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Graduate Program in Family Medicine
A thesis submitted in partial fulfillment of the requirements for the degree in Master of Clinical Science
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THE ROLE OF RELIGION AND SPIRITUALITY IN THE CARE OF PATIENTS IN FAMILY MEDICINE

(Spine Title: Religion & Spirituality in Family Medicine Patient Care)

(Thesis format: Integrated Article)

By: Michael Lee-Poy, MD, CCFP

Graduate Program in
School of Graduate and Post Doctoral Studies in Family Medicine

A thesis submitted in partial fulfillment of the requirements for the degree of
Master of Clinical Science in Family Medicine (MClSc)

School of Graduate and Post Doctoral Studies
The University of Western Ontario, London, Ontario, Canada

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THE UNIVERSITY OF WESTERN ONTARIO
School of Graduate and Postdoctoral Studies

CERTIFICATE OF EXAMINATION

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Michael Frank Lee-Poy
entitled:

THE ROLE OF RELIGION AND SPIRITUALITY IN THE CARE OF PATIENTS IN FAMILY MEDICINE

is accepted in partial fulfillment of the
requirements for the degree of
Master of Clinical Science in Family Medicine (MClSc)

Date	Chair of the Thesis Examination Board

ABSTRACT

Aims: This thesis explored patients' perspectives on discussing their religious and spiritual beliefs with their family physicians and family physicians' behaviours in discussing patients' religion and spirituality.

Methods: This thesis examined the role of religion and spirituality in patient care in family medicine using qualitative and quantitative methodologies including in-depth interviews of patients and a survey of family physicians.

Findings: The majority of participants believed that religion and spirituality was important in patient care in family medicine. Barriers and facilitators were identified to the integration of religion and spirituality into patient care. Both studies identified physician comfort level as a barrier and medical education as a potential solution.

Conclusions: The majority of participants believed that patients' religious and spiritual beliefs were important to know, but identified comfort level as a barrier to asking. Medical education on religion and spirituality in patient care is important to increasing physician comfort level.

Key Words: Family Medicine, Spirituality, Religion, Patient Care

CO-AUTHORSHIP

The research for this thesis was conceived, planned and conducted by the author.

The following contributions were made:

Drs. Judith Belle Brown and Moira Stewart provided input and advice regarding the research protocol and ethics submission.

Dr. Judith Belle Brown contributed to the thematic analysis of the qualitative study from the in-depth interviews.

Drs. Moira Stewart and Bridget Ryan assisted in survey development and provided advice and guidance in analysis of the survey data.

ACKNOWLEDGEMENTS

Working on this thesis has been a journey of self-discovery as a person and a family physician. It has affirmed my belief in the physician as a healer and a person that walks with a patient through their life journey. I am greatly indebted to the following people and owe my gratitude. To Dr. Judith Belle Brown for her invaluable advice, guidance, mentorship, inexhaustible encouragement and commitment to education. To Dr. Moira Stewart for her advice, guidance and mentorship with the quantitative research methods and her inspiring knowledge level of quantitative research methods. To Dr. Bridget Ryan for her generous time, astute analysis, guidance, mentorship and unlimited patience and inspiring knowledge and energy. To the Department of Family Medicine and The School of Graduate and Post Doctoral Studies in Family Medicine at the University of Western Ontario for their support. To the patients and family physicians who gave their valuable time to participate. To my colleagues at the Centre for Family Medicine in Kitchener for their patience, support and their dedication to excellence in patient care, teaching and research. To my husband Thomas for his ongoing support, advice, patience and love through this thesis and in our life journey together. To my parents Frank & Rose Lee-Poy for their help, constant encouragement, support and love. To my son, David, who constantly reminded me of the important aspects of life and served as an inspiration to complete this thesis. And finally, but not least, to all of our patients who entrust us to walk with them through their life journey

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Chapter 1: Introduction

1.1 Science and Religion

Historically, science and religion were closely linked. Healing and science were often inseparable. There is extensive documentation of spiritual and medical care being provided by the same person.[1,2,3] In Christian denominations, history told of God healing through the use of the same herbs and remedies practiced in medicine.[4]

1.1.1 Separation of Science and Religion

It was not until the late 1500s, during the early Renaissance era, that tensions emerged between science and religion.[5,6,7] This time period marked the birth of the scientific revolution and the emergence of the scientific or empirical method of knowing.[6] Religious communities rejected many of the discoveries made through the scientific method. In Christianity, this was epitomized by the church's denouncement of Galileo's scientific findings.[5] Medicine adopted more scientific methods and religion was seen as a barrier to knowledge and progress.[5,8] As such, scientists and medical professionals trained in the scientific method were skeptical of the role and effects of religion and spirituality on health. Scientists were taught to challenge beliefs about health that were in conflict with rational, empirical medicine.[5,9,10] Medicine adopted the Cartesian philosophy of science that complemented the empirical way of knowing. This philosophy viewed mind and body as separate. The body was seen as science and the mind and soul as the domain of the church.[3]

The rift between religion and spirituality versus medicine continued to widen. References to religion and spirituality in medicine were often referred to as dysfunction or disease.[11] Mandel, in the *Psychobiology of Consciousness*, called spirituality a "temporal lobe dysfunction".[12] The DSM-IIIR associated spirituality with psychopathology. In the DSM-IIIR glossary, 22.2% of all negative illustrations listed alluded to a religious context.[6] Any aspect of humanities in medicine that had not been empirically evaluated or scrutinized was considered unworthy of inclusion in medical practice.[6] Medicine was associated with what is commonly termed the *scientific model* of thinking.

1.1.1.1 The Scientific Model

The scientific model was a highly complex form of rational and skeptical empiricism, founded in reductionism, mechanism and materialism.[13] The scientific model strove to explain and predict human behaviour in an objective, fixed, measureable material world that operated according to defined rules.[14] The primary interest was in answering verifiable questions which were often the "how" questions.[15,16,17] Science, by extrapolation, was the application of systematic doubt to the physical or sensory experience of the world.[15] Medical science was described as separating human meaning from the world to get at the objective truth about the world. Religion and spirituality approached truth as providing meaning to the world. Therefore, religion and spirituality were at odds with the scientific way of knowing.[15]

1.1.1.2 Ontological or Theological Model

In contrast to the scientific model, religion and spirituality tended to fall under the ontological or theological way of knowing. It was argued that religion and spirituality were not governed by testable concepts, as might be the case in the scientific model. However, this did not mean that criteria or rationale did not exist for testing truths.[15] The ontological or theological way of knowing was described as asking the “why” questions.[15,16]

Religious and spiritual traditions were interested in helping a person find their place in the world, or meaning in their life.[15] Religion and spirituality did not follow the conventions of the scientific or empirical model of truth. It has been argued that religion and spirituality could not be studied or observed using the scientific model and that doing so would only lead to further alienation of religion and spirituality from medicine.[15,17]

Medical science ascribed to the “how” questions and the scientific method of knowing, which rendered religion and spirituality meaningless within this context of knowing.[15] Chibnall argued that religion and spirituality do not meet construct validity under the scientific model of knowing.[18] Cook and Campbell defined construct validity as the extent to which operations meant to represent that causal factor actually reflect some theoretical construct of interest.[19] Chibnall argued that there were no scientific models to explain religion and spirituality and guide the testing of these concepts. Thus, religion

and spirituality failed to meet the two essential scientific criteria of explanatory relevance and testability.[18] Cook and Campbell termed this *'inadequate preoperational explication of constructs.'*[19] However, Chibnall cautioned that the lack of scientific testing of religion and spirituality did not imply that they did not exist. Scientific testing assumed the null hypothesis to be true, but could not yield a direct falsity of the null.[18,20,21] In essence, he argued, the scientific model could neither prove, nor disprove religion and spirituality.

It is recognized that science, religion and spirituality each have their own unique set of rules or dogma that provide ways of understanding the world, and define rules that govern them.[16] They also run the risk of intolerable adherence to dogma and denouncing the truths of the other.[16] Scientific methodology can be too focused on only that which can be measured.[22] Similarly, religion and spirituality can be so adherent to their dogmas that they miss the truths that the scientific method can offer through observation and measurement.

1.1.2 Re-Introduction of Religion and Spirituality

From the 1500s until the 1900s, science adopted the scientific model of knowing. As Hauerwas stated, *"Cure, not care, has become medicine's primary purpose, [and] physicians have become warriors engaged in combat with death."*[23] In the early 1900s, Carl Jung reintroduced the idea that spirituality may have a role in medicine and psychological health.[11,24] He wrote that, *"Among all my patients in the second half of*

life… there has not been one whose problem in the last resort was not that of finding a religious outlook on life."[25] Victor Frankl, an Austrian psychiatrist and Nazi concentration camp survivor, published his book *Man's Search for Meaning* in 1946 that also suggested a role for spirituality and mental health.[26] Shortly after, Gordon Allport, a Harvard psychologist, published *The Individual and His Religion*[27], which was important in reintroducing the role of religion and spirituality into the scientific community.

During the 1960s and 1970s, there was a major socio-cultural shift towards pluralism. Tolerance and multi-culturalism were adopted and promoted.[3,13] The scientific community saw the development of studies that looked at religious and spiritual factors and measurements. Over the next few decades, the medical literature experienced a growth of publications on religion and spirituality.[13] By the 1990s, there was sufficient evidence supporting the relationship of religion and spirituality with health, to draw the attention of researchers across many disciplines[28] including psychology,[29] psychiatry,[30,31] family medicine,[32] gerontology,[33,34] palliative care[35,36,37,38] and nursing.[39,40] Studies on religion and spirituality grew rapidly at this time. There was also a shift in the attitude towards religion and spirituality. Religion, viewed as exclusive in its truths and rigid in its views, gained a negative association with dogma and ritual.[8,13] Spirituality, viewed in contrast to religion, referred more to the personal or subjective experience.[8,41]

Despite this growth in scientific studies examining religion and/or spirituality, there have been many criticisms of these studies. These include poor study design or methods,

inappropriate conclusions, and a failure to identify mechanisms of action.[13] This increased interest in studying religion and spirituality was tempered with the view that religion and spirituality were not scientific constructs, and hence, could not be studied strictly using the scientific or empirical method.[18]

1.1.3 Re-Integration of Religion and Spirituality

In the late 1980s and early 1990s, there appeared to be a renewed interest in religion and spirituality and health care.[3,11,42] Over the years, there has been a major increase in the number of articles published in journals on religion and spirituality.[6,13,43,44] In PubMed alone, a search for articles on "spirituality" yielded a listing of 7 articles in 1980, 72 in 1990, to 678 in 2000 and then an explosion of articles for 2315 listings in 2005 and 4948 as of 2010. The total number of listings as of December 31, 2011 was 5453.

The increased interest in the role of religion and spirituality in health care has been speculated to be multi-factorial. One suggestion is the acknowledgement of the limits of the scientific empirical model to explain nature and health fully.[5] Another proposed reason is the apparent coldness of scientific medicine, which appeared to leave out the human person and interaction. Also, the increasing acceptance of patient-centered or whole-person care included a focus on religion and spirituality.[5,43,45] In general, as Astrow et al. stated in their review article published in 2001, *"Perhaps because of a sense that something is missing in medicine today, the spiritual aspect of health care has become a topic of intense public interest."*[5 p287] Shelton, pointed out that even quantum

mechanics, a subject that is universally considered "science" demonstrated the inability of the scientific way of knowing to explain the world fully, and that *"there is more to life than meets the eye."*[14 p162] Some have termed this the *age of empowerment and consumerism,* in which physicians are informed of patients' needs, including their religious and spiritual dimensions.[7]

There is a strong movement currently to reintegrate religion and spirituality with medicine.[14,16] Theologian Martin E. Marty wrote about the modern biomedical enterprise and its focus on knowledge acquisition, technology and care delivery. He warned about an overemphasis on science and technological development in medicine: *"When technological momentum or economic necessity alone guide the health care enterprise, the sustaining impulses of respect, meaning and purpose often fall aside."*[46] Similarly many authors now call for the re-integration of religion and spirituality into medicine, physics and psychology in which humans are fully and meaningfully part of the schema of things.[14] Bishop wrote, *"Medicine sits at a critical juncture between beliefs and science – that juncture is the patient who sits before the physician… In the clinical realm, they cannot be separated... The beliefs of the patient and the processes [of medicine] cannot be separated, as if an academic exercise."* [15 p1407] This sets the current stage in which religion and spirituality are recognized to have a role in health care and physicians are encouraged to include patients' religion and spirituality in their health care as part of the patient-centered model of care.

1.1.4 Patient-Centeredness

With the rise of the patient-centered model of care in the last few decades, there has been a call for increased attention to patient values.[47,48] This is reflected in the writings of Koenig and Ellis who advocate for the integration of patients' religion and spirituality into health care and the provision of holistic care[48,49] for *"someone whose being has physical, emotional and spiritual dimensions."*[47 p360] Ellis stated, *"a strict scientific approach to medicine overlooks the importance of the meaning of life and hope to patients' well-being."*[16 p259] Anandarajah further stated, *"The true common ground and foundation for integrating spirituality into medicine lie in the healing attitude and self-awareness of the professional. Adopting a patient-centered approach, reflecting 'spiritual humility', akin to 'cultural humility', together with an attitude of service and advocacy, will likely yield better understanding and thus better therapeutic options than simply following established spiritual history protocols."*[50 p455] In a study by Curlin et al., physicians described *'negotiating within their patient's paradigm'* to find a treatment plan that was compatible with the patient's worldview.[51]

1.2 Defining Religion and Spirituality

In the medical literature, there is considerable variation in the working definitions and conceptualizations of religion and spirituality.[13,41,52,53,54] The terms religion and spirituality are difficult to define because they have powerful personal meaning for individuals[13] and are multi-dimensional concepts.[3,41,55] Despite this variability, some agreement has been gained.[13] In some cases, the terms are used synonymously, yet

most authors distinguish between the two.

The word religion is derived from the Latin word *religio*, which means obligation, rite, sacred as a noun, or reverently as an adjective.[56] This Latin derivation seems to describe more the outward expression of particular beliefs pertaining to the sacred or divine.[57] In King and Koenig's paper on conceptualizing spirituality for medical research and heath services, they defined religion as *"an organized system of beliefs, practices, ritual and symbols designed a) to facilitate closeness to the sacred or transcendent, and b) to foster an understanding of one's relationship and responsibility to others in living together in a community."*[52 p117] Other authors have also described religion as ascribing to a set of prescribed beliefs, activities or rituals regarding the sacred or divine.[3,5,6,13,41,52,53,58,59] These beliefs and practices exist amongst a community of people and are considered a "social institution".[3,6,41,58,] However, sometimes those beliefs and practices have been criticized as rigid and moralistic.[13,52]

The word spirituality is derived from the Latin word *spiritualis* which means *"of the spirit", "of breathing", "of wind/air"*.[60] King and Koenig defined spirituality as *"the personal quest for understanding answers to ultimate questions about life, about meaning and about relationship to the sacred or transcendent."*[52] Other authors similarly have defined spirituality as a personal journey[13,41,52,54,58,61] and searching for meaning in life.[3,6,17,52-55,58,62,63] The concept of searching for meaning has often been connected to the sacred, transcendent or the divine.[5,6,17,52,54,58,61-64] The sacred or

transcendent refers to a person's perception of a higher power, ultimate reality or truth.[65] Similar to religion, connection to others, the world and "the sacred" have also been described as important.[3,17,52,54,55,58,63] The personal and fluid nature of spirituality seemed to have developed in contrast to the rigidness of religion.[8,17,52] Some authors have described spirituality as an elastic term not capable of a universal definition as each individual's spirituality is unique.[17]

Regardless of how religion and spirituality are defined, the literature often cautions about prematurely defining or narrowing the definition in efforts to bring some sense of unity to the sciences as this can diminish the richness of religion and spirituality and make wrong presuppositions.[13,17,66] Ultimately, King and Koenig have suggested we use definitions of religion and spirituality *"as a means of understanding spirituality and not as an end in itself."*[52 p290]

1.3 Addressing Religion and Spirituality in Health Care

There has been much debate over the role of religion and spirituality in medicine. This includes many fields such as psychiatry,[67] family medicine,[45,47,50,68,69,70] palliative care[6,71,72] and nursing.[40,73]

Statistics. In Canada, based on 2001 census data, only 16.2% of respondents said they identified with no organized religion, while the majority identified with a Christian-based faith.[74] Past studies that surveyed populations from other countries, have shown that

up to 80% of their participants believed that religion and spirituality played a role in curing illness,[7,43,75,76,77] and in a study by Mansfield et al., 40% believed the divine or higher power was the most important factor in recovery.[75] Past studies that surveyed Americans reported that 87% believed religion and spirituality to be important in their life in general[78] and that 69-94% wanted their physician to know about their religion or spirituality if they were seriously ill.[7,75,76,77,79] Studies have found that there was a higher percentage of people desiring integration of religion and spirituality into health care for specific populations including women,[47,75] the middle-aged to elderly,[47] Anglo-Saxons,[47] African-Americans,[75] the poor,[75] the sick[75] and those with lower levels of education.[75]

Relevance to Health Care. The literature has indicated that for many people, religion and spirituality were a source or framework of meaning and purpose from which they interpreted their lives, values and experiences.[39,43,80,81,82] This framework of meaning was extremely important when patients were coping with illness,[7,43,47,48,51,76,81,83] recovering from illness[7,47,51,77,80] and making treatment decisions.[47,80,84,85,86] Koenig reported that 90% of patients used religion and spirituality in some degree to cope and more than 40% stated religion and spirituality were the most important factors that kept them going.[87] Ultimately religion and spirituality have been described as providing patients with hope and meaning.[48,49,81] To ignore religious and spiritual aspects of illness is to ignore a significant dimension of the patient's illness experience.[88]

Patient Desires. Many studies have documented patients' desires for physicians to inquire about their religious and spiritual needs in the medical encounter.[37,38,47,77,80,89,90,91,92] The majority of studies reported that 75-80% of patients wanted physicians to ask about their religion and spirituality.[47,90,91,92] Other studies have reported that 66-77% of participants felt that physicians should be aware of their religious and spiritual beliefs.[90,92] MacLean et al.'s findings indicated that 10% of patients were willing to give up time spent on medical issues in the office visit to discuss their religious and spiritual issues with physicians.[90]

Study findings have revealed that there were specific areas in which patients felt religion and spirituality should be addressed. One area was in palliative or end of life care in which 50-94% patients believed that religion and spirituality should be addressed because religious and spiritual beliefs were important to dying patients and their families[84,93,94] and they wanted physicians to address their religion and spirituality as well as their physical needs.[84,92,95] McCord et al. found that 77% of participants wanted to be asked about their beliefs when there was life-threatening illnesses, 74% wanted to be asked when there were serious medical conditions and 70% wanted to be asked when they experienced the loss of loved ones.[47] In general, patients' desire to include religion and spirituality in the health care increased as the severity of their illness increased.[43,47]

McCord et al. also found that 87% of patients felt that physicians asking about patients'

religion and spirituality would enhance the patient-physician relationship through understanding.[47] Of those who wanted physicians to ask about their religious and spiritual beliefs, 87% wanted their physician to understand how their beliefs influenced how they coped with being sick, 85% wanted their physician to understand them better as a person, and 83% wanted their physician to understand their decision-making process. Also, 67% of the participants reported that addressing religion and spirituality would encourage realistic hope, 62% felt it may change their medical treatment decisions, and 66% believed it would increase the physician's ability to give medical advice.[47] Participants reported that the least desirable times for physicians to inquire about patients' religion and spirituality included routine physicals or check-ups and visits for minor medical problems.[47,90] Only a minority of patients, between 16-17%, did not want physicians to ask about religion and spirituality.[47,84]

Despite patients' desire for physicians to ask about their religious and spiritual beliefs, the vast majority has never been asked.[7,84,92,95,96,97] Studies found that between 80-91% of patients reported never or rarely being asked by physicians about their religion or spirituality.[47,84,92,98,99] Between 10-18% of patients reported telling physicians about their religion and spirituality without being asked because they felt it was important to their health care.[47]

1.4 Health Benefits

There are a plethora of studies on the relationship between religion and spirituality in

relation to health.[55,100,101,102,103] While a few of these studies disagreed,[104] the majority of systematic reviews and studies found that there appeared to be a generally positive association between religion and spirituality in relation to health and health outcomes.[55,101,103,105,106]

1.4.1 Mental Health

Depression: Many studies reported that religion and spirituality were associated with lower prevalence and incidence of depressive symptoms.[3,59,107,108,109] There are a few Canadian studies that have reported similar findings.[110,111,112] This inverse relationship was also demonstrated for depression that was secondary to coping with an illness, such as AIDS or physical disability.[3,55,113] Two studies by Yi et al. in 2006 and 2007 examined the well-being and depression in medical residents and found that lower religion and spirituality was associated with higher rates of depression.[114,115] They also found that family medicine residents had higher rates of religion and spirituality and lower rates of depression compared to other medical specialties.[115]

Some studies also demonstrated a faster recovery time from depression for people who were religious and spiritual.[116,117,118] However, study results were not always consistent, with the relationship between religion and spirituality and recovery from depression depending on whether the patient's relationship with religion and spirituality was positive or negative.[3,119] Suicide was also negatively associated with religion and spirituality in that people with higher religious and spiritual beliefs were less likely to

commit suicide.[3,8,120,121] One reason given for this finding was that many religious doctrines prohibit suicide.[122] It has also been speculated that religion and spirituality may help provide meaning and connection that upholds peoples' desire to live.[123,124]

Anxiety: Religion and spirituality have also been found to be associated with a lower prevalence and incidence of anxiety.[3,107,108,109,121,125,126] However, anxiety tended to be higher in strict religious groups.[127] Similar to depression, negative religious or spiritual beliefs (such as a judging or punishing God) were associated with more anxiety.[109,126,128]

Schizophrenia: Religious and spiritual coping mechanisms have been shown to have positive effects on people diagnosed with schizophrenia.[125,129] Studies reported that religion and spirituality do not seem to be associated with current or lifetime risk of psychopathology.[3,130]

Coping: Studies have also demonstrated that religion and spirituality are associated with better coping in general[131,132,133] as well as in coping with AIDS, diabetes, rheumatoid arthritis, cancer and mental health.[3,59,73,101,109,131,132,134] Coping and mood have been found to be influential on the subjective experience of, and the meaning attached to physical symptoms.[135,136,137]

Studies have examined the effects of religion and spirituality on coping with grieving or bereavement;[138,139,140] however, no definitive association could be made due to a lack of

good quality studies in this area. Overall, the majority of these studies (22/32) reported positive effects, and only 3 reported none or negative effects.[57] A recently study by Cowchock et al. reported religiosity as an important part of coping with grief after a traumatic second trimester pregnancy loss.[140] Studies have also reported that religion and spirituality helped family caregivers to cope.[141,142] Feher et al. found that religion and spirituality were associated with better coping and contentment in palliative care or at the end of life.[143] There have been a few studies, in contrast, that have suggested negative religious and spiritual coping (such as divine fatalism or blame) may be harmful.[128,132,144]

Addictions: Research has found that religion and spirituality have a positive association with recovery from addictions. The literature discussed the use of faith in the treatment of alcohol abuse such as with Alcoholic Anonymous (AA) and other groups.[3] Religion and spirituality have been associated with a decreased risk of substance abuse including alcohol, marijuana and other drug use.[3,109,121,145] A report from the National Centre on Addiction and Substance Abuse at Columbia University reported that adults who did not consider religion very important were 50% more likely to use alcohol and cigarettes, three times more likely to binge drink, four times more likely to use illicit drugs and six times more likely to use marijuana.[146] Religion and spirituality have also been associated with increased quit rates and maintenance of abstinence from drinking.[147,148] In contrast, strict, restrictive and rigid religious beliefs were more likely to be associated with substance abuse.[3] Koenig et al. speculated that religion and spirituality provided

guidelines for human behaviour that reduced self-destructive tendencies and pathological forms of substance use.[109] However, when people from religious backgrounds that promoted complete abstinence started using alcohol or drugs, their substance use tended to be more severe and recalcitrant.[149]

1.4.2 Physical Symptoms

Morbidity and Mortality: Most research has suggested that religion and spirituality were associated with lower morbidity and mortality.[3,55,131,132,134,150,151] For example, studies reported higher religiousity and spirituality associated with higher self-reported health status[151,152] and conversely lower religion and spirituality associated with poorer self-reported health status[151]. High religiousity and spirituality have been associated with faster recovery times from physical symptoms.[101,153] High religiousity and spirituality were often measured by behaviours such as regular church attendance and it has been argued that the association may be biased with those who attend church being healthier than those who did not attend church, or biased due to socialization being a protective factor.[3,154,155] There were, however, some studies that showed no significant difference in mortality or morbidity based on religion and spirituality.[156,157,158] A systematic review by Astin et al. indicated there was a trend towards studies with higher quality scores (based on the scientific method of analysis) being less likely to show a treatment effect, but that this correlation was weak and not statistically significant.[150] Summation of these studies was limited by the extreme heterogeneity of the studies with the suggestion that any overall review should be interpreted with caution.[150]

Cardiovascular: The risk of cardiovascular disease has been found to be negatively associated with religion and spirituality. Many studies documented a decreased incidence of hypertension and cardiac events.[101,159,160,161] These studies showed both decreased overall mortality as well as decreased overall morbidity.

Cancer: A few studies have suggested an association between religion and spirituality and lower rates of cancer morbidity.[3,134,162] However, results in this area have been mixed. Some studies reported that there was no association,[28,163] and suggested that possibly strong religious involvement might even have a negative impact on early detection of cancer if the perception was that everything is in the hands of the divine which is labeled as divine fatalism.[3]

Preventative Health Care: Religion and spirituality have been posited to be associated with increased adherence to preventative health measures and overall healthier lifestyles.[3,100,101,164] This included positive behaviours such as increased exercise, health screening and healthier diets,[3,28,155] as well as decreased negative behaviours such as abstinence from promiscuous behaviour, alcohol, red meat or tobacco.[28,109,] Religion and spirituality have also been associated with higher treatment compliance.[165] One study by Ahrold et al. found that while religion was associated with conservative or preventative sexual attitudes and behaviours in men and women, spirituality was associated with attitudinal liberalism.[166] Some authors have suggested that religion and spirituality could play more of a role more in health promotion than in risk

reduction.[28,155]

Symptom Relief: Overall, religion and spirituality have been associated with increased positive symptoms such as greater peace, calm and contentment.[3,76,89,108,109,131,134,164] These positive symptoms were more than just the absence of negative symptoms, but have been linked with psychological health, subjective well-being and life-satisfaction.[167,168] Religion and spirituality provided a sense of meaning and purpose during difficult times, which assisted with promoting a positive world-view.[89,109] Studies have also reported religion and spirituality as being associated with decreased negative symptoms such as pain or suffering.[134,169] Although there was some concern over the nature and validity of the relationship between religion and spirituality and health,[104,170] overall, there were relatively few studies that suggested no effect or a negative effect of religion and spirituality on health and health outcomes.[3] Even if a direct patho-physiological pathway could not be elucidated, some authors have argued that religion and spirituality should be viewed as a powerful placebo effect that could be used to benefit certain patients in clinical practice.[150,171] In summary, the relationship between religion and spirituality and health is a complex one.[155]

1.5 Use of Health Care

Studies have reported religion and spirituality as being associated with increased use of regular health care services[172] and the increased use of complementary and alternative medical services.[173] Ellison further differentiated that those who described themselves

as spiritual were more likely than those who described themselves as religious to use alternative services. Religious and spiritual people were also more likely to use body-mind therapies.[173]

1.6 Health Care Decisions

Studies have described how religion and spirituality affected the patient's health care decisions.[84,86] Religion and spirituality have been found to be associated with better adherence to medical therapy.[174] Some studies have described the very prescriptive nature of some religious and spiritual beliefs, including the concepts that only the divine had power to decide life and death and divine fate.[80] These beliefs could affect decisions around advance directives, life-sustaining treatments and even preventative treatments.[80,175,176] The most notable examples are the refusal of blood products by Jehovah's Witnesses,[175] and the adult Christian Scientists or the Orthodox Reformed church's stance against antibiotics and immunizations.[176]

1.7 Patient-Physician Relationship

The patient-physician relationship has been viewed as primarily a therapeutic tool in health care.[177,178] Inquiring about patients' religion and spirituality enhances the patient-physician relationship[5,36,38,77,82,84,95] and increases the therapeutic impact of interventions.[7,77,82,86] As the patient-physician relationship develops, it is viewed as beneficial for both the patient and physician to explore the patient's religion and spirituality in the context of their health care.[107] Religion and spirituality can be viewed

as similar to other aspects of the patient-physician relationship involving different viewpoints.[179] *"Providing understanding, compassion, and hope are hallmarks of a good physician and are not necessarily faith dependent."*[47 p360] It is through this relationship that physicians begin to *"palpate the spiritualities that reside outside of medicine but are central to our patients and our own lived experience of illness and health."*[43 p374] It is within the context of the patient-physician relationship *"that spiritualities empower physicians to negotiate this terrain [of religion and spirituality in medicine] by facilitating and maintaining an entrée into the patient world."*[43 p374] Strong patient-physician relationships are thought to facilitate religious and spiritual discussions.[77,79,91] Conversely, a study by Hebert et al. reported that physician-initiated conversations about religion or spirituality were viewed as inappropriate when there was not a strong patient-physician relationship.[91]

Proposed models of bio-psycho-social-spiritual pathways include the patient-physician relationship as pivotal to the interface between religion and spirituality and medicine.[180] A strong collaborative patient-physician relationship can help to overcome many challenges and barriers to addressing religion and spirituality in health care.[181] Furthermore, a strong patient-physician relationship promotes working together with patients in spite of differing viewpoints[5,51,96] and promotes trust for making joint therapeutic decisions[82]. Finally, a genuine patient-physician relationship allows for meaningful and healing encounters to occur between the patient and the physician.[181,182,183]

1.8 Re-Integration of Religion and Spirituality into Health Care

Many authors have discussed the importance of reintegrating the role of healer back into medicine, and the role of physician as scientist and healer.[100,180,184] They contend that physicians should assess patients' religion and spirituality, and coordinate and use appropriate referral sources.[47,71,185] However, there remains some authors who believe physicians asking about a patient's religion and spirituality is controversial due to the lack of training and the potential for projecting physician views onto patients.[104,186,187]

One suggestion for integrating religion and spirituality into medicine is to be attentive and respond to the patient's verbal and non-verbal cues.[50,79,91,180] As Anandarajah stated, *"By recognizing and responding to patients' cues, we can allow patients to provide us with the language of spirituality that best suits them – whether religious or secular."*[50 p454] Anandarajah concludes that *"it is often in the appreciation of the questions, rather than the provision of answers, that healing occurs."*[180 p455] Sometimes, a compassionate and empathetic presence[48,188] and caring behaviours of physicians[48,188] is viewed as sufficient. Asking patients about their religious and spiritual beliefs in a respectful manner can be therapeutic in itself for patients and all that is required of the physician.[76,101] Sensitivity, non-judgment and respect are important to patients.[76] Simple inquiry into patients' religious and spiritual beliefs is not only viewed as therapeutic, but also considered as addressing the whole person.[36,188]

Authors have suggested that taking a brief spiritual history is a role physicians should

adopt and should be conducted in a respectful, sensitive manner.[7,36,70,77] Some authors have described physicians' role as an *"encourager"* versus a spiritual advisor, meaning physicians should encourage patients to explore their religious and spiritual beliefs but not provide or prescribe professional spiritual counseling or care.[70,77,181] Referral to a spiritual advisor has been viewed as an acceptable course of action,[7,35,36,47] but physicians should not provide in-depth religious and spiritual counseling for which they have not been trained.[7,36] A collaborative or multidisciplinary approach that includes chaplains or other spiritual advisors has been recommended.[189,190]

In summary, the diverse role of physicians in addressing medical aspects as well as the religion and spirituality of the patient has been described as a tension or *"nexus between the scientist who seeks to advance the human condition and the clinician who shares the lived experience of the patient. And it is a wondrous tension that recognizes the limits of human medicine, but the limitless human spirit."*[43 p374]

1.8.1 Barriers

Examination of the literature identified many different barriers to the integration of religion and spirituality into health care. The major barriers were time, relevance to medicine, importance to medicine, and discomfort with asking about religion and spirituality.

Time. Many studies have reported that patients, as well as physicians, identified that

physicians did not have time in their busy schedules to include asking about patients' religious and spiritual views. There was a general belief that asking about religion and spirituality would be very time consuming and add to the already busy physician schedules.[37,45,48,49,70,77,79,82,181,184,188] Lawrence noted a direct inverse relationship between perceived time constraints and meaningful discussions of religious and spiritual questions. When physicians or patients perceived there were time constraints, this led to decreased meaningful discussions of the patient's religious and spiritual beliefs between the patient and the physician.[188]

Relevance. A few studies have identified as a barrier, the perception that religion and spirituality were not relevant to medicine, and thus, not the role of physicians to inquire about.[35,45,48,191] A corollary was that religion and spirituality were not part of the physician's responsibility or business to know.[36,45,48,79,95,191]

Importance. Another identified barrier was the view that religion and spirituality were not important to medicine and health care decisions. This was considered different than being relevant to medicine. While religion and spirituality might be viewed as relevant, it may not be perceived as important to consider in this patient's specific health care and decision.[36,48,192,193]

Discomfort. The most common barrier reported was physician discomfort with religion and spirituality in the medical context.[37,40,45,48,49,82,86,184,193] This was considered to be

multi-factorial and to be affected by two main factors – the physician's personal beliefs and the physician's training.

1.8.2 Facilitators

A number of studies have identified facilitators to including religion and spirituality in medicine. Ample time for meaningful discussions was considered important,[188] as well as the physician being *'present'* and giving their undivided attention during the encounter.[77,188] This was described as *"an intention to openness, to connection with others, and to comfort with uncertainty."*[188 p409] Another facilitator was an environment that was non-judgmental and open,[48,194] which promoted validation of the patients' religious and spiritual beliefs, and reflected the physician's tolerance and respect.[48,191]

The most common facilitator to the inclusion of religion and spirituality into medicine was the patient-physician relationship.[37,77,89,179,188] This included effective communication and listening, which resulted in the integration of patients' religious and spiritual beliefs into their health care management and decisions.[179,188]

1.9 Conclusion

In the last two decades, there has been a renewed interest in the relationship between religion and spirituality and medicine. Numerous studies have reported increasing patient interest in including their religion and spirituality in their health care. In addition, research has shown that religion and spirituality have positive effects on health

care use and health care decisions. The patient-physician relationship is viewed as instrumental in integrating religion and spirituality into health care. However, patients and physicians identified barriers to the inclusion of religion and spirituality with medicine such as: time; physician views on relevance and importance of religion and spirituality to medicine; and physician discomfort with asking. A few studies also reported potential facilitators to combat these barriers, such as ample time, physician attitude, a non-judgmental environment and a strong patient-physician relationship. The increasing number of studies in this area, suggest a burgeoning desire for patients and physicians to have conversations about the patient's religion and spirituality within the context of their health care. As a practicing physician in Canada, there is a distinct void of Canadian studies to guide family physicians in this area. This has led to the purpose of this master's thesis, which is to examine the perspective of a subset of Canadian patients and family physicians on the integration of religion and spirituality into health care and the potential barriers they perceive to this integration.

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Chapter 2: Patients' Perspectives on Discussing their Religious and Spiritual Beliefs with their Family Physician

2.1 Introduction

2.1.1 Defining Religion & Spirituality

There is variation and subtle nuances to how spirituality and religion are defined in the medical literature. In most cases, the definitions for religion and spirituality are pre-defined by the researchers and not by the study participants themselves.[1,2,3]

In general, the term religion is currently associated with a defined, organized system of beliefs, practices and rituals that people subscribing to that religion follow.[1,4,5] These defined beliefs, practices and rituals further their relationship with the divine or transcendent.[1,3-5,6]

In comparison, the term spirituality is currently associated with a more fluid or amorphous personal belief system.[1,7,8] A person's spirituality was a personal quest for understanding the meaning and relationship of the sacred and transcendent in their life[1,5] and ultimately is described as the search for meaning in life.[1,5,9]

However religion and spirituality are defined, the literature is limited in describing how participants define religion and spirituality themselves. Due to so much variability in defining religion and spirituality, King and Koenig felt that religion and spirituality should

be defined at the beginning of every study so that readers knew the working definition used for that investigation.[1] In this study, the participants were asked to describe their working definitions of religion and spirituality at the beginning of the interviews.

2.1.2 Religion and Spirituality Affect Health

Numerous studies have reported a positive association between health care outcomes and religion and spirituality that range from mental health to physical symptoms.[10,11,12,13,14,15] Ultimately, studies have indicated that patients have experienced religion and spirituality, as both directly and indirectly, affecting their use of health care[16,17] and their health care decisions.[18,19,20]

2.1.3 Patients' Desire to Discuss Their Religion and Spirituality

According to census data, the vast majority of Canadians identified with a religion and/or spirituality.[21] It has been reported that as high as 83% of patients wanted their physician to directly acknowledge and include their religion and spirituality in their health care,[22,23] especially in times of illness[18,24,25] and in making medical decisions.[18,19,25] The inclusion of religion and spirituality in their health care was considered patient-centered and whole-person care that addressed the religious and spiritual as well as the mental and physical.[26]

2.1.4 Mind-Body-Spirit

The literature is replete with the need for medicine to add spirituality to the bio-psycho-social model, which has given rise to the new biopsychosocial-spiritual model.[23,27,28] This concept has also been termed the mind-body-spirit framework.[29,30] The first mention of the term biopsychosocial-spiritual model was by Hiatt in 1986.[31] It has been argued that the emotional, physical and spiritual components were connected historically, but western medicine, separated the body, mind and spirit.[32,33] Koltko-Rivera has noted that even Maslow's later work described a state of self-transcendence, which refers to the inclusion of the spirit as part of the whole person.[34] This increased interest in the mind-body-spirit connection reflects the growing acceptance of the holistic approach to medicine in which emotional and spiritual aspects of the person are as important as the physical aspects.[23,35,36,37]

The biological, psychological, social and spiritual are all distinct dimensions of patients. No single aspect can be separated from the whole person.[38] Religion and spirituality, however, is thought to impact health through multiple dimensions including through the biological, psychological and social realms.[39] Siegel et al. wrote, *"Spirituality and religion intersect with medicine at the juncture of suffering."*[40 p10] Biologically, studies have examined how religion and spirituality physically influence neurological, neurohormonal and immunologic processes.[29,39,41,42,43] Research has indicated statistically significant changes in these respective areas. Psychologically, research has demonstrated an association between religion and spirituality and self-contentment and coping that led

to improved mood and mental health.[39,44] In the social realm, studies have indicated that religion and spirituality were associated with more social functioning and activities that appeared to be related to service attendance or related activities.[39,44] Participants who reported higher socializing opportunities reported less physical symptoms and better psychological health.[39,45] However, there is recognition that there are many complex pathways through which religion and spirituality may affect health that may be neither a direct nor a simple relationship.[46,47]

Addressing patients' religious and spiritual beliefs has been considered an essential aspect in addressing the whole person, which is a crucial part in the patient-centered model of care, increasingly believed to be pivotal for high-quality patient care.[37,38,48,49,50,51] Patients have expressed a desire to be treated as whole persons, in which religion and spirituality were part of their care.[26,52,53] The underlying assumption is that each person has a religious and spiritual history, and this history helps shape whom each patient is as a whole person.[38] As Koenig stated:

> Patients are individuals with life stories, emotional reactions to illness, and social and family relationships that affect and are affected by illness. They are also people struggling with the meaning and purpose of their lives, confronting potentially dramatic changes in quality of life, independence, and well-being, changes that may bring them face to face with their own mortality. For many patients, these issues are mixed with existential and spiritual concerns, concerns that can have a direct impact on the acceptance of medical care and the recovery process.[20 p1199]

The mind-body-spirit connection is ultimately realized through the patient-centered model of care with the patient-physician relationship being key.[48]

While there has been an exponential increase in research studies and other literature on religion and spirituality and medicine, there has been a relative lack of Canadian publications on the patient's perspective on this issue. While many studies looking at patients' views exist from other countries, there are none that specifically look at a Canadian population's perspective, and none that specifically look at the integration of religion and spirituality within the discipline of family medicine. This study attempts to address this gap in the literature.

2.2 Study Question and Objectives

The purpose of this study was to examine the perspectives and experiences of patients regarding the inclusion of their religious and spiritual beliefs into their health care visits with their family physician. The specific objectives were as follows: to explore the views of patients on talking about their religious and spiritual beliefs with their family physician; to further examine how this integration may best occur in the family physician's office encounter; to explore how patients' religious and spiritual beliefs influence their health care and; to uncover perceived barriers to the integration of their religious and spiritual beliefs into their health care experience.

2.3 Methods

This study used the qualitative methodology of phenomenology to elicit patients' perspectives and experiences regarding the inclusion of their religious and spiritual beliefs in their health care. There is a paucity of research exploring the views of patients

on including their religious and spiritual beliefs in the family physician's office visit, which is primarily a personal experiential topic. Thus, phenomenonology was an effective methodology to explore this area.

2.3.1 Recruitment

A purposive sample of patients was recruited for this study to reflect a broad range of age, sex and religious and spiritual beliefs and to include individuals who were open to sharing their personal feelings about their religious and spiritual beliefs. Patients were initially informed of this study verbally by their family physician, and were given a *Letter of Information* describing the study. Those who expressed an interest in participating were placed on a list along with their basic demographic information such as age, sex and religious and spiritual beliefs, if it was self-identified. Selected participants were contacted by phone to confirm interest and to set up an interview time and location. Twelve participants participated in the study and the interviews continued until saturation of themes was reached.

2.3.2 Data Collection

A total of 12 interviews were conducted between July 2006 and April 2008. The interviews were conducted by the primary investigator at a comfortable and mutually agreed upon location and time. The confidentiality of the participants was assured. Participants were informed that their responses and views would not be shared with their family physician and would not impact their care. Participant questions were

answered and informed consent was obtained prior to starting the interview. The interviews were digitally recorded in their entirety using two digital recorders. Interviews ranged from 60-90 minutes in length. The interviewer took field notes during the interview. The interview format was semi-structured with open-ended questions to explore the definitions of religion and spirituality, the perspectives and experiences of the participants with respect to including their religious and spiritual beliefs in their health care, and how their religious and spiritual beliefs affected their health care decisions and experience of health. See Appendix 2-3.

2.3.3 Data Analysis

The digital recording of each interview was transcribed verbatim. The transcriptions and field notes were independently reviewed in detail by the two investigators to identify the emerging themes. An interpretive process was employed for thematic analysis as described by Crabtree & Miller. This involved describing (transcribing and making notes), crystallization (identification of early patterns), immersion (systematic review of data and notes), synthesis (making connections and forming a framework), corroborating (checking framework with other sources) and representing the account (written description).[54 p183] The investigators met after independently reviewing the transcripts to compare and corroborate the findings. This was an ongoing iterative process in which the investigators met frequently to organize and re-organize emerging themes, establish connections and update the coding template. The coding template was a list of themes and categories that emerged from the transcribed interviews. This

was used to organize the responses and ideas from the participants.

The technique of immersion and crystallization was used to interpret the data. This technique involves *"prolonged immersion into and experience of the text and then emergence after concerned reflection, with an intuitive crystallization of the data."*[54 p23] This is an effective method when the research aim is exploration and discovery, when there is little pre-existing information, and when the research is participatory.[54 p24] This technique was ideal for exploring patient's views on including religion and spirituality in their health care. Thus, analysis of the data occurred during the study design, during data collection and after collection. Fundamental to the technique of immersion and crystallization is that the investigators be cognitively and emotionally engaged in the process to get beyond the obvious interpretations, to listen deeply to individuals, to give proper time for reflection and to be open to uncertainty. Furthermore, this technique requires rigorous data collection and involvement of a mentor with experience.[54 p181-182] The investigators feel that the above requirements were met in this study.

2.3.4 Trustworthiness and Credibility

Trustworthiness and credibility were assessed and ensured using qualitative measures. These included: reflexivity, depth of description, accuracy, rigor, intellectual honesty and searching for alternate hypotheses and interpretations.[54 p193] In general, there was significant diversity among the sample population with respect to age, sex and religious and spiritual beliefs. In addition, the personal religious and spiritual beliefs of the

investigators were recognized and cognizance of the role this might play in interpreting the results was felt to help minimize bias. Furthermore, trustworthiness and credibility were ensured by verbatim transcription of the interviews, extensive field notes, member checking during the interviews and having both investigators independently conduct the analysis before consolidating their findings together. Methodological rigor was achieved by letting the findings lead the data collection and analysis process. The interview guide and coding sheet were adjusted throughout the process to reflect emerging themes suggested by previous interviews.

2.3.5 Ethics Approval

This study received ethics approval from The University of Western Ontario's Health Sciences Research Ethics Board (See Appendix 2-2).

2.3.6 Final Sample and Demographics

A total of twelve participants were interviewed. The participants were evenly split between male and female, and ranged in age from 29-69 years with an average age of 49 years. Their identified religious and spiritual beliefs ranged from atheist and agnostic on one end of the spectrum to religious on the other end of the spectrum (See Figures 2-1 and 2-2).

Figure 2-1 Sample Demographics

Age	Sex	Self-Identified Religion or Spirituality
29	F	Roman Catholic
32	F	Muslim
36	M	Buddhist
38	M	Atheist
42	M	Lutheran
45	M	Eastern Religion
47	M	Agnostic
58	F	Mennonite
60	F	Spiritual Materialist
68	M	Christian
68	F	Jehovah's Witness
69	F	Spiritual

Figure 2-2 Sex and Age Distribution

Sex	Number (%)
Female	6 (50)
Male	6 (50)

Age Group	Number (%)
≤ 30 years	1 (8.3)
31-40 years	3 (25)
41-50 years	3 (25)
51-60 years	2 (16.7)
61-70 years	3 (25)

2.4 Findings

Three major themes emerged from the data analysis: 1. Participants' definitions of religion and spirituality; 2. The influence of their religious and spiritual beliefs on their health care; and 3. Barriers and facilitators to integrating their religious and spiritual beliefs into their health care.

2.4.1 Definitions

Participants were asked to describe their religious and spiritual beliefs at the beginning

of the interview in order to better understand their religious and spiritual beliefs and included an exploration of what the terms *religious* and *spiritual* meant to them. Many participants found the process of formally verbalizing their definitions quite difficult despite feeling an innate familiarity with these concepts. *"I think I know what religion means, but trying to define it is not easy... I know what it means internally, but it is hard to verbalize."* What became apparent was that participants felt there was a spectrum with religious being on one end and spiritual on the other. Interwoven within this spectrum was the concept of the mind-body-spirit connection.

2.4.1.1 Religion

When defining religion, there were commonalities, but also diversity in the participants' descriptions. There were 5 subthemes related to their description of the terms religion and religious: *structure*, *exclusiveness*, *scope*, *connection* and *downward pointing*.

Structure. Religion was defined as a highly structured entity with rules or a code of ethics that prescribed certain beliefs and behaviours. *"When people say religion, I think of a somewhat more organized group where there are people sharing certain beliefs… and practice certain rituals."* In religion, structure involved the following aspects: rules for beliefs: *"Religion… is sort of all those observances of God and the sort of cultural beliefs around your particular God"*; worship practices: *"it's sort of literal what you do in churches"*; and actions: *"You try to live by the dictates of the Bible."*

Exclusiveness. Religion was often described as exclusive by both those who considered themselves religious and those who did not. Exclusiveness referred to believing their religion to be the one truth and not being fully open to other religions. As this participant stated:

> Religion would say 'Well, I'm Christian, I'm superior.' and Hindu's think 'Well, I'm superior.' and an Islam would say 'Well, we are superior.' …[Religion] is not interested in connecting people across different communities, their interest is to build *their* community.

Scope. Another sub-theme was the scope or extent to which religion influenced the lives of the participants, and their responses revealed considerable variability in how this was enacted. Some participants described the impact of religion on their life as external rules that guided them only in specific situations: *"We feel that it is a command from God not to take blood"*, whereas other participants described religion as affecting their whole life as this participant described: *"The idea is that your whole life is a practice."*

Connections. Participants viewed religion as extremely important in connecting a community of people through communal practice. A participant described religion as a:

> …communal practice or communal belief system, either the practice in terms of a ritual or a shared discussion about shared belief. It's about relation and relationships. A very strong connection is to the church and a very strong connection to the people of the church.

Another participant explained how this connection could be paramount in providing strength:

> The association before and after is encouraging and up-building and you can go

> to one of these meetings feeling very tired and down, but I find that you come away feeling built up and encouraged and ready to face another day.

Downward Pointing. Participants observed how religion was generally thought to refer to an external force (often termed as 'God') that acted externally or from "above" and impacted a person's life. In this way, religion was thought to be *downward pointing*, or working from outside of the person to the inside. Participants of different religious backgrounds described this downward pointing nature of religion. As one participant explained: *"We believe in the Koran, which is the main scripture in Islam. Angels are basically creatures that God sends to get things done."* Another participant stated: *"I feel that we are accountable to Jehovah God for the way we live our lives. I believe that He made the earth and put mankind on it for a purpose."* Some viewed this "downward" or "outward to inward" pointing as a spectrum between religion and spirituality. *"Religion does the outer work. Spirituality takes the inner journey."*

2.4.1.2 Spirituality

Spirituality appeared to be a more difficult concept for participants to describe. *"I guess I have a good idea about what people mean when they say religion. I don't have a good idea about what they mean when they say spirituality."* This was often related to spirituality being viewed as an all-encompassing word. Five subthemes emerged: open structure, inclusiveness, scope, connections and outward pointing.

Structure. Spirituality was often described as an umbrella term for any belief that

involved the spirit. *"Spirituality, of course is a much more general, universal thing. We all have it… however you define it… we all experience it… we all live with it."* Spirituality provided a framework but left the structure of expression and belief up to the individual. *"Spirituality is a certain belief that you have. It's not really tied down to any given institution."* It was this very lack of structure that seemed to differentiate spirituality from religion, yet also made it challenging to define.

Inclusiveness. Spirituality was repeatedly expressed as universal, inclusive and open to everyone. Every person was considered spiritual in their own way, including those that were religious. *"There's a spiritual component in religion."* Spirituality was accepting of all people and religions. For example, a participant described attending a spiritual retreat in which many people of different religions gathered: *"There were lots of Hindus, Muslims, Sikhs and Christians there… I think by just being there, you could tell that this is still a spiritual practice."*

Scope. In terms of scope, spirituality influenced the participants' entire lives. *"It's constant. I don't know how it cannot be expressed in everyday life in every choice I make."* Spirituality was a defining feature of how participants viewed themselves. *"It's the most important thing in my life. It would be difficult to be without it."*

Connections. Spirituality was also consistently defined by connections: a connection to a larger entity or purpose, and also a connection to people. As a participant explained:

"I do believe there is something greater than the sum of its parts. I do believe there is a connection between everything that is, was, and will be."

Outwards Pointing. Spirituality was experienced as a personal journey that worked from the inside and pointed outwards. *"Spirituality also means giving greater thought to what's happening in your own world and the world around you."* Through developing the personal spiritual self, one impacted others. *"Once a person has achieved this inner self, you become a radiating presence of love, peace, joy."*

2.4.1.3 Religious Spiritual Spectrum & the Mind-Body-Spirit Connection

In defining religious and spiritual, some participants noted that the terms were part of a spectrum in which religion was at one end and spirituality was at the other end. Most participants perceived themselves somewhere in between the two. *"My beliefs, to me are really clear. Maybe if you take the two words and put them together, I'd be more comfortable with that."* Participants described themselves on a personal journey, and the goal was to bring sense or meaning to their lives. *"I simply don't know about many things and I'm comfortable with that, because I've worked out a personal, spiritual or religious framework that for most of the time, works for me."*

Interwoven into this spectrum of religion and spirituality was the concept of the mind-body-spirit connection. Participants across the whole spectrum of religious and spiritual beliefs described the importance of the connection between the physical, the

psychological and the religious or spiritual. In sum, they described this as the mind-body-spirit connection, and it brought meaning to their lives as it connected these three different aspects together to create a reality that made sense to them.

The mind-body-spirit connection incorporated participants' religious and spiritual beliefs, and was the way religious and spiritual beliefs were integrated into their health care. Their religious and spiritual beliefs influenced their health care decisions and their experience of health and symptoms. This connection and awareness of themselves, in turn, grounded the participants in their mind, body and spirit as this participant described: *"So I'm standing firmly grounded, in my own spirit, in my own body on the Earth."*

2.4.2 Influence of Religious and Spiritual Beliefs on Health Care Decisions and the Experience of Health

During the discussion of religious and spiritual beliefs and health care, participants discussed the influence of their religious and spiritual beliefs on health care decisions and their experience of health.

2.4.2.1 Health Care Decisions

Participants stated their religious and spiritual beliefs influenced their health care decisions in two different ways: either it dictated their decisions or served as a guide.

Dictated. Some participants described rules that dictated health and medical decisions in certain situations. These were always associated with religious rules. As one participant explained: *"The only reason is because we feel that it is a command from God in the scriptures."* She carried with her a medical directive card directly stating this "command":

> I make this advance directive in a formal statement of my wishes. These instructions reflect my resolute and informed decisions… This legal directive is an exercise of my rights to accept or refuse medical treatment. I am one of Jehovah's Witnesses and I make this directive out of obedience and command of the Bible such as keep abstaining from blood.

In other religions, the rules dictated that all possible medical treatments to preserve life be utilized as this participant described:

> You know how we give people choices [in Western medicine]? You can say no to treatment. There's nothing like that in Islam. If there's treatment available, you should get it. You should take care of your body and get better.

This participant also described the rules for health dictated by her religion: *"They say in Islam, you should eat in three parts. One part is food, one part is water and one part is air."* In this way her religious and spiritual beliefs directly influenced her health and medical decisions.

Guided. Many participants described their religious and spiritual beliefs as guiding their health care decisions, which were viewed as a collaboration between their religious and spiritual beliefs and medicine. *"But I believe a positive attitude, combined with the expertise of the doctor is the more real approach that I would be most comfortable with."* Even religions that had some rules that were dictated had other parts that were

more guiding in nature. This was often described as a conscious process. *"I think it's a very deep role and I think it's [in] a large part [a] conscious role."* At other times, the influence of religious and spiritual beliefs is more unconscious. *"You know, there's certain things that you don't even think about but they're more important to you than you even thought."*

2.4.2.2 Experience of Health

In addition to examining how their religious and spiritual beliefs influenced health care decisions, participants also explored how it affected their experience of health. They described a relationship between a *decrease in anxiety and stress*, and *an increase in contentment and hope* that acted like a fulcrum.

Decreased Anxiety and Stress. Participants described how religious and spiritual beliefs helped to provide perspective or balance and therefore decreased their anxiety and stress. As one participant explained:

> I think the belief system is extremely critical… You know stress is in the eye of the beholder. One thing could send one person into crisis and the same thing will be hardly a blip on the screen for somebody else.

Another participant expanded on the idea that one's religious and spiritual beliefs could decrease worry:

> Less worries. I guess you would be more sure of your health. I can say that someone with a very strong belief thinks they are always on the side of [the right]. If you think you're right, you're going to be on the right side. Maybe that's why you don't worry as much or maybe that's why you have a certainty. It does apply to medical situations. Having a strong belief certainly will help.

While some participants depicted turning to their religious and spiritual beliefs during times of a health crisis, others proactively turned to their religious and spiritual beliefs to decrease stress and anxiety. *"Through meditation, it has some impact on my well being."* Through spiritual practices, participants found a balance and ways to decrease their overall anxiety and stress. That was evident in multiple outcomes such as decreased symptoms, decreased medication use, decreased medical visits and a decreased fear of death. A participant stated: *"People who are spiritually in alignment don't have to have symptoms… physically, emotionally, [or] mentally."* Another participant described how their religious and spiritual beliefs decreased worry around death: *"The doctor said to me, 'Don't you realize this is serious? He could die!'… but I just felt calmness from the knowledge of knowing God."*

Increased Contentment and Hope. In addition to reducing anxiety and stress, participants also discussed how religious and spiritual beliefs could increase contentment and hope. Contentment was defined as feeling positive, calm or at peace. This was an outcome in and of itself, and not necessarily a bi-product of less anxiety or stress. Contentment was felt to be directly related to health and healing. *"Something positive that you believe in can lead to a positive mind set. Your healing."*

The participants' stories revealed how hope was an important part of contentment. Hope was often connected with feeling part of something larger and ultimately provided meaning to their lives. This meaning allowed some participants to feel more content,

even when facing medical adversity as this participant described: *"There was pain, an inordinate amount of pain. But it was easier to take. I wasn't afraid of my life or death."* In this way, suffering could have meaning, and one could still be calm in the face of suffering. *"I mean suffering is a real key to learning about yourself and learning how to deal with the world around you."* Through meaning, hope and contentment could lead to the perception of increased health as this participant described: *"I think in a general way, where you are in terms of meaning and how connected you are with a sense of spirituality can enhance maintaining your health."*

2.4.3 Barriers and Facilitators to Integrating Religious and Spiritual Beliefs

Participants identified many factors that acted as either barriers or facilitators to the integration of their religious and spiritual beliefs into their health care. Underlying all of this was the patient-physician relationship.

2.4.3.1 Barriers

Participants identified barriers to the integration of their religious and spiritual beliefs into their health care. These barriers were categorized into 4 subthemes: *time*, *comfort level, importance* and *view of roles*.

Time. Time was a major barrier expressed by all of the participants. They perceived their family physicians as being extremely busy and not having enough time to discuss their religious and spiritual beliefs. *"I don't think he has time to hear about it."* Even if

family physicians did value patients' religious and spiritual beliefs in considering health care decisions and management, participants perceived that this conversation took time that physicians did not have. *"I guess when it comes to physicians and my own experience of them, they are very pressured and rushed and I don't think these discussions can be done in two minutes."*

Comfort Level. Participants believed the comfort level of family physicians with religion and spirituality impacted their decision to include or exclude religious and spiritual beliefs in patient encounters, which was reflected by two elements identified by the participants: *knowledge* and *personal beliefs*. Participants understood family physicians to be trained within the scientific medical model, which was in contrast to the spiritual or theological way of knowing. *"I mean most doctors are pretty geared towards the scientific model, which is measurable and visible, and the spiritual things are harder to put your hand on."* This lack of knowledge could result in minimal skills in addressing religious and spiritual beliefs in health care as this participant said: *"I could see him being interested in it. But I wouldn't see my doctor as having the right skill set."*

Participants also felt that family physicians' personal beliefs could affect their comfort in discussing a patient's religious and spiritual beliefs. Participants explained how family physicians might believe a person's religious and spiritual beliefs to be a private issue and thus taboo to discuss:

> There's a certain level of paranoia or some sort of thing like that, that's engulfed our society over time. People are afraid to ask things like that

> [referring to religious and spiritual beliefs], which is a shame, but that could be a barrier. They don't want to offend anybody so they don't even go there. So they end up sort of overcorrecting the other way, so faith doesn't have anything to do with it.

Family physicians' personal religious and spiritual beliefs could also influence their comfort in discussing this topic. *"Whether it would be helpful or harmful is dependent on the type of education or the belief structure of the doctor."* Participants identified how family physicians' religious and spiritual beliefs could cause problems when they encountered patients with different beliefs. *"Now if you happen to be a physician who is a fundamentalist, maybe that's going to be an issue [with my beliefs]."* Similarly family physicians who did not believe in religion or spirituality could also be biased against a patient's religious and spiritual beliefs as this participant stated: *"If it doesn't play a role in their own personal lives, I don't think that they are necessarily going to see that it might have a benefit in someone else's life."* Thus, the family physicians' personal beliefs could make them less comfortable in addressing a patient's religious and spiritual beliefs.

Importance. Participants felt that family physicians may not view it as important to address a patient's religious and spiritual beliefs. Participants described past experiences in which their physician was only interested in physical symptoms. *"Basically when I see him, he just wants to know if I'm sleeping, eating and if I seem to be manic depressive or not."* Participants perceived this as a major barrier to having their religious and spiritual beliefs acknowledged.

Roles. Participants felt that family physicians may not consider addressing religious and spiritual beliefs as one of their roles. This was perceived as a major barrier. However, most participants expressed that family physicians should integrate religious and spiritual beliefs into their medical care when possible. This was considered treating the whole patient. *"I would think this would be the most important [thing], showing a willingness to consider the patient's religious beliefs as part of the treatment."*

In summary, participants identified four main barriers to the integration of their religious and spiritual beliefs: *time*, *comfort level, importance* and *view of roles*. Comfort level included both knowledge level and family physicians' views of religious and spiritual beliefs as a private topic and also their own personal religious and spiritual beliefs.

2.4.3.2 Facilitators

Participants also identified facilitators to the integration of religious and spiritual beliefs, which were categorized into two subthemes: *knowledge* and *behaviours*.

Knowledge. Participants perceived that family physicians that were knowledgeable about patients' religious and spiritual beliefs and health care would greatly facilitate the integration of religion and spirituality into their health care. Knowledge was reflected by two elements: *the mind-body-spirit connection* and *the patient's religious and spiritual beliefs*.

Participants believed family physicians needed to be aware of the connection between the mind, body and spirit. This connection was viewed as important in their care as this participant stated: *"There is definitely a connection between the state of the mind and the state of health. That has to be recognized."* In addition, it was important that family physicians were aware that the patient's religious and spiritual beliefs were integrated into the mind-body-spirit connection.

It was also crucial for participants that family physicians were aware of the patient's religious and spiritual beliefs and the impact of the patient's religious and spiritual beliefs on their health care decisions and experience of health. *"If you were to ask, 'Do your patients have diabetes? Do you have any significant religious beliefs or spirituality and how important is that to you?' These are things that your doctor should know."* Knowledge of a patient's religious and spiritual beliefs was considered the first thing family physicians could do to facilitate the integration of the patient's religious and spiritual beliefs into the patient-physician relationship. *"The best thing is for physicians to be aware of this side."* Integral to the knowledge of the person's religious and spiritual beliefs was also the awareness of how a patient's religious and spiritual beliefs could change over time:

> It could even be like if at one point you asked someone something and then the next year you'd get a completely different answer and then the next year you'd get a completely different answer again… It's part of who the person is, so it should be addressed.

Thus, one important role of family physicians in integrating religious and spiritual beliefs

into the patient-physician relationship was knowledge. This included knowledge of the mind-body-spirit connection and knowledge of the patient's religious and spiritual beliefs.

Behaviours. Physician behaviours were another potential facilitator and were used by participants as a measure of family physicians' views on religious and spiritual beliefs and health care. *"I'm definitely gauging his reaction to see how he reacted to that. And if I was a Jehovah's Witness I would do the same thing."*

Participants felt that inquiry by family physicians about a patient's religious and spiritual beliefs was a major facilitator as this demonstrated the family physician's commitment to integrating religious and spiritual beliefs into their health care. *"If I wasn't asked, I would never broach the subject. But once the subject gets broached, I don't have that much problem talking about it."* Even those who identified as having no specific religious or spiritual beliefs appreciated the physician inquiring. *"…Asking that question is always fine, so long as the reaction to the person saying, 'No, I'd rather not talk about it,' [is respected]."*

When to inquire was important to participants. The majority of participants felt the decision of when to ask about religious and spiritual beliefs was situational, and should depend on when religious and spiritual beliefs were relevant to the reason for the office visit. Situations in which religious and spiritual beliefs might be directly connected

included anxiety, stress, mental health, marital issues, ethical issues, chronic diseases, mortality issues and end of life care. In general, religious and spiritual beliefs might also play a role in any visit in which the person seems to be struggling with something as this participant described:

> I think also that if there's a situation where you as a health care professional sense that this patient was struggling with something, are they struggling with transition, are they struggling with HIV tests, [then] you need to probe further.

For patients whose religion strongly dictated their health care decisions, asking about their religious and spiritual beliefs would be very appropriate on the first visit. *"I think right off the get go, because that way you are setting the ground right from the start and everyone knows where you are. You know, for future encounters as well."* Other participants felt it would be more appropriate to ask about religious and spiritual beliefs later, after the patient-physician relationship had developed:

> I would say probably not on the first meeting… after you've developed a bit of a relationship, after you have some trust. When you first go to a doctor's office and fill out all of those things that ask 'What is your religion?' I wouldn't want to see that. That would scare me.

Without a prior relationship, asking about a patient's religious and spiritual beliefs could be out of context and cause concern as this participant stated: *"People may make all kinds of assumptions about why you're asking these questions… [It] makes sense to explore that later, once you've had these patients for a while."*

Participants also stated the importance of how family physicians inquired about the patient's religious and spiritual beliefs. This was described as a topic in which family

physicians need to be present for the patient.

> The most important thing is that when the physician arrives in the room, regardless of what's going on outside that door, they must not appear busy… Be there for that person. For that brief period of time, it's all about them and I think that includes a direct inquiry about their overall health… I think that to make that segue to ask about your patients, as an overall human being, I think it's crucial because that provides the open [door].

Sensitivity when asking about a patient's religious and spiritual beliefs was also highlighted by participants: *"You just have to be so careful and so non-aggressive and so general about it."* Some participants described phrasing the question to make it clear that it was to help the family physician understand the needs of the patient more fully:

> If I had someone like a non-Muslim for a family doctor, I would be really appreciative of the fact that if right on the get go they were to say 'You know what? I'd like to learn more about this. There must be things that you would want to do differently because of your spirituality or your faith. I don't know about those things, just let me know whenever we can do something differently or maybe I can help you.' Just communication I guess. A common ground.

Thus, patients identified knowledge and behaviours as facilitators. Knowledge included physicians understanding the mind-body-spirit connection and also the patient's religion and spirituality. Behaviours addressed inquiring about religious and spiritual beliefs including how and when. Ultimately the patient-physician relationship was the foundation for these facilitators.

2.4.3.3 Patient-Physician Relationship

The successful integration of a patient's religious and spiritual beliefs was repeatedly described as needing a solid patient-physician relationship. One participant stated: *"So*

you get to know me more somewhat as a whole person, than as a set of symptoms."

Participants viewed the patient-physician relationship as facilitating both an increased *trust* and an increased *understanding*.

Increased Trust. Trust was extremely important to participants and enhanced the patient-physician relationship. A participant described it as:

> In that dance, that relationship, there's a trust in some ways. If you know a person very well, you may be a little bit more comfortable sharing something. So I think that the relationship you have with me and other patients will really go a long way in promoting trust.

Foundational to building trust was an attitude of openness from the family physician, which created a safe space for participants to discuss their religious and spiritual beliefs. Openness was viewed simply as: *"Initially just leaving that door for communication open."* Some participants described noticing when they felt a distinct lack of openness, which had a detrimental effect on their willingness to share their religious and spiritual beliefs and created a lack of trust. One participant recounted:

> So I walk into the office and there were posters on the wall that were clearly Christian oriented… I immediately felt threatened and nervous. I thought this was certainly a doctor that might not be comfortable with [me]. I felt very on guard.

Increased Understanding. Acknowledging religious and spiritual beliefs increased the perception that the patient and their decisions were understood.

> I think it's really important that medical people be open to the religious beliefs or lack of them with their patients, because I think it's a really important part of health care because it allows the patient to have confidence that you truly do understand where they're coming from.

Many described a desire for their family physician to know their religious and spiritual beliefs in order to facilitate an understanding of patients' views and decisions. This could lead to a mutual understanding and agreement in terms of management plans. This was extremely important to patients and as this participant, who was a Jehovah's Witness, described:

> We want to work along with the medical profession and make sure they understand because we want good treatment… The doctor wants to know where he stands, what he can do. If I were to come in to you with a particular problem and you say, 'Well, I think you need such and such surgery,' then to discuss it back and forth and then to see what comes to an agreement there.

Respect for the patient's religious and spiritual beliefs was also important and helped participants feel that their family physician understood them as a whole person. However, this did not mean the family physician had to necessarily share the same religious and spiritual beliefs as the patient. Respect for the patient's religious and spiritual beliefs was demonstrated through the physician acknowledging and valuing the person's religious and spiritual beliefs. *"Some acknowledgement that if that's important to you, then it's important to me as a physician as well. I think it can be as simple as that."* This respect enhanced the patient-physician relationship. *"That would come across in terms of the degree to which you feel respected, the degree to which your issues might be taken seriously, so that is [something] that would definitely affect the doctor-patient relationship."*

Thus, participants found that the patient-physician relationship increased trust in the

physician and increased the physician's understanding of their views and choices. Participants felt that the patient-physician relationship was the foundation that facilitated the integration of their religious and spiritual beliefs into their health care.

2.5 Discussion

This qualitative study set out to explore the views of patients on integrating their religious and spiritual beliefs in the family physician office encounter. This study was important for a number of reasons. First, it explored patients' perspectives on how they define religion and spirituality. Second, it explored how patients' religion and spirituality influence their health care decisions and experience of health. Thirdly, patients shared their perceived barriers and facilitators to the integration of their religious and spiritual views into their health care.

2.5.1 Defining Religion and Spirituality

It was not surprising that there was variability in the working definitions that patients provided for both religion and spirituality. Indeed much variation and richness exists in the current literature by both theologians and scientists on the definitions of religion and spirituality.[1-4,55] However, despite the breadth of the definitions given by the participants, there were general themes that emerged in their definitions that were similar to prior publications. For example, similar to other studies[1,3-6,12,55,56,57], participants described religion as highly structured with defined traditions and rituals and exclusive. The participants' description of spirituality as more open, all

encompassing, fluid in nature and a personal search for the sacred was also similar to definitions proposed in previous studies.[1-3,5,7,9,10,12,56,58]

2.5.1.1 The Religious-Spiritual Spectrum

In defining religion and spirituality, a number of participants contrasted the two, and inevitably drew connections and differences between religion and spirituality. Ultimately, they concluded that religion and spirituality were connected through the religious-spiritual spectrum. While this concept has been described in the literature, there is much variation and disagreement in what this spectral overlap looks like and how it should be defined or conceptualized. In different studies, religion and spirituality were viewed as being either totally separate concepts[10,59], or the same concept that was interchangeable[5,60,61,], or anywhere in between.[5,8,55,62] Thoresen et al. viewed religion and spirituality as overlapping constructs or circles similar to a Venn diagram.[5]

Unique to our study were the participants' description of a spectrum in which religion and spirituality were connected, with religion (and accompanying rules, rituals and exclusive nature) on one end, and spirituality (reflected by openness and inclusiveness) at the other end of the spectrum. Participants felt this concept embodied the personal nature of a person's religion and spirituality, while also acknowledging any aspects of rules or rituals that also existed. Most participants' religious and spirituality beliefs were somewhere in the middle, incorporating aspects of both religion and spirituality. Through defining religion and spirituality, participants were very open and

acknowledged that in the end they found a religious and spiritual framework that worked for them.

2.5.1.2 Mind-Body-Spirit

The personal religious and spiritual framework that participants described was related to what they called the mind-body-spirit connection. Their religion and spirituality (or the spirit) was connected to their physicality (the body) and their psychosocial, emotional, social aspects (the mind). This concept is not new, but is often described in the literature as the biopsychosocial-spiritual model.[23,27,28,38,49-51,53,63] Studies have described how the dimension of the spirit (religion and spirituality) is currently missing from the bio-psycho-social model, and have called for the integration of the spirit. What is unique to this study is that the participants spontaneously articulated this framework and predominantly used the words 'mind', 'body' and 'spirit' suggesting comfort with these terms. This was similar to the alternative term some researchers have used for the biopsychosocial-spiritual model.[29,30,64,65] It was through this framework that participants viewed their religion and spirituality as being intertwined with their health care.

2.5.2 Influences of Religious and Spiritual Beliefs on Health Care Decisions and the Experience of Health

Participants expressed how their religion and spirituality influenced their health care decisions and experience of health based on the mind-body-spirit connection. Their

religion and spirituality were often difficult to disentangle from health care decisions as well as their perceived general health.

2.5.2.1 Health Care Decisions

Patients who were religious explained how religions often have rules that dictated or guided their life and hence, their health care decisions. In certain religions, certain medical decisions are dictated. The most familiar is the Jehovah's Witness directive to not receive any blood products. Some participants also described the opposite, in that the directive from their religion dictated that they should receive medical treatment if it existed. Adherence with treatments and lifestyle factors are other areas in which religion has a potential effect.[10,12,15,66]

Unique to our study was that most participants described how their religious and spiritual beliefs acted as a guide, were part of who they were, and hence a part of their health care decision-making process. Prior studies have not explored the spectrum of roles that patients' religious and spiritual beliefs play in their health care decisions. The influence of religion and spirituality on health care decisions appeared to be at a conscious and unconscious level at different times. This potential influence is discussed further in section 2.5.2.3.

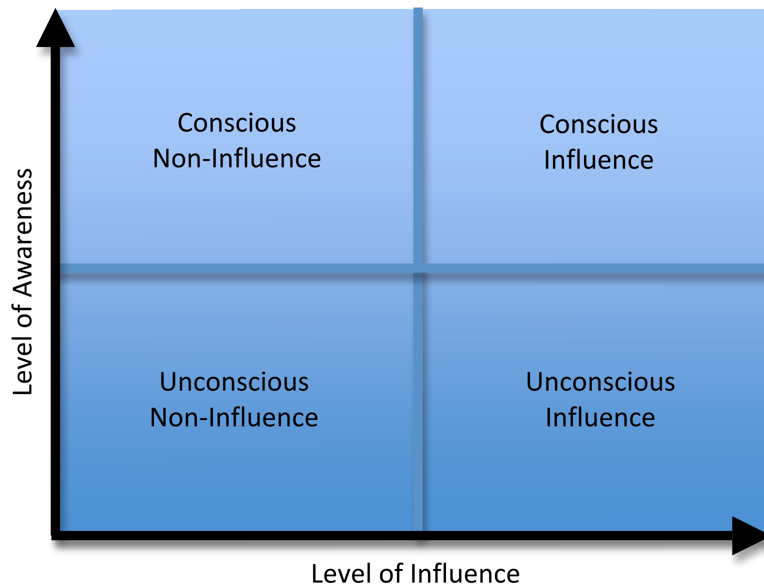
2.5.2.2 Experience of Health

This study illuminated patients' perceptions of their health as being directly influenced by their religion and spirituality. Numerous studies have demonstrated the association of both reduced anxiety and stress[12,13,61,67], and increased hope[20,68] in patients who were more religious and spiritual. However, participants in our study described an overall gestalt of better health that they perceived was attributed to their religion and spirituality.

2.5.2.3 Stages of Religious and Spiritual Influence (SORASI)

An important theme that emerged was the participant's ways of knowing the role religion and spirituality played in their health care, and in their lives in general. They described religion and spirituality playing a role either consciously or unconsciously. This is similar to the *'Four Stages of Competency'* or the *'Conscious Competence'* model of knowing in which a person moves through the stages of: unconsciously incompetent, consciously incompetent, consciously competent and unconsciously competent.[69,70] In this model, people move through the stages of not knowing they don't know to eventually acting competently without thinking about it. Similarly, this framework could be modified to fit ways of knowing the role religion and spirituality plays in health care with the four stages being: unconsciously non-influential, consciously non-influential, consciously influential, and unconsciously influential (See Figure 2-3).

Figure 2-3 Stages of Religious and Spiritual Influence (SORASI)



We termed this framework the 'Stages of Religious and Spiritual Influence ' (SORASI). In other words, a person can range from not being aware that religion and spirituality has any role (the early stages of forming a personal religious and spiritual framework) to being aware that they do not have a framework in which religion and spirituality impact their health care, to having a formed religious or spiritual framework and consciously realizing how it affects their health and decisions, to their religion and spirituality becoming a part of who they are and so unconsciously affecting their health care decisions and overall health. Many with a formed religion and spirituality described the *unconscious influence* stage, stating that their religious and spiritual beliefs were just part of who they were, and thus, questioned how could it not affect their decisions and health. This model could help to explain why religion and spirituality may be directive for some patients (conscious influence) and guiding in other cases (conscious influence

or unconscious influence).

2.5.3 Barriers and Facilitators

Participants identified numerous factors that they thought could be barriers or facilitators to the integration of their religious and spiritual beliefs into their health care. Ultimately, these factors reflected aspects of the patient-physician relationship and it was through this relationship that participants perceived their religious and spiritual beliefs could be integrated.

2.5.3.1 Barriers

The four major barriers identified by participants were time, discomfort, importance and view of roles. Similar to prior studies[20,27,37,52,71,72,73,74] time was identified as the most common barrier. However, new to this study, participants expressed the perception that the family physician was rushed or as having no time and hence was a major barrier in addressing their religious and spiritual beliefs. This would imply that even if family physicians do not themselves feel rushed for time, if patients perceive there is a time limitation to the visit, they will not broach the topic themselves. With the move of most family physicians to different models of care that remunerate time and visits differently, there is a question of whether time is still a major barrier from the physician's perspective. This would be an area for further exploration.

Participants also identified the family physician's discomfort as a major barrier. New to

our study was the participants' exploration of factors that influenced the origin of physicians' discomfort. They described two aspects. The first was the knowledge level or educational training of family physicians. They suggested that the lack of medical education on religion and spirituality results in a lack of knowledge and skill in assessing and integrating religious and spiritual beliefs into health care. This concept of lack of training has been identified repeatedly in prior studies as a major challenge.[10,18,20,73,74,75] The second aspect was physicians' personal beliefs. The association between physicians' personal religious and spiritual beliefs and outcomes had been studied previously.[27,37,39,48,74] However, what is unique to this study is the acknowledgement that patients' perception of the family physicians' discomfort is possibly the more important consideration rather than family physicians' personal religious and spiritual beliefs or discomfort itself.

Participants identified family physicians' views on the importance of religion and spirituality in health care as a potential barrier. While prior studies list similar concerns,[73,76] an important finding from this study is that participants based this perception on past experiences in which family physicians did not address the role their religion and spirituality may have played.

In general, it was the participants' perceptions that guided whether they viewed family physicians as being open to discussing their religion and spirituality and integrating it into their health care. Participants described this perception as an overall gestalt of

behaviours and signs that they observed over time. To our knowledge, there are no studies, exploring from the patient's perspective, the openness of physicians to discussing patients' religion and spirituality.

2.5.3.2 Facilitators

Participants identified knowledge and behavioural factors as potential facilitators to family physicians asking patients about their religious and spiritual beliefs. Unique to our study, participants expressed that not only do family physicians need to know about patients' religious and spiritual views but also need to know and understand the mind-body-spirit connection. Participants felt that it was through the mind-body-spirit connection that their religious and spiritual beliefs could truly be integrated into health care and this was considered to be addressing the whole patient.

Physician behaviours were the second facilitator identified by participants. Participants emphasized that family physicians should inquire only when appropriate and this should be done in the context of a patient-physician relationship. Asking outside of a formed patient-physician relationship could be threatening and counter-productive. It was equally important how the family physician asked patients. This included being present, open and non-judgmental. These are all traits that are aspects of the patient-physician relationship and considered part of the patient-centered model of care.[77] What was unique was the connection participants made between the barriers, facilitators and the patient-physician relationship.

2.5.3.3 Patient-Physician Relationship

The patient-physician relationship is a concept that has been described and utilized in family medicine for many years. The patient-physician relationship involves forming a therapeutic relationship in which trust, openness and time are viewed as being crucial to the formation of the relationship. Participants described how forming a solid patient-physician relationship increased trust in family physicians and opened the door to discussing and integrating patients' religious and spiritual beliefs. This concept is not new, the patient-physician relationship being the bedrock of the 'Patient Centered Clinical Method'.[77] However, what is unique is that participants emphasized the importance of the patient-physician relationship as foundational to the successful integration of patients' religion and spirituality in their health care decisions and experience of health.

2.6 Strengths and Limitations

Strengths. The strengths of our study include the inclusion of a broad range of demographics including sex and age through the selection process. In addition, special attention was made to select participants with a broad range of self-identified religious and spiritual beliefs including Christian, non-Christian, non-identified spirituality and atheist (See Figure 2-1). This study looked specifically at the perspective of patients and their perceptions and desires on the integration of their religious and spiritual views in their health care. This study is the first, to the best of our knowledge, to interview Canadian patients and revealed new findings from patients' perspectives that have not

previously been described in the literature.

Limitations. This study was limited by the geographical location of participants being only Kitchener-Waterloo, Stratford and London, Ontario. Thus, the results may not be generalizable to other populations. There may potentially also be a selection bias for participants who would naturally desire discussing their religion and spirituality with their family physicians.

2.7 Conclusions

Participants described their religion and spirituality as being along a religious-spiritual spectrum in which religion and spirituality were connected. It was within this spectrum that they experienced a framework that integrated the physical, social and spiritual – termed as the mind-body-spirit connection. Thus, participants experienced their religion and spirituality as interfacing with their health care through the mind-body-spirit connection. Their religious and spiritual beliefs affected their health care decisions as well as their experience of health. This was at times at a conscious level and at other times at an unconscious level and fit into a framework that we termed 'Stages of Religious and Spiritual Influence' (SORASI). SORASI may be a tool to help family physicians understand the role religion and spirituality plays in the health care of a patient and thus, when and how to discuss the patient's religious and spiritual beliefs. Major barriers such as time, discomfort, physicians' beliefs on the importance of religion and spirituality and view of their roles were identified. As well, two major facilitators to

discussing religion and spirituality with their family physicians were identified including family physician knowledge of the mind-body-spirit connection and a strong patient-physician relationship. These two elements were identified as key factors to increase discussions of patients' religion and spirituality into their health care visits with their family physician.

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Chapter 3: Family Physicians' Practices in Discussing Patient's Religion and Spirituality

3.1 Introduction

Religion and spirituality have gained increased importance in medicine and health care in the last 3 decades. Sir William Osler, often viewed as the grandfather of medicine, wrote, *"Nothing in life is more wonderful than faith - the one great moving force which we can neither weigh in the balance nor test in the crucible."* [1 p1470] Publications reflect how many physicians continue to support Sir William Osler's view that religion and spirituality are a crucial part of the person and of medicine.[2,3,4]

3.1.1 Physician Views on Religion and Spirituality

In the past two decades, studies have reported that the majority of physicians subscribe to religion and/or spirituality[5,6,7,8,9] and were twice as likely to subscribe to spirituality than to religion.[5,6,9] While the studies have suggested that physicians, in general, subscribe less to religion and/or spirituality than patients,[6,8,10] the proportion of family physicians subscribing to religion and/or spirituality tended to be fairly similar to that of the general public.[6,11,12]

Prior studies have reported that the majority of physicians believed that religion and spirituality could have a positive effect on the physical and mental health of patients.[4,5,13,14,15,16] This positive effect was especially seen with serious or life-threatening illnesses.[15,17,18] Studies indicated that the majority of physicians also

believed religion and spirituality were sources of support for patients and their families.[5,14,19,20,21] Curlin et al. found that physicians differed from the general public in that they were twice as likely to not rely on their religion and spirituality when coping with major problems in life[6], suggesting that despite the increased recognition of the importance of religion and spirituality in medicine, there was still some skepticism amongst some physicians about the exact role it played in their personal experiences of illness.[22]

The literature has indicated that the majority of physicians, nonetheless, believed they should ask and be aware of patients' religious and spiritual views in the context of their health care[4,9,15,16,23,24,25,26] and that asking patients about their religion and spirituality was an important part of their role as physicians.[15,18,24] Studies with medical learners have reported that 80% of medical students[27] and 90% of medical residents agreed that physicians should ask patients about their religion and spirituality and that this was considered being patient-centered[25]. Family medicine physicians and residents appeared to be more aligned with the concept of asking patients about their religion and spirituality compared to other specialties.[25,26] Nevertheless, some clinicians were concerned with the potential ethical and personal conflicts such questioning may cause[28,29] and felt physicians should maintain absolute religious or spiritual neutrality, in other words, a separation of church and medicine.[29,30]

Prior studies have found that physicians supported asking about patients' religion and

spirituality 4-5% of the time with minor illnesses, 43-45% of the time with major illnesses and 69-77% of the time during death and dying situations.[4,13,14,21,26,31,32] Research has also indicated that the majority of physicians supported or encouraged patients' own religious and spiritual beliefs[24,33] and believed that this support enhanced the patient-physician relationship.[14,15,34] The literature also revealed that physicians' personal religious and spiritual beliefs often influenced their beliefs and behaviours towards patients regarding their health care. Numerous studies reported that physicians who believed more strongly that religion and spirituality were important and affected health, were more likely to attitudinally support the practice of knowing and engaging in conversations about patients' religious and spiritual beliefs.[5,7,19,25,32] Armbruster et al. found that physicians who personally believed religion and spirituality were important, were more likely to talk to patients about patients' religious and spiritual beliefs if patients mentioned them to the physician.[14] Physicians who subscribed to religion were also more likely to report a conflict of their personal religious beliefs with patient decisions and medical options offered and noted that these conflicting beliefs affected their treatment plan.[5]

3.1.2 Barriers

Barriers that physicians perceived to integrating religion and spirituality into health care included time, relevance to medicine, importance to medicine, and discomfort with asking about religion and spirituality. One of the more common barriers cited in the literature was physician discomfort which was considered to be multi-factorial.[4,7,14,18,32]

One factor hypothesized to affect physician comfort level with asking was the physicians' personal beliefs. Some studies observed that physicians who believed religion and spirituality were important were more likely to support the idea of engaging in conversations with patients.[16,32,35,36,37,38] Other research has noted that some physicians believed asking about religion and spirituality could be considered unethical because they ran the risk of projecting or imposing their own beliefs onto the patient.[4,26,32,39,40] A few physicians even viewed asking about patients' religion and spirituality as potentially overstepping ethical boundaries[18,41] and an abuse of power[29]. Studies that evaluated different factors influencing physicians' attitudes about talking to patients about their religious or spiritual beliefs found that physician beliefs[42] and comfort level[7] appeared to be important, suggesting that physician beliefs and discomfort with talking to patients about their religion and spirituality may be connected.

To date, studies have suggested that physicians' personal beliefs and physician training have influenced physicians' comfort level with asking about religion and spirituality. Chibnall et al. examined a number of barriers to asking about religion and spirituality including 'interpersonally uncomfortable'; physicians' beliefs that it was not their job; physicians' belief that it was not important to health; and physician specialty. The variable 'interpersonally uncomfortable' was a combination of the responses to three separate questions that loaded as one factor in a factor analysis of the potential barriers.[7] They found in their multivariable analysis that only the variable

'interpersonally uncomfortable' was significantly associated with asking. In addition, no prior studies have attempted to specifically examine which factors were most significant in influencing physicians' level of comfort or discomfort. Ellis et al. reported that in most instances, patients felt they were able to tell which physicians were comfortable with discussing religion and spirituality as soon as they entered the room and that the perceived comfort or discomfort of the physician influenced whether patients talked about their religion and spirituality.[36]

Most studies that reported barriers performed bivariable analysis and did not look at all the factors together in their analysis. Only two studies, one by Chibnall et al. and the other by Koenig et al. performed multivariable analysis. Chibnall et al. demonstrated that the factor 'interpersonally uncomfortable' remained significant in terms of physicians engaging with patients about religion and spirituality, and Koenig et al. reported physicians' personal beliefs affected their feelings about whether or not they should discuss religion and spirituality.[7,42]

Given that these barriers (except for time) were based on physician beliefs, there were suggestions that these barriers could be remedied through education and training. Authors have suggested physician discomfort could stem from the lack or type of training physicians received.[4,7,9,18,26,32,40,41,43,44] The medical educational curriculum has been thought to de-emphasize and devalue religion and spirituality: *"We have to master the medicine part, and there is so much emphasis on it that this fact turns all else into*

fluff, and spirituality is included in that."[44 p421] Furthermore, by the nature of the selection of students for medical training, there could be a selection bias for people who agreed with the scientific way of knowing. Thus, the selection process and medical training may be biased towards an increased lack of spiritual awareness or inclination in physicians.[38]

3.1.3 Summary

While prior research has identified several perceived barriers to discussing religion and spirituality with comfort level cited as one of the more common barriers, the lack of any meaningful Canadian data on physician perspectives, and the lack of correlation of specific factors that might influence comfort level led to the topic of this study. Therefore, the purpose was to examine family physicians' perceived barriers and to determine if there were associations between these barriers and asking patients about their religion and spirituality. Identifying the important barriers perceived by family physicians may help to address the barriers to reintegrating religion and spirituality into health care.

3.2 Study Question & Objectives

Question: What are family physicians' behaviours in terms of asking patients about their religious and spiritual beliefs in the medical office encounter?

Primary Objective:

1. To study the reported behaviours of family physicians in inquiring about patients' religious and spiritual beliefs within the context of their health care.
2. To investigate if certain demographics, beliefs and health system factors are associated with family physicians' behaviours in terms of asking about patients' religious and spiritual beliefs within the context of their health care.

Secondary Objectives:

1. To explore barriers family physicians identify in asking patients about their religious and spiritual beliefs.
2. To further examine the barrier of physicians' comfort level to see what variables might be associated with comfort level.

3.3 Methods

3.3.1 Design

This study was a cross-sectional survey of family physicians on their behaviours in asking patients about their religious and spiritual beliefs, and factors potentially associated with those behaviours.

3.3.2 Sample

The sample was the complete roster of family physicians and general practitioners actively practicing in the Kitchener-Waterloo (KW) area in 2009, excluding the investigator. The Ontario Medical Association and the College of Physicians and Surgeons of Ontario provided a complete list of all practicing family physicians. Two additional family physicians that had recently opened up practice were added to the list.

The initial number was 158; however, only 155 surveys were mailed out. Excluded physicians were the investigator, one physician who was known to be retired for a number of years, and one physician who was known to be away on a sabbatical during the study time period.

3.3.3 Questionnaire Development

A self-administered questionnaire was designed to assess the views of family physicians on asking their patients about their religious or spiritual beliefs in the office visit, their comfort level with asking, their views on the importance of knowing a patient's religious or spiritual beliefs, and barriers to asking patients about their religion and spirituality (See Appendix 3-2). An initial literature search revealed there were no validated surveys of physicians that examined integrating religion and spirituality into the family physician office visit and comparing to potential barriers. There were five main studies by Chibnall et al., Curlin et al., Ellis et al., Luckhaupt et al. and Monroe et al. that surveyed physicians on the topic of spirituality and health care.[4,7,25,26,33] Outcomes in these studies were attitudes about asking patients about religious or spiritual beliefs. Additionally, Chibnall et al., Curlin et al. and Ellis et al. also asked about physician behaviours.[4,7,33] The current study was similar to Chibnall et al., Curlin et al. and Ellis et al. in that we focused on physicians' behaviours regarding asking patients about their religious or spiritual beliefs. The study was also similar to Curlin et al. and Ellis et al. in that our primary outcome measure was how often physicians asked patients about their religion and spirituality. Similar to Chibnall et al. this study used a 5-point Likert scale. The current study differed

from Chibnall et al. who had a combined outcome measure (that included asking, taking a spiritual history, routinely offering to discuss, taking a spiritual history in a health crisis, offering to discuss a patient's religion in a health crisis) that was answered with dichotomous yes or no options. This study also differed from Ellis et al. who inquired about whether family physicians asked patients about specific spiritual topics in more than 10% of the encounters in multiple care settings (outpatient, inpatient and nursing home).[4] Furthermore, Chibnall et al. and Curlin et al. focused solely on religion,[7,33] Ellis et al. focused on spirituality[4], whereas the current study included both religion and spirituality. The study's objective was most similar to Chibnall et al. whose primary objective was to identify physician beliefs about religion and medicine that predict attention to religious issues in the clinic[7], but differed slightly from Curlin et al. whose primary objective was to examine the relationship between physicians' religious characteristics and their self-reported behaviours regarding religion and spirituality in the clinical encounter.[33] This study also differed from Ellis et al. whose purpose was to assess family physicians' spiritual well-being, perceived barriers to discussing spiritual issues with patients and determine how often they discussed specific spiritual topics with patients.[4] Ellis et al. also did not compare frequency of discussing spiritual matters with patients with physician factors or identified barriers.

Survey questions for this study were based on a literature search and the qualitative portion of this thesis. The main objective was to study whether or not family physicians asked their patients about their religious and spiritual beliefs and how certain

demographics, beliefs and health system factors were associated with this outcome. Based on the previous qualitative study (Refer to Chapter 2), patients identified barriers such as the comfort of the physician, the beliefs of the physician, time, and training. There was no single study that looked at all these components in the context of a family physician's office encounter. Thus, a new questionnaire was developed that incorporated all of these factors.

Asking about religious or spiritual beliefs: Chibnall et al., Curlin et al. and Ellis et al. inquired whether physicians asked their patients about their religious or spiritual beliefs. Chibnall et al. and Curlin et al. used a yes or no dichotomous scale while Ellis et al. used a 4-point Likert scale they created (0%, 0-1%, 1-10%, >10%). Curlin et al. also inquired about how often physicians asked about religious and spiritual beliefs in certain clinical situations and used a 5-point Likert scale ranging from never to always.[33] Ellis et al. inquired about whether family physicians asked about specific spiritual topics in three different clinical settings.[4] The studies by Monroe et al. and Luckhaupt et al. surveyed physicians about their beliefs but not directly about their behaviour in asking patients about their religious and spiritual beliefs. Similar to Curlin et al., the current study asked family physicians about their behaviours in asking patients about their religion and spirituality using a 5-point Likert scale.

Comfort Level: Few quantitative surveys have asked how comfortable a physician was in asking patients about their religious or spiritual beliefs. Chibnall et al. asked if physicians

were uncomfortable with addressing religious issues and combined this question with other variables in their analysis under the term 'interpersonally uncomfortable'.[7] Curlin et al. directly asked physicians if they felt comfortable discussing a patient's religious and spiritual views, and this was in the context of a patient broaching the topic.[7] Ellis et al. listed discomfort with the subject matter as a barrier.[4] Our study assessed comfort level in general as its own factor when discussing religious or spiritual beliefs with patients.

Importance: Chibnall et al. asked whether knowing a patient's religious affiliation was important[7] while Curlin et al. asked whether it was appropriate to ask patients about their religion.[33] Luckhaupt et al. and Monroe et al. asked whether physicians should be aware of a patient's religious or spiritual beliefs.[25,26] Ellis et al inquired whether spiritual well-being was an important component of good health.[4] Similar to Chibnall et al., Monroe et al. and Luckhaupt et al., we chose to reflect on whether or not it was important for a family physician to know a patient's religious or spiritual beliefs.

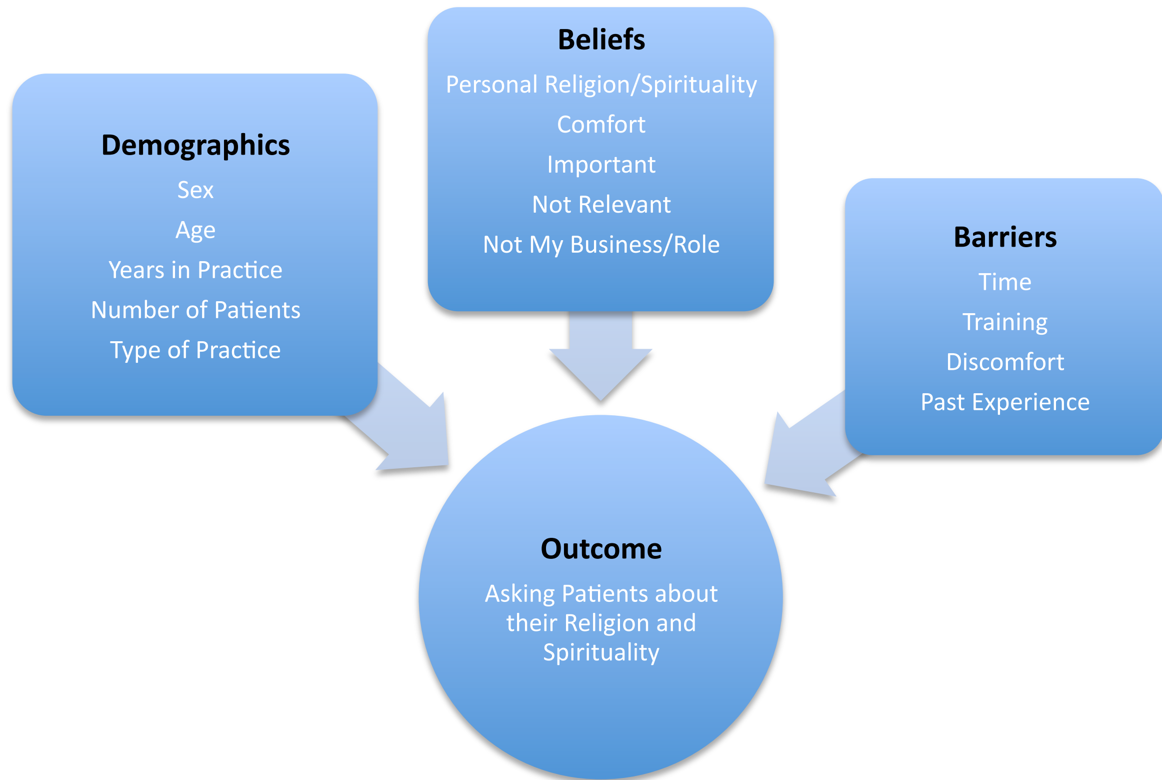
Barriers: The barriers listed on the survey were barriers identified by patients in our previous qualitative research (Please refer to Chapter 2). To confirm theme and item content validity, a literature search of identified barriers to physicians asking about religious or spiritual beliefs was also performed. The main barriers identified in the literature echoed the barriers listed in the previous chapter: time, relevance to medicine, importance to medicine and discomfort with asking about religion and

spirituality.

3.3.4 Questionnaire Items

Items fell into four categories: Demographic Factors, Beliefs, Barriers, and Outcome. Under Demographics, we included sex, age, years in practice, number of patients in their practice, and type of practice. Under Beliefs, we included personal religious or spiritual beliefs, comfort with discussing religious and spiritual beliefs with patients, physicians' beliefs that religious or spiritual beliefs are important to patient care, physicians' beliefs that religious or spiritual beliefs are not relevant to patient care, and physicians' beliefs that religious or spiritual beliefs are not the business or role of the family physician. Under Barriers, we included time, training, discomfort with discussing religious or spiritual beliefs with patients, and past experience. The Outcome measured was whether or not a physician asked about religious or spiritual beliefs. See Figure 3-1 for the Framework of Analysis.

Figure 3-1 Framework of Analysis



3.3.5 Validity Testing

3.3.5.1 Face Validity

The survey was piloted with nine Family Physicians for face validity. Participants were informed of the purpose of the study and asked to comment on construct, readability, understandability, and time needed to complete.

Feedback was given on the Likert options given for questions #1, #2 and #5. Originally question #1 regarding asking patients about their religious or spiritual beliefs included five options (Never, Rarely, Sometimes, Often, Always) similar to Curlin et al.[33] Respondents suggested changing “Often” to “Most of the Time” as this term was more

understandable. The term “Often” could be interpreted as too similar to “Sometimes”.

Question #2 regarding if physicians were comfortable discussing or asking patients about their religious or spiritual beliefs, was a 4-point Likert scale similar to Curlin et al., worded as “Not at all”, “A Bit”, “Quite”, “Completely”.[33] Suggestions were to substitute “A Bit” with “Somewhat” and “Quite” with “Very”. The pilot group respondents thought these words would be more familiar to physician respondents.

For Question #5, regarding if physicians thought it was important to know a patient’s religious or spiritual beliefs, the majority of the pilot group respondents felt a third option “Sometimes” should be added to the existing “Yes” and “No” options. Feedback was that adding a third category would be the realistic response of many physicians, as this questions does not necessarily elicit a yes or no answer.

Overall, the nine pilot group respondents thought the survey was well formatted and written, and that the questions were understandable and relevant to the study topic. The survey was considered very appropriate in length, and this short length was viewed as potentially increasing the chance that busy family physicians would complete the survey. They thought the relationship and importance of the questions to the topic of study was evident and self-explanatory. With the suggested changes, they considered the survey was easy to understand and complete. The suggested changes were made to the final version before it was mailed out.

3.3.5.2 Content Validity

Table 3-1 is a content validity matrix for Question #3 regarding barriers to family physicians in asking their patients about their religious or spiritual beliefs. The domains list the barriers that were identified as themes in the *a priori* qualitative study. One aim of the quantitative survey was to determine if the barriers perceived by patients were barriers that family physicians would report experiencing. The items listed under barriers each assessed one of the domains listed. Two items were created for the domains "Comfort Level" and "Not Part of Medicine". The first item was created because in the qualitative interviews, comfort level was referred to as discomfort for personal reasons and also discomfort in the way the patient would react. For the domain "Not Part of Medicine", participants thought this question could refer to either not being relevant to their care or not being the business or responsibility of a family physician.

Table 3-1: Content Validity Matrix for Question 3

	Domain			
Barriers Listed in Question 3	Time	Knowledge	Comfort Level	Not Part of Medicine
Time	✓			
Lack of Training		✓		
Personal Discomfort			✓	
None of my business/responsibility				✓
Not Relevant to Care				✓
Past Experience asking about religious or spiritual beliefs			✓	

3.3.5.3 Criterion Validity

In reviewing the literature, there was no study with similar purposes that could be used as a comparison for criterion validity. As Streiner stated, *"In psychiatry, the usual state of affairs is that either no other test exists which taps the same attribute, or the existing ones are inadequate for one reason or another; consequently, criterion validity is either impossible to establish or insufficient."*[45 p146] Thus, for this study, there was no externally validated survey with a similar purpose that could be used to show criterion validity. Therefore, test of construct validity was conducted.

3.3.5.4 Construct Validity

Construct validity was tested on the full sample of respondents by using selected identified barriers from Question #3 as the independent variable and comparing to Question #1 (Do you ask your patients about their religious or spiritual beliefs), Question #2 (Do you feel comfortable asking your patients about their religious or spiritual beliefs), and Question #5 (Do you think a patient's religious or spiritual beliefs is important to know). This construct validity test was conducted to assess confidence in the validity of the items designed for this questionnaire.

Question #1: Do you ask your patients about their religious or spiritual beliefs?

This question was compared to the barrier "None of my business" in Question 3. A two-tailed independent t-test showed a statistically significant negative association ($t = -2.750$, $p = 0.008$). This suggested that those physicians who identified "None of my

Business" as a barrier were less likely to ask their patients about their religious or spiritual beliefs.

Question #2: Are you comfortable discussing or asking your patients about their religious or spiritual beliefs? This question was compared to the barrier of "Personal Discomfort" in Question 3. A two-tailed independent t-test showed a highly statistically significant negative association ($t = -4.976$, $p = 0.0001$). Thus, those who identified "Personal Discomfort" as a barrier were less comfortable asking patients about their religious or spiritual beliefs.

Question #5: Do you think it is important to know a patient's religious or spiritual beliefs? This question was compared to the barrier "Not Relevant to Care" in Question 3. A two-tailed independent t-test showed a highly statistically significant negative association ($t = -3.581$, $p = 0.0001$). Thus, those who identified "Not Relevant to Care" as a barrier were less likely to answer that a patient's religious and spiritual beliefs are important to know.

Thus, for question #1, #2 and #5, the statistically significant p-values demonstrated that questions of similar constructs were highly correlated with each other and increased confidence in the validity of the items.

3.3.5.5 Test/Re-Test Reliability

The questionnaire was subjected to a test re-test reliability process involving 17 participants that included nine Family Physicians and eight Family Medicine Residents. The final modified survey was administered at time 1 and time 2 four weeks later. The test/re-test reliability was calculated (See Table 3-2).

Table 3-2: Cross-Tabulations for Test/Re-Test Reliability

	Number Concordant (N=17)	Percent (%)	Kappa	Significance
Demographics:				
Sex	17	100.00	1.000	0.0001
Age	16	94.12	N/A	N/A
Years in Practice	16	94.12	N/A	N/A
Number of Patients	15*	88.23	N/A	N/A
FHO** Practice Model	17	100	1.000	0.001
Outcome:				
Ask	13	76.47	N/A	N/A
Beliefs:				
Religion/Spirituality	16	94.12	0.767	0.001
Comfort	14	82.35	N/A	N/A
Important	16	94.12	0.875	0.0001
Not Relevant	17	100.00	1.000	0.0001
Not My Business	17	100.00	1.000	0.0001
Barriers:				
Time	17	100.00	1.000	0.0001
Training	17	100.00	1.000	0.0001
Discomfort	17	100.00	1.000	0.0001
Past Experience	17	100.00	1.000	0.0001

*1 person did not answer on the re-test
**FHO – Family Health Organization

In this study, cross-tabulations were used to show the number of times the same value occurred after a period of time (i.e. the same answer was checked off at time 1 and time 2). The same (concordant) values were represented by a percentage. A Kappa statistic represented the degree of concordance removing the influence of chance. The significance level is the possibility such a result could have occurred by chance alone. The test/re-test reliability, as represented by concordance percentages, Kappas and significance, was high for all items.

<u>3.3.6 Variables</u>

3.3.6.1 Outcome

The outcome was how often do family physicians ask their patients about their religious and spiritual beliefs. The response categories were: Never, Rarely, Sometimes, Most of the Times, and Always. The outcome was treated in the analysis as a continuous variable.

3.3.6.2 Factors

Demographics: The variables asked were: Sex (male, female), Age (years), Years in Practice (years), Number of Patients (number), and Type of Practice (solo, family health group, family health network, family health organization, community health centre, teaching, hospital, other). In our analysis, Sex and Type of Practice were treated as categorical, whereas Age, Years in Practice and Number of Patients were treated as continuous variables.

Beliefs: The variables asked were: whether the physician identified with religious or spiritual beliefs (Personal Religion/Spirituality – yes, no), comfort with asking about patients' religious and spiritual beliefs (Comfort – not at all, a bit, quite, completely), belief that it is important to know patients' religion and spirituality (Important - yes, no, sometimes), belief that patients' religion and spirituality were not relevant to health care (Not Relevant – yes, no), belief that religion and spirituality were not the business of the physician (Not My Business – yes, no). Comfort and Important were treated as continuous variables; all others were treated as categorical.

Barriers: The variables asked were: Time (yes, no), Training (yes, no), Discomfort (yes, no) and Experience (yes, no). These variables were all treated as categorical variables.

3.3.7 Data Collection

A modified Dillman method was used to distribute the self-administered questionnaire.[46] This method has been shown to increase response rates to mailed questionnaires[46], which helps to increase the external validity of the study. The survey was mailed to 155 Family Physicians in February 2009. A letter of information accompanied the questionnaire along with a stamped return envelope and separate stamped reply card. Confidentiality of the participant's response was ensured. The principal investigator sent the non-responders a reminder post-card two weeks later, a second full mailing (letter, survey and return envelope) five weeks later and a final reminder postcard nine weeks later.

3.3.8 Data Entry

The primary investigator entered data into an SPSS database using a pre-determined coding system. Accuracy of data entry was tested by checking 15 (10%) randomly selected surveys and double-checking the data entry for mistakes. No mistakes were detected. For the question regarding Barriers, there were a few comments under "other" which were either recoded as an existing barrier or left as an "other barrier". This process was conducted through independent review by two of the investigators (MLP, MS) and discussions to reach a consensus decision. One round of independent categorization and one round of discussion were completed to reach consensus. A total of 10 comments were recoded under existing barriers listed, and the remainder were coded as "other".

3.3.9 Data Analysis

Descriptive results from the questionnaire were summarized in the form of frequency tables and graphs. A framework for analysis was created to help analyze the data (See Figure 3-1). In our framework, factors from the questionnaire were divided into *demographics*, *beliefs,* and *barriers*, all of which were hypothesized to affect the outcome.

Bivariable analyses were carried out using two-sided t-tests for categorical independent variables with two levels, and one-way ANOVA statistical analysis for categorical independent variables with greater than two levels to assess the associations between

these independent variables and the outcome variable (continuous variable with a 5-point Likert scale). Multivariable analysis was conducted using multiple linear regression comparing the outcome with Age, Sex and any independent variables that were statistically significant in the bivariable analysis. Variables were considered statistically significantly associated with the outcome if the p-values were less then 0.05.

A secondary analysis was performed that compared the variable comfort in Question 2 (that was answered using a 4-point Likert scale) with those variables that were statistically significant in the bivariable analysis. Two-sided t-tests and two-way ANOVA statistical analyses were used to assess for associations between comfort and these variables. Variables were considered statistically significantly associated with Comfort if the p-vales were less than 0.05.

3.4 Results

A total of 155 surveys were mailed to family physicians in the Kitchener-Waterloo area of which 139 surveys were returned for a response rate of 89.7%. Of those who responded, one was returned with a note that stated he had retired and did not wish to complete the questionnaire. The 16 non-respondents were similar to the respondents in terms of sex (See Appendix 3-3).

3.4.1 Descriptive Results

3.4.1.1 Outcome

The outcome variable was whether or not family physicians asked their patients about their religious or spiritual beliefs. The majority (51.8%) answered *sometimes* and 4.4% said *most of the time* (See Table 3-3).

Table 3-3: Physicians Response to Asking Patients about their Religious and Spiritual Beliefs

Response	Frequency N = 137	Percent (%)
Never	9	6.6
Rarely	51	37.2
Sometimes	71	51.8
Most of the Time	6	4.4
Always	0	0

*2 participants did not respond

3.4.1.2 Demographics

Of the 139 physicians that returned the surveys, approximately 40% were female and 60% were male. The age of the participants ranged from 28 to 69 years with a mean of 48.9 years. The physicians had been in practice from 1 to 43 years, with the largest group having spent 20-29 years in practice. The practice sizes ranged from 300-6000 patients with a mean practice size of 1900 patients (See Tablet 3-4). The majority of family physicians identified being in a Family Health Organization (FHO). The different types of practice models can be found in Appendix 3-4.

Table 3-4: Demographics of Respondents

		Frequency	Percent	Mean
Demographics:				
Sex	Female	56	40.3	
	Male	83	59.7	
Age in years*	< 40	29	20.9	48.9
	40 – 49	43	30.9	
	50 – 59	42	30.2	
	≥ 60	25	18.0	
Years in Practice*	< 10	20	14.5	20.8
	10 – 19	36	26.1	
	20 – 29	54	39.1	
	≥ 30	28	20.3	
Number of Patients*	< 1000	14	10.5	1900
	1000 – 1499	24	18.1	
	1500 – 1999	28	21.0	
	2000 – 2499	39	29.3	
	≥ 2500	28	21.1	
FHO Practice Model	Yes	108	77.7	
	No	31	22.3	

*Data captured as a continuous variable but presented in this table as categorical

3.4.1.3 Beliefs

The vast majority of respondents identified having religious or spiritual beliefs (See Table 3-5). Almost half of the participants stated they were *somewhat* comfortable asking patients about their religious or spiritual beliefs. When asked if it is important to know patients' religious or spiritual beliefs, just over a quarter said *yes* and about two thirds answered *sometimes*. Over one half of the family physicians identified the belief that religion and spirituality were *'Not Relevant to Health Care'* as a barrier, and one-fifth believed that asking about patients' religion and spirituality was not their business.

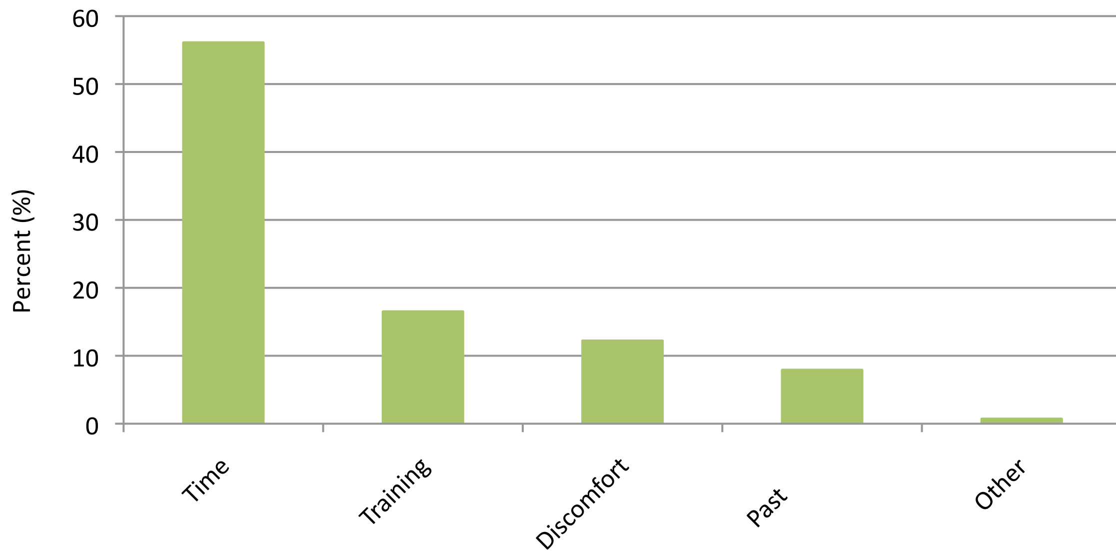
Table 3-5: Frequency Distributions

		Frequency	Percent
Beliefs			
Religion/Spirituality	Yes	112	81.8
	No	25	18.2
Comfort	Not at all	7	5.1
	Somewhat	67	49.3
	Very	47	34.6
	Completely	15	11.0
Important	No	11	8.0
	Sometimes	89	65.0
	Yes	37	27.0
Not Relevant	Yes	69	51.5
	No	65	48.5
Not My Business	Yes	30	22.4
	No	104	77.6
Barriers			
Time	Yes	78	58.2
	No	56	41.8
Training	Yes	23	17.2
	No	111	82.8
Discomfort	Yes	17	12.7
	No	117	87.3
Past Experience	Yes	11	8.2
	No	123	91.8
Other	Yes	1	0.7
	No	133	99.3

3.4.1.4 Barriers

Over one half of the family physicians identified time as barriers. One fifth of the respondents identified training as a barrier, and around one tenth identified discomfort and past experience with asking about religious and spiritual beliefs as a barrier (See Figure 3-2).

Figure 3-2: Barriers Identified by Family Physicians



Under *'Other'*, a few participants wrote comments to further clarify identified barriers. The majority of the comments described specific situations where the physician believed that patients' religious or spiritual beliefs may be relevant to care or situations when they did ask patients about their religious or spiritual beliefs.

3.4.2 Bivariable Analyses:

The framework for analysis used to analyze the data is found in the previously shown Figure 3-1. Each factor (Demographics, Beliefs and Barriers) was compared to the outcome of asking patients about their religious and spiritual beliefs. See Table 3-6.

Table 3-6: Bivariable Analysis of Demographics, Beliefs and Barriers in Relation to the Outcome of Asking Patients about their Religious and Spiritual Beliefs

Question	Response	Mean	Test	Statistic	p value
Demographics:					
Sex	Female Male	2.564 2.524	Two-Sided t-test	t = -0.341	0.734
Age			Pearson Correlation	0.068	0.427
Years in Practice			Pearson Correlation	0.095	0.272
Number of Patients			Pearson Correlation	-0.025	0.773
FHO Practice Model	Yes No	2.528 2.581	Two-Sided t-test	-0.331	0.742
Beliefs					
Physicians' Religion and Spirituality	Yes No	2.600 2.280	Two-Sided t-Test	t = 2.295	0.027*
Comfort	Not at all A bit Quite Completely	1.571 2.348 2.787 3.067	One-Way Anova	F = 14.727	0.0001*
Important	No Sometimes Yes	2.000 2.443 3.000	One-Way Anova	F = 15.423	0.0001*
Not Relevant	Yes No	2.471 2.547	Two-Sided t-Test	t = -0.650	0.517
Not My Business	Yes No	2.200 2.598	Two-Sided t-Test	t = -2.750	0.009*
Barriers					
Time	Yes No	2.592 2.393	Two-Sided t-Test	t = 1.672	0.097
Training	Yes No	2.409 2.527	Two-Sided t-Test	t = -0.701	0.489
Discomfort	Yes No	2.353 2.530	Two-Sided t-Test	t = -1.307	0.202
Past Experience	Yes No	2.909 2.471	Two-Sided t-Test	t = 3.977	0.001*

*Statistically significant

3.4.2.1 Demographics

None of the demographic factors was statistically significantly associated with the outcome.

3.4.2.2 Beliefs

Physicians subscribing to religious and spiritual beliefs was positively associated with the outcome (p = 0.027), indicating that family physicians with self-identified religious and spiritual beliefs were more likely to ask patients about their religious and spiritual beliefs. Similarly, the physician's comfort level was also significantly related to whether or not the family physician asked about religion and spirituality. The post-hoc test demonstrated all comparisons were significant except between the categories of *very* and *completely* under Comfort. The frequency of asking was higher at higher levels of comfort (p = 0.0001), suggesting physicians were more likely to ask patients about their religious and spiritual beliefs when they were more comfortable. Physicians' beliefs in the importance of religion and spirituality were also statistically significantly related to asking patients about their religion and spirituality (p = 0.0001). Post-hoc analysis showed comparisons were significant except for between the categories *sometimes* and *no*. The frequency of asking was higher when the physician's view on the importance of the patient's religious or spiritual beliefs was higher, suggesting that physicians were more likely to ask patients about their religious or spiritual beliefs the more they viewed a patient's religious or spiritual beliefs as important to know. Physicians' beliefs that religion and spirituality were not relevant were not significantly related to asking (p =

0.517); however, the belief that religion and spirituality were *'not my business'* was significantly associated negatively with asking (p = 0.009).

3.4.2.3 Barriers

Time and Training were not statistically significantly related to the outcome. However, Past Experience was statistically significant (p = 0.001). Those who identified Past Experiences as a barrier to asking patients about their religion and spirituality were actually more likely to ask patients about their religious and spiritual beliefs. This association seems counterintuitive.

3.4.3 Multivariable Analysis

Eight factors were included in the multiple linear regression analysis. These included two demographic factors (Sex, Age), four belief factors (Religion and Spirituality, Comfort, Importance, Not my Business) and two barriers (Time, Past Experience). See Table 3-7. Feeling comfortable and belief in the importance of religion and spirituality were both statistically significant in relation to asking about religion and spirituality in the multivariable analysis. Those who identified themselves as being more comfortable were more likely to ask patients about their religion and spirituality. Similarly, those who identified religious and spiritual beliefs to be important were also more likely to ask. Sex and Age remained non-significant in the multivariable analysis. Time was included in the multivariable analysis because it was fairly close to being significant in the bivariable analysis (p = 0.097) and it was the most commonly listed barrier by

patients. However, it also remained non-significant in the multivariable analysis (p = 0.268). A number of factors that were statistically significantly related to asking patients about their religion and spirituality in the bivariable analysis were no longer significantly related to the outcome when analyzed using multivariable analysis. These were Physicians' Religion and Spirituality, Not My Business and Past Experience. However, Past Experience was very close to being statistically significant (p = 0.056).

Table 3-7: Multiple Regression for the Outcome of Asking Patients About their Religious and Spiritual Beliefs

	Beta	p-value
Demographics		
Sex	0.023	0.761
Age	0.021	0.789
Beliefs		
Religion/Spirituality	-0.116	0.138
Comfort	0.400	0.0001*
Important	0.277	0.001*
Not My Business	0.010	0.905
Barriers		
Time	-0.085	0.268
Past Experience	-0.145	0.056

*Statistically significant

3.4.4 Secondary Analysis

A secondary objective of this current study was to further examine the barrier of physicians' comfort level to see what variables might be associated with comfort level. As such, secondary analysis was performed to compare physician comfort with asking patients about their religion and spirituality with the other factors, including Demographic factors (Sex, Age), Beliefs (Religion and Spirituality, Importance, Not

Relevant, Not My Business) and Barriers (Time, Training, Past Experience). In the bivariable analysis, three factors were statistically significantly related to comfort: Importance, Not My Business, and Training. Respondents who believed religion and spirituality were important reported higher comfort levels with asking patients about their religion and spirituality (Table 3-8).

Table 3-8: Bivariable Analysis of Demographics, Beliefs and Barriers in Relation to Comfort

Question	Response	Mean	Test	Statistic	p value
Demographics:					
Sex	Female Male	2.537 2.482	Two-Sided t-test	t = 0.416	0.679
Age			Pearson Correlation	0.138	0.109
Beliefs					
Physicians' Religion and Spirituality	Yes No	2.541 2.400	Two-Sided t-Test	t = 0.945	0.350
Important	No Sometimes Yes	2.546 2.360 2.864	One-Way Anova	F = 6.093	0.003*
Not Relevant	Yes No	2.537 2.422	Two-Sided t-Test	t = -0.895	0.372
Not My Business	Yes No	2.069 2.598	Two-Sided t-Test	t = -3.769	0.0001*
Barriers					
Time	Yes No	2.481 2.482	Two-Sided t-Test	t = -0.007	0.994
Training	Yes No	2.130 2.556	Two-Sided t-Test	t = -3.527	0.001*
Past Experience	Yes No	2.454 2.483	Two-Sided t-Test	t = -0.132	0.897

*Statistically significant

Respondents who listed Not my Business and Training as a barrier were more likely to report lower comfort levels with asking patients about their religion and spirituality.

These three factors were then analyzed through multivariable analysis, and all three remained significant (See Table 3-9).

Table 3-9: Multiple Regression for Factors in Relation to Physician Comfort with Asking Patients About their Religious and Spiritual Beliefs

	Beta	p-value
Beliefs		
Importance	0.171	0.044*
Not My Business	0.252	0.003*
Barriers		
Training	0.227	0.007*

*Statistically significant

3.5 Discussion

In the multivariable analysis, two factors remained statistically significantly associated with physicians asking about patients' religious and spiritual beliefs: physicians' belief in the importance of religion and spirituality and physicians' comfort level. Both deal with physicians' beliefs and not with barriers of time and training, which were also included in this study. It would appear that these barriers could be overcome in the face of commitment and beliefs.

3.5.1 Belief in the Importance of Patients' Religious and Spiritual Beliefs

This study specifically asked family physicians *"Do you think it is important to know a patient's religion and spirituality?"* and demonstrated that family physicians' views on the importance of knowing a patient's religion and spirituality were associated with whether or not they asked patients about their religion and spirituality. While a number

of studies have shown that physicians who viewed religion and spirituality as important were more supportive attitudinally of engaging in discussions with patients about religion and spirituality,[5,19,25,32,42] only three studies commented on how it affected physician behaviour. Armbruster et al. commented that physicians' views on importance affected the behaviour of engaging in conversations if it was raised but did not address physicians asking patients directly.[14] Curlin et al. reported that physicians who were more religious were more likely to address religion and spirituality in the clinical encounter.[33] Chibnall et al. reported no association between physicians' beliefs on the importance of religion and engaging in conversations with patients about their religious beliefs.[7] This study is the first, to our knowledge, to show a direct association between physicians' beliefs on the importance of knowing a patient's religion and spirituality with their behaviour of asking patients about their religion and spirituality.

The purpose of this study was most similar to the work of Chibnall et al. but our results may have differed from their findings for a number of reasons. First, Chibnall et al. surveyed only 78 physicians of which only three were family physicians[7], whereas we surveyed 155 family physicians. Second, Chibnall et al. combined multiple variables into the factor they termed *'interpersonally uncomfortable'* and did not carry out analysis using physician comfort directly.[7] Third, our study focused on Canadian physicians. While Ellis et al. also surveyed family physicians, our results differed from Ellis et al. in that they included residents, faculty and community physicians of which only 53% (57/108) of community physicians responded; inquired about asking only about specific

spiritual topics; used a 4-point Likert scale that was very limited in range; and did not do analyses comparing asking patients about their spirituality and physician factors or beliefs.[4]

3.5.2 Comfort

This study asked physicians directly about their comfort level by asking them *"Are you comfortable discussing or asking your patients about their religious and spiritual beliefs?"* This study identified comfort as a facilitator to asking patients about their religion and spirituality. While Chiball et al. looked at discomfort, it was slightly different from this study in that they did not look directly at comfort or discomfort but looked at what they termed *"interpersonally uncomfortable"*, a category which consisted of three combined variables, one of which was physician discomfort.[7] Ellis et al. only listed discomfort as a barrier, but did not inquire about comfort level or do any statistical analysis of discomfort.[4] Our analysis separated the variables of comfort and discomfort and directly examined physician comfort itself and shows that physician comfort remains significantly associated with asking patients about their religion and spirituality.

Furthermore, prior studies have not explored different factors in relation to physician comfort in order to determine which factors were significantly related. Our secondary analysis reported that there appeared to be three factors affecting physicians' comfort level – training, belief that it is not the physician's business, and belief in the importance of knowing patients' religion and spirituality. These three factors could potentially be

addressed by enhancing medical training in this area, which may have a role in increasing physicians' comfort in asking about religious or spiritual beliefs.

3.5.3 Educational Implications

The literature revealed few studies that provided suggestions on how to practically address physicians' beliefs as a barrier to asking patients about their religious or spiritual beliefs. However, some studies suggested that early exposure in medical education could increase appreciation of different religious or spiritual beliefs and possibly increase the student's comfort level.[47] These could be in the form of didactic classes, but often experiential or small group formats were preferred.[48,49,50,51,52] A few studies have described the initial piloting of programs on the importance of religion in medicine with mostly positive results;[49,50,52,53,54,55] however, these findings were limited by the lack of long-term follow-up and measurement of any effect on learners asking patients about their religious and spiritual beliefs. The more successful programs appeared to use a multi-disciplinary approach, integrating professionals trained in administering spiritual care.[49,53,54,55] Our findings support early exposure and a multidisciplinary approach, and further raise two new areas for focus: why asking about patients' religion and spirituality should be part of the physician's role, and the importance of knowing patients' religious and spiritual beliefs.

In the last decade, there has been a recognition regarding the lack of education regarding religion and spirituality in the medical curriculum. Numerous medical

organizations, medical schools, and even the World Health Organization have integrated religion and spirituality into their listed goals of health education.[56,57,58,59] The main emphasis is on communicating effectively with patients about religious and spiritual beliefs, as well as understanding and incorporating patients' cultural and spiritual contexts.[16] However, there is still much work to be done in developing these programs, with one survey of Canadian psychiatry programs showing minimal exposure to religion and spirituality in the psychiatry curriculum.[60]

3.6 Strengths and Limitations

Strengths. One strength of this study is the inclusion of all family physicians within the Kitchener-Waterloo area and the high response rate. We expanded upon past studies and asked physicians specifically about the barriers listed in the qualitative study (Refer to Chapter 2) and the literature to determine which were the barriers from a family physician's point of view. As well, a multivariable analysis was conducted to determine the association of these Beliefs and Barriers with the outcome of asking patients about their religion and spirituality. Most prior studies conducted only bivariable analysis. Our study is also the first that we are aware of, to survey Canadian family physicians about barriers, to look directly at the concept of physician comfort itself, and to explore factors that physicians may be referring to under the term *'comfort'*.

Limitations. This study was a cross-sectional study and thus cannot comment on a causal relationship. This study was conducted on Kitchener-Waterloo family physicians

and may not be applicable to other geographical areas. Data relied on self-reported information and may have been subject to reporting bias. This study was also limited to the perspectives of family physicians and therefore the results may not be generalizable to other physicians or other primary care health providers such as nurses, nurse practitioners, and physician assistants.

3.7 Conclusions

Our study is unique in identifying the major barriers to asking patients about their religion and spirituality from the perspective of Canadian family physicians. The results revealed two factors that are important to family physicians asking about patients' religion and spirituality: physicians' beliefs on the importance of knowing patients' religion and spirituality and physicians' comfort level with asking about religious and spiritual beliefs. Furthermore, in our secondary analysis, comfort was related to: lack of training, the belief that religion and spirituality was not the physicians' business and the belief that it was not important for physicians to know patients' religion and spirituality. Two significant barriers were different from prior research. Both barriers were physician beliefs that were associated with comfort level suggesting that perhaps the most important factor to address is physician comfort with asking about patients' religion and spirituality. Physician comfort can be addressed through adequate training and education. Introducing multidisciplinary experiential teaching and education modules early in the medical curriculum may help to minimize barriers to family physicians asking patients about their religious and spiritual beliefs in the context of their health care.

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Chapter 4: General Discussions and Integration of Findings

4.1 Introduction

Patients want their family physicians to ask about their religion and spirituality,[1,2,3,4,5] but the vast majority of the time, patients report that family physicians do not ask them about their religion and spirituality.[3,6,7,8,9,10] The current literature indicates that both patients and physicians identify a number of potential barriers to physicians talking to patients about their religion and spirituality within the context of their health care.[4,11,12,13,14,15,16,17,18,19] Addressing these barriers may help increase the frequency of family physicians asking patients about their religious and spiritual beliefs.

4.2 Methods

To help capture the richness and nuances of the topic under study, individual in-depth interviews with patients were conducted, as well as a survey of all family physicians that had an office practice in the Kitchener-Waterloo, Ontario area. The findings from each study are now compared and contrasted to arrive at general themes and suggestions to address the barriers identified in both studies.

4.3 Integrated Summary and Findings

In general there was a desire for the re-integration of religion and spirituality back into health care by patient participants who were interviewed and the majority of family physicians who were surveyed. Both patients and family physicians believed there was

an important role for patients' religious and spiritual beliefs in many instances in health care. However, there seemed to be a disparity between how often patients felt their family physicians asked about their religion and spirituality and how often family physicians reported they asked. Patients and family physicians both identified a number of similar barriers to physicians discussing patients' religious and spiritual beliefs in the office, which will be discussed. Overall, further education and understanding the role religion and spirituality plays in a patient's health care decision and experience of health may help increase family physicians' inquiry of patients' religion and spirituality.

4.3.1 Asking about Religion and Spirituality in Health Care

Many of the patient participants reported that they had not explicitly discussed or explored the role that their religion and spirituality played in their health care with their family physician, despite a desire to do so. A few even mentioned that their family physician appeared too busy or not interested in those details of their lives. This hindered patients in sharing how their religious or spiritual beliefs potentially affected their health care. In contrast, the majority of family physicians reported '*rarely'* or '*sometimes'* to asking patients about their religion and spirituality. This suggests that family physicians may be over-reporting or overestimating how often they ask patients about their religion and spirituality and may be missing opportunities to engage in such discussions with their patients.

While patients expressed a great interest in discussing their religion and spirituality, they

also believed that family physicians should ask based on the situation or circumstances and not necessarily at every visit. This implies that the weight patients place on religion and spirituality differs depending on the health care situation; in some situations it may be important to address, while in others, it may not. This may make it difficult for family physicians to determine in which health care situations they should ask about religious and spiritual beliefs.

4.3.2 Importance of Religion and Spirituality in Health Care

Patient participants identified that their religion and spirituality were important in their health care decisions and in their experience of health. They felt that it was through the mind-body-spirit connection that their religion and spirituality affected their health care. Many studies have discussed the importance of the mind-body-spirit connection in medicine, and how physicians need to understand the role religion or spirituality plays in the health of patients.[4,20,21,22,23] Patient participants felt that family physicians did not have an adequate appreciation or understanding of the mind-body-spirit connection and the importance this carries in the health care of patients. Potentially through early exposure and education in medical training regarding the mind-body-spirit connection, the relationship of religion and spirituality to health can be recognized, acknowledged and understood to be important in patients' health care.

In terms of patients' health care decisions, religious and spiritual beliefs often acted as a guide at an unconscious or conscious level. A framework was developed to assist in

understanding the influence of religion and spirituality on health care decisions termed the *'Stages of Religious and Spiritual Influence'* (SORASI). This framework may be helpful to family physicians in understanding the role religion and spirituality plays in the health care of the patient, and thus, in which health care situations it would be more important to address the patients' religion and spirituality. In this framework, the influence of religion and spirituality can be at four different levels. The first two stages are *unconscious non-influence* and *conscious non-influence*. In these stages, there is not a formed religious or spiritual belief that influences the specific health care decision. In the first stage, the patient is not aware that there is no influence versus the second stage in which the patient is consciously aware that their religions and spiritual beliefs do not influence this specific health care situation. The third and fourth stages are *conscious influence* and *unconscious influence*. In these two stages, the patients' religious and spiritual beliefs affect their health care with the former stage being at a conscious level and the latter being at an unconscious level. The *unconscious influence* stage was often described by patient participants as just being part of who they are and so influencing everything they do without even thinking about it.

The SORASI framework may help to determine when to address patients' religion and spirituality. Patients in the *conscious influence* stage would be natural candidates to address how their religious and spiritual beliefs influence their health and health care. A patient in the *unconscious influence* stage would be an individual for whom understanding their religion and spirituality would help the family physician better

understand the patient's health experience and health care decisions. A patient in the *unconscious non-influence* stage would be similar to the pre-contemplative stages of change, and thus, may be someone whose religion and spirituality would not be an important aspect of their health care situation at the present time. The *conscious non-influence* stage may be a more challenging situation in which the patient might be exploring and developing their religious and spiritual framework, in which case, it may be more beneficial to refer them to a trained religious or spiritual leader. The most difficult aspect in using the SORASI framework may be determining which stage a particular patient is in for a particular health care situation. It would also be helpful to remember that the same patient may be in different SORASI stages for different health care situations and that stages may fluctuate over time.

The majority of family physicians reported that it was sometimes important to know a patient's religious and spiritual beliefs. This complements the patients' beliefs that family physicians should ask them about their religious and spiritual beliefs in certain situations. The SORASI framework would also support a situational approach to discuss religion and spirituality. The SORASI framework may also help to guide how to ask and which questions would be important in regards to determining the degree of influence patients' religious and spiritual beliefs may have in their health care decision-making.

Thus, by understanding the mind-body-spirit connection that patients ascribe to, and utilizing the SORASI framework, family physicians may better understand the

importance of religion and spirituality in their patients' health care.

4.3.3 Barriers

The identified barriers to family physicians asking patients about their religion and spirituality were relatively similar between patients and family physicians in the two studies. The major barriers identified by patients and family physicians were: physician comfort level; views on the importance of religion and spirituality; and views on the role of family physician with respect to religion and spirituality in health care. However, patients also identified time as a major barrier while family physicians did not. This would imply that although physicians did not view time was a barrier, patients perceived family physicians' *"busyness"* as a reason they do not ask patients about their religion and spirituality. Thus the mere perception of the family physician being too busy could hinder discussions of religion and spirituality in the context of the patient's health care.

Noteworthy, both patients and family physicians reported that physician comfort was an important barrier to address. This suggests that comfort level may be the most important barrier to address in order to increase family physicians asking patients about their religion and spirituality. There was slight nuanced difference between the patients and physicians. While patients saw comfort level as a separate and distinct barrier, family physicians identified comfort as related to three factors: training, physician beliefs on the importance of knowing patients' religion and spirituality, and physician beliefs that knowing patients' religion and spirituality was not the role of the family

physician. The family physicians' view that discomfort encompassed these three factors would suggest that by addressing the lack of medical training, the importance of religion and spirituality to patient health care, and the role of the physician in addressing religion and spirituality relevant to health care will help to increase physician comfort with asking patients about their religion and spirituality.

4.3.4 Facilitators

Patients described how physician awareness of the mind-body-spirit connection and a strong patient-physician relationship were facilitators to discussions about religion and spirituality with their family physician. One could suggest that family physicians who have a good understanding of the connection between the mind, the body and the spirit, as well as strong patient-physician relationships may also feel more comfortable asking their patients about their religion and spirituality. Patient participants in this study felt that acknowledging the mind-body-spirit connection by discussing their religion and spirituality was addressing them as a whole person. Addressing the whole person and strong patient-physician relationships are both part of the patient-centered model of care.

Studies have examined the movement in medicine towards a patient-centered model of care. Being patient-centered includes asking patients about their context in which their health care is embedded. Understanding the context helps physicians better understand patients' worlds, and thus, better understand their experience of health and health care

decisions. This includes asking about patients' religious and spiritual beliefs and how their beliefs affect their health and health care.[15,24,25,26,27] Patient participants in this study similarly felt that the patient-centered model of care was a facilitator to encouraging discussions of patients' religion and spirituality. Furthermore, a strong patient-physician relationship was viewed as foundational and served as the interface between religion and spirituality and medicine.

4.3.5. Role for Medical Education

Both patients and family physicians identified the current medical training that physicians receive as a barrier to physicians feeling comfortable discussing religion and spirituality with their patients. Specifically they identified the lack of training and exposure to religion and spirituality in the health care context. Some authors suggest that early exposure to the concepts of religion and spirituality in medical training is crucial to influencing the attitudes of physicians in regards to the role of religion and spirituality in medicine.[14,28] Early exposure and education could potentially increase their appreciation about the role of patients' religion and spirituality as well as possibly increase physician comfort level with these discussions.[28] The family physicians responses suggest that increased comfort level includes not only enhanced medical training, but also physician beliefs on the importance of religion and spirituality in health care as well as assuming a role for asking about religion and spirituality. While there are reports of curriculum being developed,[29,30,31,32,33,34,35] there have not been any studies, to our knowledge, that have explored specific areas to be addressed in the medical

curriculum to increase physician comfort with discussing religion and spirituality in the health care setting.

Medical education could also benefit from a multi-disciplinary approach that includes various professionals in teaching religion and spirituality in health care. A few authors have reported pilot projects on multi-disciplinary approaches to teaching religion and spirituality in medicine and reported positive feedback from learners.[30,31,32,35]

Furthermore, given that family physicians identified personal beliefs and past experiences as influencing their behaviour of asking patients about religion and spirituality, there appears to be a personal or experiential component. This could suggest that religion and spirituality would be more amenable to experiential learning opportunities versus didactic teaching settings. Indeed, a number of authors have reported preference by learners for experiential small-group formats in which time was allotted for discussion in order to explore the topic more deeply.[29,31,34,36,37] Thus, education aimed at increasing physicians' comfort with talking to patients about their religion and spirituality should incorporate the following components: experiential small-group education sessions, a multi-disciplinary team, addressing the importance of religion and spirituality to patients' health care and the important role physicians can play.

4.4 Conclusion

The collective findings of the qualitative and quantitative studies suggest that patients and family physicians are interested in re-integrating religion and spirituality back into health care. Enhancing family physicians' appreciation of the mind-body-spirit connection and use of a framework (such as the SORASI framework) for understanding the influence religion and spirituality may have on patients' health care decisions is recommended. This may further family physicians' understanding of the important role religion and spirituality plays in patients' health care. The common barrier identified by patients and family physicians was physician comfort level. This embodied three components: lack of medical education, physicians' beliefs on the importance of religions and spirituality to health care, and the physicians' beliefs on the role of the family physician in addressing religion and spirituality. The barrier of physician comfort level can potentially be overcome through educational exposure to religion and spirituality early in a family physician's medical education, and allow family physicians and patients to have increased discussions on the role of religion and spirituality in the patient's health care. Medical educators and curriculum planners will have an important role in aiding the re-integration of religion and spirituality back into health care.

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Appendix 2-1 Ethics Approval for Qualitative Project

Office of Research Ethics

The University of Western Ontario
Room 00045 Dental Sciences Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. J.B. Brown
Review Number: **11629E** **Revision Number:**
Protocol Title: Patients views on discussing their personal or spirtual beliefs with their family physician
Department and Institution: Family Medicine, University of Western Ontario
Sponsor:
Ethics Approval Date: September 16, 2005 **Expiry Date:** June 30, 2006
Documents Reviewed and Approved: UWO Protocol, Letter of Information & Consent, Advertisement
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted expedited approval to the above named research study on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

This approval shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:
a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. John W. McDonald
Deputy Chair: Susan Hoddinott

Ethics Officer to Contact for Further Information			
☒ Karen Kueneman	☐ Janice Sutherland	☐ Susan Underhill	☐ Jennifer McEwen

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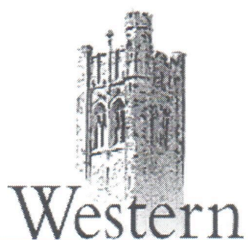
cc: ORE File
Faxed: Y / N

UWO HSREB Ethics Approval
2005-09-09 (HS-EXP)
11629E
Page 1 of 1



Office of Research Ethics

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Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. J.B. Brown
Review Number: **11629E** **Revision Number:** **1**
Protocol Title: Patients views on discussing their personal or spirtual beliefs with their family physician
Department and Institution: Family Medicine, University of Western Ontario
Sponsor:
Ethics Approval Date: July 7, 2006 **Expiry Date:** June 30, 2007
Documents Reviewed and Approved: Revised Study End Date
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted expedited approval to the above named research study on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

This approval shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:
a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. John W. McDonald
Deputy Chair: Susan Hoddinott

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Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. J.B. Brown
Review Number: **11629E** **Revision Number:** **3**
Review Date: July 3, 2008 **Review Level:** Expedited
Protocol Title: Patients views on discussing their personal or spirtual beliefs with their family physician
Department and Institution: Family Medicine, University of Western Ontario
Sponsor:
Ethics Approval Date: July 3, 2008 **Expiry Date:** August 31, 2009
Documents Reviewed and Approved: Revised study end date.
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
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Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Paul G. Harding

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Appendix 2-2 Letter of Information & Consent Form

Patients' views on discussing their personal or spiritual beliefs with their family physician

Dr. J. B. Brown, Dr. M. Stewart, Dr. M. F. Lee-Poy
University of Western Ontario, Centre for Studies in Family Medicine, London ON

This letter is yours to keep for future reference

We are conducting a study to explore the views of patients on discussing their personal or spiritual beliefs with their family physician. Personal or spiritual beliefs has been increasingly recognized as playing a potentially important role in a person's health and health outcomes. Past studies have shown a general receptiveness to personal or spiritual belief inquiry for the medical profession. We would like to know how you feel about this and how this integration of personal and spiritual beliefs into medical office visits might best be accomplished.

This research may provide information to enable family physicians to provide effective comprehensive care that includes acknowledging and integrating their patients' personal and spiritual beliefs. The study is being conducted in affiliation with the Department of Family Medicine at the University of Western Ontario, and the Centre for Studies in Family Medicine in London, Ontario.

Who: We are looking for approximately 10-15 people who are willing to share their views on their personal or spiritual beliefs and its integration into the medical office visit. If you are 18 years of age or older, understand and speak English well enough to convey your opinions and ideas, we would like to hear from you!

When: If you would like to participate in the study, Dr. Lee-Poy will contact you. If you agree to participate, the interview will take 1-2 hours of your time. Dr. Lee-Poy will meet with you at a convenient location in the next few weeks. You will be asked questions about your personal and spiritual beliefs and how you would like to see them discussed with your family physician. The interview will be audiotaped so that it can be reviewed after the interview. The tapes will be transcribed verbatim into written format. The tapes will be erased after the study is completed. In appreciation of your participation, refreshments will be provided during the session.

Risks and Benefits: There are no known risks or direct benefits to you personally from participating in this study.

Voluntary Participation: Participation is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your future care.

Confidentiality: All responses will be kept confidential. If the results of the study are published, your name will not be used and no information that discloses your identity will be released or published.

Questions: If you have any questions regarding this study, please do not hesitate to contact Dr. Brown (Principal Investigator) at the Centre for Studies in Family Medicine.

Representatives of The University of Western Ontario Health Sciences Research Ethics Board may require access to your study-related records or may follow up with you to monitor the conduct of the research. If you have any questions about your rights as a research participant or the conduct of the study you may contact the Director of the Office of Research Ethics.

Thank you.

Sincerely,

Dr. Michael Lee-Poy
Co-Investigator
Centre for Studies in Family Medicine
London ON

Dr. Judith Belle Brown
Professor, Principal Investigator
Centre for Studies in Family Medicine
London ON

Patients' views on discussing their personal or spiritual beliefs with their family physician

Consent Form

I have read the letter of information. I have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

______________________	______________________
Participant Signature	Person obtaining informed consent Signature
______________________	______________________
Participant Printed Name	Person obtaining informed consent Printed Name
______________________	______________________
Date	Date

Appendix 2-3 Semi-Structured Interview Guide for In-Depth Interviews

Introduction and Explanations (10-15 minutes):

- Welcome: Thank you for coming and taking time out of your busy schedule. We really appreciate your participation in this study, which is carried out through the University of Western Ontario.
- Introductions: Introduction of self
- Purpose: The purpose of this study, as you may have read in your letter of information, is to hear your views on the inclusion and integration of your personal or spiritual beliefs into your medical office visits, including how you think this integration would happen best.
- Confidentiality: The information that you share with us today will be confidential. Your name will not be shared or stated. In fact, your name will not be attached to the notes made from this session.
- General Instructions: We are looking for your personal views. There are no right or wrong answers that we are looking for. Please take as much time as you need to think about the questions, and feel free at any time to revisit any topic we have discussed in the past, or not mentioned. If you have a question, please do not hesitate to interrupt me. If you disagree with any statements or questions, please let me know. This session will be audiotaped and then transcribed word for word. There is an audio recorder, which we will start once the discussion has begun. Once again, your name will not appear on this audiotape. Please remember to speak loudly and clearly for the audio recorder.
- Consent: Before we begin, let me remind you that this interview and your participation in this study are completely voluntary. Feel free to not answer any questions you do not wish to answer. You may stop this interview at any time and withdraw from this study at any time. By participating in this study, you are agreeing to freely share your thoughts, and to have these thoughts included in our results. Your name will not appear in any form in our results. Your participation bears no direct benefit to you, however, will help us to further explore ways of integrating personal or spiritual beliefs into medical office visits. Do you have any questions? I will also need you to sign this consent form stating your voluntary participation in this study.
- Questions: Any further questions before we begin?

Discussion Questions:

A. Defining their Personal Beliefs or Spirituality (10-15 minutes)

1. Tell me about your personal or spiritual beliefs.
2. Why is that important to you?
3. Tell me ways that you express your personal beliefs or spirituality.
4. What were your first thoughts when I mentioned spirituality?

B. Personal Experience (10-15 minutes)

1. Have you had any past office visits with your physician in whom you discussed or felt it touched upon your personal or spiritual beliefs?
2. Tell me about those experiences.
3. Describe how those experiences affected you.
4. Tell me the one experience regarding your personal beliefs or spirituality that most affected you, and tell me why that touched you so deeply.

C. Integration of Personal Beliefs or Spirituality (45-60 minutes)

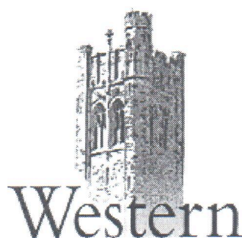
1. How do you feel about the integration of personal or spiritual beliefs into office medical visits?
2. In what cases would you want your personal or spiritual beliefs to be a part of your visit?
3. Are there any specific instances or office visits in which you would not want your personal or spiritual beliefs to be addressed?
4. How would you like your personal or spiritual beliefs to be integrated into medical office encounters?
5. How important is it for your personal or spiritual beliefs to be addressed?
6. How do you feel the integration of your personal or spiritual beliefs would affect your relationship with your doctor?
7. What are some specific things you would like to see physicians do or ask to better address or acknowledge your personal and spiritual beliefs?
8. If a physician does not know a person's personal or spiritual beliefs, what are some ways he or she can address this? Should it be addressed even if they are covering for another physician?
9. Given the limitations of time, what is the one way physicians can best acknowledge your personal beliefs or spirituality?

D. Other Questions or Comments

Closing Remarks (5 minutes):

- ▶ Thank you, once again for participating in this study and sharing your thoughts. Your comments are invaluable to this study. I would like to reiterate that all of your views and comments you have shared with us today will be held in confidentiality.
- ▶ Tell participant an estimation of when the research will be completed and inform them they are welcome to receive a copy of the research once it is completed.
- ▶ Provide interviewee with contact numbers in case they have further questions

Appendix 3-1 Ethics Approval for Quantitative Project



Office of Research Ethics

The University of Western Ontario
Room 4180 Support Services Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. M. Lee-Poy
Review Number: 15671E **Review Level:** Expedited
Review Date: November 27, 2008
Protocol Title: Family physicians' practices on discussing patients' personal or spiritual beliefs
Department and Institution: Family Medicine, University of Western Ontario
Sponsor:
Ethics Approval Date: December 10, 2008 **Expiry Date:** May 31, 2009
Documents Reviewed and Approved: UWO Protocol, Letter of Information, Reminder Postcard
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced study on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

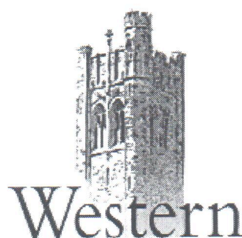
Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Joseph Gilbert

Ethics Officer to Contact for Further Information			
☐ Janice Sutherland (jsutherl@uwo.ca)	☐ Elizabeth Wambolt (ewambolt@uwo.ca)	☐ Grace Kelly (grace.kelly@uwo.ca)	☒ Denise Grafton (dgrafton@uwo.ca)

This is an official document. Please retain the original in your files. cc: ORE File

UWO HSREB Ethics Approval - Initial
V.2008-07-01 (rptApprovalNoticeHSREB_Initial) 15671E Page 1 of 1



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Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. M. Lee-Poy
Review Number: **15671E** **Revision Number:** **1**
Review Date: January 21, 2009 **Review Level:** Expedited
Protocol Title: Family physicians' practices on discussing patients' personal or spiritual beliefs
Department and Institution: Family Medicine, University of Western Ontario
Sponsor:
Ethics Approval Date: January 21, 2009 **Expiry Date:** May 31, 2009
Documents Reviewed and Approved: Revised Survey
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Joseph Gilbert

Ethics Officer to Contact for Further Information			
☐ Janice Sutherland (jsutherl@uwo.ca)	☐ Elizabeth Wambolt (ewambolt@uwo.ca)	☐ Grace Kelly (grace.kelly@uwo.ca)	☑ Denise Grafton (dgrafton@uwo.ca)

This is an official document. Please retain the original in your files.

cc: ORE File

Appendix 3-2 Letter and Questionnaire

Spirituality & Health Care: Family Physician's perspective on discussing patients' personal or spiritual beliefs

Dr. M. F. Lee-Poy, Dr. M. Stewart, Dr. J. B. Brown
The University of Western Ontario, Centre for Studies in Family Medicine, London ON

This letter is yours to keep for future reference

There are many studies suggesting a growing interest of patients to integrate spirituality into health care but that there are many barriers. I am conducting a study to explore the views and practices of family physicians on discussing patients' personal or spiritual beliefs and the potential barriers. The study is being conducted in affiliation with the Department of Family Medicine at the University of Western Ontario, and the Centre for Studies in Family Medicine in London, Ontario. It is part of my Masters in Clinical Sciences thesis.

<u>You are invited to participate!</u>
Please complete the 1 page survey which should take no longer than <u>5 minutes</u> of your time. You are one of 155 family physicians from the Waterloo Region who were randomly selected to participate. Surveys will be distributed using the modified Dillman method in which a follow up reminder will be mailed out at 2, 5 and 9 weeks. If you do not wish to participate or receive further communication, please return the postcard and mark on it "No further communication".

<u>Risks & Benefits:</u> There are no known risks to your participation in this study. The survey is totally anonymous and will not be connected back to you in any form. All information obtained will be kept strictly confidential. Participation is completely voluntary. If you do not understand a question, please leave it blank.

<u>Completed Surveys:</u> When you have completed the survey, please return it in the self-addressed and stamped envelope provided. Please also mail the postcard which allows us to track completed surveys and take you off of our reminder list. You indicate your consent to participate in the study by completing and submitting the survey. Reponses will be securely stored on a dedicated computer. No identifying data will be recorded with the responses, and all collected information will be deleted once the study is completed.

<u>Questions:</u> If you have any questions regarding this study, please do not hesitate to contact Dr. Michael Lee-Poy (Principal Investigator). If you have any questions about your rights as a research participant or the conduct of the study you may contact the Office of Research Ethics.

Thank you in advance for your cooperation. Please accept this ***$10 Starbucks gift card*** as a token of our appreciation for your time.

Sincerely,

Michael Lee-Poy, MD, CCFP
Principal Investigator

Spirituality & Health Care: Family Physician's perspective on discussing patients' personal or spiritual beliefs

Dr. M. F. Lee-Poy, Dr. M. Stewart, Dr. J. B. Brown
The University of Western Ontario, Centre for Studies in Family Medicine, London ON

Sex:	☐ Male	☐ Female		
Age:	______ yrs			
Years in Practice:	______ yrs			
Number of patients in practice:	______ ptns			
Type of Practice:	☐ Solo	☐ FHG	☐ FHN	☐ FHO
	☐ CHC	☐ Teaching	☐ Hospital	☐ Other:
Do you have a Religion/ Spirituality/Personal Belief:	☐ No	☐ Yes: ______________________		

1. Do you ask your patients about their religion/spirituality/personal beliefs?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Most of the times ☐ Always

2. Are you comfortable discussing or asking your patients about their religion/spirituality/personal beliefs?
   ☐ Not at all ☐ Somewhat ☐ Very ☐ Completely

3. Which of the following reasons prevent you from asking your patients about their religion/spirituality/personal beliefs? (Please check all that apply)
   ☐ Time ☐ Lack of training
   ☐ Personal discomfort ☐ None of my business/responsibility
   ☐ Not relevant to care
   ☐ Past experience asking about spiritual/personal beliefs
   ☐ Other: ____

4. Are there things that would make it easier to ask or discuss it with your patients? Please write them here:
   ____
   ____

5. Do you think it is important to know a patient's religion/spirituality/personal beliefs?
   ☐ Yes ☐ No ☐ Sometimes

Thank you for taking the time to complete this survey. Please return in the provided stamped envelope. Please also mail the return post card.

Appendix 3-3: Sex of Respondents Versus Non-Respondents

	Respondents N = 139		Non-Respondents N = 16	
	N	Percent	N	Percent
Female	56	40.3	6	37.5
Male	83	59.7	10	62.5

Pearson Correlation Co-efficient = 0.046
$p = 0.829$

Appendix 3-4 Different Types of Practice Models

Solo	FHG (Family Health Group)	FHN (Family Health Network)	FHO (Family Health Organization)	CHC (Community Health Centre)
Solo	Group	Group	Group	Group
Patients not rostered to practice.	Patients rostered to doctor's practice.	Patients rostered to doctor's practice.	Patients rostered to doctor's practice.	Patients rostered to the team. Most patients non-rostered
No Access & Preventative Bonsuses	Access & Preventative Bonsuses	Access & Preventative Bonsuses	Access & Preventative Bonsuses	No Access & Preventative Bonsuses
FFS*	FFS + 10% increase on fee codes for rostered patients	Blended Capitation** (75%) + 15% of FFS billings	Blended Capitation** (95%) + 15% of FFS billings	Salary

* FFS = Fee for Service (paid per patient visit)
** Capitation = fee per patient rostered. Fee determined by two variables: age and gender. Payment is for a "basket" of services that are to be included in services provided to rostered patients.

Michael F. Lee-Poy

The Centre for Family Medicine Family Health Team
Kitchener-Waterloo, Ontario

EDUCATION

DEGREE	UNIVERSITY	DEPARTMENT	YEAR
MClSc(C)	the University of Western Ontario	Family Medicine	2005-Present
CCFP	the University of Western Ontario & CFPC	Family Medicine	2005
MD	the University of Western Ontario	Medicine	2003
HonsBSc	the University of Toronto	Immunology	1998

APPOINTMENTS

DATE	RANK & POSITION	INSTITUTION	DEPARTMENT
2008-Present	PBSG Certified Facilitator	McMaster University	Family Medicine
2007-Present	Waterloo Regional Tutorial Coordinator	McMaster University	Medical School
2007-Present	Medical Foundations Tutor	McMaster University	Medical School
2006-Present	Associate Clinical Professor	McMaster University	Family Medicine
2007-Present	Resident Research Tutor	McMaster University	Family Medicine
2007-Present	Evidence Based Medicine Coordinator	McMaster University	Family Medicine
2006-Present	Adjunct Clinical Professor	Univ. of Western Ont.	Family Medicine
2005-Present	Behavioural Sciences Tutor	McMaster University	Family Medicine
2003-Present	Board Representative	Ontario College of Family Physicians	Region 3 Director

AWARDS & DISTINCTIONS

YEAR	AWARD
2010	College of Family Physicians of Canada 'Early Career Development Award' for leadership, innovation, initiative and dedication in the first five years in practice
2010	Waterloo Regional Record '40 under 40' Award for achievement in Medical Education
2009	Michael G. DeGroote School of Medicine Waterloo Regional Campus Excellence in Teaching Award (Inaugural Award)
2009	Vancouver Olympics Torch Relay Team – College of Family Physicians Relay Team
2009	Dr. Martin Bass Award for Research & Teaching
2009	OMA TC Routley Challenge Shield Award – as President of the KW Academy of Medicine
2007	Dr. Martin Bass Award for Research & Teaching
2006	Dr Keith Johnston Scholarship in Family Medicine for Research
2006	PSI Jane Sibbald Award for Leadership in Medical Education
2005	ROMP Resident Award for Family Medicine Training
2005	PSI Foundation Research Prize for Excellence in Medical Research
2005	Gamma-Dynacare Award for Excellence in Teamwork and Leadership
2005	MDS Award for Best Resident Research Presentation
2003	UWO Medical Faculty Jim Silcox Award for Extracurricular Excellence
2003	UWO Student Leadership Award for Academic & Extracurricular Excellence
2002	Canadian Rheumatology Association Research Award
2001	UWO Obstetrics & Gynecology Teaching Award
1998	U of T Gordon Cressy Award for Student Leadership
1998	U of T Student Administrative Council Scholarship for Extracurricular Involvement
1998	Fr. Madden Award for Academic and Extracurricular Excellence

PROFESSIONAL EXPERIENCE

YEAR	RANK & POSITION	INSTITUTION
2009-Present	EBM Coordinator & Tutor	McMaster University, Dept. of Family Medicine
2007-Present	Resident Research Tutor	McMaster University, Dept. of Family Medicine
2007-Present	Tutorial Coordinator & Tutor	McMaster University, Dept. of Family Medicine
2006-Present	Clinical Supervisor	McMaster University, Dept. of Family Medicine
2006-Present	Residency Program Tutor	McMaster University, Dept. of Family Medicine
2006-Present	Clinical Supervisor	Univ. of Western Ontario, Dept. of Family Medicine
2006-Present	Guest Lecturer	UW School of Optometry
2005-Present	Clinician, Board of Directors	Kitchener-Waterloo Centre for Family Medicine FHT

RESEARCH EXPERIENCE

YEAR	DESCRIPTION
2005-Present	Masters in Clinical Sciences – Research Thesis, University of Western Ontario Spirituality & Health Care: Talking to Your Family Doctor Spirituality & Health Care: The Family Physician's Perspective
2003-2005	Resident Research Project, University of Western Ontario Spirituality & Health Care: Spiritual Desires of patients at an urban London Centre
Summer 2001	Summer Medical Research Scholarship, Canadian Rheumatology Association Kawasaki's Disease: A Chart Review
1998-1999	Student Researcher, Toronto General Hospital Neonatal Lupus Erythematosus: effects on cardiac tissue
1996-1998	Student Researcher, Hospital for Sick Children Development of a rabbit model of Neonatal Lupus Erythematosus

PUBLICATIONS

1997	**Investigative methods of congenital heart block** R. M. Hamilton MD, M. F. Lee-Poy, K. Kruger MD, E. D. Silverman MD Journal of Electrocardiology 1997; 30b: 69-74
1997	**Reproduction of the features of congenital heart block in rabbit hearts** M. F. Lee-Poy, R. M. Hamilton MD, E. D. Silverman MD 1997 North American Society of Pacing & Electrophysiology Conference
1997	**Langendorff rabbit model of congenital complete atrioventricular block** M. F. Lee-Poy, R. M. Hamilton MD, E. D. Silverman MD PACE Journal April 1997; 20 #4, Part II: 1101

TEACHING & PRESENTATIONS

YEAR	DESCRIPTION
Sept 2009	Presenter at the University of Calgary Spirituality & Health Conference
2007-Present	Medical Foundations 2 & 4 Tutor: McMaster Michael G. DeGroote School of Medicine
2007-Present	Quality Assurance/Research Project Tutor, McMaster Family Medicine
2007-Present	Evidence Based Medicine Tutor, McMaster Family Medicine
2007-Present	Faculty Development Lecturer and Planning Committee, McMaster University
2006-2008	Health Sciences Course Lecturer, University of Waterloo School of Optometry
2005-Present	Masters in Clinical Sciences in Family Medicine, The University of Western Ontario
2005-Present	Clinical Supervisor, McMaster University Family Medicine
2005-Present	Family Medicine Behavioural Sciences Teacher, McMaster Family Medicine
2005-2006	Undergraduate Medicine Curriculum Development, The University of Western Ontario
Jun 4, 2008	SWOMEN & McMaster Faculty Development Session – Speaker: Motivating the Unmotivated Learner
Apr-Jun 2008	Erb Street Mennonite Church Adult Christian Education Teacher: Faith & Work
Oct 20, 2007	SWOMEN & McMaster Faculty Development Speaker: Time Effective Teaching Tips

May 9, 2007	Schulich's Annual Clinical Day in Family Medicine Research Presentation: Spirituality & Health Care – Talking to your family doctor
April 17, 2007	McMaster University Faculty Development – Speaker: Time Effective Teaching Tips
Apr 4, 2006	UWO Graduate Research Day – Presenter Spirituality & Health Care
Dec 2005	Erb Street Mennonite Church, The Community Publication – Author of Article
Dec 10, 2005	CFPC Family Medicine Forum Poster Presentation: Spirituality & Health Care
Dec 9, 2005	CFPC Family Medicine Forum – Workshop Co facilitator: Homelessness & Health Care
Oct 14, 2005	NAPCRG Conference – Poster Presentation: Spirituality & Health Care
Oct 2005	Rogers Medical Publication – Consultant Peer Reviewer
Jun 10, 2005	Trillium Primary Care Research Forum – Speaker: Spirituality & Health Care
Jun 1, 2005	UWO Family Medicine Resident Research Day – Presenter: Spirituality & Health Care

OTHER CONTRIBUTIONS

YEAR	**DESCRIPTION**
2009	International Medical Humanitarian Mission – Kurdistan, Northern Iraq
2008-Present	McMaster Family Medicine CaRMS reviewer and interviewer
2008-2011	Waterloo Regional Immigrant Loan Program Advisory Committee
2007-Present	Ontario College of Family Physicians Board Member
2007-2010	Kitchener-Waterloo Academy of Medicine Executive Member
2006-2010	Erb Street Mennonite Church Christian Education & Formation Ministry Committee
2004-Present	DaCapo Chamber Choir
2003-2009	Erb Street Mennonite Church Christian Community Ministry Committee
2003-Present	Brethren Mennonite Council (BMC) of Ontario Executive Committee
2008	McMaster Michael G. DeGroote School of Medicine COMPASS Curriculum Reviewer
2005-2007	UWO Undergraduate Medical Education Curriculum Committee
2005-2006	Together in Toronto 2006 Conference Organizing Committee Member
2003-2006	UWO Resident Selection and Recruitment Committee
2003-2006	Ontario College of Family Physicians Resident Committee, Chair 2005-2006
2004-2005	Vice-Chief Resident of the UWO Family Medicine Department
2001-2003	UWO Medicine 2003 Class Council
2001-2003	UWO Medicine Selection Committee
1999-2003	UWO Medicine Curriculum Evaluation Committee
2000 -2001	Canadian Federation of Medical Students, Local Exchange Officer for UWO
2000-2001	UWO Medicine Student Council, Communications Commissioner
2000-2001	UWO Ontario Medical Students Weekend, Speakers Committee & Workshop Facilitator
1999-2001	UWO Medical Journal Senior Ethics Editor