ORIGINAL INVESTIGATION

Do Patients Want Physicians to Inquire About Their Spiritual or Religious Beliefs If They Become Gravely Ill?

John W. Ehman, MDiv; Barbara B. Ott, RN, PhD; Thomas H. Short, PhD; Ralph C. Ciampa, STM; John Hansen-Flaschen, MD

Background: Recognizing that many Americans draw on religious or spiritual beliefs when confronted by serious illness, some medical educators have recommended that physicians routinely ask about spirituality or religion when conducting a medical history. The most appropriate wording for such an inquiry remains unknown.

Objective: To examine patient acceptance of including the following question in the medical history of ambulatory outpatients: "Do you have spiritual or religious beliefs that would influence your medical decisions if you become gravely ill?"

Methods: Self-administered questionnaires were completed by 177 ambulatory adult patients visiting a pulmonary faculty office practice at a university teaching hospital in 1997 (83% response rate).

Results: Fifty-one percent of the study patients described themselves as religious and 90% believe that prayer may sometimes influence recovery from an illness. Forty-five percent reported that religious beliefs would influence their medical decisions if they become gravely ill. Ninety-four percent of individuals with such beliefs agreed or strongly agreed that physicians should ask them whether they have such beliefs if they become gravely ill. Forty-five percent of the respondents who denied having such beliefs also agreed that physicians should ask about them. Altogether, two thirds of the respondents indicated that they would welcome the study question in a medical history, whereas 16% reported that they would not. Only 15% of the study group recalled having been asked whether spiritual or religious beliefs would influence their medical decisions.

Conclusion: Many but not all patients surveyed in a pulmonary outpatient practice welcome a carefully worded inquiry about their spiritual or religious beliefs in the event that they become gravely ill.

Arch Intern Med. 1999;159:1803-1806

From the Department of Pastoral Care, Hospital of the University of Pennsylvania, Philadelphia (Dr Ehman and Mr Ciampa), Villanova University, Villanova, Pa (Drs Ott and Short), and the Pulmonary, Allergy, and Critical Care Division, University of Pennsylvania, Philadelphia (Dr Hansen-Flaschen).

MOST AMERICANS describe themselves as religious.[1] Many turn to religious or spiritual beliefs for decision-making guidance and support when threatened by a serious injury or illness.[2-6] Given those observations, several authors[7-10] have suggested that discussion of religious or spiritual beliefs might enhance physician-patient understanding and communication. Indeed, some medical educators[11,12] have begun teaching medical students to conduct routine spiritual interviews. However, 3 published surveys of family practice patients all reported that only a minority of respondents wants to share their religious convictions with physicians.[13-15]

We question whether previous researchers examined the most appropriate approach to initiating discussions about personal religious or spiritual beliefs with patients. This study revisited this issue. We surveyed acceptance of a different approach by ambulatory patients in a university hospital pulmonary faculty practice. Our findings suggest that many patients will respond favorably to a carefully worded inquiry about spirituality or religion within the context of a routine medical history.

RESULTS

Patient characteristics are summarized in **Table 1**. On a 5-point Likert scale, 15% identified themselves as gravely ill (levels 1 or 2) and 39% as generally healthy (levels 4 or 5), while 45% chose the response equally between those 2 extremes (level 3). Fifty-one percent of the patients described themselves as religious or very religious, and 13% responded at or near the not religious end of the 5-point scale. In a separate question, 83% speci-

METHODS

We developed an 18-item, self-administered survey in 3 parts. Four core questions asked whether participants have spiritual or religious beliefs that would influence their medical decisions if they become gravely ill and whether they would want their physician to inquire about those beliefs. The key question was phrased this way: "If I became gravely ill, then I would like my doctor to ask whether I have spiritual or religious beliefs that would influence my medical decisions." We did not define gravely ill in the questionnaire, but instead left interpretation of that phrase to the individual respondents. Six questions asked about religiosity, various religious convictions, and medical advance planning. The remaining questions collected routine demographic information including the patients' impressions of their current overall state of health.

After piloting for readability and comprehension, we tested the survey for test-retest reliability. Thirty patients from the same clinic as the survey group completed the form twice, 2 to 4 weeks apart. Correlation coefficients for the 4 core questions exceeded 0.7 ($P<.001$). Only 4 of the 30 respondents changed 1 (or in one case, 2) of 4 answers between "agree" or "strongly agree" and "disagree" or "strongly disagree," suggesting that the core survey questions were reliable. Ancillary questions were also judged sufficiently reliable using linear correlation and χ^2 analyses.

The survey was administered in February and March 1997 to 214 consecutive adult patients visiting the pulmonary outpatient practice at the Hospital of the University of Pennsylvania. The study was approved by the institutional review board at that hospital. Patients were approached in the waiting room by a member of the hospital's pastoral care department, shown the survey, and asked if they would like to participate. All surveys were completed anonymously by the patients and returned immediately when completed. The surveyor was prohibited from clarifying items or elaborating on the survey. One hundred eighty-nine patients agreed to participate, but 12 were interrupted to see their physician before they finished the questionnaire. Thus, 177 surveys were suitable for analysis (83% response rate).

Relationships between the results of various questions were tested for statistical significance using χ^2 analysis. Differences were considered significant if $P<.01$.

Table 1. Patient Characteristics

Characteristics	Percent
Mean ± SD, age, y	52 ± 16
Sex	
Male	37
Female	63
Marital status	
Single	31
Married	44
Separated, divorced, or widowed	25
Race	
African American	35
White	63
Hispanic	2
Highest education attainment	
High school degree	57
College degree	20
Postgraduate degree	8
Religion	
Christian	75
Jewish	4
Other	4
No religious affiliation specified	17
Living will?	
Yes	31
No	69

Table 2. Relationship Between Religiosity and Patient Receptivity to Inquiry About Spiritual or Religious Beliefs

	Self-reported Religiosity*		
	Not Religious	In Between	Religious
I would like my doctor to ask†			
Disagree	7	8	14
No opinion	4	16	11
Agree	11	39	64

**"I consider myself to be: not religious 1 2 3 4 5 very religious."*
†"If I became gravely ill, then I would like my doctor to ask whether I have spiritual or religious beliefs that would influence my medical decisions." Responses to the 2 questions are not significantly related when tested by χ^2 analysis ($P = .07$).

fied a religious affiliation. Seventy-seven percent of the study population reported that they believe in "life after death," and 90% believe that prayer may sometimes influence recovery from an illness. When asked whether they had spiritual or religious beliefs that would influence their medical decisions if they became gravely ill, 45% agreed, 33% disagreed, and 22% offered no opinion.

Sixty-six percent of the respondents agreed or strongly agreed that they would like their physicians to ask whether they have spiritual or religious beliefs that would influence their medical decisions if they become gravely ill; 9% disagreed, 7% strongly disagreed, and 18% gave no opinion. Overall, 66% of respondents agreed that a physician's inquiry about spiritual or religious beliefs would strengthen their trust in the physician, whereas 10% disagreed and 7% strongly disagreed. Thirteen percent of them thought that a physician should not inquire if the physician might not agree with their beliefs.

Self-reported religiosity per se did not predict whether patients wanted physicians to inquire about their religious or spiritual beliefs in the event of a grave illness (**Table 2**). However, nearly all those who reported religious beliefs that would influence their medical decisions wanted to be asked about them, whereas those who did not have such beliefs tended to split on the issue of a physician's inquiry (**Table 3**). The pattern of responses was similar for the question whether

Table 3. Relationship Between Relevant Religious or Spiritual Beliefs and Patient Receptivity to Inquiry About Those Beliefs

	I Have . . . Beliefs*		
	Disagree	No Opinion	Agree
I would like my doctor to ask†			
Disagree	28	0	1
No opinion	4	24	4
Agree	26	16	74

** "I have spiritual/religious beliefs that would influence my medical decisions if I became gravely ill."*

† "If I become gravely ill, then I would like my doctor to ask whether I have spiritual/religious beliefs that would influence my medical decisions." Responses to the 2 questions are significantly related by χ^2 analysis ($P<.001$).

Table 4. Relationship Between Relevant Spiritual or Religious Beliefs and Effect of Physician Inquiry on Patient Trust

	I Have. . . Beliefs*		
	Disagree	No Opinion	Agree
It would strengthen my trust in a doctor†			
Disagree	25	3	3
No opinion	7	17	7
Agree	26	20	69

** "I have spiritual/religious beliefs that would influence my medical decisions if I became gravely ill."*

† "If I become gravely ill, then it would strengthen my trust in a doctor if he or she asked about any spiritual or religious beliefs that would influence my medical decision." Responses to the 2 questions are significantly related by χ^2 analysis ($P<.001$).

spiritual or religious beliefs would strengthen trust in the inquiring physician (**Table 4**).

Although most respondents would like their physicians to inquire about spiritual or religious beliefs under certain circumstances at least, only 15% recalled that a physician had ever done so previously.

COMMENT

In a survey limited to 1 subspecialty outpatient practice at 1 university hospital, 45% of respondents reported spiritual or religious beliefs that would influence their medical decisions if they become gravely ill. Virtually all (94%) of the respondents in that group agreed with a statement that physicians should ask gravely ill patients whether they have such beliefs. Nearly half (45%) of the respondents who denied having spiritual or religious beliefs that would influence medical decisions nevertheless agreed that physicians should ask about them. Altogether, two thirds of the study subjects welcomed such a question.

Our results differ from those reported by 3 other groups of investigators. The previous studies[13-15] reported that only a minority of patients surveyed (21%-40%) welcomed questions about spiritual or religious values in the setting of a family practice outpatient visit. It is possible that more of our pulmonary subspecialty practice patients were chronically or severely ill and thus more inclined to talk with their physicians about personal values. However (with modest sample sizes), we found no tendency for our study patients who described themselves as gravely ill to answer differently than the others. We speculate instead that the differences in our study results are largely explained by differences in the approach we tested to initiating discussions with patients about religious or spiritual beliefs.

Maugans and Wadland[13] and King and Bushwick[14] asked patients whether they would like physicians to discuss religious issues with them. Daaleman and Nease[15] inquired whether physicians should ask patients questions about their religion and personal faith. Those direct, open-ended questions may have concerned some survey respondents that an affirmative answer would encourage physicians to extend their practice beyond medical care into offering spiritual or religious advice.

Sick people in need are often willing to share highly personal information with physicians—including unusual sexual practices and illegal drug use—if they understand and accept a medical reason for such queries. Because certain behaviors are widely recognized risk factors for major diseases, the medical reason for asking about them is often apparent to the patient or can be quickly explained if necessary. On the other hand, the medical rational for a physician's direct inquiry about spirituality or religion, eg "What are your religious beliefs?" may not be so obvious to patients, leaving open the possibility for misinterpretation of the physician's motive for asking the question.

In contrast to previous investigators, we examined acceptance of an intermediate question that incorporates a reasonable medical explanation for the inquiry and implies boundaries for subsequent discussion: "Do you have spiritual or religious beliefs that would influence your medical decisions if you become gravely ill?" In addition to offering a clinical rationale for a new topic of inquiry, this question provides the patient with a quick, unrevealing avenue of exit if so desired. At the same time, this inquiry commits the physician only to a posture of openness regarding the patient's medically relevant religious or spiritual beliefs.

Our survey did not pursue the thinking of the 13 respondents (7%) who strongly disagreed with the statement: "If I become gravely ill, I would like my doctor to ask whether I have spiritual or religious beliefs that would influence my medical decisions." Did those individuals misunderstand this survey question, or might some people be offended by even an intermediate query about spirituality or religion that can simply be answered no? Clearly, more information is needed on the potential "down side" of asking questions about spirituality and religion in clinical practice. Also, more information is needed on the practical utility of such questions. Two thirds of our respondents reported that the question we studied would increase their trust in a physician. How often might that question or others like it also lead to better medical decision making?

The rationale we incorporated into our question about spirituality or religion (informed decision mak-

ing in the event of a grave illness) is probably more relevant to certain patients than to others. Indeed, some younger or generally healthy individuals may be more concerned about a physician's unexpected inquiry regarding a grave illness than the invitation to talk about spiritual or religious beliefs ("does she know something I don't know about my medical condition?"). There are other medically relevant reasons to ask about spirituality or religion. Under certain circumstances it may be more appropriate to offer an alternate explanation for the inquiry.

Because our study population was limited in scope, the results of this survey cannot be broadly generalized. Some religious views were not proportionately represented among our respondents. Also, some of the patients we surveyed might respond differently if asked again when they become gravely ill. Despite those limitations, the results of this study point to possible widespread patient acceptance of incorporating a carefully worded exploratory question about spiritual or religious beliefs within a routine medical history.

Accepted for publication October 8, 1998.

We thank Horace DeLisser, MD, for critical review of the manuscript.

Reprints: John Hansen-Flaschen, MD, the Pulmonary, Allergy, and Critical Care Division, Hospital of the University of Pennsylvania, 873 Maloney Bldg, 3400 Spruce St, Philadelphia, PA 19104 (e-mail: jflash@mail.med.upenn.edu).

REFERENCES

1. Gallup G. *Religion in America: Fifty Years: 1935-1985—The Gallup Report.* Princeton, NJ: Princeton Religious Research Center; 1985.
2. Matthews D, McCullough M, Larson D, Koenig H, Swyers J, Milano M. Religious commitment and health status: a review of the research and implications for family medicine. *Arch Intern Med.* 1998;7:118-124.
3. Grodin M. Religious advance directives: the convergence of law, religion, medicine, and public health. *J Public Health.* 1993;83:899-903.
4. Hamel R, Lysaught M. Choosing palliative care: do religious beliefs make a difference? *J Palliat Care.* 1994;10:61-66.
5. Sugarman J. Factors associated with Veterans' decisions about living wills. *Arch Intern Med.* 1992;152:343-347.
6. King M, Speck P, Thomas A. Spiritual and religious beliefs in acute illness: is this a feasible area for study? *Soc Sci Med.* 1994;38:631-636.
7. Theil M, Robinson M. Physicians' collaboration with chaplains: difficulties and benefits. *J Clin Ethics.* 1997;8:94-103.
8. Waldfogel S, Wolpe P. Using awareness of religious factors to enhance interventions in consultation-liaison psychiatry. *Hosp Commun Psychiatry.* 1993;44:473-477.
9. Matthews D. Religion and spirituality in the care of patients with chronic renal failure. *Dialysis Transplant.* 1998;27:136.
10. Schreiber K. Religion in the physician-patient relationship. *JAMA.* 1991;266:3062-3066.
11. Seidel H, Ball J, Dains J, Benedict G. *Mosby's Guide to Physical Examination.* St Louis, Mo: Mosby–Year Book; 1995:24, 40-45.
12. Bates B, Bickley S, Hoekleman R, eds. *Physical Examination and History Taking.* 6th ed. Philadelphia, Pa: JB Lippincott; 1995:5.
13. Maugans T, Wadland W. Religion and family medicine: a survey of physicians and patients. *J Fam Pract.* 1991;32:210-213.
14. King D, Bushwick B. Beliefs and attitudes of hospital inpatients about faith healing and prayer. *J Fam Pract.* 1994;39:349-352.
15. Daaleman T, Nease D. Patient attitudes regarding physician inquiry into spiritual and religious beliefs. *J Fam Pract.* 1994;39:564-568.