

Religious Beliefs and Practices in Family Medicine

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Objectives: To determine whether the religious beliefs and behaviors of family medicine outpatients differed from those of their physicians and whether patients' religiousness affects their expectations of their physicians regarding religious matters.

Design: A survey study was performed on a consecutive sample of 380 family medicine clinic outpatients and 31 family medicine faculty and residents in 2 family medicine residency programs.

Setting and Subjects: Outpatients were recruited from an outpatient clinic of a family medicine residency program in North Carolina. Family medicine physicians and residents were recruited from this program and another in Texas.

Main Outcome Measures: Scores were obtained from the Springfield Religiosity Scale, the Hoge Intrinsic Religiosity Scale, and a religious beliefs questionnaire designed for this study.

Results: Absence of religious affiliation was more com-

mon for physicians than patients. Physicians were less likely than patients to pray privately and less likely to hold intrinsic religious attitudes. Patients were more likely than physicians to be interested in their own physician's religious beliefs, more likely to feel that they should know their physician's religious beliefs, and more likely to want their physician to pray with them under certain circumstances. When sex and age were controlled, some of these differences disappeared. When compared with patients, physicians tended to be younger and male—characteristics inversely associated with religious belief and practice. Regardless of sex or age, however, the more religious the patients, the more likely the desire to know their physician's religious beliefs and share their own religious beliefs.

Conclusions: Patients are more involved in religious beliefs and practices than physicians, a finding partially explained by age and sex. The more religious the patients, the more important it is for them to know their physician's beliefs, share their beliefs with their physician, and want their physicians to pray with them.

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RELIGIOUS BELIEFS and practices are common in the United States. A 1994 Gallup Poll found that 96% of persons aged 18 years or older in the United States believe in God or a universal spirit.¹ More than 40% of Americans attend church weekly, 90% pray, and 27% read the Bible or other religious literature at least several times per week.¹ Much less is known about the religious beliefs and practices of persons with health problems who seek help from primary care physicians. There is some evidence that religious belief and practice may become increasingly important to persons as they face the uncertainty and fear caused by medical illness,² and that these beliefs and behaviors are associated with better coping and less depression,³⁻⁵ as well as better health outcomes.^{6,7} The lack of

research published in the *Journal of Family Practice* between 1976 and 1986 that included religious variables prompted Craigie and colleagues⁸ to call for an

increased emphasis on developing an original literature of record about religious variables in family medicine [to] promote the empirical assessment of the beneficial, neutral, and harmful effects of religion among family medicine patients and providers.

In one of the first studies to document religious behaviors of patients attending a family medicine outpatient clinic in Illinois, 106 consecutive patients aged 65 years or older were surveyed concerning their religious beliefs and behaviors.⁹ More than 80% indicated that the statement, "My religious faith is the most important influence in my life," was true for them; 72% reported praying at least once

SUBJECTS AND METHODS

SAMPLE

A consecutive sample of 594 English-speaking patients attending a family medicine clinic in North Carolina was approached for study participation. At the same time, a sample of 31 family medicine faculty and residents was asked to complete the same survey; these physicians were recruited from 2 family medicine residencies, one located in an urban and rural community in North Carolina and the other in an urban setting in Texas.

PROCEDURE

Institutional review boards at both residency and clinic sites approved the research project. Patients were approached prior to their clinic visit and were administered the questionnaires after obtaining written informed consent. A similar procedure was followed for the physician surveys.

MEASURES

Organizational religious activities and nonorganizational religious activities were assessed by using a modified version of the Springfield Religiosity Scale.¹⁶ Intrinsic religious attitudes were measured with the Hoge Intrinsic Religiosity Scale.¹⁸ The Hoge scale has been validated in 2 separate studies using responses of community pastors, priests, and rabbis as a criterion standard.^{16,18} Questions about expectations from patients concerning knowing their religious beliefs, sharing religious beliefs with physicians (and vice versa), praying with physicians, and knowing religiosity of physicians were designed specifically for this study.

STATISTICAL ANALYSIS

For categorical variables, the χ^2 statistic was used for bivariate comparisons; sex and age were controlled for by using the Cochran-Mantel-Haenszel method. For noncategorical variables, the Student *t* test was used for bivariate comparisons; sex and age were controlled for by using the REG procedure in SAS software (SAS Institute, Cary, NC).

a day, and 28% read the Bible at least once a day. More recently, Daaleman and Nease¹⁰ administered survey questionnaires to 80 patients (mean age, 47 years) attending a family practice center in Kansas City, Kan. In that study, 84% of patients indicated their religious affiliation as Protestant or Catholic, 7% as "other," and 5% as none. Sixty-four percent of patients stated that they prayed daily and 43% attended church weekly or more. Respondents strongly disagreed that physicians were qualified or trained to discuss religious issues with patients. Among patients who attended religious services regularly (daily, weekly, or monthly), 63% agreed that physicians should ask patients questions about their religious faith; in con-

trast, only 13% of infrequent attendees agreed that physicians should ask such questions. Likewise, 48% of frequent church attendees indicated that physicians should be more open about their own personal religious faith with patients, compared with 12% of infrequent attendees. Similar findings were reported with regard to those who prayed daily. The authors concluded that patients' frequency of religious service attendance and prayer was a good indicator of who were and were not open to their physician addressing religious issues with them. The authors admit,¹¹ however, that theirs was a convenience sample that included many employees and staff of the University of Kansas City Medical Center (who were better educated and may not have been representative of patients seen in other family practice centers).

Equally little is known about the religious beliefs and practices of primary care physicians, or their attitudes toward addressing religious issues with patients. One reason for this lack of information is that many believe that religion has no relevance to the practice of medicine.¹² What work has been done suggests that physician inquiry into religious issues of patients is infrequent and primarily restricted to life-threatening events.^{13,14} Within the past 10 years, studies have begun to systematically examine physicians' attitudes in this regard. A survey of a random sample of 160 Illinois physicians asked about experiences they had with elderly patients mentioning religious issues during a medical visit.¹⁵ Fifty-one percent of physicians said "rarely or never," 43% said "sometimes," and 5% noted "often or always."

In that study, the strongest predictors of physicians' belief in the appropriateness of addressing religious concerns were 2 attitudinal variables that indicated an understanding of the importance of religion in the lives of older adults and an awareness that patients might want their physician to pray with them. When asked whether physicians thought patients in some circumstances might want their physician to pray with them, 37% said yes; almost the same percentage also said that they had prayed with patients. In a separate study of 66 geriatric medicine clinic and senior center participants in the Illinois area, 71% said that they wished their physician to pray with them if they were sick or near death.¹⁶ This research suggested that patients' and physicians' attitudes toward physicians addressing religious issues and even participating in religious activities with patients during a medical encounter might significantly differ.

In a more recent study of 594 family physicians practicing in 7 different states, King and colleagues¹⁷ reported that 37% agreed with, 9% were undecided, and 54% disagreed with the statement, "Patients' religion is none of my business." In that study 16% agreed with, 22% were undecided, and 61% disagreed with the statement, "Discussing religion would turn patients away from my practice." To what extent these physicians' personal religious beliefs and practices may have influenced their feelings in this regard is unknown. Thus, controversy exists over whether patients want physicians to address religious issues during the context of a medical visit. There is also concern over the differences in religious beliefs and behaviors of physicians and patients that might in-

fluence whether physicians think addressing religious issues with patients is appropriate.

To add to our understanding of patients' and physicians' religious beliefs and practices, and attitudes toward bringing religious issues in the context of a medical encounter, we initiated the present study. The primary aim was to examine and compare religious beliefs of patients and physicians. Three major dimensions of religiousness were assessed: organizational religious activities, private religious activities, and intrinsic religiousity. To date, this represents the most detailed examination of religious beliefs and behaviors of patients and physicians. Based on prior research, we hypothesized that (1) religious behaviors and attitudes of patients would significantly differ from those of their physicians, (2) patients' expectations of their physicians concerning the sharing of religious beliefs and patient prayer would significantly differ from similar expectations of physicians of their own physicians (which might, in turn, influence what physicians thought patients expected of them), and (3) patients' expectations of their physicians would depend on the religiousness of patients.

RESULTS

Complete survey responses were collected from 380 patients and 31 physicians (12 physicians from the North Carolina sample and 19 physicians from the Texas sample). These data reflected a 64% patient response rate, 63% physician response rate from the North Carolina sample, and a 100% physician response rate from the Texas sample. Patients in the sample are representative of a strong ethnic and culturally diverse community. Both residency programs are community-based residencies with equally diverse resident and faculty population. The physician samples from both sites varied only by sex (larger proportion of men in the Texas sample) and race (a larger proportion of African American subjects in the North Carolina sample). No information is known about either the patient or physician nonrespondents. A comparison of the population characteristics of patients and physicians is provided in the **Table**.

Are religious behaviors and attitudes of patients significantly different from those of physicians? Religious behaviors differed to some degree between patients and physicians. Patients were significantly more likely to pray at least once a day than were physicians (61% vs 29%; $P < .001$). This association, however, weakened when sex and age were controlled ($P = .09$). No other differences in religious activity were observed. Church attendance, other religious group activity, Bible reading, religious television viewing and radio listening, and percentage of income contributed to the church were not significantly different between patients and physicians.

Although religious behaviors were largely similar between patients and physicians, intrinsic religious attitudes did not appear to be so in the bivariate analyses. Physicians were significantly less likely than patients to report that 6 of 11 religious attitudes were true of them: "My faith involves all of my life," "I experience the presence of the Divine," "Nothing is as important to me as serving God the best I know how," "I try to carry reli-

Sociodemographic Characteristics of Patients and Physicians*

	Patients (n = 380)†	Physicians (n = 31)	P
Age, mean ± SD, y	41.7 ± 15.2	35.3 ± 10.1	<.01
Female sex	78.4	34.5	<.001
Education, mean ± SD, y	13.6 ± 2.4	NA	NA
Residency year‡			
1	NA	16.1	NA
2	NA	16.1	
3	NA	22.6	
Faculty and other	NA	45.2	
Race			
White	67.4	70.0	.40
African American	24.8	16.7	
American Indian	3.2	0.0	
Other	4.6	13.3	
Marital status			
Married	59.9	48.3	.23
Divorced	13.2	3.5	
Single/widowed	26.9	48.3	
Denomination			
Protestant	54.3	33.3	<.01
Catholic	12.0	26.7	
Other	27.3	20.0	
None	6.4	20.0	

*Data are given as percentage, unless otherwise specified. NA indicates not applicable.

†Number may vary by up to 5% depending on variable.

‡Specialty of 27 physicians (89%) was family medicine.

gion into all my other dealings in life," "I always seek God's guidance in making every important decision," and "My religious faith is the most important influence in my life." When age and sex were controlled, however, the only personal religious attitude that distinguished patients from physicians was "Nothing is as important to me as serving God the best I know how" ($P = .03$).

What expectations did patients and physicians have of their physicians with regard to religion? Almost one half of patients (43%) were interested in knowing their physician's religious beliefs, a percentage that tended to be greater than for physicians (26%). Patients and physicians did not differ in their opinions about whether patients should share religious beliefs with their physicians, with 73% of patients and 77% of physicians having such feelings. Likewise, patients and physicians did not differ in their estimation of the religiosity of their physicians, with 13% of patients and 22% of physicians estimating that their physicians were not religious. Patients felt about the same as physicians concerning feelings about whether physicians should share religious beliefs with patients (67.9% vs 73.2%) and whether they were interested in sharing their religious beliefs with their physicians (38.8% vs 25.8%). Patients did, however, appear (on bivariate analysis) to differ from physicians in the proportion of those who would like their physician to pray with them; 67.3% of patients compared with only 35.5% of physicians felt this way ($P < .001$). Likewise, patients were somewhat more likely than physicians to think that patients should know the religious beliefs of their physicians (40.6% vs 23.4%). When age and sex were controlled, the association with desire for physician prayer

retained its significance ($P = .05$), although the associations with knowing physicians's beliefs disappeared.

Did the religiousness of patients affect their expectations of their physicians? Without question, it did. No matter how religiousness was defined—whether by level of participation in organizational religious activities, level of participation in private religious activities, or intrinsic religiosity—patients' expectations of their physicians with regard to knowing about, sharing, or participating in religious activities with physicians, were heavily influenced by the religiousness of the patient. The more religious the patients, the more they wished to know, share, or participate in religious activities with their physician.

COMMENT

In this study, we found many similarities between the beliefs of patients and their physicians. On the other hand, physicians were more likely than patients to be unaffiliated with any religious tradition, somewhat less likely to pray daily, and less likely to hold intrinsic religious attitudes. Patients were also more likely than physicians to want their physician to pray with them in certain circumstances. The more religious that patients were (regardless of how religiousness was measured), the more they wanted to know about the religious beliefs of their physicians and share their own religious beliefs with them.

Only 2 other studies have examined and compared the religious beliefs and practices of physicians and patients.^{13,19} In a study of 115 active members of the Vermont Academy of Family Physicians and 135 outpatients from family medicine clinics in Vermont, Maugans and Wadland¹³ found that 28% of physicians compared with 9% of patients indicated no religious affiliation (similar to our 20% of physicians and 6% of patients). Patients in that study were more likely than physicians to believe in God (91% vs 64%), more likely to believe in an afterlife (60% vs 45%), more likely to use prayer (85% vs 60%), and more likely to feel close to God (74% vs 43%). A high percentage of physicians in that study believed that the physician has a right (89%) and the responsibility (52%) to inquire about religious factors, and 88% reported that they at least occasionally addressed religious issues with patients. While 40% of patients believed that physicians should discuss religious issues with patients and 30% indicated that they would like their physicians to do this with them, most patients did not recall physicians ever addressing religion with them.

A study at Duke Hospital, Durham, NC, compared the religious beliefs and behaviors of 130 physicians and 77 hospitalized patients (older than 18 years) to determine whether there were any differences between them.¹⁹ The study revealed, as did the present study, that the religious backgrounds of physicians were very different from their patients. While 38% of patients were Baptist, only 2% of physicians were Baptist. While only 1% of patients were Catholic, 26% of physicians were Catholic. While there were no Jewish patients and no patients without a religious affiliation, 10% of physicians were Jewish and 9% of physicians had no religious affiliation. Likewise, 62% of patients reported that they attended church

or synagogue weekly or more often, compared with only 35% of physicians who attended services this frequently. As far as using religion as a resource for coping with stress, 44% of patients indicated that religion was the most important factor that enables them to cope with problems in their lives; only 9% of physicians indicated that religion was the primary way that they coped. Therefore, in all studies thus far conducted, patients and physicians have been quite different in terms of their religious backgrounds, beliefs, and behaviors; most of these studies, however, did not control for sex and age. In the present study, we found that many differences between physicians and patients disappeared when sex and age were controlled.

What is evident from both the present study and earlier work is that physicians' and patients' religious beliefs and practices may affect whether (1) physicians believe it is appropriate to address religious issues and (2) whether patients want them to. Because the religious backgrounds, beliefs, and behaviors of physicians are different from those of their patients, physicians may not realize the importance of religion to many patients or the need to address these religious issues. The information from this study should provide clues to physicians about when and when not to address religious issues with patients. It should also inform them about how their own personal religious beliefs and prejudices may affect their willingness to address religious issues with patients when it becomes necessary.

LIMITATIONS

To what extent are these results generalizable? Our sample of physicians was relatively narrow, the majority being residents who were relatively young (mean age, 35 years). The family medicine teaching clinic, however, functions similar to private practices in the community and is not believed to be significantly different from other primary care practices. The patients, as mentioned previously, are believed to be representative of a culturally diverse community. Compared with the general US population, patients in our sample were more likely to be women (78% vs 52% for general population) and African American (25% vs 12% for general population).²⁰ Education level of our patient sample was also higher than US norms. Compared with persons aged 25 years or older in the United States, 91% of our sample had a high school education or beyond, compared with 75% for the general US population.²⁰ While data regarding income and insurance coverage of the sample were not obtained, statistics of the entire family medicine clinic population suggest an even mix of low, middle, and upper classes as well as insurance coverage. The sample, nevertheless, may have been different from the clinic population on both variables.

A comparison of the religious characteristics of our sample with those of a random sample of persons living in the United States surveyed by the Gallup organization^{1,21} found the following differences: religious affiliation (Protestant, 54% vs 58%; Catholic, 12% vs 27%; no affiliation, 6% vs 9%), church attendance weekly or more often (51% vs 43%), pray daily or more often (61% vs

75%), and read the Bible daily or more often (20% vs 17%). Thus, except for there being fewer Catholics in the sample, the differences were not that notable. Our sample was also predominantly Christian in religious background. In light of this factor, the data from this study are primarily generalizable to persons from this religious tradition. Given the fact that more than 90% of Americans affiliate with a Christian tradition,¹ these results are probably applicable to most health care settings in the United States, although regional differences may exist.

CLINICAL IMPLICATIONS

Many patients, particularly those for whom religion is important, are interested in knowing their physician's religious beliefs, want to share their own beliefs with their physicians, and under certain circumstances, want their physician to pray with them. Should this occur? This is clearly a delicate issue in the context of the physician-patient relationship. Neither this article nor much previous research provides clear guidelines in this area. Some reasonable suggestions, however, may be made. If the patient has strong religious beliefs and spiritual needs that may be affecting his or her physical or mental health, then the physician should at a minimum know about those beliefs and provide an atmosphere in which such beliefs may be discussed. Whether a physician should reveal his or her own personal beliefs or pray with patients should be left up to the individual physician. Supporting patients' own religious beliefs, particularly if not obviously harmful to their health, is part of good clinical care—especially since these beliefs are often used by patients to cope with the stresses caused by health problems.²² Such support provides comfort, and providing comfort is within the role of the physician. Forcing personal religious beliefs on patients or criticizing their beliefs (unless clearly harmful), on the other hand, is not part of that role.

How is it best to address religious issues with patients when the physician and patient differ in beliefs? Any discussion or intervention in this sensitive area should be patient-centered. What are the patient's beliefs? How important are they to the person and how might they be affecting the person's health? Are religious beliefs being used to bring comfort and facilitate coping, or are they creating excessive guilt or distress that are destructive to well-being and health? Such questions can be explored in a warm, open, and nonjudgmental manner, even if the physician's beliefs differ from those of the patient. Studies have shown that nonreligious therapists using religious-oriented therapy with religious patients actually achieve better results than do religious therapists.²³ Thus, having a different belief system from the patient should not prohibit the physician from addressing health-related spiritual needs. If the physician's personal beliefs or competency in this area prevent him or her from addressing religious issues with a patient, then referral to a religious professional may become necessary (just as referral to any other specialist is done). Neglecting or

disregarding health-related religious beliefs or needs of patients, however, is not an appropriate response.

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