Patient Attitudes Regarding Physician Inquiry into Spiritual and Religious Issues

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Background. Most physicians do not address spiritual and religious issues with patients, although there are data documenting the relationship between religious variables and disease, health, and well-being. The purpose of this study was twofold: to examine patient attitudes regarding physician-directed inquiry about issues related to spiritual matters and faith; and to identify screening variables that would identify patients who would be receptive to such a discussion.

Methods. A Spiritual and Religious Inquiry (SRI) questionnaire was administered to patients presenting for care in a family practice center.

Results. Patients' frequency of religious service attendance (at least monthly) predicted their acceptance of physician inquiry into their religion and personal faith ($P<.01$) and acceptance of physician referral to pastoral professionals for spiritual problems ($P<.01$).

Conclusions. This study supports the use of frequency of religious service attendance as a screening variable for patients receptive to physician-directed inquiry into religious and spiritual issues. It also confirms that patients are accepting of physicians' referring patients to pastoral professionals (ie, clergy) for spiritual problems.

Key words. Religion and medicine; primary health care; spirituality; physician-patient relations. (*J Fam Pract 1994; 39:564-568*)

There is a growing body of evidence documenting the interrelationship between patients' religious and spiritual lives and their experiences of disease, health, and well-being.[1] Although there is little population-based research exploring this interrelationship, the role of spiritual and religious issues in health care is an important aspect of medical practice.[2] One reason for the lagging development of research in this field is a perceived lack of relevance in clinical practice.[3] Despite this perception, research supports the interaction of spiritual and religious variables with studies examining outcomes in patient care,[4] health care delivery systems,[5] and epidemiology.[1]

The studies of patient-physician interaction and the role that spirituality and religious issues play in that encounter are primarily focused on the specialties of oncology,[6] geriatrics,[7] and psychiatry.[8] In the primary care setting, research suggests that physician inquiry into religious issues is infrequent and limited to serious and life-threatening events.[9,10] One study suggests that most physicians do not address this aspect of a patient's health because of a lack of awareness of its importance, personal discomfort with the subject matter, or a fear of projecting their own beliefs onto their patients.[10] Physicians might be more willing to initiate such a discussion if they could identify receptive patients in their clinical practices.

This study was based on three assumptions: First, spiritual and religious issues have a place in the physician-patient encounter since they are a component of patient health and well-being. The second assumption was that physicians will be more willing to explore these areas if they are confident that patients will be receptive. Finally, by initiating and exploring such issues, physicians will be able to identify patients with spiritual problems. This study was designed to examine patient attitudes and perceptions regarding physician-initiated inquiries into per-

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sonal faith, spirituality, and religious beliefs in a patient-care encounter. The study also sought to determine whether there was an association between five independent patient-reported variables and patient receptiveness to a physician-directed inquiry into spiritual and religious issues.

Methods

This study was reviewed and approved by the Human Subjects Committee of the University of Kansas Medical Center in Kansas City before its initiation. The study subjects were a convenience sample of patients of a university-based family practice center, which also serves as a residency teaching site. Over a 2-month period, patients aged 18 years or older who came to the center for medical care and health maintenance were approached in the waiting room by nursing staff prior to their appointments.

The staff were instructed to ask the potential subjects whether they would be interested in completing a questionnaire that would ask their opinions regarding religious and spiritual issues. Patients were informed that this was a voluntary study and that nonparticipation would not affect their care. They were asked to complete the questionnaire as accurately, completely, and independently as possible and to return it to the nursing staff before leaving the clinic. They were also asked to refrain from discussing the questionnaire with anyone until they had returned it. No follow-up was conducted.

The Spiritual and Religious Inquiry (SRI), a self-administered, written instrument, was designed specifically for this study to assess patient attitudes regarding physician inquiry of spiritual and religious matters. It was not validated prior to its use, nor was it compared with any other religious instrument. Although the terms *religion* (*religious*) and *spirituality* are distinct,[11] we used them interchangeably, since we believe that most patients use these terms synonymously, and that an attempt to differentiate between the two would have been confusing.

The first section of the SRI is a patient-reported measure of the independent variables of age, education level, prayer frequency, religious denomination, and frequency of attendance at religious services. Age has been shown to have a significant association with religious issues in a medical context.[7] Religious denomination and frequency of religious service attendance, although narrow and somewhat imprecise, have been the two most widely studied variables in this field.[1] Prayer frequency is another variable that was selected primarily as a measure of intrinsic religious motivation. The final variable chosen was the patient's highest level of education.

The second section consisted of a series of 11 statements pertaining to physician-directed inquiry into patient spiritual and religious beliefs. These question were presented with a 5-point Likert scale, on which 5="strongly agree" and 1="strongly disagree." The respondents were asked to circle the number that best corresponded with their level of agreement or disagreement. The midpoint of the scale (3) was chosen to equal "agree" to eliminate the option of giving a neutral response. The final item on the questionnaire invited patients to share any thoughts the survey had provoked.

After completion of the survey, respondents' answers were entered into a database using Epi-Info (Centers for Disease Control, Atlanta, Ga). Both descriptive and inferential analyses were performed on the dataset.

Results

One hundred survey questionnaires were distributed to patients who visited the family practice center; 80 were returned for a response rate of 80%. Since participants were asked to complete and return the SRI individually, the remaining 20 surveys could not be accounted for. Returned surveys that were only partially completed by the participants were included in the dataset. Individual items not completed were excluded from analysis. The number of patients who refused the initial invitation to participate was not recorded.

The age of those surveyed ranged from 20 to 87 years, with a mean of 47.11 and standard deviation of 16.31. Three patients, aged 10, 16, and 17 years, were surveyed in error and were not included in the database. Patients expressed a predominantly Christian orientation, with 84% reporting affiliation with a Protestant or Catholic denomination. Nearly 7% stated their religion as "other," and 5% reported having no religious affiliation. Four percent of the respondents reported a Jewish orientation.

Sixty percent of the patients were educated beyond high school, identifying themselves as either having some college, graduate, or professional school education, or by being a college graduate. Twenty-seven percent were high school graduates; 12% stated they had only partially completed high school.

Table 1 lists the degrees of respondents' prayer frequency and religious service attendance. Sixty-four percent of the patients stated that they prayed daily, whereas 20% rarely prayed. Attendance at religious services fell into a bimodal pattern, with approximately 43% reporting weekly attendance and 40% reporting that their attendance was rare.

Respondents disagreed with most statements of the SRI concerning physician inquiry into a patient's spiritual

Table 1. Frequency of Prayer and Religious Service Attendance, As Reported by Patients Completing a Self-Administered Written Survey

Frequency	% of Patients Who Pray (n=75)	% of Patients Who Attend Religious Services (n=76)
Daily	64	1
Weekly	15	43
Monthly	1	12
Yearly	0	4
Rarely	20	40

NOTE: Some respondents did not complete survey items pertaining to frequency of prayer and religious service attendance.

or faith history, with two exceptions. The subjects agreed that physicians should refer patients to a pastoral professional (ie, a minister, rabbi, or priest) for spiritual problems ($\bar{X}$=3.07, standard deviation [SD]=1.36), but they also felt that patients will seek out help for spiritual or religious problems on their own ($\bar{X}$=3.14, SD=1.25). The respondents strongly disagreed that doctors were qualified ($\bar{X}$=1.92, SD=1.02) or trained ($\bar{X}$=1.76, SD=1.01) to discuss religious issues with patients.

Analyses of variance (ANOVAs) were performed to determine whether a significant variance existed between subjects' openness to physician inquiry into spiritual and religious issues and their stated religion and level of education. No significant differences existed between group responses based on these variables.

To analyze possible differences in responses based on frequency of religious service attendance, this variable was dichotomized into frequent attendees (daily, weekly, and monthly) and infrequent attendees (yearly or rarely). Frequency of prayer was also dichotomized into daily and nondaily prayer. The SRI Likert scale was dichotomized by grouping respondents scoring 1 or 2 on the scale into disagreers, and those scoring 3 through 5 into agreers (Table 2).

Respondents who regularly attend religious services generally agreed that physicians should ask patients questions about their religious and personal faith (63%). Very few (13%) infrequent attendees felt that physicians should ask such questions. This trend was also consistent with attitudes toward a spiritual or religious evaluation being part of the medical record, with most of the frequent attendees (68%) agreeing and few infrequent attendees (10%) agreeing. Frequent attendees more often (59% vs 28%) agreed that patients should discuss religious and faith issues with their physician. Most (90%) of the frequent attendees felt that physicians should refer patients with spiritual problems to pastoral professionals, whereas

Table 2. Relation Between Frequency of Religious Service Attendance and Patient Agreement with Survey Statements Regarding Physician Inquiry into Spiritual and Religious Issues

Survey Statement	% of Respondents Who Agree* with Statement: Attend Religious Services Frequently† (n=43)	Attend Religious Services Infrequently‡ (n=33)	*P* Value
Doctors should ask patients questions about their religion and personal faith	63	13	<.01
A religious or spiritual evaluation should be part of a patient's medical record	68	10	<.01
Patients should discuss religious and faith issues with their doctor	59	28	<.01
Doctors should refer patients to pastoral professionals (minister, priest, or rabbi) for spiritual problems	90	48	<.01
Doctors should be more open about their own personal religious faith with patients	48	12	<.01

**Agree=response of 3, 4, or 5 on a Likert scale ranging from 1 to 5, on which 5=strongly agree.*
†Daily, weekly, or monthly.
‡Yearly or rarely.
NOTE: Four respondents did not complete the survey item pertaining to frequency of religious service attendance.

slightly less than one half (48%) of the infrequent attendees agreed with this statement. Finally, frequent attendees more often (48% vs 12%) expressed the belief that physicians should be more open about their own faith (Table 2).

A chi-square analysis showed that subjects who prayed daily were more likely (56% vs 19%; $P<.01$) to agree that physicians should ask questions about their religion and personal faith. Similarly, these respondents were more likely (59% vs 19%; $P<.01$) to agree that such information should be included in their medical record. There were no significant differences with respect to other issues, eg, religious evaluation being part of the medical record and physicians being more open about their own faith).

Discussion

The purpose of this study was to examine patient attitudes regarding physician-initiated and directed inquiry of spir-

itual and faith issues. These results suggest that patients' frequency of religious service attendance and prayer may identify patients who would be open to such a discussion. This information could easily be recorded on patient-reported written intake histories.

The most consistent finding of this study concerned patient attitudes regarding physician referral to pastoral professionals for spiritual and religious problems. Patients generally agreed that physicians should refer patients with spiritual problems to clergy or other professionals trained in this area. Primary care physician referral patterns and decisions regarding referrals to clergy have been minimally studied. Koenig et al[7] briefly mentioned that fewer than one half of the physicians they surveyed reported a pattern of referral to clergy when their elderly patients were near death or experiencing great distress. In this study, there was no mention of physician, patient, or clergy demographics, or of reasons given for referral. Jones[10] looked at British general practitioners' attitudes toward the involvement of clergy in patient care. An overwhelming majority (>97%) agreed that clergy could be of help in caring for patients with terminal illness or bereavement. Despite this consensus, over 85% of general physicians did not refer or did so only occasionally (1 to 6 referrals per year). Failure to refer was attributed to four factors: the physician's lack of religious belief; a need for the "right" clergy to be available; an assumption that the religious patient would self-refer and the nonreligious patient would not want referral; and lack of knowledge regarding the utility of clergy in clinical practice. This study does support the assumption of the "self-referring religious patient," but whether this actually occurs in clinical practice is unclear.

There are many spiritually sensitive physicians in primary care who, recognizing that their patients have spiritual needs or problems, would like to address them but hesitate to do so because they are uncertain whether these patients will be receptive. Is it possible to screen patients in a discreet and nonthreatening way (such as in a patient-reported intake history form)? The frequency of attendance at religious services may be a variable that can be used in such a manner.

Much of the religious service attendance literature is clustered around a few particular disease entities or health-related topics and is viewed as intertwined with issues of socialization or social support.[1] Socialization probably does play a role in patients' attitudes toward a physician-directed inquiry about their faith. Patients who frequently attend religious services are familiar with formal institutional structures and are comfortable with or relatively accepting of figures of authority and professional competence. This level of acceptance and comfort may cross over into other institutional (ie, medical) structures and individual (ie, physician) interactions.

The influence of institutional socialization (ie, familiarity with organizational systems) appears to be much stronger than denominational acculturation (ie, identification with religious traditions or rituals) in determining patients' attitudes toward physician-directed inquiry about their faith. Because Catholics are considered more highly socialized within their own faith traditions,[12] some association of Catholicism with the SRI results was expected. However, this was not the case here. An association with prayer frequency, which was used as a measure of intrinsic religious motivation, was also expected. Respondents who prayed daily agreed that physicians should inquire about a person's faith and that the response should be a part of the medical record. However, daily prayer did not seem to be associated with significant differences in how persons responded to most of the survey questions. Again, lack of association seems to highlight an institutional influence.

Maugans and Wadland[9] found that many family physicians recognized health care maintenance visits as an acceptable time for religious inquiries and suggested that religious questions could be incorporated into routine history-taking[9]; however, few instruments have been developed for such use.[13–15]

This study had several limitations. Since a convenience sample was used, the study was subject to selection bias. Although nursing staff were instructed to randomly select patients, some staff could have preferentially enrolled patients who they believed would be receptive to such a study. In an attempt to minimize bias, the survey was distributed among three suites and 15 nursing staff over a 2-month period. The study population was relatively small and composed of patients in a university-based, urban family practice residency training center. There was a predominantly Christian orientation. It is unclear whether this study's findings are applicable to other populations.

In summary, this study was designed to provide a means of examining how patients felt regarding a physician-directed inquiry of spiritual and religious issues. Although respondents in the study generally agreed that physicians should refer patients to pastoral professionals for assistance with spiritual problems, they also expressed the belief that patients seek out help for spiritual or religious problems on their own. The second objective was to identify any screening variable that could be reported in a discreet and nonthreatening way for the purpose of identifying patients who would be receptive to such a discussion. Religious service attendance is one such variable.

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