Original Article

Providing Guidance to Patients: Physicians' Views About the Relative Responsibilities of Doctors and Religious Communities

Alexander H. Sheppe, BA, BS, Roscoe F. Nicholson, III, MA, Kenneth A. Rasinski, PhD, John D. Yoon, MD, and Farr A. Curlin, MD

Objectives: Patients' religious communities often influence their medical decisions. To date, no study has examined what physicians think about the responsibilities borne by religious communities to provide guidance to patients in different clinical contexts.

Methods: We mailed a confidential, self-administered survey to a stratified random sample of 1504 US primary care physicians (PCPs). Criterion variables were PCPs' assessment of the responsibility that physicians and religious communities bear in providing guidance to patients in four different clinical scenarios. Predictors were physicians' demographic and religious characteristics.

Results: The overall response rate was 63%. PCPs indicated that once all medical options have been presented, physicians and religious communities both are responsible for providing guidance to patients about which option to choose (mean responsibility between "some" and "a lot" in all scenarios). Religious communities were believed to have the most responsibility in scenarios in which the patient will die within a few weeks or in which the patient faces a morally complex medical decision. PCPs who were older, Hispanic, or more religious tended to rate religious community responsibility more highly. Compared with physicians of other affiliations, evangelical Protestants tended to rate religious community responsibility highest relative to the responsibility of physicians.

Conclusions: PCPs ascribe more responsibility to religious communities when medicine has less to offer (death is imminent) or the patient faces a decision that science cannot settle (a morally complex decision). Physicians' ideas about the clinical role of religious communities are associated with the religious characteristics of physicians themselves.

Key Words: complementary and alternative medicine, doctor–patient relationship, patient guidance, religion/spirituality, religious community

For physicians, the role that religious communities play in medical decision making is complicated. More than half of all Americans participate in local religious congregations (61%) and say religion is extremely important in their lives (56%).[1] It is no surprise, then, that religious communities often influence patients' medical decisions.[2,3] Moreover, numerous studies have found that regular participation in a religious community is associated with improved physical and mental health outcomes.[4–14] Physicians themselves report that religious communities often help patients cope with and navigate the experience of illness.[2,3]

Key Points

- Primary care physicians indicated that once all medical options have been presented to patients, physicians and religious communities both are responsible for providing guidance to patients about which option to choose.
- Primary care physicians ascribe more responsibility to religious communities when medicine has less to offer (death is imminent) or the patient faces a decision that science cannot settle (a morally complex decision).
- Physicians' ideas about the clinical role of religious communities are associated with the religious characteristics of physicians themselves.

From the Pritzker School of Medicine, the Department of Comparative Human Development, the Section of General Internal Medicine, Department of Medicine, and the Section of Hospital Medicine and Ethics, Department of Medicine, University of Chicago, Chicago, Illinois.

Reprint requests to Dr Farr A. Curlin, University of Chicago, 5841 S Maryland Ave, MC 2007, Chicago, IL 60637. E-mail: fcurlin@medicine.bsd.uchicago.edu

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For a patient facing a medical decision, his or her physician and religious community represent two sources of guidance that at times can conflict.[2,3,15,16] In particular, when religious communities encourage patients to act against their physicians' clinical recommendations,[2,3,16] doctors sometimes conclude that in trying to provide guidance, the religious community is actually causing harm.[2,3] Although studies have documented that physicians' religious characteristics shape their clinical practices,[3,17–23] to date no study has examined doctors' opinions about the role that patients' religious communities should play in guiding patients' clinical decisions.

The present study uses data from a national survey of primary care physicians (PCPs) to assess how much responsibility physicians believe religious communities bear in providing guidance to religious patients in four different clinical contexts and how much responsibility religious communities bear relative to physicians. Based on findings from prior studies, we hypothesized that PCPs would ascribe more responsibility to religious communities in situations in which medicine has less to offer (death is imminent) or the decision is based more on values than on scientific data (the patient faces a morally complex decision).[22,24–29] We further hypothesized that regardless of the scenario, PCPs who are more religious would be more likely to indicate that religious communities are responsible for providing guidance to patients.

Methods

Between September 2009 and June 2010, we mailed a confidential, self-administered questionnaire to a stratified random sample of PCPs drawn from the American Medical Association Physician Masterfile, a database intended to include all of the physicians in the United States. Our sample consisted of 1504 US generalist physicians with a primary board specialty of internal medicine, family medicine/practice, or general practice and with no secondary subspecialty. To increase minority religious group representation, we used validated surname lists to create four strata and oversampled from these strata.[30–32] We sampled 121 PCPs with typical south Asian surnames, 171 PCPs with typical Arabic surnames, 86 PCPs with typical Jewish surnames, and 1126 additional PCPs (from all individuals whose surnames were not on one of these ethnicity-based lists). The first mailing included a $20 bill and the third offered an additional $30 for participation. All of the data were double keyed, cross-compared, and corrected against the original questionnaires. The study was approved by the University of Chicago institutional review board.

For these analyses the primary criterion variables were the responses of PCPs to the following survey item: "Once the medical options have been described to patients, how much responsibility do physicians and religious communities have for providing guidance to patients in each of the following situations (assuming patients belong to a religious congregation or community)? The patient: (a) faces a frightening medical diagnosis or crisis, (b) will die within a few weeks, (c) suffers from anxiety or depression, and (d) faces a morally complex medical decision." For each scenario, response options were none, a little, some, or a lot, coded zero to three.

Primary predictors were measures of religious characteristics of PCPs. Religious affiliation was categorized as none, Hindu, Jewish, Muslim, Catholic (includes Eastern Orthodox), evangelical Protestant, nonevangelical Protestant, or other religion. We measured the importance of religion by asking, "How important would you say your religion is in your life?" Response options were "Not applicable. I have no religion," "Not important in my life" (these two options were grouped together for analyses), "Fairly important in my life," "Very important in my life," or "The most important part of my life." The demographic characteristics (sex, race, age, region, and immigration history) of PCPs also were included.

Stratum weights were calculated to account for oversampling from the ethnic surname strata (the design weight). We also created a poststratification adjustment weight to correct for a slightly higher response rate among US medical school graduates (65% response) versus international medical school graduates (56% response; $P = 0.002$) and among physicians whose roles are primarily teaching or "other" (75%, 103/138) versus office-based, hospital-based, research, administrative, or unclassified (62%, 793/1288; $P = 0.004$). Weights were the inverse probability of a person with the relevant characteristic being in the final dataset. The final weight for each case/respondent was the product of the design weight and the poststratification adjustment weight. This enabled us to adjust for sample stratification and variable response rates to generate estimates for the population of US PCPs.[33] We used paired t tests to examine how the mean responsibility that PCPs ascribed to physicians and to religious communities differed across the four clinical scenarios. Within each scenario, we compared the mean responsibility ascribed to religious communities with that ascribed to physicians. We used the Pearson chi square test and multivariable logistic regression to test whether physicians' religious and demographic characteristics were associated with believing that religious communities have "a lot" of responsibility for providing guidance in each scenario. Lastly, we generated overall mean ratings (across all four scenarios) of physician and religious community responsibility. We then used ordinary least squares multivariable linear regressions to assess the extent to which each physician characteristic independently predicted religious community responsibility, physician responsibility, and religious community responsibility relative to physician responsibility. Statistical significance was measured at $\alpha = 0.05$ and was not adjusted for multiple comparisons. All of the analyses were conducted using the survey design–adjusted commands of STATA SE statistical software (version 11.0, StataCorp, College Station, TX).

Results

Of the 1504 PCP cases fielded, 77 had invalid addresses or were no longer practicing medicine. Among the eligible physicians, the response rate was 63% (896/1427). The response

rates varied by stratum: 53% (85/162) among those with typical Arabic surnames, 56% (63/112) among those with typical south Asian surnames, 70% (59/84) among those with typical Jewish surnames, and 64% (689/1069) among the remaining PCPs. Response rates did not differ significantly by age, sex, region, or board certification. Respondents' demographic and religious characteristics are shown in Table 1.

As seen in Table 2, PCPs indicated that both physicians and religious communities are responsible for providing guidance to patients, with mean responsibility for groups falling between "some" and "a lot" in all four clinical scenarios. PCPs rated physician responsibility most highly for the scenario in which a patient faces a frightening diagnosis or medical crisis, followed by patient death within a few weeks and by a patient experiencing anxiety or depression, and lowest when a patient faces a morally complex medical decision (mean ratings 2.9 vs 2.8 vs 2.6 vs 2.4, respectively; $P < 0.0001$ for all of the comparisons). PCPs rated religious community responsibility most highly when a patient will die within a few weeks, then by a patient facing a morally complex decision, followed by a patient facing a frightening diagnosis or medical crisis, and lowest when a patient experiences anxiety or depression (mean ratings 2.7 vs 2.4 vs 2.3 vs 2.0, respectively; $P < 0.0001$ for all comparisons). On average, PCPs indicated that even after the medical options have been described to patients, physicians still have more responsibility than religious communities for providing guidance in all of the scenarios with the exception of a morally complex medical decision, for which there was no significant difference.

Table 1. Respondent characteristics (n = 896)

Characteristic	No. (%)[a]
Sex	
Female	324 (36)
Male	572 (64)
Race	
White	625 (71)
Black or African American	53 (6)
Asian	142 (16)
Hispanic or Latino	41 (5)
Other	22 (2)
Age, y[b]	
25–36	226 (25)
37–44	224 (25)
45–53	225 (25)
54–65	221 (25)
Region	
South	295 (33)
Northeast	198 (22)
Midwest	216 (24)
West	187 (21)
Religious affiliation	
None	96 (11)
Hindu	42 (5)
Jewish	97 (11)
Muslim	60 (7)
Roman Catholic and Eastern Orthodox	212 (24)
Protestant, evangelical	95 (11)
Protestant, not evangelical	227 (26)
Other religion	39 (4)
Importance of religion	
Not important/not applicable	215 (25)
Fairly important	283 (32)
Very important	251 (29)
Most important	127 (15)

[a] *Percentages may not sum to 100 as a result of rounding.*
[b] *Average respondent age 44.7 years, standard deviation 10.2, range 25–65.*

Table 2. Average responsibility PCPs believe physicians and religious communities bear for providing guidance to patients (0 = none, 1 = a little, 2 = some, 3 = a lot)

	Physician	Religious community	
Scenario	Mean (SD)	Mean (SD)	*P*
Frightening diagnosis/ crisis	2.9 (0.4)	2.3 (0.8)	<0.0001
Death within a few weeks	2.8 (0.5)	2.7 (0.6)	0.0002
Anxiety/depression	2.6 (0.5)	2.0 (0.8)	<0.0001
Morally complex medical decision	2.4 (0.7)	2.4 (0.8)	0.3100

PCP, primary care physician; SD, standard deviation.

Table 3 shows the likelihood that a PCP would indicate that religious communities have "a lot" of responsibility in each scenario and stratified by PCP characteristics. PCP responses differed significantly by religious affiliation and by importance of religion (χ^2; $P < 0.01$ in every scenario). In each case, evangelical Protestants were most likely to indicate that religious communities have "a lot" of responsibility, as were those who rated religion as the "most important" part of their lives. With respect to the scenario in which the patient experiences anxiety or depression, PCPs with a religious affiliation of none (adjusted odds ratio [OR] 0.3, 95% confidence interval [CI] 0.1–0.8), Jewish (OR 0.2, 95% CI 0.1–0.5), Roman Catholic/Eastern Orthodox (OR 0.5, 95% CI 0.3–0.9), or nonevangelical Protestant (OR 0.5, 95% CI 0.3–0.9) were less likely to say that religious communities have "a lot" of responsibility. The same was true for those with religious affiliations of none (OR 0.3, 95% CI 0.1–0.6), Jewish (OR 0.2, 95% CI 0.1–0.6), and Hindu (OR 0.4, 95% CI 0.2–0.99) in the scenario in which the patient faces a morally complex medical decision. Compared with PCPs who stated that religion was "not important" or "not applicable," those who stated that religion was the "most important" part of their life were more likely to believe that religious communities have "a lot" of

Table 3. PCPs' agreement that religious communities have "a lot" of responsibility to provide guidance in 4 scenarios, by PCP religious affiliation and importance of religion

	Frightening diagnosis/crisis			Death within a few weeks			Anxiety/depression			Morally complex medical decision		
	Bivariate		Multivariable[a]	Bivariate		Multivariable[a]	Bivariate		Multivariable[a]	Bivariate		Multivariable[a]
Religious characteristic	No. (%)	P (χ^2)	OR (95% CI)	No. (%)	P (χ^2)	OR (95% CI)	No. (%)	P (χ^2)	OR (95% CI)	No. (%)	P (χ^2)	OR (95% CI)
Religious affiliation												
None	32 (32)	0.002	0.7 (0.3–1.5)	66 (70)	0.001	0.7 (0.3–2.0)	18 (19)	<0.0001	0.3 (0.1–.8)[c]	36 (34)	<.0001	0.3 (0.1–0.6)[c]
Hindu	14 (32)		0.5 (0.2–1.4)	26 (63)		0.4 (0.1–1.2)	11 (28)		0.4 (0.1–1.2)	15 (32)		0.2 (0.1–0.6)[c]
Jewish	31 (35)		0.7 (0.3–1.5)	62 (68)		0.5 (0.2–1.2)	11 (12)		0.2 (0.1–.5)[c]	44 (53)		0.4 (0.2–0.99)[c]
Muslim	20 (32)		0.4 (0.2–1.1)[b]	37 (68)		0.5 (0.2–1.3)	15 (27)		0.4 (0.1–1.1)[b]	30 (53)		0.4 (0.2–1.1)[b]
Roman Catholic/Eastern Orthodox	99 (48)		1.0 (0.5–1.8)	172 (81)		0.8 (0.3–1.9)	58 (30)		0.5 (0.3–0.9)[c]	130 (64)		0.7 (0.3–1.3)
Protestant, evangelical	55 (62)		1.0 referent	82 (88)		1.0 referent	48 (55)		1.0 referent	72 (77)		1.0 referent
Protestant, not evangelical	112 (49)		1.1 (0.6–1.9)	188 (85)		1.0 (0.4–2.3)	71z (30)		0.5 (0.3–0.9)[c]	140 (59)		0.6 (0.3–1.1)[b]
Other religion	18 (44)		0.7 (0.3–1.7)	29 (73)		0.6 (0.2–1.7)	14 (36)		0.5 (0.2–1.2)	22 (58)		0.5 (0.2–1.3)
Importance of religion												
Not important/not applicable	74 (35)	<0.0001	1.0 referent	146 (70)	0.0005	1.0 referent	43 (21)	<0.0001	1.0z referent	91 (44)	<.0001	1.0 referent
Fairly important	101 (36)		0.9 (0.5–1.5)	206 (74)		1.2 (0.7–2.2)	58 (23)		0.8 (0.5–1.5)	147 (52)		1.1 (0.7–1.8)
Very important	123 (49)		1.5 (0.9–2.5)	208 (86)		2.3 (1.2–4.4)[c]	83 (35)		1.3 (0.7–2.4)	163 (65)		1.6 (0.98–2.8)[b]
Most important	85 (69)		3.3 (1.7–6.4)[c]	107 (86)		2.3 (1.03–5.1)[c]	64 (52)		2.2 (1.1–4.3)[c]	92 (72)		1.9 (0.98–3.8)[b]

[a]*Multivariable analyses also include sex, age, race, and region as covariates.*
[b]*$0.05 \leq P \leq 0.10$.*
[c]*$P < 0.05$.*
CI, confidence interval; OR, odds ratio; PCP, primary care physician.

responsibility when the patient faces a frightening diagnosis or medical crisis (OR 3.3, 95% CI 1.7–6.4), when the patient will die within a few weeks (OR 2.3, 95% CI 1.03–5.1), and when the patient experiences anxiety or depression (OR 2.2, 95% CI 1.1–4.3).

Table 4 shows the results of ordinary least squares regression analyses for mean, across-scenario ratings of the responsibility for providing guidance. Models are presented for physician responsibility, religious community responsibility, and the responsibility of religious communities relative to physicians. In adjusted analyses, PCPs older than 44 years rated both physician and religious community responsibility more highly than those aged 36 years or younger and male PCPs rated physician responsibility lower than did female PCPs (b = −0.08, 95% CI −0.13 to −0.02). Compared with white PCPs, Asian PCPs rated physician responsibility lower (b = −0.12, 95% CI −0.23 to −0.01) and Hispanic/Latino PCPs rated religious community responsibility higher (b = 0.18, 95% CI 0.01–0.36). Compared with evangelical Protestants, PCPs rated religious community responsibility lower if they had no religious affiliation (b = −0.29, 95% CI −0.49 to −0.08) or were Hindu (b = −0.44, 95% CI −0.7 to −0.18), Jewish (b = −0.27, 95% CI −0.43 to −0.1), Muslim (b = −0.32, 95% CI −0.54 to −0.09), or other religion (b = −0.24, 95% CI −0.46 to −0.01). Muslims rated physician responsibility more highly compared to evangelical Protestants (b = 0.20, 95% CI 0.05–0.36). Compared with PCPs who said religion was "not important" or "not applicable," PCPs who said religion was "very important" in their life or the "most important" part of their life rated religious community responsibility more highly (b = 0.24 and 0.30, respectively, 95% CI 0.09–0.38 and 0.13–0.47, respectively). Those who said religion was "most important" also rated physician responsibility more highly (b = 0.14, 95% CI 0.01–0.26).

The relative responsibility of religious communities (compared with physicians) was rated lower by PCPs from the northeast United States (b = −0.15, 95% CI −0.28 to −0.02) compared with those from the south and higher by Hispanic/Latino (b = 0.24, 95% CI 0.09–0.39) and Asian (b = 0.19, 95% CI 0.03–0.34) PCPs compared with those who were white. Evangelical Protestants rated the relative responsibility of religious communities higher than did PCPs from all of the other religious groups. To illustrate the combined effects of these independent predictors, PCPs who were older than 44 years, were from the south, were evangelical Protestant, and for whom religion was "very" or "most" important (n = 31) rated religious community responsibility relative to physician responsibility 0.7 points higher (mean −0.01 vs −0.71; $P = 0.0002$) than PCPs who were aged 44 years or younger, from the northeast, held any affiliation other than evangelical Protestant, and for whom religion was not important (n = 63).

Discussion

This national survey found that PCPs believe that once the medical options have been described to patients, physicians still bear more responsibility than religious communities to provide guidance to patients about which option to choose across three of four clinical scenarios studied. PCPs believe religious communities have "some" or "a lot" of responsibility to provide guidance, particularly in settings of imminent patient death and when the patient faces a morally complex medical decision. Rating the religious community's responsibility more highly is associated with older age, Hispanic or Latino ethnicity, evangelical Protestant affiliation, and an indication that religion is "very important" or the "most important" part of one's life.

Findings from prior studies led us to predict that PCPs would believe that religious communities have more responsibility to provide guidance when patients face imminent death or a morally complex medical decision. Luckhaupt et al[22] found that as the gravity of a patient's condition increased, primary care residents were more likely to endorse addressing spiritual and religious issues in the patient encounter. Monroe et al[24] found that most physicians "would not ask about spiritual issues unless a patient were dying." Daaleman and Frey[25] found that physicians were most likely to refer patients to clergy for issues associated with end-of-life care (76%) and for marital and family counseling (73%) and were less likely to refer for depression and mood disorders (39%). In a national survey of physicians from all specialties, Rasinski et al[34] found that one in two (50%) physicians say they often or always inquire about religious/spiritual issues when patients are facing the end of life, and the next highest percentage (30%) was for situations in which patients face an ethical dilemma.

PCPs seem to believe that the responsibility of religious communities increases in situations in which medicine has less to offer (death is imminent) or the decision is based more on values than on scientific data (the patient faces a morally complex decision). With respect to the former, even 70% of those with no religious affiliation and 70% of those who indicated religion is not important in their lives said religious communities have "a lot" of responsibility to provide guidance to a religious patient when the patient will die within a few weeks. With respect to morally controversial decisions, studies suggest that in such cases physicians tend to shy away from providing directive guidance to patients. Yoon et al[35] found that among obstetrician-gynecologists who endorse directive counsel for typical medical decisions, more than half reject giving directive counsel for morally controversial decisions. In the present study, physicians ascribed to themselves more responsibility than religious communities in all clinical scenarios except when the patient faces a morally complex decision; for this, PCPs see themselves as sharing essentially equal responsibility with religious communities for providing guidance.

The finding that more religious PCPs were likely to endorse a guiding role for religious communities corroborates prior findings. Curlin et al[17] found that physicians with high religiosity are substantially more likely than those who are not highly religious to report that patients often mention religious/spiritual

Table 4. OLS linear regressions of PCPs' agreement that physicians, religious communities have responsibility to provide guidance

Characteristic	Religious community responsibility[a]	Physician responsibility[a]	Religious community responsibility relative to physicians[a]
Age, y			
26–36 (referent)	—	—	—
37–44	0.10	0.02	0.09
45–53	0.20[c]	0.12[c]	0.08
54–65	0.18[c]	0.11[c]	0.07
Region			
South (referent)	—	—	—
Northeast	−0.090	0.06	−0.15[c]
Midwest	−0.003	0.02	−0.02
West	−0.001	−0.02	0.02
Race			
White (referent)	—	—	—
Black or African American	−0.03	−0.06	0.03
Asian	0.07	−0.12[c]	0.19[c]
Hispanic or Latino	0.18[c]	−0.07	0.24[c]
Other	−0.03	−0.09	0.02
Sex			
Female (referent)	—	—	—
Male	−0.06	−0.08[c]	0.02
Religious affiliation			
None	−0.29[c]	0.15[b]	−0.43[c]
Hindu	−0.44[c]	0.10	−0.58[c]
Jewish	−0.27[c]	0.02	−0.29[c]
Muslim	−0.32[c]	0.20[c]	−0.52[c]
Roman Catholic and Eastern Orthodox	−0.12[b]	0.10[b]	−0.23[c]
Protestant, evangelical (referent)	—	—	—
Protestant, not evangelical	−0.11[b]	0.06	−0.17[c]
Other religion	−0.24[c]	0.08	−0.31[c]
Importance of religion			
Not important/not applicable (referent)	—	—	—
Fairly important	0.07	0.07	0.03
Very important	0.24[c]	0.10[b]	0.15[b]
Most important	0.30[c]	0.14[c]	0.19[b]
Constant	2.32	2.54	−0.23
Observations[d]	835	847	834
R^2	0.14[c]	0.06[c]	0.11[c]

[a]*Entries are unstandardized regression coefficients from OLS multivariable regression models including all variables in the table. Criterion variables in the first 2 models are mean responsibility scores across all 4 scenarios. The criterion variable in the third model is the mean of the difference of these responsibility scores (religious community minus physician).*
[b]*$0.05 \leq P \leq 0.10$.*
[c]*$P < 0.05$.*
[d]*PCPs who answered fewer than 2 of our 4 scenarios were excluded from analysis.*
OLS, ordinary least squares; PCPs, primary care physicians.

issues, to believe that religion/spirituality strongly influences health, and to interpret the influence of religion/spirituality in positive rather than negative ways. They also found that physicians who identify themselves as more religious and more spiritual, particularly those who are Protestants, are more likely to endorse a variety of ways of addressing religion/spirituality

in the clinical encounter.[20] Similarly, Luckhaupt et al[22] found that primary care residents with higher personal spirituality are more likely to say that they should be involved with a patient's religious/spiritual life. Monroe et al[24] found that physicians with higher spiritual well-being scores on the questionnaire were more likely than those with lower scores to ask about patients' religious beliefs and were more likely to pray with patients. Daaleman and Frey[25] examined clergy-referral patterns and found that physicians who reported a greater degree of religiosity had an increased tendency to refer to clergy. Evangelical Protestants stood out from all of the other religious groups. Evangelicals ascribe more responsibility to religious communities, perhaps because evangelicals tend to have higher rates of church attendance and frequency of prayer than other religious groups.[1] On the whole these findings make clear that physicians' own religious characteristics are associated with their ideas about the role of patient religiosity and religious communities in health and health care, perhaps calling for increased conversation between physicians and patients in this area.

We note several unanticipated findings that invite further research. Compared with whites, Hispanics/Latino PCPs rated religious community responsibility higher and Asian PCPs rated physician responsibility lower. In addition, Muslim PCPs rated physician responsibility more highly than any other religious group. PCPs from the northeast rated relative religious community responsibility lower than southerners, even after adjusting for religious differences among those physicians. Future research is needed to corroborate and explain these associations.

This study has several limitations. First, we surveyed only PCPs; doctors in other clinical domains may encounter different patient and clinical decisions. The four clinical scenarios presented were described without detail and different doctors may have envisioned different specific contexts when answering the questions; future studies using experimental vignettes would help to minimize this type of variability. Although statistically significant, we cannot say whether differences in responsibility ratings are clinically meaningful; furthermore, the cross-sectional design of the study does not allow causal inferences to be drawn regarding the associations we found. Finally, as with all surveys, respondent characteristics may have systematically affected respondents' willingness to respond to the survey, and self-reports are imperfect measures of actual beliefs and practices.

Conclusions

Most PCPs believe that physicians and religious communities both are responsible for providing guidance to patients, with the responsibility of religious communities increasing when medicine has less to offer (death is imminent) or the patient faces a decision that science cannot settle (a morally complex decision). Physicians' ideas about the clinical role of religious communities are associated with the religious characteristics of physicians themselves.

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