their physician might judge them for their spiritual views or consider their raising spiritual questions inappropriate.

We identified facilitators of spiritual discussions, such as communicating a willingness to have these discussions. One respondent noted that physicians whose lives are characterized by spiritual maturity might serve as agents of patients' spiritual growth,

consistent with a previous study's themes of caregiver spirituality and physician vocation and mission.[14]

Limitations

Because qualitative research aims to uncover new perspectives rather than to make generalizable assessments, our findings may not apply to all physicians or to all family physicians. Although our respondents did not represent all major world religions, ethnic groups, and cultures, they did offer a diversity of spiritual and religious perspectives. Finally, our study gives only physicians' perspectives. We are currently studying patients' perspectives of situations that elicit spiritual questions and of potential barriers to spiritual assessment. We will use themes from our patient and physician qualitative studies to frame questions for a national patient questionnaire regarding physicians' spiritual assessment.

CONCLUSIONS

Physicians differ in their comfort and practice of addressing spiritual issues with patients, but affirm a role for themselves in responding to patients' spiritual concerns. Perceived barriers, physicians' role definition, familiarity with factors likely to prompt spiritual questions, and the recognition of principles guiding spiritual discussions form the context for family physicians' discussions of spiritual issues with patients. This context is important to consider when training medical students and residents in spiritual assessment. Careful attention to this context will also enhance the practicing physician's skill in providing patient-centered assistance with spiritual health concerns.

· ACKNOWLEDGMENTS ·

The authors wish to acknowledge Arej Sawani, who assisted in data collection; Sheri Price, who assisted in manuscript preparation; and Richard Ellis, MD, MPH, Daniel Vinson, MD, MSPH, Steven Zweig, MD, MSPH, and Dale Smith, who reviewed the manuscript and offered editorial suggestions.

REFERENCES

1. Matthews DA, McCullough ME, Larson DB, Koenig HG, Swyers JP, Milano MG. Religious commitment and health status: a review of the research and implications for family medicine. Arch Fam Med 1998; 7:118-24.
2. McKee DD, Chappel N. Spirituality and medical practice. J Fam Pract 1992; 35:201-8.
3. McBride JL, Arthur G, Brooks R, Pilkington L. The relationship between a patient's spirituality and health experiences. Fam Med 1998; 30:122-6.
4. King DE, Bushwick B. Beliefs and attitudes of hospital inpatients about faith healing and prayer. J Fam Pract 1994; 39:349-52.
5. Koenig HG, Smiley M, Gonzales JAP. Religion, health and aging: a review and theoretical integration. Contributions to the study of aging, no. 10. New York, NY: Greenwood Press; 1988:129-40.
6. Ehman JW, Ott BB, Short TH, Ciampa RC, Hansen-Flaschen JH. Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill? Arch Intern Med 1999; 159:1803-6.
7. Ellison CW. Spiritual well-being: conceptualization and measurement. J Psychol Theol 1983; 11:330-40.
8. Fitchett G. Spiritual assessment in pastoral care: a guide to selected resources. Decatur, Ga: J Past Care Pub 1993: JPCP monograph no 4.
9. Kuhn CC. A spiritual inventory of the medically ill patient. Psychiatr Med 1988; 6:87-100.
10. Maugans TA. The spiritual history. Arch Fam Med 1996; 5:11-16.
11. Onarecker CD. Addressing your patients' spiritual needs. Fam Pract Manage 1995; 44-49.
12. Koenig HG, Bearon LB, Dayringer R. Physician perspectives on the role of religion in the physician-older patient relationship. J Fam Pract 1989; 28:441-8.
13. Ellis MR, Vinson DC, Ewigman B. Addressing spiritual concerns of patients: family physicians' attitudes and practices. J Fam Pract 1999; 48:105-9.
14. Craigie FC, Hobbs RF. Spiritual perspectives and practices of family physicians with an expressed interest in spirituality. Fam Med 1999; 31:578-85.
15. Crabtree BF, Miller WL. A qualitative approach to primary care research: the long interview. Fam Med 1991; 23:145-51.
16. Crabtree BF, Miller WL, eds. Doing qualitative research. 2nd ed. Thousands Oaks, Calif: Sage Publications; 1999.
17. Kuzel AJ. Sampling in qualitative inquiry. In: Crabtree BF, Miller WL, eds. Doing qualitative research. Thousand Oaks, Calif: Sage Publications, 1992:31-44.
18. Gilchrist VJ. Key informant interviews. In: Crabtree BF, Miller WL, eds. Doing qualitative research. Thousand Oaks, Calif: Sage Publications, 1992:70-89.
19. The ethnograph. Version 4.0. Amherst, Mass: Qualis Research Associates; 1994.
20. Crabtree BF, Miller WL. A template approach to text analysis: developing and using codebooks. In: Crabtree BF, Miller WL, eds. Doing qualitative research. Newbury Park, Calif: Sage Publications; 1998.
21. Miles MB, Huberman AM. Qualitative data analysis: an expanded sourcebook. 2nd ed. Thousand Oaks, Calif: Sage Publications; 1994.
22. Boyatzis, RE. Transforming qualitative information: thematic analysis and code development. Thousand Oaks, Calif: Sage Publications; 1992: 93-109.
23. Dossey LD. Do religion and spirituality matter in health? A response to the recent article in The Lancet. Alternative Therapies 1999; 5:16-18.
24. Post SG, Puchalski CM, Larson DB. Physicians and patient spirituality: professional boundaries, competency, and ethics. Ann Intern Med 2000; 132:578-83.
25. Foglio JP, Brody H. Religion, faith, and family medicine. J Fam Pract 1988; 27: 473-4.
26. Maugans TA, Wadland WC. Religion and family medicine: a survey of physicians and patients. J Fam Pract 1991; 32:210-3.
27. Oyama O, Koenig HG. Religious beliefs and practices in family medicine. Arch Fam Med 1998; 7:431-5.
28. Pfeifer MP, Sidorov JE, Smith AC, Boero JF, Evans AT, Settle MB, EOL study group. The discussion of end of life medical care by primary care patients and physicians: a multicenter study using structured qualitative interviews. J Gen Intern Med 1994; 9:82-8.
29. Farber SJ, Egnew TR, Herman-Bertsch, JL. Issues in end-of-life care: family practice faculty perceptions. J Fam Pract 1999; 49:525-30.
30. Hatch RL, Naberhaus DS, Helmich LK, Burg MA. Spiritual involvement and beliefs scale: development and testing of a new instrument. J Fam Pract 1999; 46:476-86.

JFP