Healing Without Gloves: Can Religion Influence the Interaction Between the Patient and the Healthcare Provider

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Healing Without Gloves: Can Religion Influence the Interaction Between the Patient and the Healthcare Provider

Quinn Navarro, B.A. Biology, B.A. Religious Studies, University of Redlands 2018

Abstract

This study explores the potential impact of religion on the relationship between healthcare providers and their patients. It combines literature-based research with a personal reflection upon meaningful engagements with patients that took place over a period of two years. The goal is to better define the role that religion plays in the relationships cultivated between doctors and their patients. I begin my research by documenting links between religion and medicine, dating back to ancient times. This basis underscores why the connection between religion and medicine remains relevant today. My personal reflection provides insight that ultimately contributes to the claim that religion can impact patient experiences in healthcare settings. Research on this claim is supported by a review of literature from the perspectives of healthcare providers and patients. I use this research to provide evidence that a link between religion and medicine can benefit the experiences of both the patient and the provider. In conclusion, I consider the positive implications of implementing religious training for healthcare providers.
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Narrative

In the midst of a busy week, you sit on a paper covered bed listening to a nurse explain that your physician will arrive shortly to begin your routine check-up. You remember the check-up procedure better than the back of your hand. You’ve seen this very same doctor, at the very same hospital, for a number of years now. You can nearly predict every question your doctor will ask you and how your appointment will proceed. Yet, what catches your attention is the predictable continuity in your experiences visiting the hospital. You realize that every time you pay a visit to the hospital, you spend ten minutes finding a parking spot. You approach the hospital building, hardly noticing your surroundings. In such a rush to get in and out of the building, your eyes remain fixed on the sliding glass doors that mark the entrance. You walk to the same directory and look for your doctor’s name. You find it amusing that despite many visits to this hospital, you forget your doctor is on the fourth floor. Upon checking in (five minutes after your appointed time), you sit impatiently in the waiting room. When a nurse periodically opens the door, you become slightly irritated as s/he calls the names of other patients instead of yours.

Eventually, a nurse leads you to the very bed you sit upon now. At this point, it typically takes the doctor about five minutes to knock on your door and promptly enter the room to begin your examination. Until then, your mind is usually distracted by what happened at work that day, or what you need to get done later (with the exception of this visit, where your mind is busy recalling your routine thought process). At this point, your wandering mind is interrupted by the knocking and entrance of your physician. He greets you and begins typing away on a computer prior to beginning your check-up. As the doctor leans forward to look closer at the screen, you notice a beaded necklace with a religious
symbol dangling from his neck. He subconsciously tucks the necklace back out of sight without saying a word. He then begins your check-up by gauging your vitals and asking familiar questions. You effortlessly answer the questions as he reviews your recent lab results.

Before you know it, the appointment ends and you find yourself trying to remember where you left your car. You leave the parking lot with your mind fixed on your interaction. You ponder how your doctor never portrayed a hint of religious character, despite the hidden necklace. You glance over to your review mirror and acknowledge your dangling necklace with the very same religious symbol. Why is it that religion is hidden in medicinal settings? Would your experiences with your doctor be different if it was not? Suddenly, you notice you drove past a church. You drive this street nearly every day, yet you had never identified this building as a religious establishment. Then you think, maybe religion is not really hidden in hospitals after all. Perhaps it was simply your failure to recognize it all along. If that is the case, how long has it gone unnoticed? How would your experiences change if it was noticed? It is these questions that drive the present study. It is likewise these questions which ultimately provide further insight on how religion can impact the experiences of both healthcare providers, and their patients.

**Methodology/History of Scholarship**

In contemporary society, religion and medicine are often viewed as antithetical. However, this thesis argues that in foundational ways religion and medicine remain inherently linked. My study begins with a summary of earlier investigation of the ancient connection between medicine and religion. I then examine how religion and medicine continue to shape the relationship between contemporary healthcare providers and their
patients. This reflection is rooted in stories drawn from my own experience as a Pediatric Patient Care Unit Volunteer at Loma Linda Children’s Hospital. Finally, the essay engages a broader body of research that explores the role of religious influence on the overall medical experience – from the perspective of both patient and provider. Throughout, my goal is to answer two primary questions: Can religion exert positive influence on current medical practice? If so, what does this look like?

**Ancient Medicine**

Many factors distinguish a contemporary hospital visit from those that existed thousands of years ago. However, in exploring links between religion and medicine, five ancient healing sites underscore the foundational character of such connection. Each of these medical loci serves simultaneously as a holy site to Hindus, Jews, Christians, Buddhists, and Muslims. The degree to which each links medicine with religion - across traditions, is important to recognize. Like this paper, such uniformity suggests the inherent linkage of medicine and religion, without advocating for one religion over another. Spanning a range of geographical environs, chronological periods, and belief systems, such consistent melding of medical and religious settings invites further inquiry.

Located in India, Venkateswara Temple is dedicated to Sri Venkateswara, said to be an incarnation of the deity Vishnu. Constructed during the 4th century CE, the walls in the temple's inner sanctuary are inscribed with a description of what was once a

hospital. This hospital contained fifteen beds for patients. It was administered by both a physician (Kodani Ramesh-wathan Bhattar) and a surgeon (Calliyakkirivai Pannuvan). As recorded, the inscription also included a number of stored medicines that were used in the hospital.¹

A second ancient medicinal site was located in Jerusalem. After the destruction of the First Temple of Jerusalem, a Second Temple was constructed. Begun in 516 BCE, the temple was later refurbished by Herod during the first century CE. Within the first courtyard of the temple was the northwest chamber. This was known as the Chamber of Lepers, and was set apart for those who came to the temple to be cleansed. The chamber served as a refuge for individuals, who hoped to be healed of their leprosy via purification methods administered by the priests.²

A third location is the Abbey of Montecassino. Originally home to a pagan temple built in honor of the god Apollo, upon Saint Benedict’s

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arrival in 529 CE, the temple was destroyed in order to begin construction of an Abbey. While primarily designed as a living establishment for monks, the monastery (dedicated to John the Baptist) was a also place where Saint Benedict cared for others, particularly the sick. In fact, until his death, Benedict made healing the sick a top priority, and is described as serving the ill and the poor in various medical capacities. It is likewise reported that he prioritized this over all other Christian duties.³

A fourth location, the Borobudur Temple, is also still standing. It is located in the Province of Indonesia – a region globally known for its rich heritage in both Buddhism and Hinduism. The Temple was constructed in Central Java, during the 8th and 9th centuries CE by the Sailendra dynasty.⁴ It is said that the temple operated as a sort of pharmacy, where Indonesian drugs, also known as “jamus”, were stored in the temple. Records list: ‘kumiskucing’ to treat ringworm, ‘patikan kebo’ to treat asthma and bronchitis, ‘betel’ used as an antiseptic, and ‘cabe jamu’ used as a sedative.⁵

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A fifth and final site was built during the Dynasty of Mengujekids (early 13th c. CE). Known as the Great Hospital of Divriği, it was constructed in a building that adjoined the well-established Great Mosque of Divriği. Solely dedicated to healing the sick, the complex provided many rooms for patients. It even contained a dynastic tomb chamber. The building is comprised of two stories, each containing rooms for patients. Unlike many Islamic hospitals, the Great Mosque and Hospital of Divriği remain standing to this day.6

These five locations are differentiated by a number of factors. Geographical location, religious affiliation, and methods of practice make each site unique. However, in addition to focusing upon differences, it is also important to pay attention to similarities. All five of these sites incorporate both religion and medicine into their purpose. With this in mind, recall the question posed as you drove away from the hospital. How might your experience visiting your doctor change if religion was present (or successfully recognized), as it was in these ancient medicinal sites. Let us explore how the presence of religion within a hospital setting can influence one’s hospital experience, primarily in ways that contribute to the physician-patient interaction.

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**Experiential**

Since September of 2015, I have spent time at Loma Linda Children’s Hospital as a pediatric patient unit volunteer. As a volunteer, my responsibilities revolve around serving patients. I deliver food and beverages, sanitize rooms/items, and answer phone calls, but interacting with patients is my primary responsibility. While my assignment is in pediatrics, more often than not I also interact with family and friends of the children admitted in the hospital. With my primary focus being to serve patients, I find myself simply speaking with the patients and their family for the majority of my shifts. Now, it is worth noting that Loma Linda University Medical Center is a Seventh-day Adventist Organization. This however does not mean that every patient or employee is a practicing seventh-day Adventist. I perceive the primary motivation behind this affiliation is making people whole in both body and spirit—dare I say, medicine and religion. To clarify, this organization does not directly impose religion upon any of their patients. From my experience in the children’s hospital, the most noticeable distinction between this organization and one that is not religiously affiliated is the aesthetic. Throughout the entire building are paintings, pictures, murals, signs, and other decorations of the sort that visually depict the religion. Most notably in the pediatric unit is the presence of a bible verse above the entrance to every patient’s room. Other than that, as far as the patient is concerned, this organization operates similarly to any other medical center. By elaborating on select experiences of mine, I address how my education in religious studies has impacted my interactions with patients.

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At the start of my volunteer experience, I encountered a patient that recently underwent a limb amputation surgery. I remember the child expressing he had only started 1st grade, which came as a surprise due to the child’s independence and ability to communicate. Despite surgically having part of his leg removed, his independence and optimism was inspiring. For example, as I was pushing him in his wheelchair into an elevator, he asked if he could push the button for the first floor. I felt disheartened telling him I didn’t think he could reach the button, as the wheelchair could only get so close to the panel. Not to mention, his mobility within the wheelchair was very limited, as movement of his recovering limb was advised to be minimal. However, his confidence was enough to convince me to allow him a chance. To my surprise, his motivation surpassed his shortcomings. He stretched far enough to reach the elevator button without the slightest movement of his recovering limb. The facial expression displayed in his reaction was not in the slightest dumbfounded (although mine probably was), but rather gratifying. His relaxed posture and slight smirk indicated his pride without saying a word.

After leaving the elevator, we headed for the children’s theater - a room built specifically for showing films on Friday afternoons. The theater provides a place for children to escape (somewhat) the aesthetic of a hospital. It is also a general rule that healthcare providers (doctors and nurses) cannot enter the theater. This is to preserve any comforting feelings the children may have due to the absence of these providers. The patients are accompanied by volunteers (such as myself) as they enjoy a g-rated film with other pediatric patients. Children may also be accompanied by family and friends during the movie. However, I find that parents quite often leave the hospital at that time in order to take care of other responsibilities while their child enjoys a film. This particular
afternoon, it was just me and the young boy getting ready to watch a movie. In addition to showing a film, the hospital provides the children with a variety of candy, popcorn, juices, sodas, and other movie-watching snacks (as their diet permits). In the case of this patient, he neglected to eat lunch and prepared to eat loads of popcorn and candy. This was clearly not his first movie day.

I brought him a bag of popcorn and some chocolate peanut butter cups per his request. He looked up at me with an eager smile that said the movie was about to start. Before he indulged in his snacks, he casually mentioned that before he was allowed to eat his food, his parents usually said a prayer. His gaze then fixed on mine. His innocence poured out of his eyes and filled me with sheer compassion. After nearly a month of volunteering, this was the first encounter that brought about religion in a way that seemed, well, absolutely necessary in the context of medicine. Who was I to tell the child no? Was I to deprive him of his tradition by not praying for him, or by telling him to pray for himself? The thought of possible implications from me denying to say grace seemed nonsensical. Would he still choose to enjoy his snacks if nobody said grace? Would this create internal conflict within him as a result? Then sympathy got the best of me. Despite his childish optimism, he just underwent a surgery that resulted in him losing part of his leg. Without regret, I confess smiling and saying a short prayer with him. I must say, nothing made me happier than watching him devour his candy and popcorn that day.

As previously mentioned, one of the most prominent aspects of religious aesthetic in this hospital is the presence of a bible verse above the doorway to every patient’s room. While I stray from describing these decorations as ‘in your face’, they are without a doubt hard to miss. This is so even amongst the chaos and lack of attentiveness to surroundings
during a hospital experience. Nonetheless, they make an easy topic for conversation with patients and their visitors. To recall, these patients are children. They are most often accompanied by family members (specifically parents). My encounters as a volunteer regularly include interactions with the parents of these admitted children. Pertaining to the bible verses above the door of each room, I frequently ask parents for their thoughts on such decorations. This gently sparks a conversation about religion in the context of medicine.

Although, I was not permitted by the Institutional Review Board to conduct any sort of research on these people. Thus my reflection lacks any qualitative data concerning the opinions of bible verses above every doorway- by extension, making religion present in the context of medicine. However, I do recall such conversations invoking responses that either expressed appreciation for these decorations, or gently asserted that the decorations made no difference in their experience at the hospital. They allowed me to connect with people in a way that seemed abnormal within the confines of a hospital.

In one instance, I simply spoke with a teenage patient about his experience so far at Loma Linda. From there we engaged in a rather in-depth conversation about his wavering faith. I will avoid recalling the conversation verbatim, but this interaction was heartfelt and wholesome. I truly believe my connection with this patient contributed to him feeling less like someone who is viewed as a subject and more like a patient that is viewed as a person. I do admit that this conversation was essentially me listening to him and acting as a mentor to him. I also think my personal religious background was a crucial factor to the development of the conversation. However, I think a basic understanding of the patient’s
religion would have sufficed. Not only could the patient be listened to, but a conversation could also provide him with some hope in light of his current situation.

Would this be too much to ask of a physician? One aspect of this question is time. I spent over an hour talking with this boy. Unquestionably, the conversation was not heartfelt and genuine from the beginning. It needed to be fostered. It required time. In other words, I think the conversation and resulting impact would be drastically different had I only spoke with him for ten minutes. Yet, does a physician have time in their day to speak with every patient for an hour? It can be argued that no, physicians simply cannot interact with all their patients to the extent that I did. As a result, this is why chaplain services and volunteers are offered. Additionally, there is undoubtedly a barrier formed between this teenage boy and a doctor in terms of authority. Would a doctor making an effort to diminish this barrier be more impactful on the patient? Maybe so. Is this reasoning enough to force doctors to converse with each patient for at least an hour? Maybe not. But this should be considered when figuring out how to improve interactions between the provider and the patient.

Nevertheless, I hope my interaction with the boy was influential to him. I hope he still cherishes that memory as I do. But admittedly, I think he would be more inclined to do so if I was a doctor. I believe the recognized efforts to break down the social barrier between a prestigious medical doctor and a mere high school student would contribute to a heavier impact on the patient. Now the original question posed (if this was too much to ask a physician) becomes easier to answer with the identification of this potential beneficial outcome. Notwithstanding, let us avoid undermining the intense training demanded of physicians. Still, the physician would not require an expert’s knowledge about each
religion. Is a basic understanding of the major world religions not a simple request? After all, such an education seems minuscule compared to a rigorous medical school curriculum.

Research

It is interesting that my observations are not unique. Rather, a number of primary research studies affirm similar conclusions. Each contributes a unique component in formulating an answer to my research questions. While these studies predominantly privilege Christian traditions, each suggests patterns that bolster my premise, in this paper as a whole. While Christianity serves as a basis for investigation, by no means does my research solely pertain to Christianity. In fact, I would argue that any conclusions drawn from studies incorporating predominantly Christian samples should be applied to other religions as well. In broad strokes, these studies demonstrate how religion (not just Christianity) can benefit the relationship between healthcare providers and their patients. Likewise, one can extrapolate wider emphases despite the underrepresentation of other world religions in this literature.

In their study of "Religious Perspectives of Doctors, Nurses, Patients, and Families," Harold G. Koenig, Margot Hover, Lucille B. Bearon, and James L. Travis underscore the importance of recognizing religion’s presence in the lives of all participants in the medical process. However, this study provides particular insight into religious identities of healthcare providers and patients. As a result, this work establishes a foundation for further investigation. Through analysis undertaken at Duke University Medical Center, these researchers provide insight into the role religion plays in the lives of individuals. The data they have collected suggests a majority of healthcare providers and patients believe in
a higher power.\textsuperscript{8} However, while a significant percentage of patients (43.8%) and their families (56.1%) rely on those beliefs as a coping mechanism, only 25.6% of nurses use religion to cope with work-related stress. An even lower percentage of physicians (8.7%) report overt reliance on religion. These scholars suggest that such, “differences ... raise the possibility of a bias in religious perspective among healthcare providers that might interfere with their ability to recognize and respond to the spiritual needs of patients.”\textsuperscript{9}

This data suggests evident differences in spiritual belief between healthcare providers and those who benefit from their care. This difference may limit the extent to which a healthcare provider can serve their patients. Religion may likewise play an inhibitory role in the care provided to patients. In this case, addressing the differences in spiritual beliefs among providers and patients may offer an opportunity for providers to maximize the quality of care for the sake of their patients. Although this study was conducted over 15 years ago, it suggests a potential disconnect between healthcare provider and patient in contemporary medical settings.

In exploring further, my investigation will address two fronts: the perspective of the provider and that of the patient. My goal is to develop a more inclusive ethic that accounts for viewpoints from both the patient and provider. Additionally, I hope that this bilateral perspective will provide conclusions that present religion as a means for enhancing the relationship between providers and patients.


\textsuperscript{9} Koenig, et al. 1991, 255.
Provider’s Perspective

It is well known that healthcare providers (particularly physicians) invest heavily in education and training, prior to practicing medicine. However, some scholars suggest that the intensive curriculum demanded of physicians, could be improved. In their study, "An assessment of US physicians’ training in religion, spirituality, and medicine," Kenneth A. Rasinski, Youssef G. Kalad, John D. Yoon, and Farr A. Curlin report that the Association of American Medical Colleges recommends that physicians incorporate religion and spirituality in assessing treatment.\(^\text{10}\) However, this study documents that nearly half of physicians (not including psychiatrists) never discuss religion and spirituality with their patients.\(^\text{11}\) In exploring why physicians refrain from conversing with patients about religious topics, these scholars turn to a study conducted by Farr A. Curlin, John D. Lantos, Chad J. Roach, Sarah A. Sellergren, and Marshall H. Chin.\(^\text{12}\) The latter study examines the effects of physician training, relative to religion, spirituality, and medicine.

In this study, "Religious characteristics of U.S. physicians," data was collected via surveys administered to two thousand active physicians, practicing within the United States.\(^\text{13}\) These doctors were selected randomly from the American Medical Association Physician Masterfile. The survey was delivered confidentially via post on three different occasions. Approximately 63% of the surveys were completed (a total of 1,144


\(^{11}\) Rasinski, et al. 2011, 944.


Data relative to physician beliefs was compared to that collected in a broader social survey. Surprisingly – given the percentages cited by Koenig, et al., the majority of surveyed physicians associated themselves with some type of religion. These concentrations affirm the presence and role of religion in the lives of healthcare providers. Religious diversity is also apparent in this sample population. In their responses, physicians identified with faiths that are not only Abrahamic, but also Hindu, Buddhist, and ‘other’. Although, 60% of physicians did identify as Christian (Protestant + Catholic), which parallels the data for the general population. Thus, physicians most probably find themselves caring for a patient that identifies with a Christian faith. Being that a majority of physicians also identify with a Christian faith, it is possible that caring for patients with likewise beliefs could be enhanced. In turn, this spectrum of religious diversity seems crucial when considering how physicians might care

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>Physicians, % (N)</th>
<th>U.S. Population, % (N)</th>
<th>P (X²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>38.8 (427)</td>
<td>54.7 (600)</td>
<td>.00</td>
</tr>
<tr>
<td>Catholic</td>
<td>21.7 (244)</td>
<td>26.7 (370)</td>
<td>.01</td>
</tr>
<tr>
<td>Jewish</td>
<td>14.1 (181)</td>
<td>1.9 (26)</td>
<td>.00</td>
</tr>
<tr>
<td>None</td>
<td>10.6 (117)</td>
<td>13.2 (198)</td>
<td>.06</td>
</tr>
<tr>
<td>Hindu</td>
<td>5.3 (59)</td>
<td>0.2 (1)</td>
<td>.00</td>
</tr>
<tr>
<td>Muslim</td>
<td>2.7 (33)</td>
<td>0.5 (5)</td>
<td>.00</td>
</tr>
<tr>
<td>Orthodox</td>
<td>2.2 (22)</td>
<td>0.5 (7)</td>
<td>.00</td>
</tr>
<tr>
<td>Mormon</td>
<td>1.7 (17)</td>
<td>0.4 (6)</td>
<td>.00</td>
</tr>
<tr>
<td>Buddhist</td>
<td>1.2 (13)</td>
<td>0.2 (3)</td>
<td>.01</td>
</tr>
<tr>
<td>Other</td>
<td>1.8 (18)</td>
<td>1.6 (21)</td>
<td>.70</td>
</tr>
<tr>
<td>Total</td>
<td>100 (1125)</td>
<td>100 (1427)</td>
<td></td>
</tr>
</tbody>
</table>

Table 1. Religious Affiliation Among Physicians. The data above shows the percentage of each religious affiliation for both a sample of physicians and for the general population as a whole.

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14 Curlin et al. 2005, 631
15 Curlin et al. 2005, 630; In fact, only 10% of the sample population claiming to be atheist, agnostic, or not holding any religious beliefs whatsoever (631). This suggests that religion does play a role in the lives of a majority of doctors.
16 Curlin et al. 2005, 631
17 Curlin et al. 2005, 631
for their patients. A more diverse staff of physicians could increase quality of care for a broader range of patients.

In conducting their study, these scholars also collected more particular characteristics associated with religion (displayed in Table 2). While the data affirms the notion that physicians attempt to cope without relying on a religious figure (and perhaps are trained to do so), nearly half (48%) admitted to coping religiously by searching for strength, support, and guidance from God in some way, shape, or form.\textsuperscript{18}

Additionally, nearly 46% of the physician sampling population claimed to attend some sort of religious service at least

<table>
<thead>
<tr>
<th>Religious Characteristic</th>
<th>Physicians (N=1,146) (%)</th>
<th>U.S. Population (N=1,145) (%)</th>
<th>Odds Ratio Adjusted for Affiliation OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrinsic religiosity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I try hard to carry my religious beliefs even into all my other dealings in life (Agree or Strongly agree)</td>
<td>58</td>
<td>73</td>
<td>0.6 (0.5 to 0.7)</td>
</tr>
<tr>
<td>Attendance at religious services</td>
<td>10</td>
<td>10</td>
<td>0.4 (0.2 to 0.5)</td>
</tr>
<tr>
<td>Never</td>
<td>10</td>
<td>10</td>
<td>0.4 (0.2 to 0.5)</td>
</tr>
<tr>
<td>Once a month or less</td>
<td>44</td>
<td>41</td>
<td>0.9 (0.7 to 1.1)</td>
</tr>
<tr>
<td>Two times a month or more</td>
<td>46</td>
<td>40</td>
<td>1.8 (1.4 to 2.2)</td>
</tr>
<tr>
<td>Beliefs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Believe in God</td>
<td>76</td>
<td>83</td>
<td>0.8 (0.5 to 1.0)</td>
</tr>
<tr>
<td>Believe in life after death</td>
<td>59</td>
<td>74</td>
<td>0.6 (0.5 to 0.8)</td>
</tr>
<tr>
<td>Religiosity and spirituality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious and spiritual</td>
<td>52</td>
<td>52</td>
<td>1.2 (0.99 to 1.5)</td>
</tr>
<tr>
<td>Religious, not spiritual</td>
<td>4</td>
<td>9</td>
<td>0.4 (0.2 to 0.6)</td>
</tr>
<tr>
<td>Spiritual, not religious</td>
<td>20</td>
<td>9</td>
<td>2.4 (1.8 to 3.2)</td>
</tr>
<tr>
<td>Neither religious nor spiritual</td>
<td>23</td>
<td>20</td>
<td>0.6 (0.5 to 0.8)</td>
</tr>
<tr>
<td>Religious coping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I look to God for strength, support, and guidance (Agree a lot or Quite a bit)</td>
<td>48</td>
<td>64</td>
<td>0.6 (0.5 to 0.7)</td>
</tr>
<tr>
<td>I try to make sense of the situation and decide what to do without relying on God (Agree a lot or Quite a bit)</td>
<td>61</td>
<td>29</td>
<td>3.5 (2.9 to 4.1)</td>
</tr>
</tbody>
</table>

\textsuperscript{18} Curlin et al. 2005, 631

Table 2. Religious Characteristics of Physicians. Percentages of physicians from a sample that identify with a particular religious characteristic are shown. The same for the general population. Ratios of the percentages are displayed for each variable.
twice a month.\textsuperscript{19} It is interesting to consider the degree to which this may have shaped the religious understanding physicians brought to their practice. Additionally, 58\% of this group note some attempt to integrate their intrinsic religious beliefs into everyday practice (the table notes Intrinsic Religiosity).\textsuperscript{20}

In exploring the intersection between religious coping and intrinsic religiosity, the data was also categorized by physician specialties. Here, intrinsic religiosity is defined as the attempt to carry religious beliefs into all aspects of life.\textsuperscript{21} Such a definition provides insight on the specific contexts in which physician-patient conversations regarding religion might occur (assuming physician beliefs are correlated with inquiry on such conversations). With exceptions for psychiatry and radiology, a majority of physicians from every specialty claim to be intrinsically religious (as displayed in Table 3). Such evidence suggests that a majority of physicians are residually equipped to relate to their patients in some religious way, shape, or form.

\begin{table}
\centering
\begin{tabular}{|c|c|c|c|c|}
\hline
Primary Specialty (N) & Intrinsic Religiosity\textsuperscript{1} & Religious Coping\textsuperscript{1} \\
\hline
& \% & OR [95\% CI] & \% & OR [95\% CI] \\
\hline
[U.S. population\textsuperscript{1} (1445)] & 73 & 1.0 [referent] & 64 & 1.0 [referent] \\
Family practice (158) & 70 & 0.9 [0.6 to 1.2] & 58 & 0.8 [0.5 to 1.1] \\
Pediatric subspecialties (80) & 64 & 0.7 [0.3 to 1.4] & 51 & 0.6 [0.3 to 1.2] \\
General pediatrics (87) & 61 & 0.6 [0.4 to 0.9] & 49 & 0.5 [0.3 to 0.8] \\
Obstetrics and gynecology (80) & 60 & 0.5 [0.3 to 0.9] & 49 & 0.5 [0.3 to 0.9] \\
Surgery—all (100) & 62 & 0.6 [0.4 to 0.9] & 51 & 0.6 [0.4 to 0.9] \\
Medical subspecialties (231) & 52 & 0.4 [0.3 to 0.6] & 41 & 0.4 [0.2 to 0.6] \\
General internal medicine (129) & 52 & 0.4 [0.3 to 0.6] & 45 & 0.5 [0.3 to 0.7] \\
Anesthesiology (39) & 50 & 0.4 [0.2 to 0.7] & 56 & 0.7 [0.3 to 1.4] \\
Psychiatry (100) & 49 & 0.4 [0.2 to 0.6] & 36 & 0.3 [0.2 to 0.5] \\
Radiology (25) & 48 & 0.3 [0.2 to 0.5] & 27 & 0.2 [0.1 to 0.5] \\
Other (133) & 57 & 0.5 [0.3 to 0.7] & 49 & 0.5 [0.4 to 0.8] \\
\hline
\end{tabular}
\caption{Physician Associations by Specialty. Physicians are categorized by their specialty in this table. Each specialty shows the percentage of physicians that are religiously intrinsic, and percentages for those who use religion as a coping mechanism.}
\end{table}

\textsuperscript{19} Curlin et al. 2005, 631
\textsuperscript{20} Curlin et al. 2005, 631.
\textsuperscript{21} Curlin et al. 2005, 631.
This makes the argument for the value of further training more compelling. However the study concludes by noting that a mere 23% of physicians claimed to receive any form of religious/spirituality training while studying medicine.\textsuperscript{22} With this, physicians expressed reticence in starting conversations concerning religion and spirituality. They also suggested that they would feel much more comfortable if patients displayed interest in such conversations. However, context did play a role in determining when physicians felt more comfortable addressing these matters with their patients. For patients experiencing problems that concerned their lives (possible death scenarios), nearly 50% of physicians report inquiring about religion/spirituality,\textsuperscript{23} yielding the highest percentage of physician initiated discussion. In turn, situations related to other ethical dilemmas resulted in 30% of physicians reportedly conversing with patients about religious matters. Interaction in other situations - frightening diagnoses (27%), depression (15%), and minor illnesses/injuries (1%) – was less frequent.\textsuperscript{24}

Analysis of religion/spirituality in the lives of practicing physicians is limited within the study conducted by Curlin et al. One obvious reason is that the survey was self-reported rather than directly observed. Secondly, only 56% of the selected physicians completed the survey. While it is impossible to know why 44% of the surveyed population chose not to respond, one might assume that some of physicians do not identify with any religious/spiritual beliefs, and thus saw no importance in participating in the study. Measures of 'intrinsic religiosity' are also ambiguous. For example, attempting to incorporate and/or draw upon religious beliefs during everyday situations (including that

\textsuperscript{22} Curlin et al. 2005, 632; training referring to topics covered in books, personal involvement with religion/spirituality, and unspecified sources.

\textsuperscript{23} Curlin et al. 2005, 632.

\textsuperscript{24} Curlin et al. 2005, 632.
of practicing medicine) can be perceived differently by different individuals. Some doctors, may envision this as physician initiated conversations about religion/spirituality. Others, may express religious beliefs in a more reserved manner, which may not be detectable by the patient. While both of these physicians might claim to be intrinsically religious, there is no guarantee that such claims will actually influence their interactions with patients. Elsewhere, it is possible that attempting to integrate religion into one’s daily routine might be unsuccessful. Because levels of religious commitment are not clearly defined by this study - other than measuring religious service attendance - there is essentially no way to monitor the level of commitment a physician has to expressing intrinsic religiosity in the presence of their patients. Overall, commitment can look different from one physician to another, or vary from one tradition to another.

It is easy to conclude that religion plays a role in the majority of physicians’ lives, but the idea of this presence being used as a tool to better physician-patient interactions is still unclear. Despite claims of intrinsic religiosity, a majority of physicians report that they feel uncomfortable bringing up these conversations with their patients. Furthermore, as elaborated by Campbell et al. with regards to ethics training, integrating a more intensive curriculum during medical school cannot guarantee ethical doctors as a result of said training. The same reasoning can be applied to the concept of religious/spiritual training during medical school. As reworded, there is no guarantee that doctors will use this training within the context of clinical practice. Thus, imposing further training upon medical students is questionable in terms of productivity and, ultimately, success.

These studies establish that some physicians do not mind discussing religion/spirituality if the patient brings it up. As a result, Christy Ledford and a group of collaborators undertook a complementary study to investigate how a patient’s disclosure of religion and/or spirituality influence a physician’s patient centered communication (PCC). In this study, patients were given directions, specifically labeled as an Objective Structured Clinical Examination (OSCE), on how to present themselves to their physician. In these situations, patients either inquired about or disclosed personal religious/spiritual information relative to their medical state (Table 4).

Physician responses were categorized in three different ways: (a) efforts of conversation control, (b) partnership building, and (c) supportive talk. These responses ultimately allow the motives of a physician's conversation tactics to be revealed.

Furthermore, establishing this categorization, or code, offers some insight into how religion and medicine are currently integrated when conversations are initiated by

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28 Ledford et al. 2015, 139
patients. It also indicates how physicians can improve in order to make such interactions constructive for building relationships with patients (Table 5).

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>Sample Quote</th>
</tr>
</thead>
</table>
| Control    | Physician asserts communicative control.        | Patient: “I wondered if you find comfort in that healing that other people may be praying for you if in a difficult time or hard time because I could use some comfort.”  
Physician: “I’d rather take it back to you. You’re the first priority.”  
Physician: “This is your diagnosis. This is about you; it’s really not about me.” |
| Partnership building | Physician assesses patient input for decision making. | Physician: “Do you feel like it would be beneficial to you if I prayed for you or we prayed together?”  
Physician: “Do you need any extra resources from us?” |
| Supportive talk | Physician expresses affective support to patient. | Physician: “I think that’s a good thing to do especially if you have a strong faith. I think that’s a great way to kind of help release some of the anxiety that you have.”  
Physician: “I understand that a new diagnosis, especially a diagnosis that had a poor outcome with your mother, can cause a lot of anxiety.” |

Table 5. Coding Scheme with Sample Quotes from Data. The code for determining the effect of the phrase on the interaction between the patient and physician is displayed above. Quotes are supplemented from data.

In documenting this work, Ledford’s group found it important to include the demographics of patient characteristics, suggesting that interactions between any two people can vary depending on each person’s gender, ethnicity, and religion. For example, Table 6 provides demographic information/characteristics. However, one could argue that the number of inquiry cases and the number of disclosure cases by each group of patients is of greater importance. For example, the total

<table>
<thead>
<tr>
<th>Gender</th>
<th>Disclosure</th>
<th>Inquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>10/27</td>
<td>10/24</td>
</tr>
<tr>
<td>Male</td>
<td>17/27</td>
<td>17/24</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>20/27</td>
<td>20/24</td>
</tr>
<tr>
<td>Black</td>
<td>3/27</td>
<td>3/24</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1/27</td>
<td>1/24</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>1/27</td>
<td>1/24</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School</td>
<td>20/27</td>
<td>20/24</td>
</tr>
<tr>
<td>College</td>
<td>5/27</td>
<td>5/24</td>
</tr>
<tr>
<td>Self-identified religious affiliation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>3/27</td>
<td>3/24</td>
</tr>
<tr>
<td>Methodist</td>
<td>3/27</td>
<td>3/24</td>
</tr>
<tr>
<td>Baptist</td>
<td>1/27</td>
<td>1/24</td>
</tr>
<tr>
<td>Other</td>
<td>1/27</td>
<td>1/24</td>
</tr>
<tr>
<td>Age</td>
<td>31.13</td>
<td>31.11</td>
</tr>
<tr>
<td>Years of practice</td>
<td>3.64</td>
<td>3.63</td>
</tr>
<tr>
<td>Perceived importance of religion/spirituality</td>
<td>4.19</td>
<td>4.19</td>
</tr>
</tbody>
</table>

Table 6. OSCE Participant Characteristics. Specific qualities of the participants who acted as patients are provided above. Three columns indicated the total numbers and percentages of the participants, those who were assigned to disclose information about religion/spirituality, and those who were assigned to inquire about religion/spirituality.

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29 Ledford et al. 2015, 140.
number of inquiries presented was 45 and the total number of disclosures was 46.\textsuperscript{30}

When analyzing this data, it is evident that a minority of physicians found it necessary to exert their control over the conversation. Whether the majority found it pertinent to the patient's well-being that religion/spirituality be discussed is less apparent. Although, perhaps physicians felt uncomfortable during the situation. If this were the case, maybe physicians simply refused to deny the patient of a time to vent their feelings. Regardless, a minority of physicians found it necessary to control the conversation by avoiding the inquiry, and even less so with a disclosure. As it happens, patient disclosure triggered the most responses from physicians in both partnership building and supportive talk related feedback. Patient disclosure slightly yielded more partnership building style responses rather than supportive talk. Yet, when it comes to patient inquiry, the difference between the two is hardly considerable (Figure 1).

Perhaps the most interesting aspect of this study is the number of physicians who participated in a conversation about religion/spirituality when prompted by their patients.

\textsuperscript{30} Ledford et al. 2015, 140
A majority chose this, rather than resorting to a physician-centered perspective like that adopted by the minority of physicians who manifested conversation control tactics. However, due to sample size and single site characteristics of the experiment, the study claims that statistical significance is more difficult to determine.\\(^{31}\)

**Patient’s Perspective**

In order to observe how relationships between healthcare providers and patients are affected by the presence of religion, one study provides insight by turning to the patients. In "Do Patients Want Physicians to Inquire About Their Spiritual or Religious Beliefs If They Become Gravely Ill?" John W. Ehman, Barbara B. Ott, Thomas H. Short, Ralph C. Ciampa, and John Hansen-Flaschen explore the effects of religious engagement on trust and comfort, from the perspective of the patient.\\(^{32}\) The research comprised of a multiple question survey that gathered information based on patient characteristics and opinions on religious integration in physician oriented care. At the University of Pennsylvania Medical Center, 177 adult patients who visited the pulmonary outpatient practice completed the survey within a two month time frame. This survey was administered in the waiting room by faculty of the pastoral care department.\\(^{33}\)

Of the 177 patients who completed the survey, approximately 77% claimed to believe in “life after death.” An even higher percentage (90%) held the belief that illness recovery could be influenced by prayer.\\(^{34}\) Responses varied to questions about the patients’

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\\(^{31}\) Ledford et al. 2015, 138  
\\(^{33}\) Ehman et al. 1999, 1803  
\\(^{34}\) Ehman et al. 1999, 1804
preference with respect to physicians inquiring about religious and/or spiritual beliefs while the patient was (theoretically) severely ill.

Table 7 (labeled Table 2 in the source) shows the number of patients who would prefer physicians inquire about their religious/spiritual beliefs in the instance they became severely ill. These patients were categorized by their self-identified religiosity. Exactly 50% of the non-religious patients preferred to still have their physician ask about their beliefs, while the other two groups had a majority of their study population prefer the physician’s inquiry. Overall, this data indicates that a majority of these patients would appreciate their physicians asking about their beliefs.

Table 8 displays the results of patients responding to whether their physician should ask about their religious/spiritual beliefs. However, there is a difference between this data and that of Table 7. These patients were categorized based upon whether their own religious/spiritual beliefs would influence their medical decisions if they were severely ill. These results display nearly all of the patients with these influential religious beliefs would appreciate a physician’s inquiry. On the other hand, patients without these beliefs were split on this issue, with nearly half still appreciating the physician’s questioning. As for those without a clear opinion on these beliefs, none of them objected to
such scrutiny of a physician. In conclusion, a majority of patients would appreciate if they were asked by their doctor about their religious/spiritual beliefs.

The data presented in Table 9 also documents the responses of patients. Categories are likewise similar to those used in collecting the data displayed in Table 8 (the degree to which religious/spiritual beliefs might influence medical decisions). However, these patients were additionally asked whether or not their trust in a physician would be enhanced if the doctor was concerned with their religious/spiritual beliefs during a time of severe illness. While response patterns are similar to those provided in Table 8, opinions among patients who did not claim to have strong religious beliefs were surprising. An overwhelming majority of patients...

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

<table>
<thead>
<tr>
<th>I Have . . . Beliefs*</th>
<th>Disagree</th>
<th>No Opinion</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would like my doctor to ask†</td>
<td>28</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Disagree</td>
<td>4</td>
<td>24</td>
<td>4</td>
</tr>
<tr>
<td>No opinion</td>
<td>25</td>
<td>16</td>
<td>74</td>
</tr>
</tbody>
</table>

* "I have spiritual/religious beliefs that would influence my medical decisions if I became gravely ill."† "If I become gravely ill, then I would like my doctor to ask whether I have spiritual/religious beliefs that would influence my medical decisions." Responses to the 2 questions are significantly related by χ² analysis (P < .001).

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

<table>
<thead>
<tr>
<th>I Have . . . Beliefs*</th>
<th>Disagree</th>
<th>No Opinion</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It would strengthen my trust in a doctor†</td>
<td>25</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Disagree</td>
<td>7</td>
<td>17</td>
<td>7</td>
</tr>
<tr>
<td>No opinion</td>
<td>26</td>
<td>20</td>
<td>69</td>
</tr>
</tbody>
</table>

* "I have spiritual/religious beliefs that would influence my medical decisions if I became gravely ill."† "If I become gravely ill, then it would strengthen my trust in a doctor if he or she asked about any spiritual or religious beliefs that influence my medical decisions." Responses to the 2 questions are significantly related by χ² analysis (P < .001).

Table 8. Relationship Between Relevant Religious or Spiritual Beliefs and Patient Receptivity to Inquiry About Those Beliefs. In this data, patients claimed to have beliefs that their spiritual/religious influences would impact the way they would make medical decisions if they had become gravely ill. Additionally, patients were asked if they would prefer to have their physician inquire about religion/spirituality in the case the patient was gravely ill. The table indicates in the title that it was the third table in the article, but in this paper it is the eighth (as shown by this legend).

Table 9. Relationships Between Relevant Spiritual or Religious Beliefs and Effect of Physician Inquiry on Patient Trust. Patients responded to whether or not they had beliefs that their spiritual/religious influences would impact the way they would make medical decisions if they became gravely ill. Then patients indicated if their trust in their physician would be enhanced if their physician were to inquire about their spiritual/religious beliefs in those gravely ill situations. The table indicates in the title that it was the fourth table in the article, but in this paper it is the ninth (as shown by this legend).
affirmed that a physician’s inquiry about their religious beliefs would strengthen their trust in those doctors. In fact, even patients who weren’t religious still expressed that their trust would be strengthened in physicians who asked about their beliefs (except for seventeen patients who did not provide clear answer). Overall, a majority of patients would develop more trust in their physicians in these particular circumstances.\textsuperscript{35}

This study also documents that only 15\% of the patients surveyed ever encountered a doctor who inquired about their religious/spiritual beliefs. These results vary significantly from previous studies conducted in a similar manner. Earlier research suggests a smaller percentage of patients (21\%-40\%) indicated that they would appreciate physicians inquiring about their religious/spiritual beliefs.\textsuperscript{36} Differences in hospital location, treatment departments, and patient religiosity could very well account for these observed shifts. However, it is arguable that an additional reason for these shifts might simply be a function of the surveys’ wording. Daaleman and Nease asked whether physicians should ask patients questions about their religion and personal faith.\textsuperscript{37} In turn, Ehman’s group argues that this direct and open-ended question, could be intimidating for patients to answer – especially without any given context to the situation in which a physician might pose such a question.\textsuperscript{38} This context is more clearly defined by Ehman’s team as “during a time of grave illness.” Results suggest that providing this context will leave patients more open to existential discussion of religion and spirituality.

\textsuperscript{35} Ehman et al. 1999, 1805
\textsuperscript{37} Daaleman, T and Nease, D. 1994, 568.
\textsuperscript{38} Ehman et al. 1999, 1805
This study offers some insight when considering the practical aspects of integrating medicine and religion. Ethically speaking, such interaction hinges on both the patient and the provider’s willing participation. This study offers useful insight into the patient’s perspective. Yet, as noted, the circumstances in which this type of interaction takes place are significant. For example, asking a patient about their religious beliefs during a regular physical examination - one in particular where the patient is undoubtedly healthy without medical problems - might be unreasonable. The patient could be uncertain of the physician’s intentions when asked the question. Possible misconceptions could be: wondering if the physician knows something they don’t, or becoming uncomfortable by the physician’s effort of trying to make the interaction better than it needs to be. On the other hand, the patient may enjoy speaking about their beliefs. Perhaps they understand and appreciate that such a query is the physician’s effort to make the interaction more personal and less procedural.

Further investigation of the patient’s perspective raises additional questions that should be considered. For example, one essay offers a personal recollection from a patient, who was asked of his/her religious preference. Charles Krauthammer’s “Will It Be Coffee, Tea, or He? Religion Was Once a Conviction. Now It Is a Taste” recalls a personal experience at a hospital that asked of his religious preference.39 This work was full of intended comical responses to this situation, such as the following, “Preference? I take my coffee black, my wine red... and my shirts lightly starched. Oh yes, and put me down for Islam.”40 Despite the intent and age of this essay, my extrapolation from it raises an interesting question about

contemporary (and future) healthcare. It may be possible that incorporating religion into a typical physician-patient interaction can open a door that leads to future demands of physicians in order to increase patient comfort. While this may seem like a reasonable door to open - and it is fair to recognize that the idea of religion in medicine may already be opening this door - it needs to be done carefully. The point of this is to avoid two possible outcomes: overwhelming the physician with an abundance of knowledge in various fields that might possibly contribute to patient comfort, or a change in healthcare operations so that patients are assigned to physicians who can cater to their specific needs. These are both examples of potential ethical dilemmas (among many) that need to be considered when designing an appropriate integration of religion and medicine.

In exploring the benefits of integrating religion into healthcare practices, it is fair to say that a physician’s knowledge of other non-medicine-related fields and/or social issues could also contribute to quality care. While a patient may not feel comfortable discussing religion during an interaction with their doctor, s/he might be impacted by other social issues. For example, physicians with a background in women and gender studies might be more adept at addressing the needs of patients who are subjected to gender discrimination. Such training predisposes a physician to using their education in a way that can be professionally empathic for patients who are experiencing such discrimination. Similarly, if a physician has an education in political science, s/he might be more attuned to engage a patient’s political beliefs and thus relate to them in a way to make them more comfortable. While these may be considered valid claims, the ethical dilemma arises as

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41 US Census Bureau, "Reported Voting and Registration, by Sex and Single Years of Age: November 2014." July 1, 2015
such: how much knowledge should be considered unreasonable on the behalf of physicians? While medical ethics may call for physicians to avoid inflicting more harm than good, who gets to define whether an interaction is beneficial or not? If the patient does, why should they not demand a doctor who can provide an interaction that would make them more comfortable during a particular procedure/visit? The point here is that demanding physicians to address religion/spirituality with their patients may result in further demands of physicians to address other issues with their patients.

The next ethical dilemma rooted within this essay by Krauthammer builds upon the previous. If it is unethical to demand a physician to be trained in every social issue (that is, those that would offer potential for a better patient interaction), would the dynamic of typical healthcare in this society demand a shift towards obscenely specialized providers? Would patients essentially apply for physicians who specialized in a particular religion and/or social issue? This type of demand would place a great amount of strain upon aspiring physicians. Some of whom may not know what specialty of medicine they would like to pursue, let alone predetermine what type of patient interactions they will facilitate. Not to mention, the demand for certain physicians could be problematic. What if the number of aspiring physicians who are trained to deal with one particular social issue exceeds the number demanded by patients? Would this dilemma result in a failure to provide quality healthcare to patients due to a lack of preferred physicians? Needless to say, certain integrations of religion with medicine calls for caution. The potential for ethically problematic outcomes should undoubtedly be considered.

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Krauthammer, 1998, 92

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**Conclusion**

Investigating whether the presence of religion in medicinal settings influences the interaction between healthcare providers and patients is a multidimensional process. As a result, this paper juxtaposes several studies in order to develop a reasonable conclusion. Curlin et al. provide contemporary similarities and differences regarding religion and spirituality among providers and patients. They observe that physicians are more likely to attend religious services, but patients are more likely to apply their religious perspectives to other areas of life. Furthermore, reliance on religious beliefs as coping mechanisms varies between providers and patients. These scholars also observe that this is not enough evidence to precisely conclude whether such differences affect patient experiences. However, they suggest that it seems reasonable to believe such disparity contributes to the disconnect between physicians and patients. Derivatively, it is valid to assume the resolution of this ‘disconnect’ might enhance the relationship between providers and patients. This could foster more genuine interactions and more holistic experiences for the patient and provider alike.

Ledford et al. explore the effects of religion and spirituality in medical practices. After observing physician and patient interactions, they conclude that this integration holds significant importance. These researchers suggest physicians are uncomfortable when initiating religious conversations. As a result, this leads to a physician-centered perspective of care, which can limits the extent to which the patient’s needs are addressed. Training physicians to appropriately initiate and respond to religious/spiritual conversations may improve their ability to care for patients. A physician’s awareness of

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43 Curlin et al. 2005, 632
their own intuitive responses can also contribute to enhanced interaction. Based on these research results, Ledford et al. conclude that the benefits of incorporating religious training into medical curricula are significant.44

Ehman et al. turn to the patient’s perspective on integrating religion into medical care. In their sample population, 90% of those who were religious believed prayer could influence illness recovery. Two-thirds of the sample also stated that they would welcome the incorporation of questions about religious beliefs alongside questions about their medical history records. Of these respondents, however, only 15% reported a physician ever initiating such inquiry.45 This suggests a ‘mis-match’ in provider-patient religious interactions. Ehman et al. note that their results cannot be generalized for the greater population due to limited sample size. However, it is reasonable to assume that the results of somewhat limited study are not exceptional in terms of physician conduct. Even on a limited scale, this research suggests that training physicians to address religious/spiritual beliefs is more likely to improve patient-physician interactions. In fact, the study found only 16% of respondents would not welcome a physician’s inquiry on the matter. Ehman et al. suggest that carefully wording these questions could prevent discomfort among these patients.46 Even such qualitative distinctions underscore the importance of implementing this training. The fact that the number of patients who would appreciate physicians asking about their religion/spirituality was higher compared to values obtained in similar studies,47 suggests that there is room for continued research in this area.

44 Ledford et al. 2015, 141
45 Ehman et al. 1999, 1803
46 Ehman et al. 1999, 1803
Potential ethical dilemmas caused by integrating religion and medicine into provider-patient interactions also need to be considered. Krauthammer argues that if such dilemmas are not properly addressed, this could have serious implications for the healthcare system. The question of how much training may be required of physicians is important. This study's consideration of the cost and benefits of such training raises valid questions.

From a personal standpoint, I provided examples of religion being intentionally integrated with medicine. Of importance is that my stories are merely observations that were gathered prior to my decision to begin researching this topic. Under no circumstances did I collect observations in a biased way that promotes the integration of religion and medicine. In fact, I experienced plenty of interactions that were not related to religion and were in fact meaningful. Therefore, I cannot claim that religion is required in order for patients to have a meaningful interaction with healthcare providers. However, in light of my research and experiences, I argue that religion does have a place in healthcare. Furthermore, history makes this evident by showing how religion and medicine were once inherently linked. Yet from one point of view, as presented in this thesis, religion and medicine remain linked to this day. Perhaps it is merely our disregard of this linkage that resulted in its absence from patient-provider interactions. Subsequently, this has made interactions less wholesome. By evidence provided herein, increasing the quality of patient-provider interactions begins by recognizing the presence of religion/spirituality and implementing proper ways for providers to utilize it.
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