2014

Patient preference for physician prayer in medical situations

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PATIENT PREFERENCE FOR PHYSICIAN PRAYER IN MEDICAL SITUATIONS

A Thesis Submitted
in Partial Fulfillment
of the Requirements for the Designation
University Honors

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May 2014

Introduction

As medical issues present themselves in an individual's life, some may resort to religion and spirituality. Because health care providers care for the individual, these practitioners need to be aware of the connections that occur within the realm of spirituality and medicine. The overall purpose of this study was to examine the attitudes of physician use of prayer during medical visits in a sample of adults. Specifically, four research questions were examined: Overall, do patients want their physicians praying for them? Overall, do patients prefer a certain type of physician prayer (i.e., active, silent or physician distant intercessory prayer)? Does patient preference of the type of physician prayer depend on the medical situation? Medical situations included all medical visits, a routine office visit, a hospital visit, an emergency room visit, a surgical setting, and a terminal illness. Does worship attendance within the past year affect patient preference of physician prayer?

It is important for physicians to be aware of any desire for prayer in the medical setting. In the ever-changing world of medicine, patients are looking for connections to their physicians and religion may play a role in this patient-physician relationship. Not only does religion provide a sense of hope and comfort in difficult situations, but can effectively enhance medical communication through a strengthened patient-physician bond. While prayer in medicine may seem like a foreign concept, it could potentially have its place in medicine, which will be examined and elaborated upon in this study.

Patient Preference for Physician Prayer in Medical Situations

As individuals grapple with medical issues, some may turn to religion and spirituality. Moreover, because health care practitioners work with individuals, practitioners need to be sensitive to the interactions between spirituality and medicine. The purpose of this study was to examine the concepts of spirituality and religion in modern medicine. The review begins by comparing similarities and differences between spirituality and religion, focusing on barriers and benefits of religion and medicine, and analyzing the differences in physician versus patient research studies.

What is Spirituality and Religion?

Religion and spirituality are two terms used in daily life with definitions elusive to most people. The terms religion and spirituality address both beliefs and faiths. Believing in a god, attending a religious service, self-identified religiosity, and application of religion beliefs in other areas of life, are all components of religion and spirituality (Behan et al., 2012). Hope, meaning, comfort, strength, peace, love and connection are terms associated with someone who has religious and spiritual beliefs.

Although the two words are commonly interchangeable, a few scholars attempt to discuss the differences between religion and spirituality. According to Post, Puchalski, and Larson (2000), spirituality can be defined as those beliefs that pertain to ultimate meaning and a purpose in one's life. For example, spiritual individuals will often know the purpose of their daily activities and how they relate to the greater community. Spirituality can be thought of as the ideas behind humanity that give meaning and purpose to the ways the individuals live their lives, how they express connection to the moment, to themselves, to others, to nature and to a sacred being (Puchalski et al., 2009).

Spiritualties are a set of beliefs, stories and practices that respond to basic human desire to find meaning and purpose in life (Daaleman, 2004). Daaleman notes that these beliefs, stories and practices do not necessarily have to be linked to religion beliefs or practices.

Post and colleagues (2000) discuss the importance of spirituality in autonomy. Those who have a high level of spirituality may feel complete and able to enter all challenges of life independently without fear. In medical situations, patients with high levels of spirituality may experience autonomy and control, having the confidence and perseverance to move forward in treatments without fear. Spirituality may in fact encompass a belief in a power greater than oneself; a purpose in life; faith; trust in providence; prayer; meditation; group worship; ability to forgive; ability to find meaning in suffering; and gratitude for life, perceived as a gift (Post et al., 2000). According to Masters and Spielmans (2007), individuals who pray during times of stress may find strengthened faith and an increased sense of confidence in a positive, or at least manageable, outcome. Spirituality and prayer likely play a large role in the autonomy, confidence and mental strength of patients.

Religion, on the other hand, is often associated with strict doctrine and beliefs. It has been stated to create distinct identities, behaviors and expectations (Guilfoyle & St. Pierre-Hansen, 2012). For example, a person may need to follow a specific doctrine or moral code when practicing a religion. The authors continued that many would conclude that spirituality is a much *looser* term that may not be as defined. For example, religion may encompass a specific doctrine individuals should follow, where spirituality encourages a connection with something greater than the self.

In general terms, religion and spirituality are often used interchangeably due to the vast number of similarities and will be used as such throughout this review (Armbuster, Chibnall & Legett, 2003; Behan et al., 2012; Daaleman, 2004; Ehman, Ott, Short, Ciampa, & Hansen-Flaschen, 1999; Guilfoyle & St Pierre-Hansen, 2012). Personal faith or a belief in something and a meaning of life can be attributed to both religion and spirituality. For the purpose of this paper, spirituality and religion can be defined as doctrine and traditions that provide a foundation for understanding the totality of human experience, primarily for communities of faith (Daaleman, 2004).

Barriers and Benefits of Religion in Medicine

While some people may be unreceptive to the discussion of religion in medicine, others are far more willing to converse on the topic of religion in order to experience the positive benefits. Positive benefits may include a sense of hope, confidence, and the expulsion of fear during medical encounters (McCord et al., 2004). In reviewing the literature, the many barriers and benefits to physician use of religious discussion with patients were uncovered and will be explored.

The patient-physician relationship is a critical component of any medical visit and must be considered when discussing religion, as to not misuse the patient's trust. Many physicians believe religious discussion is unethical in a medical setting, as such discussions could lead patients to feel like they were being converted to a specific religion, potentially damaging the patient-physician relationship (Lo, Ruston and Kates, 2002). The patient-physician relationship is crucial to effective and efficient medical treatments. Without the trust and compliance of a patient, successful treatment of the patient is likely decreased and thus some physicians are concerned about religious

discussions. Some physicians felt unskilled and uncomfortable approaching the topics, believing religion was a private matter, and choosing not to discuss religion with patients (Lo et al., 2002). Even when the physician felt comfortable discussing religion with patients, there was a lack of training and confusion over the applicability of such topics (Armbuster et al., 2003). For example, some physicians may have a desire to express ideas of religion to patients, but were unsure how to do so effectively and appropriately, lacking the necessary training. According to Post, Puchalski, and Larson (2000), when patients feel their spiritual needs are not met in a medical setting, they may be driven away from effective medical treatment. Such patients value their religion and deem it a necessary component of any medical evaluation; if the physician does not provide in that area, the patient will disregard any medical advice given to them by that physician. It is important to note that the discussion of religion with patients can both potentially assist and harm the patient-physician relationship and is a gray-area where many physicians struggle. These discussions may assist a patient who is very religious, but may harm the relationship with a patient who does not align with any religion.

Other major barriers to religious discussion lie in the way the medical system is set up in this day and age. Lack of time was one of the largest barriers to discussing religion due to the short appointment times necessary for physician practices to operate (Armbuster et al., 2003; Guilfoyle & St. Pierre-Hansen, 2012; MacLean et al., 2003). As patients visit the offices of medical practitioners, they expect adequate medical care. However, the time necessary to provide such care is limited and thus religious discussions often are delayed, if they even happen, until the more pressing medical issues are addressed. Only 10% of those surveyed in one study wanted to take time away from

medical discussion in order to talk about spiritual issues, and 78% opposed discussion of religion due to time constraint (MacLean et al., 2003). The authors continued by comparing general practice versus hospital offices and noticed that those in a general setting experienced overburdened physicians who struggled to address even the most important medical conditions during an office visit. Therefore, many general practitioners likely do not have time to discuss religion with their patients. Awareness of the barriers to using religion in a medical setting can assist physicians in thinking about ways to overcome them.

The discussion of religion in medicine has been shown to have positive impact on a patient's mental well-being. According to Lo et al. (2002), by responding to patients' spiritual and religious concerns and needs, physicians may help them find comfort and closure near the end of life. Not only does religion provide comfort and closure, but it can provide hope as well. A major benefit of discussing religion with patients was that patients often find hope, meaning, comfort, strength, peace, love and connection through religion (Behan et al., 2012). According to Levin and Taylor (1997), the practice of prayer and the connections with others can serve as a source of comfort, strength and support in times of stress. As patients experience hope in their lives, they may be more willing to press forward approaching their medical condition with full strength instead of giving up both mentally and physically.

The patient-physician relationship is a very important aspect in medicine. As patients trust their physicians they are more likely to express concern about and elaborate on medical issues, hopefully leading to more effective treatment plans. According to Sloan (2009), in this day and age, many see the attention to religious and spiritual needs

by a physician as personalizing or individualizing the patient's medical encounter. This is important to ensure the patient is open and expressive of health concerns crucial to effective treatment by the physician. Not only does this discussion provide a personalizing factor, it also promotes a level of trust that can increase the quality of the patient-physician relationship (Daaleman, 2004). Physicians can connect with patients on a much deeper level as they gain the trust and confidence with patients, effectively leading to better treatment plans.

As advances in medicine take place, one would assume patients would want more medication, however, the trends show patients desire alternative ways of treatment in many instances. Patients want a holistic approach and viewpoint from their physician and spirituality and religion can play a large role in this domain. Daaleman (2004) states that a largely patient-driven trend to understand and frame the illness experience in more holistic ways should include religious and spiritual discussion. This holistic form may take place in a form of prayer or other methods. Moreover, patients who used prayer for health concerns compared to those who did not use prayer for health concerns, reported higher levels of perceived helpfulness and efficacy of medical treatment prescribed by the physician (Daaleman, 2004). This is important, as many patients will continue to follow a prescribed course if they believe the treatment is effective. Many patients are looking for a holistic approach to health and medicine and spirituality and religion can play a large role in this area. No matter how one views the positives or negatives of religion in medicine, it is important to realize that all patients are different and all will have various needs. Individualized attention is necessary for true patient care and can incorporate religion and spirituality, if appropriate.

Physician Perceptions of Religion in Medical Settings

Numerous studies have examined the physician perspective of religion in medicine (Armbuster et al., 2003; Cadge & Ecklund, 2009; Curlin et al., 2007; Ellis, Vincent, Ewigman, 1999; Kuyck, Wit, Kuyvenhoven, 2000; Mann et al., 2005; Post et al., 2000). Each physician may have varying ideas on what religious discussions are appropriate and at what times. In this portion of the review, the focus will be on studies in which physicians were questioned regarding the use of religion in their medical practice.

Some physicians may not deem religious discussion appropriate, but 96% of physicians consider spiritual well-being an important health component (Ellis et al., 1999). Spiritual well-being may contribute to reduced stress and a positive outlook on the challenges of life, potentially leading to increased health and wellness. Studies have shown that many physicians will discuss the fear of death in terms of religion, but will shy away from other religious discussion topics (Kuyck et al., 2000). Similarly, Ellis et al. (1999), reported that less than 20% of physicians reported discussing spiritual topics other than fear of dying in less than 10% of patients. Therefore, data suggests that some physicians are more willing to discuss spirituality with increasing severity of patient illness. As patients become closer to the end-of-life, they may be more willing to receive, and a physician may be more willing to provide, religious discussion because many will become more in touch with their mortality. Only 16% of general practitioners discussed religion or spirituality with patients during a routine office visit (Kuyck et al., 2000). The authors also found that 79% of general practitioners discussed religion or spirituality in dire situations where survival may not be guaranteed. Many physicians suggest that religious discussion be directed towards a chaplain in most routine cases. The idea of

addressing patient spirituality concerns is crucial, as physicians are at the forefront of patient care and can many times have a direct impact in the shortest amount of time. Many physicians do believe spiritual well-being is an important part of a person's life and should be taken seriously when discussed in a medical setting.

Physicians have multiple options for providing religious discussions requested by patients. For instance, physicians can either participate directly; they can refrain from discussion at all costs; or they can refer the patient to a chaplain or other pastoral staff in a medical setting (Cadge & Ecklund, 2009). Only 58% of physicians believed they should address patient concerns, regarding spirituality, by themselves (Ellis et al., 1999). Prayer can be a large component of religion and spirituality. Physicians may pray with patients in various ways, such as silent, active, or distant intercessory prayer (MacLean et al., 2003). Silent prayer being prayer without vocalizing, active being vocal prayer with the patient, and distant intercessory prayer being prayer outside the patient visit. While it is difficult to distinguish the means as to how a physician should provide religious or spiritual discussion, such discussions may be beneficial for the patient in their medical treatment.

Studies have been completed to compare the differences in religious discussion seen in varying types of physicians (Armbuster et al., 2003; Curlin et al., 2007; Magyar-Russell, Fosarelli, Taylor, & Finkelstein, 2008). For instance, psychiatrists may be more willing to discuss religious beliefs compared to others physicians (Curlin et al., 2007). The authors also concluded that 93% of psychiatrists think it is appropriate to ask about a patient's beliefs, where as 53% of other physicians believe this to be true. Not only can one see such differences in the field of mental health, but one can look at the pediatric

realm. Non-pediatric physicians are twice as likely to discuss religious matters with patients compared to pediatric physicians (Armbuster et al., 2003). This could potentially correlate with the patient population and ages at which one would begin to comprehend and desire religious discussion. According to Armbuster et al. (2003), pediatric resident physicians were significantly more likely than faculty to report being asked to pray at times of health crisis. Different physicians, in different specialties, may choose to approach the religious discussion concept in various ways, but each physician may provide their patients with an important part of their well-being.

While many physicians may have second thoughts before discussing religion with patients, it appears most physicians believe spirituality and religion can have a significant impact on their patients' overall health and well-being. Some physicians may approach the discussion directly and others may feel the need to refer to a chaplain. Discussions may depend upon the patient population of each physician. For example, a pediatric physician may have a more challenging time discussing religious topics than a geriatric physician due to the maturity level of the patient. There are many variables that go into such discussions and one must be cognizant of all the factors. Another way to analyze patient preference for religious discussion, is to ask the patient themselves, which will be expanded upon in the next section.

Patient Perceptions of Religion in Medical Settings

While gathering data on a physician's perspective in terms of religion and spirituality is important, it is necessary to analyze the patient's side as well, in order to compare and contrast their views on religion and spirituality. According to McCord et al. (2004), 83% of patients wanted physicians to ask about spiritual beliefs in at least some

circumstances. Not only do some physicians want to discuss religion, there are many patients who also wish to discuss religion and spirituality during a medical visit.

In analyzing medical situations, such as a routine office visit, hospital stay, or surgical setting, one can see the patient's desire for prayer increases with the severity of illness. For instance, MacLean et al. (2003), states that 19% patients agree with physician prayer in a routine office visit, 29% are in agreement in a hospitalized setting, and 50% agree in a near-death scenario. Patients felt that the most appropriate time for discussion of religion and spirituality came during life-threatening illnesses (77%), serious medical conditions (74%), and loss of loved ones (70%) (McCord et al., 2004). This trend clearly denotes the fact that patients prefer to have religion interaction or discussion with physicians in a time of crisis. In comparing such statistics with physician based research, one sees that only 16% of physicians discussed religion in a regular office visit, but 79% discussed religion in the face of a severe, potentially terminal, illness (Kuyck et al., 2000). The routine office visit may not be the most appropriate time for such discussions because of the lack of severity in medical condition and fear of the patient. When the situation turns for the worst, patients want and expect more discussion of spirituality and religion with their physician. Therefore, both physicians and patients seem to agree that the discussion of religion and spirituality is most relevant in times of medical crisis.

Patients often have many reasons for wanting to discuss religion with their physician and each discussion should be individualized for the patient. McCord et al. (2004), found that the most important reason for religious discussion is the desire for a patient-physician understanding. People want their physician to understand them and they want to be able to trust their physician. Religion can provide a connection between

physician and patient by invoking a deeper understanding of how the patient lives their life. Patients also believed that information about their spiritual beliefs affects physicians' ability to encourage realistic hope (67%), give individualized medical advice (66%), and provide effective medical treatment based on their individual values (62%) (McCord et al., 2004). Additionally, prayer said by others (physician) in the presence or with the knowledge of the patient may be correlated with positive psychological benefits in the patient regarding their treatment (Masters & Spielmans, 2007).

People often associate prayer with religion – an aspect that can provide others with a sense of hope. According to Merriam-Webster (2013), prayer is defined as a petition or address to God or a god in word or thought. Patients seemed to be more open to regular discussion of religion, compared to actual prayer. Research by MacLean et al. (2003), shows that 33% of patients accept simple discussion of religion; 28% accept physician silent prayer; and 19% accept physician prayer with the patient. In a randomized study, when patients were escorted to the exam room and randomly prayed with by the physician during the visit, 90% of the patients accepted the prayers from their physician (Mann et al., 2005). These data show that patients are either open to or desiring prayer during a medical encounter. The study also examined patient satisfaction after prayer during the office visit; however, no difference in satisfaction was found between patients who received prayer and those who did not receive prayer during the visit. It is important to note, however, that this study did not denote what type of prayer patients agreed to.

Some patients may choose to receive active prayer, where the physician prays in the room with the patient. Others may choose silent prayer and some patients may choose

to have the physician use distant intercessory prayer, or prayer outside of office hours (Masters & Spielmans, 2007). In the setting of a terminal illness, 70% of patients would welcome physician inquiry into their religious beliefs, 55% would appreciate silent prayer, and 50% believe their physician should pray with them (Behan et al., 2012). While each patient may prefer a different type of prayer, it can still be an important part of some patient's life and a physician must be aware of this to effectively connect with the patient.

Patient desire for religious discussion and prayer with a physician usually increases with the severity of the illness. Statistics show that fewer patients wish to have religious talks during a routine visit due to time constraints, compared to a life-threatening hospital stay (Kuyck et al., 2000). Patients want to be understood by their physician and have a high level of trust with their physician, but they may not be willing to give up their valuable time during an office visit for prayer.

The Current Study

The reviewed studies have furthered our knowledge about the experiences physicians and patients have with religion and medical visits. However, the studies also lead to additional inquiries. For example, there is limited information about the use of prayer in the medical field. Many of the articles focused solely on the broad concept of religion and spirituality in medicine, without examining prayer in these situations. Because 90% of patients believe that prayer may sometimes influence recovery from an illness (Ehman et al., 1999), prayer can be influential in a medical encounter. Prayer is understood by many patients and can be incorporated to a variety of religions and belief systems.

Additionally, physicians can use prayer in a variety of ways. In the current study, prayer types included: active prayer with a patient, silent prayer with a patient, and distant intercessory prayer by they physician. Physicians need to be aware of what patients want when they use prayer in a medical practice. One cannot assume that each patient desires individualized prayer at the moment of a clinical visit. While Behan et al. (2012) stated that in terminal situations, 70% of patients would welcome physician inquiry into their religious beliefs, 55% would appreciate silent prayer, and 50% believe their physician should pray with them, research needs to continue to examine patient's desire for physician prayer in various medical situations. In the current study, the different medical environments included all medical visits, a routine office visit, a hospital visit, an emergency room visit, a surgical setting, and a terminal illness.

Research Questions

The overall purpose of this study was to examine the attitudes of physician use of prayer during medical visits in a sample of adults. The four specific research questions of this study were: Overall, do patients want their physicians praying for them? Overall, do patients prefer a certain type of physician prayer (i.e., active, silent or physician distant intercessory prayer)? Does patient preference of the type of physician prayer depend on the medical situation? Medical situations include, all medical visits, a routine office visit, a hospital visit, an emergency room visit, a surgical setting, and a terminal illness. Does worship attendance within the past year affect patient preference of physician prayer?

Methodology

The purpose of this study was to examine patients' preferences for physician use of different types of prayer during various medical visits, as well as analyze the differences in prayer preference based upon worship or no worship attendance, in a sample of adults.

Participants

Participants (N = 198) were faculty and staff at a Midwest university. Of the 1300 faculty and staff randomly contacted, 221 participants provided their consent to participate in the study (response rate of 17%), with 198 participants completing the survey for a completion rate of 90%. The average age of the sample was 47$\pm$12.70 years old, with 68.2% of the participants being female. The population sample was 93.9% white, with 2% being Hispanic or Latina and the other participants identifying as African American, Native American or Asian.

Overall, 73% of participants identified as being spiritual or religious. In regards to religious affiliation, 39.4% aligned with Protestantism, 19.4% with Catholicism, 11.1% as agnostic or atheist, 12.6% with no religious affiliation and 12.1% as other. Approximately half (57%) of the participants attended worship attendance at least once per month. When asked about their health, 96% perceived their health to be either good or excellent. On average, participants visited the doctor four times during the year with eight participants reporting that their doctor had prayed with them during one of their visits.

Survey Instrumentation

Participants began the survey by answering demographic questions about their age, gender, race/ethnicity, religion and how many times they have attended organized worship services within the past year. Additional demographic questions asked about general health status and the number of times one has seen a doctor in the past year.

The primary survey assessed patient preference for physician prayer in specific medical situations and was adapted from a previous study (see MacLean et al., 2003). The original 112-item survey had seven questions related to prayer. These seven questions were adapted for the current study in two different ways. First, the original survey asked about prayer in a global sense, while the current study included three different types of prayer (i.e., active, silent, and after office hours prayer by the physician). Second, the original survey did not contain a wide variety of medical situations, however, the current study included the following medical situations: all medical situations, routine office visit, hospital stay, emergency room visit, surgical operation, and terminal illness. With these adaptations, the survey used in the current study had 20 questions. A sample question was, "my doctor should say a silent prayer for me during a routine office visit." The participants assumed the doctor's religion to be the same as their own. Participants responded to each question on a 5-point Likert Scale from 1 = *strongly agree* to 5 = *strongly disagree*.

Procedure and Statistical Analysis

After Institutional Review Board approval, faculty and staff members at a Midwest university were sent an email via a random listserv requesting participation in the study. Faculty members were sent one electronic email containing study information

and a link to the electronic survey via online survey software. Clicking the link opened up the first page of the survey, which was the informed consent. If participants clicked no to the informed consent, their browser exited the survey. If participants clicked yes to the informed consent, they began the survey. Time for completion took approximately five minutes. Participants were able to stop the survey at any time.

Data Analysis

Data were analyzed using SPSS. Analyses included frequencies of demographic variables, such as gender and religion, as well as descriptives of demographic variables, such as age. Analyses also examined the degree to which participants agreed with their physicians praying for them. Combining active, silent, and distant intercessory prayer into one mean value completed an average of the prayer values for each medical setting. Participants were then separated into two groups – worship (at least once in the last year) and no worship in the last year. Then, six independent *t*-tests were conducted in order to determine differences in the preference of physician prayer for each medical setting based on worship attendance.

Results

Table 1 through Table 6 display the means and standard deviations for all questions pertaining to patient preference of physician prayer in various medical situations. Overall, participants disagreed that their doctor should pray with or for them in all medical situations (see Table 1). Similar results were seen in each medical situation (see Tables 1-6), the higher mean value for active prayer suggests that participants tended to disagree that doctors should pray together with their patients. The large standard deviation for each setting does show wide variability in the data, suggesting a range of

responses. The overall trend, however, was that participants became more neutral (neither disagree or agree) to the view that physicians should engage in active prayer as the medical situations increased in intensity. For instance, Table 2 shows a mean active prayer value of 3.93 for clinical situations, where Table 6 shows a mean active prayer value of 3.33 for terminally ill situations. Participants became more open to the belief that physicians should actively pray with patients when the medical situations were terminal.

In terms of distant intercessory and silent prayer, participants seemed to align more towards a neutral to disagree stance (see Tables 1-6). Mean values for distant intercessory and silent prayer decreased as the situation became more terminal, meaning patients felt more strongly that doctors should pray for them silently and after-hours as their medical situation became more critical. However, values seem to consistently fall between 3.00 and 3.55 (see Tables 1-6). No matter the situation, participants seemed to either be opposed or neutral regarding the belief that physicians should pray with patients. There was an increase in the belief that physicians should pray for patients as the medical situation became more intense (Table 2 and Table 6), however, the level to which participants would agree to prayer was still low.

Table 1

Preference of Prayer in All Medical Situations

Question	*M*	*SD*
In all medical situations, my doctor should pray with or for me.	3.68	1.10
In all medical situations, my doctor should silently pray for me.	3.29	1.17
In all medical situations, my doctor should actively pray with me.	3.78	1.08
In all medical situations, my doctor should pray for me after office hours.	3.43	1.03

Note: 1 = strongly agree and 5 = strongly disagree

Table 2

Preference of Prayer in Routine Clinical Situations

Question	*M*	*SD*
If I went to the clinic for a routine office visit, my doctor should silently pray for me.	3.54	1.09
If I went to the clinic for a routine office visit, my doctor should actively pray with me.	3.93	1.02
If I went to the clinic for a routine office visit, my doctor should pray for me after office hours.	3.54	1.05

Note: 1 = strongly agree and 5 = strongly disagree

Table 3

Preference of Prayer in Hospital Situations

Question	*M*	*SD*
If I were in the hospital, my doctor should say a silent prayer for me.	3.25	1.24
If I were in the hospital, my doctor should actively pray with me.	3.65	1.20
If I were in the hospital, my doctor should pray for me after office hours.	3.31	1.12

Note: 1 = strongly agree and 5 = strongly disagree

Table 4

Preference of Prayer in Emergency Situations

Question	*M*	*SD*
If I were in the emergency room, my doctor should say a silent pray for me.	3.15	1.31
If I were in the emergency room, my doctor should actively pray with me.	3.58	1.27
If I were in the emergency room, my doctor should pray for me after office hours.	3.27	1.14

Note: 1 = strongly agree and 5 = strongly disagree

Table 5

Preference of Prayer in Surgical Situations

Question	*M*	*SD*
If I were undergoing a surgical operation, my doctor should say a silent pray for me.	3.15	1.28
If I were undergoing a surgical operation, my doctor should actively pray with me.	3.57	1.27
If I were undergoing a surgical operation, my doctor should pray for me after office hours.	3.26	1.15

Note: 1 = strongly agree and 5 = strongly disagree

Table 6

Preference of Prayer in Terminally Ill Situations

Question	*M*	*SD*
If I were terminally ill, my doctor should say a silent prayer for me.	3.03	1.37
If I were terminally ill, my doctor should actively pray with me.	3.33	1.39
If I were terminally ill, my doctor should pray for me after office hours.	3.17	1.19

Note: 1 = strongly agree and 5 = strongly disagree

After examining patient preference of physician prayer, six independent *t*-tests were performed to determine the relationship between worship attendance and preference of prayer in various medical situations. The dependent variable was the average of the three prayer conditions for a particular medical setting (e.g., clinical situations) and the independent variable was worship or no worship attendance in the last year. The dependent variable was determined by combining participants who had attended worship at least once in the past year (n = 111) into one group and participants who did not attend a worship service (n = 81) in the past year into another group. Table 7 displays the means

and standard deviations for the combined prayer conditions for each medical setting. As the medical situation intensity increased, there was a trend showing an increase in the belief that physicians should pray with patients.

An independent *t*-test was conducted to compare all medical situation preference of prayer in worship or no worship conditions. There was a significant difference between the scores for those participants who had worshipped and those participants who had not worshipped, $t(192) = 7.71$ $p < .001$, suggesting that individuals who attended at least one worship service in the last year had a viewpoint that physicians should pray for patients in all medical situations. The same relationships existed for (a) clinical situations, $t(190) = 6.91$, $p < .001$; (b) hospital situations, $t(191) = 7\ .59$, $p < .001$; (c) emergency situations, $t(187) = 7.16$, $p < .001$; (d) surgical situations, $t(189) = 7.09$, $p < .001$ and; (e) terminally ill situations, $t(188) = 7.36$, $p < .001$.

Table 7

Preference of Prayer in Various Medical Situations Based on Worship Attendance

Medical Situation	Worship *M, SD*	No Worship *M, SD*
All Medical Situations	3.12, 0.91	4.10, 0.81
Clinical Situations	3.30, 0.92	4.19, 0.81
Hospital Situations	2.94, 0.99	4.03, 0.94
Emergency Situations	2.86, 1.01	3.95, 0.99
Surgical Situations	2.87, 1.05	3.95, 1.01
Terminally Ill Situations	2.67, 1.12	3.87, 1.09

Note: all means between worship and non worship groups are significantly different at $p < .001$

Discussion

In a professional medical setting, decisions about religion may not always be black and white; there may be ambiguity. The purpose of this study was to examine the preferences of patients for physician prayer in various medical situations ranging from a routine clinical visit, to a terminal illness. The study also examined patient preference of varying types of prayer: active, silent and distant intercessory and whether worship attendance affected prayer preference. Results of this study, overall, showed that participants tended to disagree that physicians should use prayer in any medical settings. Similar results were seen in a study completed by Ellis et al. (1999), who reported that less than 20% of physicians reported discussing spiritual topics other than fear of dying with less than 10% of patients. However, as the medical experience became more critical, the general consensus was that prayer was more accepted and appropriate at such times. This result is similar to the MacLean et al. (2003) study, where only 19% of patients wanted physician prayer in a routine clinic visit, 29% in a hospital setting and 50% in a terminal situation. Results from the current study supported past research that patients tend to be more open to prayer in more intense medical situations. This finding is important for physicians to understand as it allows them the opportunity to be forthcoming with prayer or religious discussion in critical situations versus routine situations.

Three main forms of prayer were analyzed in this study; distant intercessory, active and silent prayer (MacLean et al., 2003). In the current study, active prayer was the least accepted form of prayer in any medical situation. The study completed by MacLean et al. (2003), reported that 28% of patients were willing to accept silent prayer, but only

19% accepted active prayer from a physician. These findings suggest that patients, likely, do not see prayer as a normal part of a medical visit. Other explanations for this finding include the limited time that exists during medical visits (Armbuster et al., 2003; Guilfoyle & St. Pierre-Hansen, 2012; MacLean et al., 2003) and ethical concerns, where patients may feel their physician is pushing religion upon them (Guilfoyle & Pierre-Hansen, 2012; Lo et al., 2002; Sloan, 2009). Often times the physician is placed in the leadership role, denoting power and responsibility, but this position may cause patients to feel undue pressure when discussing religion and prayer with their physician. By declining active prayer, patients effectively distant themselves from the potential religious discussion from the medical visit, eliminating conflicts of ethics. When analyzing silent and distant intercessory prayer, patients felt indifferent towards a belief that physicians should pray with patients. Silent or distant intercessory prayer may have been slightly more accepted due to the fact that it did not occur actively with the patient. In these circumstances patients may feel more comfortable with prayer, as they are not directly involved.

Worship attendance impacted perceptions about whether physicians should pray in various medical situations. While this variable has not been examined in previous studies, the current study found that worship attendance does increase the likelihood of the acceptance of prayer in medical situations. One can speculate that those who attend worship commonly align themselves with religious beliefs and since prayer is commonly seen within the religious institution, a correlation can be established. Those who attend worship are more likely to be religious or spiritual and those who are religious or spiritual tend to agree with prayer. Therefore, those who attend worship are more likely to agree

with physician prayer. However, even with the increase in the acceptance of prayer for those who attend worship compared to those who do not attend worship, participants still do not completely agree with physician prayer. Perhaps, with the knowledge that a patient attends worship, a physician can offer prayer as part of the medical visit. It seems that worship attendance may increase the likelihood of physician prayer acceptance when compared to no worship attendance; however, physician prayer is still not widely accepted, likely due to the barriers that exist and the cultural norm of religion being a private venture.

A number of limitations of this study are acknowledged. First, 68% of participants were women. Women may hold different views about prayer in medicine in comparison to men and also visit the doctor more frequently (Azari, Bertakis, Callahan, Helms, & Robbins, 2000). Second, each question assumed that the physician was of the same religion as the patient. This decision was made in order to control extraneous variables and ensure that all participants were interpreting the question in the same manner. In a real medical visit, if the physician practices a different religion compared to the patient, the patient may not feel as comfortable discussing prayer compared to a situation where the physician practices the same religion. For some, it may be rare to find a physician with the same religious beliefs therefore, it is important for future studies to explore this concept. Third, various comments were made by participants concerning the wording of the questions. This study used the word "should" when discussing physician prayer in a medical visit, as taken from the MacLean et al. (2003) study; however, various individuals commented that this wording made it seem as though physicians were expected to pray with their patients. Participants commented that using the words "could"

or “would be open to” physician prayer may have been represented a desire for physician prayer instead of an expectation. It is possible that using this change in wording in future studies may produce greater agreement with physician prayer. Lastly, each situation was hypothetical for most participants. It is unlikely that each participant has experienced each medical setting discussed in the study and therefore the participants were making a decision based on a scenario, not real experience. If participants were to experience the various medical situations, they may alter their responses based on their feelings at such points. It is difficult for one to know the feelings of having an emergency procedure or a terminal illness unless one is currently in that situation. Future research should continue to explore these areas in order to understand, more fully, the use of prayer by physicians.

For those in the medical profession, prayer may seem foreign and unknown since it is normally not discussed in medical education practices (Kuyck et al., 2000). The current study provides an insight into the implications that prayer may have in different medical settings. From the results, patients do not believe physicians should active pray with them in most medical situations. As a medical practitioner, it may be wise to refrain from active prayer unless it is clear the patient desires such actions. The majority of physicians do not feel they have adequate training in religious topics to provide such discussion or prayer with patients (Armbuster et al., 2003). Unless a physician attends worship on a regular basis, the basic religious concepts may not be clear enough to present to a patient. For instance, most pastors must undergo masters or doctoral programs to gain a position in the church. While physicians undergo significant training, it is not in the religious area and thus they may not feel competent to discuss such topics with patients. However, there are options that a physician can pursue to provide

appropriate care for the patient. According to Cadge and Ecklund (2009), physicians can either participate directly in religious discussions; they can refrain from religious discussion at all costs; or they can refer the patient to a chaplain or other pastoral staff in a medical setting. This range of options allows physicians to utilize religion and spirituality during various medical visits to deepen the patient-physician relationship.

Silent prayer and distant intercessory prayer may be appropriate, if the patient gives proper consent. Since distant intercessory prayer can be performed outside of a medical visit, patients may feel more comfortable with the idea of physician prayer, as they will not be in direct contact at the time of prayer. Many practices these days will ask for religious affiliation on their general patient information sheet, opening the door for potential religious discussion and prayer upon patient consent. This information, regarding religious affiliation being included on the patient information form, is important to consider given that prayer by physicians is more accepted with patients who attend worship services in comparison to those who do not attend worship services. If a medical practitioner has a patient who identifies with a specific religion and expresses worship attendance, it may be appropriate to bring up topics of prayer with his or her consent. Active prayer is the least agreed upon method to perform with patients, however, from the results discussed above, it may be appropriate to utilize silent and distant intercessory prayer for those patients who express desire. Interestingly enough, 83% of patients wanted physicians to ask about spiritual beliefs in at least some circumstances (McCord et al., 2004). The authors continued by emphasizing the fact that religious discussion or prayer was an important component of patient-physician understanding. Physician active and silent prayer can provide an additional aspect to patient care, but

must be completed with patient consent and done at the appropriate time. Distant intercessory prayer, completed outside of patient contact, does not necessarily require patient consent, but can still provide an additional patient care component in a medical setting. Patients are seeking patient-physician communication and prayer may be a key component in regards to this concept. Either way, patient preference of physician prayer should be studied in further detail, offering more effective and complete guidelines for practicing physicians.

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This Study by: Blaine M. Schlawin

Entitled: *Patient Preference of Physician Prayer in Medical Situations*

has been approved as meeting the thesis or project requirement for the Designation University Honors.

4.21.14 _____

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4/9/14 _____

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