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A Comparison of the Wishes of Hospitalized Patients Regarding Prayer From Healthcare Professionals in Religious Based and Non Religious Based Healthcare Facilities

Jessica White
Tracy Polley
May 2, 2010

A Thesis Presented to Meet Partial Requirements
for a Master of Science in Nursing Degree
Southern Adventist University
School of Nursing

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Jessica White and Tracy Polley

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Jessica White, MSN, RN & Tracy Polley, MSN, RN

Abstract

Aim

This paper examines patient's desire for prayer from their health care providers and looks at the difference in prayer frequency between religious and non-religious based hospitals.

Background

Continued debate surrounds this concept: How much spiritual care should be integrated into the medical field? Many theorists have included spirituality as an integral part to holistic care. Therefore healthcare providers should address prayer and spirituality.

Method

A convenience sampling of 93 patients was taken from a government and a religious based hospital in southeastern Tennessee. The questionnaire used was specifically designed for the study. Information collected included demographics, religious affiliation, habits and prayer desires in relationship to the healthcare they received.

Findings

A statistically significant difference was found between the prayer activities of the chaplains at the two facilities ($\chi^2 = .002$, $P < 0.05$), with greater frequency of prayer with patients at the religious based hospital. No statistical significance was found in the prayer activity of the doctors, nurse practitioners, physician assistants, nurses and nursing assistants between the two facilities. Data revealed that patients frequently desired prayer and these needs were not met.

Conclusion

Patient's spirituality must be addressed; healthcare providers need to strive to better meet patients spiritual and prayer needs. In many circumstances patients desire their healthcare providers to offer prayer.

TABLE OF CONTENTS

<u>ACKNOWLEDGEMENTS</u>	<u>3</u>
<u>ABSTRACT</u>	<u>4</u>
<u>CHAPTER 1-INTRODUCTION</u>	<u>8</u>
BACKGROUND AND SIGNIFICANCE	8
PROBLEM STATEMENT	8
PURPOSE	9
HYPOTHESES	ERROR! BOOKMARK NOT DEFINED.
FRAMEWORK	9
CONCEPTUAL & OPERATIONAL DEFINITIONS	10
ASSUMPTIONS	10
MAJOR LIMITATIONS	10
SUMMARY	11
<u>CHAPTER 2 – REVIEW OF LITERATURE</u>	<u>12</u>
INTRODUCTION	12
BENEFITS OF PRAYER	12
PATIENTS’ ATTITUDES TOWARD PRAYER AND DESIRES FOR PRAYER	13
INITIATION OF PRAYER DISCUSSIONS	15
HEALTHCARE PROVIDERS’ ATTITUDES TOWARD PRAYER	15
FREQUENCY OF PRAYER FROM HEALTHCARE PROVIDERS	16
SUMMARY	17
<u>CHAPTER 3 – METHODOLOGY</u>	<u>18</u>
INTRODUCTION	18

RESEARCH DESIGN	18
SETTING	18
SAMPLE	18
ETHICAL CONSIDERATIONS	19
INSTRUMENTATION	20
DATA COLLECTION	21
DATA ANALYSIS	21
LIMITATIONS	22
PLAN FOR DISSEMINATION OF FINDINGS	22
<u>CHAPTER 4 – DATA ANALYSIS</u>	<u>23</u>
INTRODUCTION	23
PARTICIPATION AND DEMOGRAPHICAL DATA	23
INSTRUMENT RELIABILITY	23
ANALYSIS OF HYPOTHESIS	24
SUMMARY	24
<u>CHAPTER 5 - DISCUSSION</u>	<u>26</u>
RESULTS	26
LIMITATIONS	31
RECOMMENDATIONS	32
SUMMARY	32
<u>REFERENCES</u>	<u>34</u>

<u>APPENDICES</u>	<u>38</u>
APPENDIX A	38
APPENDIX B	44
APPENDIX C	46
APPENDIX D	50
<u>TABLES</u>	<u>26</u>
TABLE 1: FREQUENCY OF PRAYER	26
TABLE 2: PATIENTS' WISHES VERSUS REALITY	28
<u>FIGURES</u>	<u>30</u>
FIGURE 1	30

Chapter 1-Introduction

Background and Significance

Spirituality is not often viewed as an important aspect of healthcare, but there is a myriad of evidence that states otherwise. Many nursing theorists, such as Florence Nightingale (Alligood & Tomey, 2006) and Betty Neuman (2001), acknowledge the importance of spirituality in treating the whole person. It has been shown through research that in order to promote total health, all facets of the individual must be addressed. However, more research is needed to further explain the role of spirituality in health, and how healthcare providers can care for the spiritual needs of their patients.

The majority of Americans realize that there is a spiritual element to their health. Ninety-six percent of Americans believe in a divine power (Herbert, Jenkes, Ford, O'Conner, & Cooper, 2001). In addition, 82% of Americans believe that prayer has healing power and that it increases their sense of well being (Narayanasamy & Narayanasamy, 2008). Patients who have a dimension of spirituality in their lives usually enjoy life more despite illness, and have a more positive outlook on life (Brady, Peterman, Fitchett, Mo, & Cella, 1999).

When patients use religion to cope, it can reduce stress and positively affect their health (Magyar-Russell, Fosarelli, Taylor, and Finkelstein, 2008). There seems to be a connection between poorer health and shorter life spans among people with unhealthy spiritual lives, (Gordon, 2008). More specifically, prayer seems to activate the immune, hormonal, and cardiovascular systems to heal disease, illness or injury (Newberg, D'Aquili, & Rause, 2002). It is obvious that spirituality does play a role in health, and therefore should be addressed.

Problem Statement

Throughout history, nursing has considered holism to be a foundation of care. However, the majority of nurses and nurse practitioners are not caring for their patients holistically,

especially when it comes to spirituality (Hubbell, Woodard, Barksdale-Brown, and Parker, 2006; McCauley et al., 2005; Vance, 2001). Other primary care providers, such as physicians and physician assistants, are also failing to provide spiritual care (Gordon, 2008; Magyar-Russell et al., 2008; McCauley et al., 2005). Hubbell et al. (2006) as well as King and Bushwick (1994) found that the majority of nurse practitioners and physicians rarely address prayer, if at all. Although spiritual care as a standard of practice has been encouraged, there still appears to be a low number of patients receiving spiritual care.

Purpose

The purpose of this study was to determine if hospitalized patients desire their healthcare providers to pray with them. The goal was to discover whom patients' desire to receive prayer from, and factors contributing to their wishes regarding prayer. Finally, this study was to assess how often healthcare providers actually pray with their patients.

Research Questions

The following three objectives were chosen for this study: first, to discover how frequently healthcare providers take time to pray with their patients. Secondly, to determine if hospitalized patients desire prayer from healthcare providers. And last, to address whether patients prefer their healthcare provider to ask if they would desire prayer or if the patients would prefer to request prayer from their provider when desired.

The research questions this study addressed were, "How many healthcare providers pray with their patients?" and "Do hospitalized patients want their healthcare providers to offer prayer voluntarily or by request of the patient?"

Framework

The framework chosen for this research was the Neuman Systems Model. Developed in 1970, the Neuman Systems Model assists nurses in evaluating and caring for the whole patient

(Neuman, 2001). It provides a comprehensive systems approach for holistic and wellness-focused nursing care. There are five variables that constitute a whole client: physiological, psychological, developmental, sociocultural, and spiritual. There are also intra-personal, inter-personal, and extra-personal stressors, which can penetrate the client's lines of resistance and lines of defense (Neuman, 2001). Neuman's framework best applies to this study because it looks at the patient holistically and includes spirituality as an important aspect of patient care and health. It helped to guide research to determine if prayer could strengthen patients' lines of defense and resistance and in turn improve their health and well being.

Conceptual & Operational Definitions

Prayer is defined as a devout petition to God, or the act of addressing or communing with God for the purpose of spiritual worship and supplication. Participants or patients in this study were hospitalized in a religious based hospital or government hospital in southeastern Tennessee. For the purpose of this study, healthcare providers were defined as doctors, nurse practitioners, physician assistants, nurses, therapists, aides, transporters, chaplains and any hospital personnel who have personal contact with patients.

Assumptions

Beyond the scope of this study, it was assumed that prayer is instrumental to ones's spiritual well-being and that good spiritual health has a positive impact on a patient's overall physical health. Also, an assumption of this study was that healthcare providers frequently neglect to address the spiritual dimension as they give patient care. It was assumed that they omit this care because they do not know how to tactfully and inoffensively approach the subject.

Major Limitations

One of the limitations of this study was that all participants were hospitalized patients. This represented a specific sample with different stressors than an outpatient population or those

simply visiting their healthcare provider for an annual checkup. Thus, results from this study produced limited generalizability. Also, this study did not represent for profit hospitals, further limiting the application of study results to all hospitals.

Summary

Spirituality is a real and integral part of every human being. Research has shown that it can influence the physical condition of patients and therefore needs to be addressed. The aim of this study was to discover how to approach this highly personal and sensitive topic in a way that will help healthcare providers identify and meet patients' spiritual needs.

Chapter 2 – Review of Literature

Introduction

Prayer, belief in a higher power, and other spiritual practices have been used as a part of treating disease and illness since the beginning of time. Christians and members of other religions have known for centuries that prayer and spirituality are beneficial to health and involved in the healing process. Eventually, physicians wanted to know if prayer, spirituality, and illness had a medical relationship. In the late nineteenth century, researchers began conducting studies on the benefits and effectiveness of prayer (Galton, 1872). In the early 1980's, Byrd (1988) at San Francisco General Hospital, conducted one of the most famous double-blind research studies on the efficacy of prayer. He found that prayer does have a positive physical effect on ill and recovering patients. Numerous studies have confirmed Byrd's findings. This chapter will cover some of the current research pertaining to the study of prayer in the healthcare setting. It will review literature discussing the benefits of prayer for the patient, patients' attitudes toward prayer and their desires for prayer from their healthcare providers, patients' preferences in regard to the initiation of discussions regarding prayer and spirituality, healthcare providers attitudes toward prayer, and the frequency that prayer is provided by healthcare providers. Search terms used to locate scholarly articles for this chapter included prayer, spirituality, spiritual care, healthcare, nursing, physician, and perspective.

Benefits of Prayer

Numerous studies have been conducted on the topics of prayer and spirituality and their relation to health. According to Narayanasamy & Narayanasamy (2008), 82% of Americans believe that prayer has healing power and that it can increase a person's sense of well-being. Lang, Poon, Kamala, Ang, and Siti (2006) found that prayer was a method that patients use to cope with their illness. With the help of spiritual support, patients said they experienced an

improved appetite, better ability to cope mentally, an increased awareness of their own spiritual needs, and a more positive mindset. Spirituality has also been shown to reduce stress and increase coping mechanisms, lower blood pressure, enhance the function of the immune system, and improve pain control (Narayanasamy & Narayanasamy, 2008). Prayer activates the immune, hormonal, and cardiovascular systems to heal disease, illness or injury (Newberg et al., 2002).

Magyar-Russell et al. (2008) found that when patients use religion to cope, it can reduce stress and positively affect their health. Patients who have a dimension of spirituality in their lives usually have a more positive outlook and enjoy life more despite their illness (Brady et al., 1999). However, according to psychiatry professor Dr. Harold G. Koenig, there seems to be a connection between poorer health and shorter life spans among people with unhealthy spiritual lives (Gordon, 2008).

Patients' Attitudes Toward Prayer and Desires for Prayer

Spirituality plays an important role in health and many patients would like their healthcare providers to pray with them. According to Barnes, Powel-Griner, Mcfann, and Nahin (2004), 45% of patients use prayer for health reasons, 43% pray for their own health, and almost 25% request others to pray for them. Puchalski (2001) found that 66% of pulmonary outpatients at the University of Pennsylvania admitted that having their healthcare provider inquire about their spiritual beliefs would increase their trust in that provider. Of those who felt spirituality was important, 94% wanted their beliefs and values to be addressed. Fifty percent of those who said spirituality was not important to them still felt that spirituality should at least be inquired about and addressed.

Herbert et al. (2001) found that prayer and faith in times of illness and health was very important for comfort, support, and guidance. Some participants viewed the physician as a vehicle for God to work through. Many attributed their improvement in health to prayer.

Intercessory prayer gave them a sense of intimate connection, and they found the knowledge that someone was praying for them to be very comforting. Some patients stated that they even prayed for their physicians. Most indicated receptiveness to discussion about spiritual matters with their physician or clergy. Also, some of the patients said that a physician's refusal of their request for prayer would cause them to seek care elsewhere.

Lang et al. (2006) found that patients expected nurses to provide spiritual care in the hospital due to their unique characteristics of being attentive, caring, communicative, responsible, understanding, and friendly. They felt that spiritual care should be administered under three conditions: nurses have time to provide spiritual care, have the same faith as the patient, and the patient is willing to accept such care. In addition, Creel (2007) found that patients experienced feelings such as alienation when nurses did not extend themselves and care about their patient's emotional and spiritual needs. Creel also found that when a nurse addressed a patient's spirituality, the patient perceived the nurse as more caring and selfless. Patients also rated overall care received as higher from nurses who did address spirituality, than from the nurses who did not.

Patients usually perceive nurses as more caring and personal if the nurse takes time to discuss spirituality with them (Leeuwen, Tiesinga, Post, and Jochemsen, 2006). Hanson et.al (2008) discovered that 45-73% of the participants in their study believed that various types of spiritual care helped them to better understand themselves and their illness. Fifty-five percent of spiritual care recipients were very satisfied, or somewhat satisfied, with the spiritual care they received. Seventy-two percent felt that the spiritual care they had experienced played a valuable role in meeting their spiritual needs. Fifty-four percent felt spiritual care was very valuable as a resource to find inner peace.

Initiation of Prayer Discussions

According to Herbert et al. (2001), patients were divided as to whether spiritually oriented dialogue should be a part of medical practice. The most frequently mentioned barrier to spiritually oriented conversation was the patients' perception that the physician was too busy. For this reason, these patients preferred to discuss their beliefs with nurses. Patients stated it would be comforting to know if their physician prays. Some felt that the appropriate context for spiritual care would be during a major illness while others preferred for it to be incorporated into routine medical care. The participants wanted physicians to acknowledge that spirituality and religion are important to patients. Some patients requested that their physicians pray with them. However, if the physician felt uncomfortable with this topic the patients would rather be referred to clergy.

Healthcare Providers' Attitudes toward Prayer

Many healthcare providers believe that spiritual care is an important part of routine patient care (Hubbell et al., 2006). Studies have shown that nurses and physicians who are comfortable with their spirituality are more likely to broach the topic of spirituality with their patients (Chung, Wong, & Chan, 2007; Curlin, Chin, Sellergren, Roach, & Lantos, 2006; Ellis, Campbell, Detwiler-Breidenbach, & Hubbard, 2002). Various professional organizations including The National Organization of Nurse Practitioner Faculties, Institute of Medicine, the National Hospice and Palliative Care Organization, and Joint Commission on Accreditation of Healthcare Organizations have developed position statements relating to spiritual care and competency among practitioners (Hubbell et al., 2006; Taylor, 2002). However, while healthcare practitioners may feel that spirituality and prayer are important for their patients' health, many do not routinely provide this care because they do not feel competent (Gordon, 2008; Hubbell et al., 2006; Magyar-Russell et al., 2008; McCauley et al., 2005; Vance, 2001). Some even view

spiritual care as an “extra” that may be skipped if time does not allow (Magyar-Russell et al., 2008; McCauley et al., 2005; Vance, 2001). Monroe et al. (2003) found that most physicians would only bring up the topic of prayer or spirituality with very ill patients, but would pray with any patient if asked.

According to McCauley et al. (2005), healthcare professionals feel that spirituality is important to their patients’ health and should be addressed. They found that 95% believe spirituality affects the health of their patients, 68% felt it their duty to address spirituality, and 47% felt it should be included in standard patient history. However, as found in other studies, they determined that practitioners feel they do not have the appropriate education, or time to perform spiritual care. They also reported provider discomfort, concern of offending patients or projecting their beliefs on a patient, and difficulty identifying receptive patients as reasons spiritual care may be withheld.

Frequency of Prayer from Healthcare Providers

Although spiritual care as a standard of practice has been encouraged, there still appears to be few patients receiving it. According to King and Bushwick (1994), over 75% of Americans expect physicians to respond to their spiritual needs as part of medical care, but less than one out of 10 physicians do, even with terminal patients (Gordon, 2008). Many nurse practitioners feel that spiritual care is an important part of nursing practice (Hubbell et al., 2006). However, 73% do not routinely provide spiritual care to their patients. This disparity seems to be attributed mostly to inadequate education of the healthcare providers (Gordon, 2008; Hubbell et al., 2006; Magyar-Russell et al., 2008; McCauley et al., 2005; Vance, 2001). Leeuwen et al. (2006) found that many nursing schools neglected educating their students on how to address the spiritual health of their patients. Need for additional training was identified as it heightened awareness and improved professional care involving spirituality and its availability to hospitalized patients.

Medical and nursing schools need to realize the importance of spiritual care and educate their students to be able to provide complete care to their patients.

Summary

Assessing an individual's spiritual health is vital to providing holistic care for patients in the hospital. Prayer and other methods of spiritual care have been shown to improve patient-provider relationships, bring comfort, and promote healing (Koenig, 2007). However, unsolicited spiritual care may need to be avoided as it has the potential to damage the patient-provider relationship, increase stress, and evoke uncomfortable feelings (Castledine, 2008). Spiritual care should not be forced on patients and it should not replace medical care; but it should be used as complementary therapy in willing patients. If spiritual care is used in this way, it can greatly improve the quality of care that is given to patients and in turn increase their quality of life.

Chapter 3 – Methodology

Introduction

This chapter will discuss the process that has been developed to collect data for this research project. It will cover a range of topics including design, sample, instrumentation and ethics, data collection and analysis, and dissemination of findings. This chapter will also outline some of the limitations for this project.

Research Design

To address the purpose statement, a quantitative study was used. This method was selected because quantitative data can be more easily analyzed to describe the problem. To further examine the problem, a non-experimental, univariate descriptive design was chosen. At this time, there is not much research describing how often hospitalized patients want their healthcare providers to pray with them. The purpose of this study was to generate information on this topic and to encourage further research.

Setting

The setting for the study was in the southeastern United States in the area of the country considered the “Bible belt.” The research was conducted at two different hospitals in southeastern Tennessee. One facility, a government hospital, is a large nonprofit teaching hospital (including a Level-One Trauma Center) with approximately 818 beds. The second, a religious based hospital, is a smaller 365-bed facility that is part of the Catholic denomination.

Sample

This sample included patients from two facilities, a religious based and a non-religious based hospital. Participants were chosen from several units at both hospitals. The individual participants were selected using convenience sampling. Multiple hospital care units were included in the study to give a diverse sample. These units were specifically chosen because they

include a varied patient population and diagnosis profile. This selection allowed for research data to be collected on patients with varying diagnoses, prognoses, and acuity.

Each hospital unit had approximately 10-15 patients participating in the study. During the research, 50-60 patients from each hospital completed the questionnaire, for a total of 119. Of those collected, 25 surveys had to be discarded due to incomplete information (10 from the government hospital and 15 from the religious based hospital), and one was discarded because it was mistakenly collected from a hospice patient.

Ethical Considerations

One of the biggest concerns with research is protection of the participants from harm and privacy of their contributed data. Attention was given to protect the participants of this study from harm as well as protect their privacy. The participants were informed from the beginning of the study that their participation was voluntary. The patients were given the survey only after verbally consenting to participate. They were informed through an attached cover letter that completing the survey was their consent to participate in the research. Only the researchers for the project collected the data. They appeared in professional dress, and wore their school name badge to pass out the survey. The purpose was to reduce any further association with patient care at the hospital facility. The hospital staff was not included in the data collection process or notified of the patients' decision to participate. This was to help ensure that patients did not experience any harm or change in their care as a result of the study. Once completed, the questionnaires were collected from the participants in sealed envelopes to help protect anonymity and stored either in a secure location in the Southern Adventist University School of Nursing building or in a locked safe in the researchers homes.

Before the project was initiated, it was reviewed and approved by the Institutional Review Board of each participating hospital and of Southern Adventist University. Any

subsequent changes in the plan or the questionnaire after it had been approved were given to the individual boards for additional review.

When the researchers were collecting the surveys, there was the potential to encounter participants who wished to have prayer during their current hospital stay. If patients verbally requested to have someone pray with them, the researcher was to notify the primary nurse who would then put in a referral for the hospital chaplain.

Instrumentation

The primary aim of this survey was to discover if patients desire healthcare providers to pray for them. Other basic demographics and potential influencing factors were also assessed. The data were collected using a structured, self-report questionnaire. The questionnaire used fixed alternative questions to elicit specific information from the participants. Most of the questions were multiple-choice format with a few dichotomous and checklist questions.

Patients were questioned on basic demographics such as age, gender, ethnicity, and marital status. Health status, religious preference and background, social support, and the patients' attitudes toward prayer were also briefly addressed. The questionnaire included questions to determine which, if any, hospital staff had prayed with the patient since admission. Then the patients were asked if they wished that a healthcare provider would have prayed with them during their hospitalization, and if so, which provider. They were also allowed to specify if they wished for only family, friends, and personal clergy to pray with them (see appendix A for example questionnaire).

The questionnaire was developed specifically for this research study. The individual variables were determined and then questions formed to elicit answers to address each variable. Before use, the questionnaire was reviewed by experts for construction, content, spelling and grammatical errors. Then the questionnaire was trialed on a small group, similar to the proposed

sample, in order to enhance the validity and assess usability of the assessment tool. The sample group was given the opportunity to make suggestions if the content on the questionnaire was not clear or was confusing in any way. Any necessary changes to enhance the clarity of the tool were made at that time. Finally, to address reliability, a Cronbach's alpha test was computed.

Data Collection

The researcher approached the patient in his or her room and explained to them the nature of the study, that participation was voluntary, and offered the patient the option to participate. To participate the patient had to be alert and orientated, able to read and write English, able to complete the questionnaire without assistance, not be under Hospice Care, be admitted to a non-hospice unit, and 18 years of age or older. Participants who expressed a desire to participate were then provided with a copy of the questionnaire to complete. The researcher continued to the next room until an adequate sample size was reached for the unit, which consisted of approximately 10-15 surveys per unit visit. Questionnaires were collected after 30-60 minutes or after participants had adequate time to finish. The participants were notified that they may contact the researchers at an e-mail address provided on the cover letter if they wanted to know the results of the study. To protect the patient's privacy, no identifying factors were listed on the questionnaire or envelope.

Data Analysis

After the data were collected, the results of the study were analyzed using the Statistical Package for the Social Sciences (SPSS) data analysis software. Because the study is a descriptive design, the results were presented using descriptive statistics. SPSS was used to compute percentages and frequencies for each question. Chi square tests were also conducted to analyze for any statistical significance between variables. Graphs, charts and tables were used to display data in a concise manner.

Limitations

There are several limitations in the design of the study. The first is that the purpose of the study is to collect descriptive data. The design of a descriptive study does not allow for any causal relationships to be established from correlations calculated. At the conclusion, recommendations will be made for future research. A second limitation is that the study is non-randomized. The participants are selected by the researchers leading to a high risk of bias in the selection process. To help decrease some of the selection bias, the researchers proposed to randomly select a participant from the qualifying patients on the individual units by selecting every other patient room. However, as discussed later, this was not able to be carried out as planned. Finally, one of the biggest limitations of this study is that it was conducted in the area of the United States that is considered the “buckle” of the “Bible Belt.” To compensate for this, data were collected from a governmental, non-religious facility in addition to the religious based hospital. However, because of the heavy population of Christians in the area, the results may be biased toward Christians as a whole even with the inclusion of a large non-religious based facility.

Plan for Dissemination of Findings

Once the data were analyzed, the results were written as a research report. These results were presented to the master’s level nursing students and the faculty at Southern Adventist University. A copy of the study results was made available to the patients involved in the study and the participating healthcare facilities.

Chapter 4 – Data Analysis

Introduction

This chapter will discuss the participation of patients in this study from the two hospitals evaluated. The patient demographics included age ranges, marital status, gender and religious preference. Also included is the instrument reliability of the tool created for this research study. Finally, an analysis of the objectives and research questions will be presented.

Participation and Demographical Data

There were a total of 93 participants involved in this study, 49 from the government hospital and 44 from the religious based hospital. The ratio of male to female patients involved in the study was 45.2% male and 52.8% female; of these individuals 52.7% were married and 47.3% were divorced, single or widowed. Of the participants interviewed, 90.3% were Caucasian and 9.7% were African American, Hispanic, and American Indian.

Out of participants 95.7% considered themselves “Christians,” and 4.3% of participants had “No religious preference.” When asked about the importance of spirituality, 88.2% stated that spirituality was very important to their health. In addition to feeling that spirituality is important to their health, 91% of patients participating said they believe “prayer works.”

Instrument reliability

Reliability is the ability of an instrument to consistently measure the same variable. In this study, reliability was calculated using the Cronbach’s alpha. Although controversial, a minimum acceptable value for reliability is between 0.7 and 0.8. The Cronbach's Alpha score calculated for the instrument used in this study was 0.794, which is considered to be highly reliable.

Analysis of Research Questions

The main objective of this study was to discover if patients wanted prayer during their hospitalization. Study objectives were, 1) to discover how frequently healthcare providers take time to pray for their patients, 2) to determine if hospitalized patients desire prayer from healthcare providers, 3) to address whether patients prefer their healthcare provider to ask if they would desire prayer or if the patients would prefer to request prayer from their provider.

Analysis of the collected data revealed healthcare providers prayed with 30.1% of the participants during their hospital stay. The physicians, nurse practitioners, and physician assistants prayed with 7.5% of patients. The registered nurses, licensed practical nurses, and nurse's assistants prayed with 7.5% of the patients as well. The support staff (including therapists, laboratory and dietary personnel) prayed with 6.5%. The greatest activity came from the chaplains who prayed with 15.1% of the patients. The individual percentages of patients that were prayed with by healthcare providers do not add up to 30.1% because more than one provider prayed with some of the patients (See table 1).

In addition, it also found that 64.5% of patients would like their healthcare provider to ask them if they would like to be prayed with, while 24.7% of patients prefer to bring up the topic of prayer themselves, and 10.8% of patients did not want prayer from their healthcare providers at all. Further, it was discovered that 77.4% of patients said that they wanted prayer while hospitalized.

Summary

This section presented the patient survey findings. It was found that the majority of the sample surveyed between the two hospitals was a mostly a Caucasian and Christian population. The consensus was that few patients were actually prayed with, while most desired prayer during their hospitalization.

Table 1. Frequency of prayer

	Who Prayed		What patients desire	
	Government	Religious	Government	Religious
MD/NP/PA ¹	2	5	17	28
Nurse/CNA ²	4	3	17	22
Support staff	2	4	12	18
Chaplain	2	12	23	25
Family	-	-	32	35
Friend	-	-	31	34
Your clergy	-	-	39	38
None of the above	0	1	-	-
No one prayed	41	24	-	-
TOTAL patients from each facility	49	44	49	44

Note. This table represents the providers who prayed with patients and what they really wanted.

The numbers represent the numbers of patients who checked boxes on the “check all that apply” questions. Some patients selected more than one answer so the numbers do not add up to the total number of participants. (N=93)

¹ Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant (PA)

² Certified Nursing Assistant (CNA)

-No value for this cell (all answer choices were not available for both questions)

Chapter 5 - Discussion

This final chapter will be the discussion of the data collected and the summary of the study. It will include sections on the results, limitations, and recommendations for further study. In addition to discussing the findings of this study, data from other studies will be compared to help give a more complete picture of patient wishes. This will assist healthcare professionals to be more informed of patients' wishes regarding prayer and enable them to holistically care for their clients.

Results

Frequency of prayer from healthcare providers. After analyzing the data collected, some of the results were found to be statistically significant. The Pearson's Chi Squared test was used due to the nature of the data being mostly nominal. It was discovered that there was a statistical difference in the frequency of prayer offered by providers for patients between the government run hospital and the religious based hospital. This difference was attributed to the work of the chaplains. The chaplains at the religious based hospital had a statistically significant greater frequency of prayer with patients than the chaplains from the government hospital ($\chi^2 = .002$, $P < .05$). However, it was also found that there was no statistically significant difference between facilities for frequency of prayer with patients by doctors, nurse practitioners and physician assistants ($\chi^2 = .184$, $P < .05$), or by nurses and nursing assistant's at the two facilities ($\chi^2 = .806$, $P < .05$).

Patients' attitudes toward prayer and desires for prayer. One of the objects of this study was to determine patients' attitudes towards prayer. From the patients that participated from the religious based hospital and the government hospitals it was discovered that 91.4% believed in prayer, and 61.3% said that they prayed daily. These results are consistent with the study

previously mentioned by Barnes et al (2004), which stated that 45% of patients use prayers for health reasons, 43% pray for their own health, and almost 25% request others to pray for them. Lang et al. (2006) pointed out that patients expect nurses to provide spiritual care in the hospital. Herbert et al. (2001) further found that prayer is very important to patients in relationship to illness.

According to the patients surveyed in this study, it was discovered that 77.4% of patients wanted providers to address their spirituality by praying with them during their hospital stay (see table 2 for a breakdown of the results by hospital). Taking this into consideration, the overwhelming evidence points to the fact that patients' consider prayer important and would like it to be incorporated into the care they receive. While neither facility is meeting the percentage of patient requests for prayer, the religious facility has a significantly higher rate of prayer than the government facility.

Table 2. Patients' wishes versus reality

	Did the patient want prayer?		Did they actually receive prayer?	
	Government	Religious	Government	Religious
Yes	69.4	86.4%	16.3%	45.5%
No	30.6%	13.6%	83.7%	54.5%

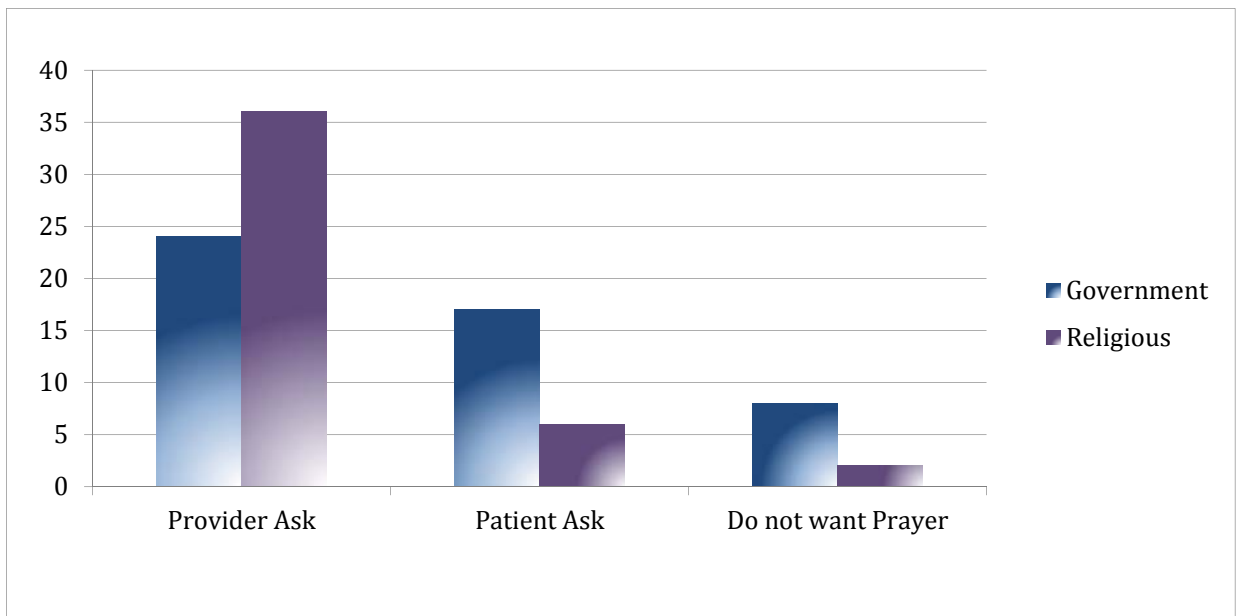
Initiation of prayer discussions. The literature review chapter discussed patients' ideas of prayer and who should bring up the topic of prayer (Herbert, et al., 2001). Patients were divided in their opinions of spiritual discussions as part of medical care. They were also concerned that their healthcare providers were too busy to take the time to pray with them.

In the data collected for this study, 77% of participants wanted their healthcare providers to pray with them while in the hospital. The responses were broken down into patients who wanted their healthcare providers to bring up the subject of prayer, those who wanted to ask for prayer themselves, and those who did not want prayer at all. Of those responses, 64.5% thought the healthcare provider should bring up prayer, 24.7% wanted to ask for prayer themselves, and 10.7% did not want prayer at all (see Figure 1). This shows that although patients may be concerned about taking the healthcare provider's time, they (89.2%) would like the topic of spirituality addressed. Below the figure illustrates the number of patients at each facility that wanted their provider to offer prayer, wanted to bring up the topic of prayer themselves, or did not want prayer at all.

Patient comments. When the study was undertaken, it was not anticipated that patients would share their opinion in a means other than completing the questionnaire. Upon reviewing the surveys, it was discovered that several patients had left comments on the bottom, beside the corresponding question, or anywhere on the questionnaire they could find space. The following section includes comments that some patients wrote on their questionnaire. Most were very favorable of the study and the topic it addressed, while others looked at spirituality and religion as something outside of healthcare's scope of practice. However, these comments added more insight to patient's wishes and attitude toward this subject.

A patient from the government hospital wrote a comment when asked "If you had a preference during your hospital stay, would you have wanted the hospital staff to pray for you?" The patient stated that he would want the hospital staff to pray with him "only if they were members from the Church of Christ."

Figure 1 Did patients want their healthcare providers to initiate prayer discussions?



An older man from the government hospital did not want prayer from the staff and said, “Prayer is not within the job description of hospital staff.”

Another patient from the government hospital wrote on the bottom of their questionnaire, “Only want those who believe in God (thru the shed blood of Jesus) heals in many ways, thru doctors, thru medicine, thru the laying on of hands, working of miracles, the prayer and His word. I think this is a wonderful study to be conducted. Thank you very much!”

When asked if they would want someone from the hospital to pray with them, a patient from the government hospital wrote, “It would depend upon the situation and the personal relationship and respect of that individual.” Another patient from the religious based hospital wrote on the bottom of her questionnaire “Prayer works!”

A patient from the religious based hospital wrote after the question, “Would like anyone from the hospital to pray with you? He answered “no” but then wrote, “Not necessary for me personally, however, I would never refuse the offer.” Another patient when asked to answer the last question on the survey checked every option listed and said, one can “Never get enough prayers!”

A patient from the religious based hospital said that he would like hospital staff to pray with him and suggested, “Admission reps also could ask” about patients’ prayer preferences. He also commented further that he wasn’t prayed with but, “I am not offended that no one did [pray with me] in the circumstances. Myself and family pray daily.” He further wrote at the bottom of the survey, “It was comforting to receive care at a hospital that was Christian based. It gave me a sense of well-being. Thanks to all.”

Limitations

The following section will discuss some of the limitations discovered while conducting this study. In reviewing the process of collecting data, several of the outlined methods were not possible. These limitations were due to differences in hospital dynamics and patient health status.

In the methods section, the plan was to include patients from orthopedic, medical-surgical, cardiac, and oncology units. However, when the data collection process was implemented, the actual units varied between the two hospitals. The units surveyed in the religious based hospital were orthopedic, medical surgical, cardiac, cardio-thoracic surgery, gastroenterology/urology, and oncology. The units evaluated at the government hospital were orthopedic/medical surgical, cardiac/cardiac-thoracic surgery, nephrology, stroke/telemetry, and oncology. This difference, along with the limited supply of participants (as discussed in the next paragraph), lead to additional units being selected than originally intended.

It was also found that many patient care units at the two hospitals differed widely in their number of patients. As a result of this, the initially planned method of selecting every other patient room was unable to be carried out. This was partially because units did not enough patient beds to accommodate this method of participant selection. Also, some patients' hesitation to participate in the study, and empty rooms on specified units made this method of collecting data challenging.

Another aspect of the data collection that varied from the original plan was the allowance of family and friends to assist patients in filling out the questionnaire. It was found that due to many patients' health status they were unable to fill out the questionnaire themselves. Subsequently, patients dictated their wishes to family or friends present at bedside.

Recommendations

Further research is needed in the area of prayer. Spirituality and prayer are a part of the medical field often neglected and hard to quantify. Recommendations for further research would include looking deeper into the reception or need of prayer to find a way fulfill the needs of patients that desire prayer and not offend the small percentage that does not. A good suggestion by one patient was that a screening tool could be used by medical facilities to inquire about patients' spiritual needs upon admission. However there are also issues that the initial admission of a patient is frequently under emergency or hurried circumstances to facilitate medical treatment.

Further difficulties could have been avoided by taking a better look at the layout of both facilities before beginning to collect data to see what types of specialty floors each hospital possessed and how these compared. Interesting insight might be gained by looking into the different medical areas of the hospital. This would involve looking at various units in the hospital to see if the perception of prayer and spirituality is influenced by the prognosis of the patient.

In reflecting on this study, future research into what made the difference in the chaplain involvement between the government facility and the religious based hospital would be of interest. Are the chaplaincy programs run differently? Are there correlating reflections in the patients' satisfaction with the spiritual care they receive? Do patients seek out a religious based hospital in hopes of receiving more spiritually based care? These and countless other questions need to be addressed in future research in order to better understand spirituality in relation holistic care.

Summary

This study was conducted to evaluate the wishes of patients regarding prayer while hospitalized. While research has been done in many areas of healthcare in relation to prayer, no

studies of prayer in the hospital were found. This study was undertaken to give healthcare providers a clearer understanding of the wishes of hospitalized patients regarding prayer. Of the patients surveyed, it was found that almost nine out of ten patients would like for someone to address their spirituality, two-thirds of the patients expected their healthcare providers to bring up the topic, and three-fourths wanted prayer while hospitalized.

Patients wish for healthcare providers to take the initiative to evaluate their patients' spirituality as a part of their routine medical care. Healthcare providers ask questions relating to everything else in their patients lives except spirituality. Although one out of ten patients would not like their spirituality addressed, the majority do, and expect it to be done. In light of the results of this study, healthcare providers need to be informed of the opinions of their patients and begin to include spiritual care in their routine evaluation of and care for their patients.

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Appendix A

----- HOSPITAL

INFORMED CONSENT TO PARTICIPATE IN A RESEARCH STUDY

STUDY TITLE

1. Introduction

You are being asked to volunteer for a research study. This study is being conducted at ----- Hospital and ----- Hospital. The Investigators in charge of this study are Jessica White, RN and Tracy Polley, RN. The Sponsor of the study is Southern Adventist University School of Nursing.

2. Purpose of This Research Study

The purpose of this research study is to examine how often hospitalized patients want prayer from their healthcare providers and how often they actually receive it.

3. Length of Your Participation

Your participation in the study will last approximately 30 minutes.

4. Where the Study is Being Done and Number of People Participating

This study is taking place in Memorial and Erlanger Hospital, and about 120 people total are expected to take part from between the two facilities.

5. Study Procedures

Before you take part in this research study, the study must be explained to you and you must be given the chance to ask questions. You must read this informed consent form. You will be given a copy of this consent form to take home with you.

If you agree to take part in this study, the following will happen:

I will explain how to complete the survey. I will leave the survey with you and return to your room to pick it up in about 30 minutes. After you have filled out the survey, you will place it in an envelope and seal it before I return to pick it up. That way I will not know what answers that you chose on the survey.

6. Possible Risks or Side Effects of Taking Part in this Study

The only risk of this study is that you may emotionally uncomfortable while answering the questions about prayer. You are free to stop the survey at any time if you feel uncomfortable with the questions.

7. Payment for Taking Part in this Study

You will not receive any payment or compensation for participating in this study

8. Possible Benefits to You for Taking Part in the Study

There are no direct benefits to you for participating in this study. However, this study will help healthcare providers to be more aware of their patients' desires regarding prayer while hospitalized.

9. About Participating in this Study

Your participation in this study is voluntary. You may stop participating in this study at any time. Your decision not to take part in this study or to stop your participation will not affect your medical care or any benefits to which you are entitled. If you decide to stop taking part in this study, you should tell the Investigator.

To participate in this study you must be alert, be able to read and write English, be able to complete the questionnaire without assistance, be at least 18 years of age or older, and not be a patient in a hospice unit.

Investigator and/or the Sponsor may stop your participation in the study at any time if they decide that it is in your best interest. They may also do this if you do not follow instructions.

10. Compensation for Injury

By completing this survey, you will not waive any of your legal rights or release the parties involved in this study from liability for negligence.

11. Confidentiality of Study Records and Medical Records

Information collected for this study is confidential. The Principal investigators Jessica White, RN and Tracy Polley, RN will have access to your surveys. The surveys will be stored in a locked safe for confidentiality. In the event of any publication regarding this study, your identity will not be disclosed. Please do not include your name or identify yourself in any way on the survey itself.

12. Names of Contacts for Questions About the Study

If you have any questions about your rights as a research subject, you can call ----- Hospital’s Institutional Review Board at (phone number). If you would like to find out the results of this study once it is completed, please feel free to e-mail the researchers at hospital_prayer_study@yahoo.com.

VOLUNTEER'S STATEMENT

I have been given a chance to ask questions about this research study. These questions have been answered to my satisfaction. If I have any more questions about taking part in this study, I may ask the researcher when she returns to pick up my questionnaire.

I understand that my participation in this research project is voluntary. I know that I may quit the study at any time without harming my future medical care or losing any benefits to which I might be otherwise entitled. I also understand that the Investigator in charge of this study may decide at any time that I should no longer participate in this study.

If I have any questions about my rights as a research subject in this study I may contact:

----- Health Care System
Institutional Review Board
IRB Office-----
Address-----
Telephone: -----

By completing this survey, I have not waived any of my legal rights or released the parties involved in this study from liability for negligence. I have read and understand the above information. I agree to participate in this study. I have been given a copy of this form for my own records.

Dear Research Participant:

You are being asked to volunteer in a research study. This study is being conducted at ----- Hospital and ----- Hospital. The investigators in charge of this study are Jessica White, RN and Tracy Polley, RN. The sponsor of this study is Southern Adventist University School of Nursing.

The purpose of this research study is to examine how often hospitalized patients want prayer from healthcare providers and how often they actually receive it.

Your participation is voluntary and if you choose not to participate, you simply will not complete this form. If you choose to participate, all of your information will be kept confidential.

One of the investigators will explain how to complete the survey and leave for you to complete the questionnaire. You will place the completed questionnaire in an envelope and seal it. The investigator will pick up your survey in 30 minutes.

Sincerely,

The Researchers

Please select the most appropriate answer (choose only one, unless directed otherwise)

Prayer Questionnaire

1. Age:
 - 18-34
 - 35-44
 - 45-54
 - 55-64
 - 65-74
 - 75 or older
2. Gender
 - Male
 - Female
3. Marital Status
 - Single
 - Married
 - Divorced
 - Widowed
4. Ethnicity
 - Hispanic
 - Caucasian
 - Asian/Pacific Islander
 - African American/Black
 - American Indian/Alaskan Native
 - Other: _____
5. Health status
 - Rarely ill
 - Sometimes ill
 - Frequently ill
6. Reason for this hospitalization
 - Emergency/Unexpected
 - Chronic/ongoing illness
 - Planned procedure/surgery
7. Support received from family or friends
 - High degree of support
 - Above average degree of support
 - Average degree of support
 - Below average degree of support
 - No support
8. Religious Background
 - Atheist
 - Buddhist
 - Christian
 - Hindu
 - Muslim
 - No religious preference
 - Other: _____
9. Current Religious Preference
 - Atheist
 - Buddhist
 - Christian
 - Hindu
 - Muslim
 - No religious preference
 - Other: _____
10. How important is spirituality in relation to your health?
 - Very important
 - Somewhat important
 - Unsure
 - Not important
11. How often do you pray?
 - More than once a day
 - Once a day
 - A few times a week
 - Once a week
 - A few times a month
 - Once a month
 - Every few months
 - Not at all
12. Your beliefs/attitudes about prayer:
 - I believe prayer works
 - It helps some
 - I'm not sure
 - I don't believe in prayer

13. When you are hospitalized:
- Would you like your healthcare provider to ask you if you would like prayer?
 - Would you like to bring up the topic of prayer yourself when you are ready?
 - I don't want to be prayed with
14. Has any hospital staff prayed with you during this hospitalization?
- Yes
 - No
15. If someone from the hospital staff prayed with you, who was it? (Check all that apply)
- Doctor/Nurse Practitioner/Physician's Assistant
 - Nurse/Nursing Assistant
 - Support staff (Physical Therapy, Respiratory Therapy, Transport, etc.)
 - Hospital Chaplain
 - None of the above
 - No hospital staff prayed with me during my hospital stay
16. If you had a preference during your hospital stay, would you have wanted the hospital staff to pray with you?
- Yes
 - No
17. If you had wanted someone to pray with you while you were a patient, who would it be? (Check all that apply)
- Doctor/Nurse Practitioner/Physician's Assistant
 - Nurse/Nursing Assistant
 - Support staff (Physical Therapy, Respiratory Therapy, Transport, etc.)
 - Hospital Chaplain
 - Family member
 - Friend
 - Your pastor/minister/priest etc.

Appendix B

Prayer Questionnaire Results

1. Age:

18-34 yrs	7.5%	55-64 yrs	21.5%
35-44 yrs	10.8%	65-74 yrs	22.6%
45-54 yrs	18.3%	75 + yrs	19.4%

2. Gender:

Male	45.2%
Female	54.8%

3. Marital Status:

Single	12.9%	Married	52.7%
Divorced	17.2%	Widowed	17.2%

4. Ethnicity:

Hispanic	1.1%	Caucasian	90.3%
Asian	0%	Black	6.5%
Indian	2.2%	Other	0%

5. Health Status:

Rarely Ill	44.1%	Sometimes	29.0%
Frequently	26.9%		

6. Reasons for this hospitalization:

Emergency	51.6%	Chronic	23.7%
Planned	24.7%		

7. Support received from family and friends:

High	81.7%	Above avg	10.8%
Average	4.3%	Below avg	3.2%
No Support	0%		

8. Religious background:

Atheist	0%	Buddhist	1.1%
Christian	93.5%	Hindu	0%
Muslim	0%	No Pref	5.4%

9. Current Religious preference:

Atheist	0%	Buddhist	0%
Christian	95.7%	Hindu	0%
Muslim	0%	No pref	4.3%

10. How important is spirituality to health:

Very imp	88.2%	Somewhat	7.5%
Unsure	3.2%	Unimportant	1.1%

11. How often do you pray:

>1 daily	61.3%	Once daily	17.2%
>2 weekly	11.8%	Once weekly	0%
>2 x monthly	5.4%	Once month	0%
q few months	3.2%	Not at all	1.1%

12. Your beliefs/attitudes about prayer

I believe	91.4%	Helps some	5.4%
Not sure	3.2%	Don't believe	0%

13. When you are hospitalized who would you like to bring up the topic of prayer:

Provider	64.5%	Patient	24.7%
No prayer	10.8%		

14. Has any hospital staff prayed with you this hospitalization:

Yes	30.1%	No	69.9%
-----	-------	----	-------

15. Who prayed with you in the hospital:

MD/NP/PA	7.5%	RN/LPN/CAN	7.5%
Supp staff	6.5%	Chaplain	15.1%
None listed	1.1%	None prayed	69.9%

16. Did you want hospital staff to pray with you:

Yes	77.4%	No	22.6%
-----	-------	----	-------

17. Who would you have wanted to pray with you:

MD/NP/PA	48.4%	RN/LPN/CAN	41.9%
Supp staff	32.3%	Chaplain	51.6%
Family	70.2%	Friend	69.9%
Pastor	82.8%		

Appendix C



October 19, 2009

Ms. Jessica White
8922 Finney Point Drive
Ooltewah, TN, 37363

Ms. Tracy Polley
10063 Central Ave.
Ooltewah, TN 37363

Dear Ms. White and Ms. Polley:

The Institutional Review Board (IRB) has approved your revisions for your research entitled "*A Comparison of the Wishes of Hospitalized Patients Regarding Prayer From Healthcare Professionals in Religious Based and Non Religious Based Healthcare Facilities.*" The committee understands that you will interview selected hospitalized patients with three objectives in mind: (1) To discover how frequently health care providers take time to pray for their patients; (2) To determine if patients desire prayer from health care providers; (3) To address whether patients prefer their health care provider to ask if they would desire prayer or if the patients would prefer to request prayer from their provider when desired. The sample will be from hospitalized patients potentially selected from Erlanger and Memorial Hospitals in downtown Chattanooga. Due to the fact that you are dealing with human subjects, it is important that all data remain confidential.

It is our understanding that your research is being conducted through Southern Adventist University and that both of you, Jessica White and Tracy Polley, are the Principal Investigators. All participation in your research must be voluntary and data kept in a secure location. The study is expected to be concluded by May 31, 2010, and at the end of the study data collected must be destroyed in an appropriate manner.

Sincerely,

Robert S. Coombs, D.Min., Ph.D.
Professor, School of Education/Psychology
Southern Adventist University



College of Medicine, Chattanooga
Scientific Review Board
960 East Third Street
Suite 102
Chattanooga, TN 37403
Tel: (423) 778-3818 • Fax: (423) 778-4170

November 2, 2009

Tracey Polley, R.N., BSN
10063 Central Avenue
Ooltewah, Tennessee 37363

RE: Your application dated 10/15/2009 regarding study number 09-087: Do Health Care Providers Offer Prayer with patients, Do Patients Wish Healthcare Providers to Pray Form them. (N/A)

Dear Ms. Polley:

The Chairman of the UT College of Medicine Institutional Review Board reviewed your application for the new study listed above. This study qualifies as exempt from review under the following guideline: 45 CRF 46:101 Category 2.

You are free to conduct your study without further reporting to UT-College of Medicine Institutional Review Board .

Thank you for keeping the board informed of your activities.

Sincerely,

Stacey Hendricks, CIM
IRB Administrator

Sincerely,

A handwritten signature in black ink that reads "Stacey Hendricks". The signature is written in a cursive, flowing style.

Stacey Hendricks, CIM
IRB Administrator

Memorial Hospital

October 9, 2009

Jessica White
8922 Finney Point Dr.
Ooltewah, TN 37363

RE: Study number 09.09.03
PRAYING IN HEALTHCARE: A Comparison of the Wishes of Hospitalized Patients Regarding Prayer From
Healthcare Professionals in Religious Based and Non-Religious Based Healthcare Facilities. (Southern Adventist
University)

Dear Jessica/Tracy:

Your study number is 09.09.03. Your request for approval of the new study listed above was reviewed at the 9/8/2009, meeting of the Memorial Hospital Institutional Review Board.

Memorial Hospital's federal wide assurance number is FWA00000418 which assures compliance with federal regulation. As Chairman of the Memorial Hospital IRB, I hereby certify that this action of the Board was taken in accordance with these regulations for the protections of human subjects.

This is to confirm that your application was approved for the protocol Prayer in Healthcare dated September 27, 2009. The Informed Consent Form dated September 8, 2009 signature authorization was waived and participant will answer questionnaire as their agreement to participate in this study.

You are granted permission to conduct your study as described in your application effective immediately. The study is subject to continuing review on or before 9/8/2010, unless closed before that date.

Please note that any changes to the study as approved must be promptly reported and approved. Some changes may be approved by expedited review; others require full board review. Contact Sherry Baiertl at 423-495-6022 or by e-mail at sherry_baiertl@memorial.org if you have any questions or require further information.

Sincerely,



Kent Grotefendt, MD
IRB Chairperson

Appendix D

+ CATHOLIC HEALTH
INITIATIVES

**Memorial
Health Care System**

Certificate of Completion

is hereby granted to:

Jessica White

for satisfactory completion of

Research Training Modules

August 31, 2009
Date


Sherry Patel, RN, BS
IRB Coordinator

+ CATHOLIC HEALTH
INITIATIVES

**Memorial
Health Care System**

Certificate of Completion

is hereby granted to:

Tracy Polley

for satisfactory completion of

Research Training Modules

August 23, 2009
Date


Sherry Baierl, RN, BS
IRB Coordinator