

How Are Religion and Spirituality Related to Health? A Study of Physicians' Perspectives

Farr A. Curlin, MD, Chad J. Roach, BS, Rita Gorawara-Bhat, PhD, John D. Lantos, MD, and Marshall H. Chin, MD, MPH

Background: Despite expansive medical literature regarding spirituality and medicine, little is known about physician beliefs regarding the influence of religion on health.

Methods: Semistructured interviews with 21 physicians regarding the intersection of religion, spirituality, and medicine. Interviews were transcribed, coded, and analyzed for emergent themes through an iterative process of qualitative textual analysis.

Results: All participants believed religion influences health, but they did not emphasize the influence of religion on outcomes. Instead, they focused on ways that religion provides a paradigm for understanding and making decisions related to illness and a community in which illness is experienced. Religion was described as beneficial when it enables patients to cope with illness but harmful when it leads to psychological conflict or conflict with medical recommendations.

Conclusions: Empirical evidence for a "faith-health connection" may have little influence on physicians' conceptions of and approaches to religion in the patient encounter.

Key Words: faith-health connection, physicians, religion, spirituality

The relation between faith and health is the focus of increasing attention within medicine. Each year, national scientific conferences¹ and hundreds of articles in professional journals examine the relation between religion, spirituality, and health. In addition, the majority of medical schools

and a growing number of postgraduate programs include training in the subject as part of their curriculum.² Although religion and spirituality have become firmly established concepts in the medical imagination, leaders in medicine continue to debate their relevance to health and healthcare.

Arguments for the relevance of religion and spirituality to health and medicine have generally followed two lines of reasoning. The first is that religion and spirituality, like culture, economics, and social status, are extraphysiologic aspects of life that bear on patients' experiences of illness in profound ways. In this vein, interest in religion and spirituality is an unsurprising extension of the same currents in medicine that have promoted cultural competence³⁻⁵ and concepts such as patient-centered,⁶ narrative,⁷ and holistic⁸ medicine. Each reflects efforts to recover a more humane medicine by emphasis on elements of human experience that cannot be adequately described through the biologic/mechanical framework for understanding disease that is the foundation of modern conventional medicine.

The second and more controversial line of reasoning is that religion and spirituality are relevant to medical practice because there is evidence for associations between them and

Key Points

- All physicians in this study said they believe religion influences health, but they did not describe that influence in terms of effects on medical outcomes.
- Physicians described religion as providing a paradigm for interpretation and decision making related to illness and a community in which illness is experienced and endured.
- Physicians described religious influences as beneficial when they enable patients to cope with suffering and adhere to difficult medical regimens but harmful when they generate psychologic conflict or when they lead patients to decline medical recommendations.
- This study suggests that the level of empirical evidence for a "faith-health connection" may have little influence on physicians' conceptions of and approaches to religion in the patient encounter.

From the Sections of General Internal Medicine and Geriatrics, Department of Medicine, the Section of General Pediatrics, Department of Pediatrics, and the Pritzker School of Medicine, The University of Chicago, Chicago, IL.

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

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a variety of health outcomes.⁹ A large number of mostly epidemiologic studies have examined the relation between markers of religion or spirituality and health outcomes, and most report positive relations between the two. Critics argue that such research is fundamentally flawed in ways that call into question any putative associations,¹⁰ but enough data have been produced for scientists to begin to postulate a range of hypotheses for an instrumental relation. Those hypotheses invoke psychologic,^{11–15} social,^{16–20} and biological^{21–23} mechanisms and more controversial ones such as prayer^{24,25} and the nonlocal mind.²⁶ If religion and spirituality are associated with health outcomes, some would argue, then they are relevant to medical practice.

Although patient-focused epidemiologic and clinical research offers tools for understanding the relation between religion, spirituality, and health, in this study we turn to the experiences and interpretations of practicing clinicians for another perspective. The encounter between clinician and patient remains the heart of health care, and physicians have a unique and privileged vantage point from which to observe the ways that a patient's religion or spirituality influences a patient's experience of illness. Yet, we know little about how practicing physicians make sense of any connection between religion, spirituality, and their patients' health. Do physicians think of religion and spirituality as extraphysiologic aspects of human life that are relevant regardless of their measurable effects? Or do they think of them as having an instrumental effect on medical outcomes, or in some other way? This study examines what practicing physicians think about the relation between religion, spirituality, and health.

Materials and Methods

Participants

We conducted one-to-one, semistructured interviews with 21 physicians selected to include a range of different religious backgrounds (7 not religious, 6 Protestant, 4 Jewish, 2 Catholic, 1 Hindu, 1 Buddhist), practice settings (5 from a county hospital with a predominantly poor African-American and Latino patient population, 13 from three other academic medical centers whose referral areas include both underserved and affluent communities, 3 in private practice in relatively affluent suburbs), and clinical specialties (8 general internists, 4 obstetrician-gynecologists, 6 medical subspecialists, 1 radiologist, 1 pediatrician, and 1 medicine-pediatrics specialist). The average age of participants was 42 years, and 7 were women. Qualitative researchers commonly use similar purposive sampling strategies as a way of exploring the dimensions along which the concepts of interest vary.²⁷ Physicians were referred from colleagues, local medical and religious leaders, and from other participants. No physicians refused participation.

Grand tour question:

What do you think is the relationship, if any, between a patient's faith, religion, or spirituality, and his or her health? – Explain.

Follow up probes:

1. *Do you think religion or spirituality has a negative effect? Explain.*
- *Can you recall examples that would illustrate what you have described?*
2. *Do you think religion or spirituality has a positive effect? Explain.*
- *Can you recall examples that would illustrate what you have described?*
3. *You may have noticed over the past few years that much has been written about the effect of religion on health. Have you followed any of this discussion? What are your thoughts about it?*
- *Do you think the effects of faith or spirituality on health can be explained in scientific terms? Explain.*

Fig. Interview questions.

Interviews

Each interview was conducted by one of the investigators, lasted an average of 1 hour, and followed an interview guide centered on open-ended grand tour questions designed to “elicit narratives detailing the informant's conception of the identified domains.”²⁸ This paper focuses on participants' responses to the question, “What do you think is the relation, if any, between a patient's faith, religion, or spirituality, and his or her health?” Follow-up probes and questions were used to clarify and explore participants' comments further (Figure). We constructed and revised the interview guide based on insights from pilot interviews and review by expert colleagues.

Data analysis

Interviews were tape-recorded and transcribed verbatim. We analyzed the resulting transcripts by using an iterative process of textual analysis informed by the principle of constant comparison.²⁹ After the first and the sixth interviews, the investigators independently coded the full transcripts by identifying and labeling discrete units of text that referred to one or more concepts relevant to the study purpose. They subsequently met together to develop a consensus and create a working code book of categories, subcategories, and concepts. Using qualitative analysis software (Atlas TI, Scolari/Sage London, United Kingdom), we then coded all prior and subsequent transcripts according to the code book formulations. When new concepts emerged, addenda to the code book were made. At various points throughout the study, an inductive approach to the data was used to identify emergent themes and to identify relations and patterns between the themes. Finally, representative quotes were chosen to tangibly demonstrate the themes we identified.

To ensure the trustworthiness of our findings, we used credibility checks commonly used in qualitative research. To honor the principle of reflexivity,³⁰ before data collection, the investigators independently wrote extensive responses to the interview questions and then jointly wrote summaries of the personal dimensions that each brought to the research table. After data analysis, an experienced qualitative analyst, with knowledge of the reflexivity summaries, systematically reviewed and coded a portion of the transcripts to assess the consistency and fidelity of

the analysis and to search for competing conclusions. The process of bringing to bear multiple perspectives in data collection, analysis, and interpretation strengthens the credibility of the analysis and is known as investigator triangulation. Finally, we conducted interviews until we reached theme saturation—a point after which subsequent interviews produced no substantial new themes.

Results

Definitions

We included both of the terms religion and spirituality in our questions without giving them explicit definitions, but we noticed that when physicians used the term spirituality, they almost always referred to beliefs and practices related to particular religious communities and religious traditions. For that reason and for simplicity, our findings will be presented as physicians' perspectives on how religion is related to health.

Religion and health

Physicians emphasized three basic ways that religion influences health. First, they noted that religion forms the paradigm from which many patients understand, cope with, and respond to illness. Second, they noted that many patients are members of, and are therefore shaped by, religious communities. Finally, they described ways that religious paradigms and religious communities at times lead patients to make decisions that conflict with medical recommendations. Physicians interpreted influence of religion in complex ways that reflected their own judgments regarding the benefits offered by the religious ideas or behaviors, relative to those offered by recommended medical therapy. Physicians did not talk about the instrumental or biomedical effects of religion on health, and only indirectly discussed influences on specific health outcomes.

Religion as paradigm for interpreting illness. Physicians often described religion as a framework from which many patients make sense not only of their illness but also of the world: "Clearly, there is a population of patients for whom the way they interact with the world is always through their faith"(interview 16). The religious framework serves as a source of meaning and a guide for decision making.

"I think a lot of people find meaning through their religion."¹⁰

"I also think that certain faiths and beliefs actually help guide people in making medical decisions on what they are willing to do, and what they are not willing to do."⁹

Physicians noted that suffering elicits particularly religious or spiritual introspection as patients seek to put their illness in perspective and to find peace despite physical suffering. Introspection and interpretation from a religious framework yields ideas and behaviors that physicians interpret as

influencing health in functional or dysfunctional ways. On the one hand, physicians described religion as helpful when it allows a patient to cope with and find comfort in crisis.

"I think that for many patients their faith gives them a support or a grounding, a place they can come back to for strength. I think that a faith in God or a higher power can give people a sense of hope that can profoundly influence them when they are ill and in need of hope."¹³

Participants also noted that a common result of religious introspection is for the patient to relinquish control of the illness to God: "It's in God's hands."¹⁶ By shifting to an external locus of control, through faith, that God or something greater than themselves is active in their illness, patients find strength and hope that enable them to maintain a positive outlook despite tenuous circumstances:

"I think those who believe in a higher power find strength in it when faced with uncertainty. I think that those who pray will find solace in it when faced with difficult illnesses or uncertain futures."¹⁵

On the other hand, physicians described some religious patients' interpretations as dysfunctional and even harmful. First, they noted that patients find it hard to accept possibilities that fall outside their religious framework: "they wouldn't be as apt to accept what I have to say if it didn't fit within their framework of what they were expecting as an answer."¹² Furthermore, although physicians felt that an external locus of control can help patients by allowing them to cope with suffering, they said that for some patients "trusting God" expresses a sort of fatalism in which patients avoid taking responsibility for their own health. An example is a patient who attributes his medical nonadherence to a faith that "God will take care of me."

"With certain patients. . .it has the opposite effect. . .it makes people take less control over themselves and less responsibility."¹³

Physicians were most complimentary of patients who steer what they perceive as a middle course in which religion is a resource that does not displace medicine but helps patients cope with illness and maintain adherence to difficult medical regimens.

"I guess it can go either way. I definitely think there are some patients who say, 'Well, I don't have to think about my diabetes because God is going to take care of that.' In that way I think it can come into conflict with my goals for the patient. More often I think the patient feels that somehow God or their faith is helping them to manage their illnesses in terms of watching what they eat or taking their medication regularly, or just dealing with the kind of the emotional impact that a lot of chronic illness have."⁸

Religion as community in which illness is experienced. Participants frequently made reference to the substantial influence exerted by patients' religious communities. Again they described such influence as helpful in certain aspects, but harmful in others. For the most part, physicians said that

religious communities have a positive, supportive influence, mediated through the provision of emotional and logistical support to patients:

“I think many times that religion, especially a very organized kind of religion, can be a very strong source of support for a patient, both from mundane sorts of things like having other church members who will bring over meals or who will provide transportation, and from things that are much more intangible.”⁸

“People that are married live longer. People who go to church live longer. These are all, to me, ways that people are supported.”⁷

Yet, physicians also described some influences of the religious community as harmful. They said that religious communities at times exert undue pressure on a patient to choose a particular medical option. One example given was of a young woman who desired an abortion but whose family and community believed abortion was immoral:

“Her parents basically said that she would burn in hell if she terminates and she’s continuing the pregnancy, even though she doesn’t want to. She understands the medical situation and that it’s even risky for her to continue the pregnancy, but she doesn’t want to be ostracized by her community.”³

The influence of religious communities was linked to prenatal and neonatal decisions at many levels, from types of contraception permitted, to elective abortion, to how neonates with severe congenital disease should be handled. Physicians said that patients will undergo substantial, and to some physicians’ minds, unwarranted risks because of the influence of the religious community, and patients’ health can be harmed by the guilt that is imposed. In that context, some physicians judged certain religious views as outdated and out of touch:

“I think if he [the Pope] came to my clinic and spent any time talking to my patients and saw what they deal with that maybe the church would have a greater understanding of what they’re imposing on people.”³

Of note, even when members of the religious community are not actively involved in persuading the patient to make a particular decision, the moral claims of the religious community may weigh heavily in the patient’s mind. Physicians said that the resulting mental and spiritual struggles can create pain, anxiety, and fear.

“Sometimes [religion] can also be an added source of stress for people who have guilt or who have what they feel are unresolved spiritual issues.”⁸

Physicians noted that they sometimes find it difficult to distinguish the influence of religion from that of culture, particularly when both are unfamiliar to the physician. Physicians gave examples that included Asian families in which decisions are made by a family member rather than by the patient and Muslim families in which there are limits on how females can interact with the physician in terms of both physical contact and decision making. In these cases, religion and

culture appear intertwined, and physicians do not have adequate knowledge to determine which aspects are distinctively religious.

Religion as mediator of conflict with medical recommendations. Physicians frequently spoke about ways that patients’ religious paradigms and/or their religious communities introduce conflict with medical recommendations. Conflict appeared to arise first in areas in which a medical recommendation directly conflicts with the religious paradigm of a patient. Almost all participants mentioned the case of Jehovah’s Witnesses refusing blood products, a situation in which a generally uncontroversial standard of care conflicts with a specific religious tenet. More prominent were those situations in which the medical profession has a less coherent medical recommendation and the decision making is ethically charged—for example, prenatal and end-of-life decisions. In these cases, values and world views collide when the religiously based decision making of either the patient or the physician comes into conflict with what the other believes is the correct course of action.

The more common setting for conflict was described as one in which patients to varying extents “choose faith over medicine.” These were cases in which a treatment or treatment plan was not explicitly forbidden by a patient’s religion but still the patient, after considering the options in the context of his or her religious commitments, chose to delay or decline the medically recommended course of action. In declining the medical recommendation, patients were described as opting to “pray” or “trust God.” Physicians expressed ambiguity about the relative benefits or harms of such decisions, depending on the physician’s confidence in the efficacy of the medical therapy offered. Details of the conflict and controversy caused by religion and spirituality have been more thoroughly described elsewhere.³¹

Science and the relation between religion and health

Physicians did not often describe the influence of religion on health in biomedical or other scientific terms. Still, we asked them explicitly about their impressions of the empirical literature and whether or not they believed the influence of religion on health could be explained in scientific terms. Those who were familiar with the medical literature described it as suggestive of, but not able to prove, a link between religion and positive health outcomes. They generally believed that science could explain at least some of the effects—mentioning brain chemistry, stress reduction, and other mechanisms—and they expected new scientific explanations to be forthcoming. At the same time, most expressed doubts that scientific explanations would ever fully account for the relationship between religion and health, and several were critical of focusing on biomedical outcomes.

“I was offended by the way the media treated [a study of

the influence of religious support near the end of life]: ‘There’s no difference in survival outcome and all people died.’ Survival?! Outcome?! I’m like, what about the lives of these women? What if they were happier toward the ends of their lives? What if they coped better?’²

Limitations

Qualitative methods are powerful for generating “thick descriptions”³² of the ways that physicians think about this complex topic. Yet, as with most in-depth qualitative studies, the sample was small and was chosen for theoretical reasons. As such, we cannot use any statistical inference to predict how the themes we found are distributed within the broader population of physicians. It is certainly conceivable that somewhat different themes would emerge in a different sample. Finally, the analysis and interpretations are those of the authors, and different investigators might have come to somewhat different interpretations of the same data. Future studies are warranted to see if these findings are corroborated by other investigators in other settings.

Discussion

Physicians in our sample were in agreement that religion has an important impact on health, and most believe that the impact is primarily a positive one. However, our participants did not refer to scientific evidence to explain the health effects of religion nor to justify a place for religion in clinical care. Because there is abundant empirical research in the medical literature, we did not expect such scarce mention of biological mechanisms and direct influence on health outcomes. Even controversial mechanisms such as the healing power of prayer and supernatural agency were seldom mentioned and were addressed only when we queried our respondents directly. Instead of focusing on the effects of religion on medical outcomes, our participants focused on the overall influence of religion in patients’ lives. Through the lens of the clinical encounter, physicians appear most often to observe religion as an influence on the ways in which patients cope with and make decisions related to their illnesses.

There is ongoing debate within the medical profession about the appropriate place of religion and spirituality in patient care. Much of that debate turns on whether or not there is substantive evidence for a causal and beneficial relation between aspects of religion/spirituality and objective health outcomes. In fact, both proponents and critics of spiritual inquiry have grounded their arguments at least partially in the strength or weakness of the scientific evidence for a “faith-health connection.”^{33–35} Our study suggests that a determination of the relative strength of an association between religion and health outcomes may do little to influence physicians’ behaviors. Several authors have warned about the ethical pitfalls of treating religious beliefs or practices as a sort of pill or therapy that can be recommended because of

putative health benefits.^{10,34,36,37} Our study suggests that physicians are unlikely to do so, if only because they are unlikely to think of the influence of religion in terms of direct health benefits at all. If that is the case, then further consideration of appropriate behavior in this arena should probably turn more on how physicians can seek accommodations when patients disagree with medical recommendations for religious reasons and how physicians can be attuned to and empathetic toward the ways that religion often allows patients to cope with suffering and illness.

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It is better to know some of the questions than all of the answers.

—James Thurber