Physician Perspectives on the Role of Religion in the Physician–Older Patient Relationship

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A study of 160 family physicians and general practitioners found that the majority of physicians believed that religion has a positive effect on the mental health of older patients, and many believed that religion has a positive effect on physical health. While more than one half reported that patients only rarely, if ever, mentioned religious issues during a medical visit, a significant proportion of the physicians felt they should address religious issues when an older person indicates religion's importance and that religious issues should not be reserved completely for the clergy. Nearly two thirds of the physicians felt that prayer with patients was appropriate under certain circumstances, and over one third reported having prayed with older patients during extreme physical or emotional distress. Older physicians were less likely than younger to have positive attitudes toward addressing religious issues. The strongest predictors of physicians' belief in the appropriateness of addressing religious concerns were two attitudinal variables that indicated an understanding of the importance of religion in the lives of older adults and an awareness that patients might desire to engage in prayer with them. Hence, the beliefs and attitudes of the physician appear to be important factors in determining their receptivity to discussion of religious issues, which in turn may influence whether patients mention such issues in the context of the medical visit.

The gerontological and sociological literature is quite convincing that religious beliefs and affiliations play a significant role in the lives of many older people. For over ten years, national surveys have repeatedly provided data to support the disproportionate importance of religion in the lives of older persons when compared with younger persons.[1,2] Research findings indicate, for example, that older people have higher rates of church attendance than the general population and are more likely to be involved in other church activities, to profess orthodox beliefs, and to engage in private prayer.[2,3] The relationship between religion and mental health suggests that religion is a mediating factor in coping with the losses of later life and therefore could be a deterrent to the development of affective disorders such as depression.[4–12] In fact, a recent study found religion (participation and belief) to be second only to health in predicting subjective well-being among persons aged 75 years and over.[13]

From a social psychological standpoint, religious beliefs and behaviors could affect older people's physical health (adversely or positively) by influencing symptom recognition, symptom attribution, health care-seeking behavior, and compliance with medical regimens. From a negative standpoint, excessively guilty religious people might view physical symptoms or signs of disease as just punishment for past sins. Feeling they deserve such punishment, they might not seek medical assistance. Also, people who believe that God will heal them in a supernatural manner may bypass ordinary medical interventions for what could be treatable illnesses; consequently, diseases may progress that might have been treated at earlier stages.

From a positive perspective, the Judeo-Christian tradition holds that the human body was created in God's image and that it is the temple of the soul. Any abuse of the body—excessive alcohol use, cigarette smoking, or even failure to seek and comply with medical recommendations—is considered by many to be contrary to fundamental religious doctrine. Some religious persons, therefore, may be inclined to seek medical care and to

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comply with medical therapy out of the sense of obligation to care for their physical bodies as God has directed them. In addition, the social contact and concerned attitudes of fellow churchgoers may enhance the likelihood that physical signs and symptoms of disease would be detected and identified as requiring medical attention. Supporting such speculation is the work of Naguib et al,[14] who found church membership and participation to be associated with an increased likelihood of involvement in a cervical cancer screening program.

Little is known about the degree to which physicians use these facts and theories to shape their treatment interventions. A number of articles from the fields of psychiatry and clinical psychology[15–20] discuss the issue of whether it is appropriate for mental health professionals to address religious issues in psychotherapeutic relationships. The documentation on the prevalence of these practices and their outcomes remains quite limited; additionally, there has been little focus on the role of religion in the physician–older patient relationship specifically.

The literature on the socialization of physicians and on the physician-patient relationship suggests that those trained in the traditional medical model of patient care follow norms that proscribe infusion of religion (along with other so-called personal matters) into the treatment context. One study[21] suggests that even family medicine physicians trained recently with exposure to the biopsychosocial model of health care are reluctant to address psychosocial concerns because of implicit beliefs that such matters are outside a physician's domain. Some physicians in that study believed that psychosocial issues have nothing to do with medical problems, that psychosocial concerns are a low priority for physicians, that attention to psychosocial matters requires more knowledge and emotional resources than they can offer, and that patients do not want physicians to address psychosocial issues. Many physicians, therefore, either may be unaware of the impact that religious factors may play in health and disease or are unwilling to deal with such concerns. According to Barsky,[22] however, the failure of physicians to address psychosocial concerns may have contributed to patient dissatisfaction over the depersonalization and mechanization of health care.

The great diversity of religious belief and expression and the controversial nature of religion as a topic of conversation increase the possibility of discordance between patients and practitioners in discussing religious subjects. Despite the sensitivity of such topics, however, religious matters may be quite relevant in the primary care of the religious older patient facing the complex and troubling problems of chronic or acute illness and other stressful life events; discussion of religious issues may be quite valuable, if not essential, for understanding the patient and ensuring effective treatment and compliance. A preliminary study of 72 community-dwelling older people indicated that a substantial majority (85 percent) agreed that "my religious faith is the most important influence in my life," and many (78 percent) indicated that, in times of great emotional or physical distress, they would like their personal physician to pray with them.[23] The religious subjects were significantly more likely than the nonreligious to want their physicians to pray with them.

The present study was undertaken to investigate physicians' beliefs about the role of religion in the lives of their older patients and the appropriateness of addressing religious issues with patients in the treatment context. It was hypothesized that physicians would vary in their attitudes and practices regarding religious issues in patient care depending on such demographic factors as their age, sex, the percentage of patients in their practice who are older than 60 years, and the size of town in which they practiced. It was also hypothesized that physicians who believed more strongly that religion was important to older people and that their patients would like to interact with them on these issues would be more likely to consider religious issues relevant to medical care. It was anticipated that those physicians whose patients frequently mentioned religious issues or who had actually prayed with patients would, because of their experiences, have a more accepting attitude toward addressing religious needs.

METHODS

The cross-sectional study was conducted by means of questionnaires mailed or distributed in person to 210 general practitioners and family physicians in Illinois. Participants were recruited through two procedures. First, a 5 percent probability sample was selected from the Illinois physicians listed in the American Academy of Family Physicians (AAFP) membership directory. Questionnaires were mailed to these 113 physicians with the instructions that the purpose of the survey was to explore their experiences and attitudes concerning the topic of religion and their older patients. The initial mailing and up to three reminder letters yielded 73 completed questionnaires (for a response rate of 72 percent). A comparison of respondents with nonrespondents using data from the membership directory revealed no significant differences in age or sex. Nonparticipants were more likely than respondents to reside and practice within or near a large urban center and to be of foreign birth.

A second group of respondents was recruited from physicians attending a geriatric medicine lecture series. This audience was given the same instructions as those surveyed by mail and asked to fill out the questionnaire on site. Of the 97 questionnaires distributed, 87 were completed (for a response rate of 90 percent). The final

sample drawn from the two groups totaled 160 respondents.

A comparison of responses of the two groups on each of the 23 items in the questionnaire revealed that the only difference between the groups was in average age, with the first group containing only practicing physicians, whereas the second group contained 17 residents and five medical students, which skewed the age distribution. Because the two groups showed no significant differences in other demographic characteristics, the two groups were combined to form a sample of 160 respondents upon whose responses descriptive and statistical analyses were performed.

The instrument distributed to respondents was a 23-item self-administered questionnaire. The first five items asked respondents about demographic characteristics; the remaining 17 items asked about their beliefs and practices regarding the role of religion in the lives of older people and in the physician-patient relationship. Most questions had a 10-point Likert scale on which respondents were to circle the number that best corresponded to their answer. Seven items offered dichotomous response options.

Data from the Likert-scaled items were treated as interval in nature, and *t* tests and Pearson correlations were performed utilizing scale scores ranging from 1 to 10. The chi-square statistic was used to analyze data with dichotomous responses. Stepwise multiple regression (which selects the most influential variable first) was used to sort out the independent effects of physician characteristics and attitudes on belief in the appropriateness of addressing religious issues in the context of a medical visit.

TABLE 1. DEMOGRAPHIC CHARACTERISTICS OF PHYSICIAN SAMPLE (N = 160)

Characteristics	Number	Percent
Age (years)		
<60	116	73.4
≥60	42	26.6
Sex		
Male	140	88.6
Female	18	11.4
Specialty		
Family or general practice	130	82.3
Other specialty	8	5.1
Physician in training	14	8.9
Student physician	6	3.8
Size of town of practice		
<1000	4	2.7
1000–9,999	40	27.0
10,000–49,999	49	33.1
50,000–100,000	35	23.6
>100,000	20	13.5
Percentage of patients aged ≥ 60 years		
<10	80	51.3
10 to 50	67	42.9
>50	9	5.8

RESULTS

The majority of the respondents were middle-aged, male family physicians or general practitioners from moderate-sized towns in Illinois (Table 1). The mean age of the sample was 47.6 years with a standard deviation of 15.0 years. Approximately one half (48.7 percent) of the physicians had practices with more than 10 percent of their patients aged 60 years or older. Over one half of the physicians (56.7 percent) practiced in communities of 10,000 to 100,000 people.

The physicians had quite varied beliefs about the importance that religion has in the lives of older people. Over two thirds of those responding (68.6 percent) definitively agreed that strong religious beliefs and frequent involvement in religious activities have a positive effect on mental health; a somewhat smaller percentage (42.4 percent) agreed with its positive impact on physical health (Table 2). Sixty people agreed that religiosity had a positive impact on both mental and physical health. More than two thirds of the sample (67.4 percent) felt that the statement "religion is the most important influence in the life of an older adult" is or tends to be true, although the mean score of 6 was just above neutral or midpoint.

The majority of the sample (62.7 percent) felt that older patients would not like to have their physician pray with them during severe illness or emotional distress. As Table 3 reflects, however, most physicians felt that when older patients indicate that religious issues are of importance to them, physicians could at least sometimes appropriately address religious issues in the context of a medical visit; only 8.2 percent felt that such discussions were rarely or never appropriate. Nearly all (87.7 percent) agreed that physician involvement is appropriate when the patient makes a direct request for help in this area. Many agreed that religious involvement is even appropriate when the patient indirectly conveys the message to the physician that religion is important to them (81.5 percent). A smaller majority (65.8 percent) believed that to address religious issues during extreme circumstances such as bereavement or impending death is appropriate for physicians, even if the patient gives no indication that religion is important to him. Less than one third of the respondents (30.6 percent) agreed to any extent that attention to religious needs of their patients should be reserved entirely for the clergy or should be delegated to their nurse.

The physicians differed somewhat on the specific religious actions that were appropriate in the care of the religiously oriented patient who is dealing with severe emotional turmoil, is very sick, or is near death. Most

TABLE 2. PHYSICIANS' BELIEFS ABOUT IMPORTANCE OF RELIGION FOR OLDER PEOPLE (N = 160)

Belief	Mean Rating	Number (Percent)	Number (Percent)	Number (Percent)
		Negative Effect [1–3]	Little or No Effect [4–7]	Positive Effect [8–10]
Affects mental health	7.9	3 (1.9)	46 (29.5)	107 (68.6)
Affects physical health	7.1	4 (2.6)	83 (55.0)	64 (42.4)
		Not True [1–5]		True [6–10]
Religion is most important influence on life in older patients	6.0	47 (32.6)		97 (67.4)
		No [1–5]		Yes [6–10]
Patients want to pray with physician	4.5	96 (62.7)		57 (37.3)

Numbers within brackets refer to Likert scale groupings

TABLE 3. PHYSICIANS' NORMATIVE BELIEFS ABOUT RELIGION IN MEDICAL CONTEXT (N = 160)

Belief	Mean Rating	Number (Percent)	Number (Percent)	Number (Percent)
		Never or Rarely [1–3]	Sometimes [4–7]	Often or Always [8–10]
Physician may address religious issues in general	6.9	13 (8.2)	82 (51.9)	63 (39.9)
		Not Appropriate		Appropriate
If specific request	N/A	18 (12.3)		128 (87.7)
If implied request	N/A	27 (18.5)		119 (81.5)
If no request	N/A	50 (34.2)		96 (65.8)
		Never or Rarely [1–3]	Sometimes [4–7]	Often or Always [8–10]
Nurse may address religious issues	5.1	55 (35.5)	64 (41.3)	36 (23.2)
		Disagree [1–5]		Agree [6–10]
Clergy only should address religious issues	3.9	109 (69.4)		48 (30.6)
		Not Appropriate		Appropriate
Physician may:				
Encourage patient beliefs	N/A	33 (23.1)		110 (76.9)
Join patient in prayer	N/A	48 (33.6)		95 (66.4)
Share own beliefs with patient	N/A	53 (37.1)		90 (62.9)

N/A =not applicable
Numbers within brackets refer to Likert scale groupings

physicians (76.9 percent) believed that encouragement or support of the patient's own religious beliefs was not inappropriate behavior. The majority (66.4 percent) also reported that praying with patients was not inappropriate behavior for physicians. Among the behaviors explored, the sharing of a physician's own beliefs with the patient was the most frequently designated as inappropriate (37.1 percent). Nevertheless, most physicians felt that even this behavior was not inappropriate with older patients during times of crisis.

As for experience (Table 4), physicians reported a low to moderate incidence of their older patients mentioning religious issues in the context of a medical visit; 51.3 percent rarely or never encountered such matters. Over one

TABLE 4. PHYSICIANS' EXPERIENCE WITH RELIGIOUS INTERACTIONS (N = 160)

Experience	Mean Rating	Number (Percent)	Number (Percent)	Number (Percent)
		Rarely or Never [1–3]	Sometimes [4–7]	Often or Always [8–10]
Frequency of patient mention of religion	4.0	80 (51.3)	67 (42.9)	9 (4.8)
		No		Yes
Have prayed with patients	N/A	98 (62.8)		58 (37.2)
		Not at All [1–3]	Somewhat [4–7]	A Great Deal [8–10]
Prayer helped	7.1	6 (10.7)	19 (33.9)	31 (55.4)
		Rarely or Never [1–3]	Sometimes [4–7]	Often or Always [8–10]
Referral to clergy	6.9	11 (7.1)	75 (48.1)	70 (44.9)

N/A = not applicable
Numbers within brackets refer to Likert scale groupings

third (37.2 percent) of the physicians reported having prayed with their older patients when the patient was in great distress or near death. Of those physicians who had prayed with their patients, 89.3 percent felt that it helped somewhat or a great deal. Fewer than one half (44.9 percent) reported a usual pattern of referring patients to clergy when in such a situation.

The age of the physician responding to the survey was significantly correlated with beliefs about the importance of religion to older patients as well as the appropriateness of religious interactions. Unexpectedly, physician age was negatively correlated ($r = -.32$) with a belief that older patients under certain circumstances would desire their physician to pray with them. Physicians also differed by age in their opinions as to what would be appropriate behavior for physicians to pursue regarding patients' religious needs. A Student's t test of differences in group means revealed that the mean age of physicians who believed it appropriate to encourage or support patients' religious beliefs was significantly younger than that of physicians who felt this action to be inappropriate (47 vs 55 years, $P < .01$). Of physicians aged 60 years and older, only 22 percent had prayed with their patients compared with 40 percent of those younger than 40 years ($\chi^2 = 6.4$, $df = 2$, $P < .05$). Only 75 percent of the older physicians who prayed with their patients felt that this activity helped at least somewhat, whereas 100 percent of the younger physicians felt that it was helpful.

Physicians with greater percentages of older patients in their practices answered many of the questions quite similarly to the other physicians in the sample. Those with more geriatric patients, however, were significantly less likely to believe that older patients would like their physician to pray with them ($r = -.21$). Furthermore, among all physicians who had prayed with patients, those with an older clientele were less likely to believe that prayer had actually helped the patient ($r = -.41$). These findings may be explained, however, by the strong intercorrelation ($r = .44$) between physician age and percentage of older patients in their practice.

The sex of the physician had virtually no relationship to any attitudes and practices reported, although the small number of women in the sample makes interpretation inconclusive. The size of town in which a physician practiced was unrelated to most physician attitudes and practices; the single observed relationship indicated that physicians from larger towns were less likely to believe that religion was the central influence in the lives of older people ($r = -.27$).

Many physicians who tended to believe that religion is the most important influence in the lives of older people also believed that it is appropriate for a physician to address religious issues ($r = .45$). Similarly, physicians who believed that religion has an impact on physical or mental health were more likely to feel that religion is a proper subject for discussion ($r = .30$ and $r = .23$, respectively). Physicians who believed that patients would like their doctors to pray with them were significantly more likely than others to express an acceptance of dealing with religion in the medical context ($r = .54$). Physicians whose patients frequently mentioned religious issues were somewhat more likely than others to believe it appropriate to address religious issues ($r = .23$); also those physicians who had actually prayed with patients reported more frequent mention of religious issues by their older patients (mean score 4.7 vs 3.6, $P < .001$).

Further analysis by multiple regression revealed that physician attitudes and experiences had a much stronger

role in predicting normative beliefs than did demographics. Selected physician beliefs and demographic variables were regressed in a stepwise fashion on the variable measuring physician belief in the appropriateness of discussing religious issues with patients. Only two variables—both concerning physician beliefs—were significantly and independently related to the appropriateness variable. Physicians' belief that elderly patients were receptive to shared prayer and that religion was an important influence in the life of an older adult explained approximately one third (35.2 percent) of the variance in the appropriateness variable. Neither demographic characteristics of physicians nor characteristics of their medical practices had significant independent effects in determining physician beliefs on the appropriateness of addressing this subject with patients.

DISCUSSION

For the most part, the physicians in this study acknowledged the strong influence that religion plays in the lives of older adults as conveyed in popular stereotype, although they underestimated the influence as reported by older people themselves in other studies. Interestingly, a significant proportion of the sample expressed the belief that religion had a positive impact on mental and physical health. Nevertheless, most physicians had some ambivalence about addressing religious issues as part of a medical visit, as is evidenced by the fact that the modal response was 6 on a 10-point scale, just above the midpoint; that is, large numbers responded that it was sometimes appropriate.

A larger number of physicians endorsed participating in religious discussions under conditions that were least intrusive to the patient, that is, when the patient initiated the subject with a direct request for help as opposed to when the physician inferred a need. Similarly, physicians were somewhat more likely to support more passive and less intimate forms of religious interaction such as encouragement and support of a patient's religious beliefs rather than joint prayer or discussion of the physician's own religious beliefs. These preferences may reflect physicians' desire to maintain interpersonal boundaries which respect the privacy of patients or which eliminate the need for self-disclosure.

It is interesting and provocative that older physicians and those physicians with older patients were more likely to believe that very sick patients do not want to pray with their physicians and, among those who had prayed with patients, were more likely to question the benefit of prayer. That physician age dropped out as a significant correlate of physician appropriateness in addressing religious issues does not preclude the possibility that age is independently related to this attitude. It is possible that a true association with age was masked by the order in which variables were entered into the regression equation. The consistency of the significant associations found with other similar variables, however, suggests that physician age is indeed related to how receptive physicians are in addressing religious issues with their patients. It is possible that older physicians were socialized more strongly to the medical model in their training and were therefore less likely to consider attention to psychosocial issues appropriate.[24] Although physician age was not a factor in determining the appropriateness of "addressing" religious issues, it may be that joint prayer is seen by the older physician as too active and intimate an expression of religiosity to be considered appropriate. Younger physicians with more explicit training regarding the handling of psychosocial concerns may be less reluctant to address such intimate issues in an active fashion, particularly when aware of the literature on the possible beneficial effects of religion on health and well-being.

Also worth noting is that physicians report relatively infrequent mention of religious issues by their older patients during medical visits. This phenomenon suggests that older people adhere to the same ambivalent norms as physicians regarding the appropriateness of certain topics and behaviors in that setting. This interpretation fits with the observations of Greene et al,[25] who found that older people conceptualize the medical encounter as solely medical and consider the mention of other, personal concerns inappropriate. Their study also showed, however, that older patients are willing to address psychosocial concerns when the physician takes the lead in raising the issues. A more recent article by Greene et al[26] reported that physicians are more likely to respond to the psychosocial concerns of older patients if the topics are physician-initiated than if they are patient-initiated. Since the frequency of religious interactions in the present study was correlated with physicians' belief about the appropriateness of addressing religious issues, it may be that physicians create a climate of interest in and responsiveness to patient concerns in this area, thereby yielding more frequent mention of such matters. It is less likely that patients' mention of religion has led physicians to recognize its importance and to define office or bedside norms accordingly.

The data show that physicians vary greatly in the attention they give the religious needs of patients in their practices. Interestingly, however, neither physician characteristics nor the demographics of their practice predict either the willingness to address religious issues or the frequency with which physicians are expected to address religious issues by their patients. The best predictors of physicians' attitudes toward dealing with religion in the

medical context are beliefs and attitudes regarding the centrality and significance of religion in the lives of older people. Physicians who believe that religion is an important influence in the lives of older adults are much more likely to feel it is appropriate for them to deal with religious issues. On the other hand, physicians who accord religion less significance are not only less likely to believe it is appropriate to address religious concerns, but also less likely to refer patients to clergy for such issues. Since it is the physician who may often play a key role in directing resources available to the hospitalized older patient during times of severe illness or near death, the physician who is uninformed on the importance of religious issues may impede the patients' accessibility to help for religious concerns and deprive them of the comfort that such assistance may render.

Because the sample of physicians is racially and regionally homogeneous, predominantly male, and consists of only family physicians and general practitioners, the findings of this study are not generalizable to a more heterogeneous and specialized physician population. It would be interesting to ask the same questions of geriatricians, who would presumably be more closely attuned to the needs of the older patient. Another interesting study would be to survey black physicians, who because of the traditional strength of the church in the black community, may acknowledge the role of religion and church support in the lives of elders.

It would be valuable to examine the attitudes of physicians in relationship to their own religious affiliations and beliefs, determining the degree to which those who are more religious believe that religious issues are appropriate and relevant for discussion in medical care settings. Open-ended interviews could help clarify how physicians interpreted the term *religious issues* and could deepen understanding of the nature of their ambivalence in addressing such issues.

The findings suggest a number of implications for education and practice. Training of new physicians could include didactic instruction and discussion of the role that religion plays in the lives of older people, stressing complex interrelationships of religion and health as well as the variability of religious beliefs and practices among older people. Given the high correlation between knowledge of the centrality of religion in the lives of older people and willingness to address religious issues, more information could make some physicians more receptive. At the very least, such instruction would help physicians acknowledge the religious needs of some of their patients and suggest possible referral options to trained counselors or clergy.

Because the study revealed that most physicians believe it is at least sometimes appropriate to address religious issues, physicians previously reluctant to discuss religious issues may feel encouraged to venture into what may be a fruitful area for exploring patients' psychosocial needs. The norms for doing so, however, are not well established, as was indicated by the variation in the conditions under which such interaction was deemed appropriate and in the behaviors that were sanctioned. Because religion is such a sensitive subject, it can be difficult for physicians to initiate discussion, to identify areas that are relevant to health, and to contain discussion to matters in which they can be a competent and helpful resource. The norms of ethical behavior for physicians in a position of authority and patients in a vulnerable state of mind or dependency require that physicians not impose their personal attitudes toward religion or specific beliefs on patients[27] or make an "unwarranted intrusion."[26]

Physicians wanting to address such needs should begin to listen more carefully for indications that religious matters may be relevant to a particular patient's care and may broach the subject and pursue it depending how the patient responds. Gradual negotiation may be required to arrive at a satisfactory level of open communication on this subject. An older physician responding to the present survey reported that the slightest interest on his part in discussing religious issues often "opened up the floodgates" to a profusion of related concerns. Perhaps it is just this reaction that makes many physicians reluctant to initiate such discussions. Nevertheless, for primary care physicians willing to listen, recognition of issues that are highly important to religious older patients could lead to improved diagnosis and a more appropriately tailored plan for treatment. At the same time, considerate acknowledgment of issues that are highly salient to the patient (especially in times of extreme stress) has significant potential for strengthening the physician-patient relationship.

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