

Religion in primary care

Let's talk about it

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Religion continues to be an important element in the lives of many of our patients, despite an increase in atheism, and even antitheism, in academic and popular press.¹ A 2008 Harris-Decima poll found that 72% of Canadians believed in God.² Interest in the integration of spirituality, religion, and medicine is increasing: there are more than 1600 published studies on the relationship between religion and mental and physical health.^{3,4}

The broad concept of spirituality fits well with family medicine's perception of holistic care. But for many of our patients, spirituality means religion. Although often used interchangeably, religion and spirituality are different. They can inform each other but are separate. Religions create, at times, very distinct identities, behaviour, and expectations. This is quite distinct from the more amorphous, less delineated, more nebulous notion of spirituality. In many social scenarios, religion divides people and we often shy away from discussing it. But how relevant is religion in the care and healing of our patients? Are physicians more comfortable with the concept of spirituality and less so with religion? Can it be a dimension in the patient-physician interaction, and how is it best addressed?

Throughout human history man has sought a transcendent explanation of his existence. The varied stories of the world's great faiths give eloquent testimony of this across the expanse of time and the divide of culture. Religion attempts to answer that eternal question: What is the purpose of existence? The answer seems to be 2-fold. The first is the relationship of man with the divine, with what many call God. This relationship extends beyond the limits of our corporeal reality to the spiritual realm with its notions of infinite and eternal. The second purpose of existence focuses on our relationship with others. The emphasis is to become useful and productive members of society, thus contributing to our personal well-being and that of others.

Religion and health

Religion's contribution to health and well-being is controversial. History reveals how religion has directly contributed to wars, suffering, and destruction. Yet whatever the devastation laid at the feet of religion, it has easily been exceeded by that of man-made creeds. The

horrors, particularly in the past 100 years, of fascism, imperialism, communism, socialism, capitalism, and racism come readily to mind. Still, this is hardly a ringing endorsement for the positive contribution of religion to the health of the human family.¹

Despite this rather gloomy analysis, accounts abound of religion helping people live lives that are rich with meaning and significance. It influences individuals and groups to come to the assistance of others. The Christian concepts of *agape* and *caritas*, and their fellows, such as *zakat* in Islam and similar concepts in all the great religions, speak to a preoccupation with assisting in the well-being of others. This has given rise to endeavours, particularly in education and health care, that have benefited countless millions.

If we take the position that religion can contribute positively to the human condition, it might be helpful to understand how this is achieved.

It is not clear what elements of religion are essential. Are the intrinsic elements of one's relationship with God most important? Are the extrinsic elements of religious practices and relationship with community more important? Social cohesion might lessen conflict and promote health. Altruism, philanthropy, and caring for others might be key elements, almost paradoxically, in caring for oneself. Perhaps the interplay between the highly personal and private relationship with God becomes fully evolved only when it is expressed tangibly in helping others and contributing in a meaningful way to society.

Most studies on this topic use religious attendance as a measure for extrinsic religiosity.⁵ Studies examining intrinsic elements are harder to evaluate (and less common) than those evaluating religious commitment, as they lack consensus on the term *spirituality* and struggle to measure an intangible concept.⁶

A literature review found that 80% of the relevant studies showed a positive association between religious commitment (using various measures of religious involvement) and health status, with 15% showing neutral associations and 5% showing negative associations.⁷ Studies on religious commitment and mental health showed very similar percentages (83% positive, 14% neutral, and 3% negative).⁸ Religiosity was also associated with longer life expectancy.⁶ One American

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study in 1998 (n=232) examined the relationship between religious attendance and recovery from heart surgery. Six months after surgery, 11% of the nonreligious patients had died while none of the 37 “deeply religious” patients had died.⁹

Others are more critical of the data. Sloan and colleagues’ 1999 analysis finds methodologic issues to be abundant in the existing studies, including failure to control for multiple comparisons and for confounding variables and covariates. They conclude that the evidence is “weak and inconsistent.”⁴ In a 2010 Gallup poll (n=550 000) that controlled for a number of demographic and geographic variables,¹⁰ people who considered themselves very religious had only slightly higher physical health index scores than those who were not religious (78.0 vs 76.6).¹⁰

Despite flaws in most studies, some do control for confounding variables and suggest that the relationship between religious attendance or observance and health status is causative.¹¹ Religious attendance requires getting to services and might simply be associated with mobility, a marker of health. Matthews and colleagues highlight studies that suggest an inverse relationship between attendance and disability.⁶ They examine the suggestion that religious attendance simply leads to health-promoting behaviour. Yet, when controlling for such behaviour, the positive effects of religion remained.⁶

Spiritual discussions with patients

How do we approach our patients who are religious? Is religion merely another cultural variable or a marker for other factors that better explain variability in disease and health? Is it enough for physicians to know of varied cultural elements of the many religions—a form of cultural competence? How do we assess and help those who do not belong to a defined religion, yet for whom the spiritual dimension of health is important?

The percentage of patients who want to be asked about their spiritual beliefs ranges greatly (4% to 80%) depending on the setting¹² and severity of their illnesses.¹³⁻¹⁵ A 2003 American multicentre survey (n=456) showed that one-third of primary care patients wished to be asked about religious beliefs during routine visits, but not at the expense of discussing their medical concerns.¹²

A 2002 American random-digit-dial telephone survey (n=1052) found that while 69% would want spiritual discussions if seriously ill, only 3% would want those discussions with physicians.⁵ Ambulatory care patients (n=177) expressed a higher desire to discuss spirituality with physicians: 66% said that religious inquiry would increase their trust in the physician and almost 50% indicated religious beliefs would influence their medical decisions.¹³

There are no known Canadian studies examining physicians’ perspectives on religious discussion in their

practices. What is clear from the American data is that even when physicians strongly believe that religion or spirituality has an influence on health,^{16,17} they rarely discuss religion with their patients.¹⁸⁻²¹ The reasons include lack of time, lack of training in taking spiritual histories, concerns about projecting personal beliefs, difficulty identifying receptive patients, physician upbringing, culture, and their own lack of spirituality.^{20,21}

Sloan and colleagues acknowledge positive and negative effects of religious-oriented dialogue. They identify several ethical issues around the involvement of religion as adjunctive medical treatment and argue that it might be an abuse of physicians’ power and authority if they appear to be imposing their beliefs upon patients. They suggest the possibility that religious discussion might actually do harm, as linking religion with health might reinforce self-blame and the idea that illness is due to insufficient faith.⁴ Rumbold also suggests that spiritual care might be counterproductive, as spirituality enhances autonomy, which could be eroded by a doctor’s involvement.²² He suggests that “the experts will have taken over this aspect of life as well.”²²


Successful interventions in this area require a high degree of personal and spiritual maturity.²³ This requires the physician to reflect on his or her approach to religion and on a spiritual dimension of health. Increased attention to this in preclinical training seems logical so that the ethical dimensions are explored in tandem with other relevant cultural domains.

Spiritual assessment should “seek to elicit the thoughts, memories and experiences that give coherence to a person’s life.”²² It need not be an intrusive or invasive process. It opens another chapter in the story of the life of a patient. It might help us understand how and why patients approach their lives, and give us a richer understanding of how individual patients interpret the challenges they face. It might assist the therapeutic alliance in useful and unexpected ways. The very act of acknowledging a spiritual dimension in health allows the patient to know that we are sensitive to needs, aspiration, and concerns in this arena.

There is a danger here. If we blunder into the spiritual or religious journey of another with judgmental, insensitive, and unhelpful comments and analyses, we will do more harm than good. Another caveat, *physician know thyself*, rings particularly true in this arena. We will be called upon to examine our own worldview with respect to religion and our inherent biases.

A better understanding of how religion can affect our health has important implications for training, for practice, and for research. If we take the position that religion can contribute to the well-being of the individual and, by extension, society, family physicians might find it useful to understand and encourage its heuristic effect. This challenges us to research this area further,

particularly in Canada. It adds another dimension to the physician-patient relationship and asks us to look at the communities we serve with a new lens.

Religion is an important aspect in the lives of so many in our world. Perhaps we can help it to be both helpful and healthful. 

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Competing interests

None declared

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References

- Hitchens C. *God is not great: how religions poison everything*. Toronto, ON: McClelland and Stewart Ltd; 2007.
- The Canadian Press. *Almost a quarter of Canadians don't believe in any God, new poll says*. Toronto, ON: CBC; 2008. Available from: www.cbc.ca/canada/story/2008/06/03/f-religion-poll.html. Accessed 2012 Jan 20.
- Kliwer S. Allowing spirituality into the healing process. *J Fam Pract* 2004;53(8):616-24.
- Sloan RP, Bagiella E, Powell T. Religion, spirituality and medicine. *Lancet* 1999;353(9153):664-7.
- Mansfield CJ, Mitchel J, King DE. The doctor as God's mechanic? Beliefs in the Southeastern United States. *Soc Sci Med* 2002;54(3):399-409.
- 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(2):118-24.
- Craigie FC, Liu IY, Larson DB, Lyons JS. A systematic analysis of religious variables in the *Journal of Family Practice*, 1976-1986. *J Fam Pract* 1988;27(5):509-13.
- Larson DB, Greenwold-Milano MA. Are religion and spirituality clinically relevant in health care? *Mind Body Med* 1995;1(3):147-57.
- Oxman TE, Freeman DH Jr, Manheimer ED. Lack of social participation or religious strength and comfort as risk factors for death after cardiac surgery in the elderly. *Psychosom Med* 1995;57(1):5-15.
- Newport F, Agrawal S, Witters D. *Very religious Americans lead healthier lives: relationship holds when controlling for key demographics*. Washington, DC: Gallup; 2010. Available from: www.gallup.com/poll/145379/religious-americans-lead-healthier-lives.aspx. Accessed 2012 Jan 20.
- Kark JD, Shemi G, Friedlander Y, Martin O, Manor O, Blondheim SH. Does religious observance promote health? Mortality in secular vs religious Kibbutzim in Israel. *Am J Public Health* 1996;86(3):341-6.
- MacLean CD, Susi B, Phifer N, Schultz L, Bynum D, Franco M, et al. Patient preference for physician discussion and practice of spirituality. *J Gen Intern Med* 2003;18(1):38-43.
- Ehman JW, Ott BB, Short TH, Ciampa RC, Hansen-Flaschen J. Do patients want their physicians to inquire into their practices? What does the evidence say? *Ann Behav Med* 2002;24:69-73.
- Maugans TA, Wadland WC. Religion and family medicine: a survey of physicians and patients. *J Fam Pract* 1991;32(2):210-3.
- McCord G, Gilchrist VJ, Grossman SD, King BD, McCormick KE, Oprandi AM, et al. Discussing spirituality with patients: a rational and ethical approach. *Ann Fam Med* 2004;2(4):356-61.
- Curlin FA, Roach CJ, Gorawara-Bhat R, Lantos JD, Chin MH. How are religion and spirituality related to health? A study of physicians' perspectives. *South Med J* 2005;98(8):761-6.
- Wilson K, Lipscomb LD, Ward K, Replogle WH, Hill K. Prayer in medicine: a survey of primary care physicians. *J Miss State Med Ass* 2000;41(12):817-22.
- King DE, Bushwick B. Beliefs and attitudes of hospital inpatients about faith healing and prayer. *J Fam Pract* 1994;39(4):349-52.
- Anderson JM, Anderson LJ, Felsenthal G. Pastoral needs for support within an inpatient rehabilitation unit. *Arch Phys Med Rehabil* 1993;74(6):574-8.
- Ellis MR, Campbell JD, Detwiler-Breidenback A, Hubbard DK. What do family physicians think about spirituality in clinical practice? *J Fam Pract* 2002;51(3):249-54.
- Ellis MR, Vinson DC, Ewigman B. Addressing spiritual concerns of patients: family physicians' attitudes and practices. *J Fam Pract* 1999;48(2):105-9.
- Rumbold BD. A review of spiritual assessment in health care practice. *Med J Aust* 2007;186(10 Suppl):S60-2.
- Waldfoegel S. Spirituality in medicine. *Prim Care* 1997;24(4):963-76.