Asking patients about their religious and spiritual beliefs

Cross-sectional study of family physicians

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Abstract

Objective To examine family physicians' practices in and opinions on asking patients about their religious and spiritual beliefs, as well as physicians' comfort levels in asking.

Design Cross-sectional study using self-administered questionnaires.

Setting Kitchener-Waterloo, Ont.

Participants A total of 155 family physicians with office practices.

Main outcome measures Frequency of asking patients about their religious and spiritual beliefs and physicians' comfort levels in asking. Separate multiple linear regression analyses were conducted for each of these outcomes.

Results A total of 139 questionnaires were returned for a response rate of 89.7%. Of the respondents, 51.8% stated that they asked patients about their religious and spiritual beliefs sometimes. Physician opinion that it was important to ask patients about religious and spiritual beliefs ($P=.001$) and physician comfort level with asking ($P<.001$) were significantly associated with physicians' frequency of asking patients about their religious and spiritual beliefs. Comfort level with asking patients about their religious and spiritual beliefs was significantly associated with the opinions that it was important to ask ($P=.004$) and that it was their business to ask ($P=.003$), as well as with lack of training as the reason for not asking ($P=.007$).

Conclusion This study found that family physicians were more likely to ask patients about their religious and spiritual beliefs if they had higher comfort levels in asking or if they believed that asking was important. Further, this study found that family physicians' comfort level with asking was higher if they believed that it was important to ask and that it was their business to ask about religious and spiritual beliefs. Physician comfort levels with asking patients about religious and spiritual beliefs can be addressed through adequate training and education.

EDITOR'S KEY POINTS

- There are many barriers to integrating religious and spiritual beliefs into health care. This study examines family physicians' reasons for not asking patients about their religious and spiritual beliefs, evaluates the concept of physician comfort level in asking, and explores factors that contribute to physicians' comfort levels.

- The authors identified higher level of comfort as a facilitator of asking patients about their religious and spiritual beliefs. As comfort in asking was related to behaviour of asking, and training was statistically significantly associated with comfort level, including religion and spirituality in medical education might help to increase physicians' comfort levels in asking patients about their beliefs and hence increase physician frequency in asking patients about their religious and spiritual beliefs.

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Questionner les patients sur leurs croyances religieuses et spirituelles

Une étude transversale auprès de médecins de famille

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Résumé

Objectif Déterminer si les médecins de famille ont l'habitude de questionner leurs patients sur leurs croyances religieuses et spirituelles, et sonder leur opinion à ce sujet ainsi que leur niveau de confort pour le faire.

Type d'étude Étude transversale à l'aide de questionnaires auto-administrés.

Contexte Kitchener-Waterloo, Ontario.

Participants Un total de 155 médecins de famille pratiquant en cabinet.

Principaux paramètres à l'étude La fréquence à laquelle les médecins questionnent leurs patients sur leurs convictions religieuses et spirituelles, et leur niveau de confort lorsqu'ils le font. Des analyses de régression linéaires multiples distinctes ont été menées pour chacun de ces paramètres.

Résultats On a obtenu 139 réponses aux questionnaires, pour un taux de réponse de 89,7%. Parmi les répondants, 51,8% ont déclaré qu'ils interrogeaient parfois leurs patients au sujet de leurs convictions religieuses et spirituelles. L'opinion du médecin quant à l'importance de poser de telles questions au patient ($P = ,001$) et son niveau de confort lorsqu'il le fait ($P < ,001$) étaient significativement associés à la fréquence à laquelle il les posait. Le niveau de confort du médecin au moment de poser de telles questions était significativement associé à l'importance qu'il y attachait ($P = ,004$) et à sa conviction qu'il lui appartenait de le faire ($P = ,003$); les médecins disaient aussi que c'est par manque de formation qu'ils ne posaient pas ce genre de question ($P = ,007$).

Conclusion Cette étude a révélé que les médecins de famille étaient plus susceptibles de questionner leurs patients sur leurs croyances religieuses et spirituelles lorsqu'ils se sentaient plus à l'aise d'en parler ou qu'ils croyaient qu'il était important de le faire. L'étude a aussi montré que le niveau de confort du médecin de famille lorsqu'il pose ce type de question était plus élevé chez celui qui croit qu'il est important de le faire et que cela relève de sa responsabilité. Une formation adéquate permettrait d'accroître le niveau de confort du médecin qui questionne un patient à propos de ses convictions religieuses et spirituelles.

POINTS DE REPÈRE DU RÉDACTEUR

- Plusieurs obstacles font en sorte que les croyances religieuses et spirituelles ne sont pas intégrées aux soins de santé. Cette étude voulait connaître les raisons pour lesquelles les médecins de famille ne questionnent pas les patients sur leurs croyances religieuses et spirituelles, évaluer à quel point les médecins sont à l'aise avec ce genre de question et cerner les facteurs qui déterminent leur niveau de confort dans ce domaine.

- Les auteurs ont constaté qu'un niveau de confort plus élevé rendait plus facile le fait de questionner un patient sur ses convictions religieuses et spirituelles. Et puisque ce sentiment de confort était lié au comportement associé au questionnement, et que la formation était statistiquement et significativement associée au niveau de confort, le fait d'inclure la religion et la spiritualité dans l'éducation médicale pourrait aider à accroître le niveau de confort du médecin lorsqu'il questionne un patient sur ses croyances et l'amener à questionner plus souvent ses patients à ce propos.

Cet article a fait l'objet d'une révision par des pairs.
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Sir William Osler wrote, "Nothing in life is more wonderful than faith—the one great moving force which we can neither weigh in the balance nor test in the crucible .... Faith has always been an essential factor in the practice of medicine."[1] The literature reports that most physicians believe that religion and spirituality can have a positive effect on the physical and mental health of patients, especially those with serious or life-threatening illnesses, and can be sources of support for patients and their families. Most physicians also believe that physicians should ask and be aware of patients' religious and spiritual beliefs in the context of their health care and that asking patients about their religious and spiritual beliefs is an important part of their role as physicians.[2-9]

Factors that physicians perceived to be barriers to integrating religious and spiritual beliefs into health care included time, relevance, importance to medicine, and discomfort with asking about religion and spirituality. One of the more common reasons for not asking cited in the literature was physician discomfort, which was considered to be multifactorial.[3,7,10-12] However, there are no Canadian studies of physicians' practices in and opinions on asking patients about their religious and spiritual beliefs, and no studies that look at factors that correlate with physicians' comfort levels in asking.[13,14] Thus, the purpose of this study was to examine family physicians' practices in asking, their opinions on asking, and their comfort levels in asking patients about their religious and spiritual beliefs.

METHODS

Design and sample

This study was a cross-sectional, self-administered questionnaire mailed to family physicians about asking patients about their religious and spiritual beliefs. The sampling frame was the complete roster of family physicians and general practitioners actively practising in the Kitchener-Waterloo, Ont, area in 2009, excluding the principal investigator (M.L.P.). The Ontario Medical Association and the College of Physicians and Surgeons of Ontario provided a complete list of all practising family physicians in Kitchener and Waterloo. Two family physicians who had recently started practice were added to the list (N = 158). Three were excluded: the principal investigator, a retired physician, and a physician on leave.

Questionnaire development

A self-administered questionnaire was designed to assess how frequently family physicians asked their patients about their religious or spiritual beliefs in office visits, their comfort level with asking, their opinions on asking, and their reasons for not asking. Questions for this study were based on a literature search and a qualitative study conducted previously[15] in which patients identified general barriers to being asked about their religious and spiritual beliefs such as the comfort of the physician, the beliefs of the physician, time, and training. The literature search did not reveal any validated questionnaires.

Data collection

A modified Dillman method was used to distribute the self-administered questionnaire.[16] This method has been shown to increase response rates to mailed questionnaires.[16] The questionnaire was mailed to 155 family physicians in February 2009. A letter of information accompanied the questionnaire along with a stamped return envelope. Confidentiality of the participants' responses was ensured. The principal investigator sent the nonresponders a reminder postcard 2 weeks later, a second full mailing (letter, questionnaire, and return envelope) 5 weeks later, and a final reminder postcard 9 weeks later.

Variables and data analysis

Physicians' frequency of asking patients about their religious and spiritual beliefs was measured on a 5-point Likert scale (never, rarely, sometimes, most of the time, always). Independent variables from the questionnaire were divided into physician demographic characteristics, independent religious and spiritual beliefs, opinions on asking, and reasons for not asking, all of which were hypothesized to be associated with the frequency of asking patients about their religious and spiritual beliefs. Demographic variables were sex, age, years in practice, number of patients, and type of practice model. The independent belief variable determined presence of religious of spiritual beliefs among physicians. Opinions on asking included comfort with asking (not at all, somewhat, very, completely), importance of asking (yes, no, sometimes), relevance of asking (yes, no), and the opinion that it was "not my business" (yes, no). Reasons for not asking included insufficient time, lack of training, discomfort, past experience with asking, and other. All responses to reasons for not asking were yes or no. Comfort with asking was also considered as an outcome in a separate analysis.

Bivariate analyses were carried out using *t* tests and 1-way ANOVA (analysis of variance) as appropriate. Multivariate analysis was conducted using multiple linear regression of physician frequency of asking patients about their religious and spiritual beliefs with those independent variables that were statistically significant ($P \leq .05$) in the bivariate analysis.

A secondary multiple regression analysis was performed with comfort as the outcome with those variables that were statistically significant in the bivariate analyses.

Ethics approval was obtained from Western University's Institutional Review Board for health sciences research involving human subjects.

RESULTS

Of the 155 questionnaires mailed to family physicians, 139 of them were filled out, for a response rate of 89.7%. Of those who responded, up to 6 respondents did not answer certain questions (1 for years in practice; 6 for number of patients; 2 for frequency of asking patients about religious and spiritual beliefs; 2 for independent religious or spiritual beliefs; 3 for comfort with, 2 for importance of, 5 for relevance of, and 5 for attitude toward asking; and 5 for each of the identified reasons for not asking). One questionnaire was returned blank with a note stating the respondent had retired and did not wish to complete the questionnaire. This questionnaire was not included in the analysis. The 16 nonrespondents were similar to the respondents in terms of sex. It was not possible to compare the respondents and nonrespondents on any other variable.

Table 1 reports the description of the survey respondents. Approximately 40% of the respondents were female. Age ranged from 28 to 69 years with a mean (SD) of 48.9 (9.5) years. The physicians had been in practice from 1 to 43 years, with a mean (SD) of 20.8 (10.3) years. Practice sizes ranged from 60 to 6000 patients, with a mean (SD) practice size of 1900 (861). Most respondents (77.7%) were part of a family health organization practice model.

Table 2 presents respondents' independent spiritual and religious beliefs, as well as their frequency of asking, opinions on asking, and reasons for not asking patients about their religious or spiritual beliefs. Most respondents (81.8%) had their own religious or spiritual beliefs. Most respondents (51.8%) said that they asked patients about their religious or spiritual beliefs sometimes and 4.4% of respondents said they asked most of the time. Almost all respondents (94.9%) were at least somewhat comfortable asking patients about their religious or spiritual beliefs. When asked if it was important to ask patients about their religious or spiritual beliefs, most respondents (65.0%) answered that it was important sometimes. A little more than half of respondents believed that religious and spiritual beliefs were not relevant to health care, and one-fifth believed that it was not their business to ask patients about their religious and spiritual beliefs. More than half of respondents (58.2%) indicated time was a reason for not asking patients about religious and spiritual beliefs. Lack of training was identified as a reason for not asking by a minority of respondents (17.2%), and around one-tenth of respondents indicated that discomfort and past experiences with asking about religious and spiritual beliefs were reasons for not asking.

Table 1. Demographic and practice characteristics of respondents: *N* = 139.

CHARACTERISTICS	N (%)*
Demographic	
Sex	
• Female	56 (40.3)
• Male	83 (59.7)
Age,† y	
• < 40	29 (20.9)
• 40–49	43 (30.9)
• 50–59	42 (30.2)
• ≥ 60	25 (18.0)
Practice	
No. of years in practice†	
• < 10	20 (14.5)
• 10-19	36 (26.1)
• 20–29	54 (39.1)
• ≥ 30	28 (20.3)
No. of patients†	
• < 1000	14 (10.5)
• 1000–1499	24 (18.1)
• 1500–1999	28 (21.0)
• 2000–2499	39 (29.3)
• ≥ 2500	28 (21.1)
FHO practice model	
• Yes	108 (77.7)
• No	31 (22.3)

FHO—family health organization.
*Not all respondents answered all questions.
†Data captured as a continuous variable but presented in this table as categorical.

In the multivariate analysis, 8 factors that were significant in the bivariate analyses were included in the multiple linear regression analysis (**Table 3**.) Comfort level ($P < .001$) and believing that it was important to ask about religious and spiritual beliefs ($P = .001$) were both significantly positively associated with family physicians asking about their patients' beliefs.

A secondary objective was to further examine what variables might be associated with comfort level. Three variables were statistically significantly related to comfort in the bivariate analysis. These 3 variables (important to ask, not my business to ask, and lack of training as a reason to not ask) remained associated with comfort level in the multiple regression analysis (**Table 4**). Respondents who believed that it was important to ask reported higher comfort levels with asking patients

Table 2. Respondents' frequency of asking about religious and spiritual beliefs, independent religious and spiritual beliefs, and opinions on asking and reasons for not asking patients about their religious or spiritual beliefs

VARIABLES	N (%)*
Frequency	
Asked patients about their religious and spiritual beliefs	
• Never	9 (6.6)
• Rarely	51 (37.2)
• Sometimes	71 (51.8)
• Most of the time	6 (4.4)
• Always	0 (0.0)
Independent belief	
Having own religious or spiritual beliefs	
• Yes	112 (81.8)
• No	25 (18.2)
Opinions on asking	
Comfort level	
• Not at all	7 (5.1)
• Somewhat	67 (49.3)
• Very	47 (34.6)
• Completely	15 (11.0)
Important to ask	
• No	11 (8.0)
• Sometimes	89 (65.0)
• Yes	37 (27.0)
Not relevant to ask	
• Yes	69 (51.5)
• No	65 (48.5)
Not my business to ask	
• Yes	30 (22.4)
• No	104 (77.6)
Reasons for not asking	
Time	
• Yes	78 (58.2)
• No	56 (41.8)
Lack of training	
• Yes	23 (17.2)
• No	111 (82.8)
Discomfort	
• Yes	17 (12.7)
• No	117 (87.3)
Past experience	
• Yes	11 (8.2)
• No	123 (91.8)
Other	
• Yes	1 (0.7)
• No	133 (99.3)

*Not all 139 survey respondents answered all questions.

about their religious and spiritual beliefs. Respondents whose opinion was that it was "not my business" to ask and who listed lack of training as a reason for not asking were more likely to report lower comfort levels with asking patients about their religious and spiritual beliefs.

DISCUSSION

This study demonstrated that family physicians were more likely to ask about religious and spiritual beliefs when they were more comfortable with asking or believed that asking was important. Further, this study found that family physicians' comfort levels were higher when they believed it was important to ask about religious and spiritual beliefs.

While a number of studies have shown that physicians who believed that religious and spiritual beliefs were important were more supportive attitudinally of engaging in discussions with patients about religion and spirituality,[5,12,17,18] only 3 commented on how it affected physician behaviour. Armbruster et al found that physicians' perceptions of importance affected the behaviour of engaging in conversations if the topic were raised but did not address physicians asking patients directly.[3] Curlin et al reported that physicians who were more religious were more likely to address religion and spirituality in the clinical encounter.[19] Chibnall and Brooks reported no association between physicians' beliefs about the importance of religion and engaging in conversations with patients about their religious beliefs.[11] The present study is the first, to our knowledge, to show a direct association between physicians' opinions on the importance of asking patients about their religious and spiritual beliefs, and how frequently they asked patients about their religious and spiritual beliefs.

This study asked physicians directly about their comfort levels and identified comfort as a facilitator of asking patients about their religious and spiritual beliefs. No other study has directly looked at the concept of physician comfort. Furthermore, this study explored the relationship between different factors and physician comfort. Three factors affected physicians' comfort levels: training, the opinion that it is the physician's business to ask, and the opinion that it is important to ask patients about their religious and spiritual beliefs. Because comfort with asking was related to the reported behaviour of asking, and training is statistically significantly associated with comfort, we hypothesize that further medical education can help to increase comfort and hence increase physician frequency of asking patients about their religious and spiritual beliefs. Our findings support early exposure to this topic in training and raise 2 new areas for focus: why asking patients about their religious and spiritual beliefs should be part of the

Table 3. Multiple regression analysis of the factors that were statistically significant in the bivariate analyses of asking patients about their religious and spiritual beliefs

FACTORS	β COEFFICIENT	*P* VALUE
Demographic characteristics		
• Sex	0.023	.761
• Age	0.021	.789
Independent beliefs		
• Having own religious and spiritual beliefs	-0.116	.138
Opinions on asking		
• Comfort level	0.400	<.001*
• Important to ask	0.277	.001*
• Not my business to ask†	0.010	.905
Reasons for not asking		
• Time	-0.085	.268
• Past experience	-0.145	.056

*Statistically significant.
†The positive association here is with those who disagreed with the statement that asking was not their business. In other words, respondents believed asking was their business.

Table 4. Multiple regression analysis for factors in relation to physician comfort with asking patients about their religious and spiritual beliefs

FACTORS	β COEFFICIENT	*P* VALUE
Opinions on asking		
• Important to ask	0.171	.044*
• Not my business to ask†	0.252	.003*
Reasons for not asking		
• Lack of training	0.227	.007*

*Statistically significant.
†The positive association here is with those who disagreed with the statement that asking was not their business. In other words, respondents believed asking was their business.

physician's role, and why it is important to know patients' religious and spiritual beliefs. In the past decade, there has been acknowledgment of the lack of education regarding religion and spirituality in the medical curriculum. Numerous medical organizations, medical schools, and the World Health Organization have integrated religion and spirituality into their listed goals of health education.[20-23]

Strengths and limitations

There are many strengths to this study. One is the inclusion of all family physicians within the Kitchener-Waterloo area and another is the extremely high response rate. We expanded upon past studies and asked physicians specifically about reasons for not asking from a family physician's point of view. Also, a multivariate analysis was conducted, contrasting with most previous studies that only used bivariate analysis. Our study is also the first that we are aware of to question Canadian family physicians about reasons for not asking, to look directly at the concept of physician comfort itself, and to explore factors that contribute to physicians' comfort levels.

This study, however, was cross-sectional and thus cannot comment on a causal relationship. This study also did not specifically inquire about when discussions on religious and spiritual beliefs occurred. Future research needs to explore whether there are specific conditions or circumstances in which inquiring about religious and spiritual beliefs is more important. This study was conducted in a limited geographic region with family physicians and might not be applicable to other geographical areas or to other physician specialties or other primary care health providers such as nurses, nurse practitioners, and physician assistants.

Conclusion

This study found that family physicians were more likely to ask patients about their religious and spiritual beliefs if they had higher comfort levels in asking or if they believed that asking was important. Physician comfort levels might be addressed through adequate training and education. Introducing multidisciplinary experiential teaching and education modules early in the medical curriculum might help to minimize barriers to family physicians asking patients about their religious and spiritual beliefs in the context of their health care. Further research is needed to explore and evaluate effective ways of delivering the medical school curriculum to increase comfort levels in asking patients about their religious and spiritual beliefs.

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Contributors
All authors contributed to the concept and design of the study; analysis and interpretation; and preparing the manuscript for submission. **Dr Lee-Poy** was responsible for all the data gathering and data entry.

Competing interests
None declared

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