

# Spiritual Beliefs and Barriers Among Managed Care Practitioners★

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**ABSTRACT:** *Purpose:* Ninety percent of American adults believe in God and 82% pray weekly. A majority wants their physicians to address spirituality during their health care visit. However, clinicians incorporate spiritual discussion in less than 20% of visits. Our objectives were to measure clinician beliefs and identify perceived barriers to integrating spirituality into patient care in a statewide, primary care, managed care group. *Methods:* Practitioners completed a 30-item survey including demographics and religious involvement (DUREL), spirituality in patient care (SPC), and barriers (BAR). We analyzed data using frequencies, means, standard deviations, and ANOVA. *Findings:* Clinicians had a range of religious denominations (67% Christian, 14% Jewish, 11% Muslim, Hindu or Buddhist, 8% agnostic), were 57% female and 24% had training in spirituality. Sixty-six percent reported experiencing the divine. Ninety-five percent felt that a patient's spiritual outlook was important to handling health difficulties and 68% percent agreed that addressing spirituality was part of the physician's role. Ninety-five percent of our managed care group noted 'lack of time' as an important barrier, 'lack of training' was indicated by 69%, and 21% cited 'fear of response from administration'. *Conclusions:* Managed care practitioners in a time constrained setting were spiritual themselves and believed this to be important to patients. Respondents indicated barriers of time and training to implementing these beliefs. Comparing responses from our group to those in other published surveys on clinician spirituality, we find similar concerns. Clinician education may overcome these barriers and improve ability to more fully meet their patients' expressed needs regarding spirituality and beliefs.

**KEY WORDS:** communication barriers; managed care; spirituality in medicine; training.

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### *Purpose*

Ninety percent of American adults believe in God and more than 82% pray at least once a week (Gallup, 1990).<sup>1</sup> Studies demonstrate that a majority of patients want their physicians to address their spiritual beliefs (Daaleman and Nease, 1994; King and Bushwick, 1994; Daaleman and Frey, 1999; Ehmaan et al., 1999; Hebert et al., 2001). The majority of physicians acknowledge the importance of spirituality in health, and more than 50% think it is the responsibility of the physicians to address spiritual concerns (Maugans and Wadland, 1991; Ellis et al., 1999). Despite this, physicians incorporate spiritual discussion in less than 20% of patient visits (Ellis et al., 1999) and only 11% of physicians discuss spirituality frequently (Maugans and Wadland, 1991).

Current literature increasingly demonstrates a strong association between spirituality and health (Ellison and Levin, 1998; Mueller et al., 2001). A higher level of spirituality has been associated with less mortality from cardiac reasons (Goldbourt et al., 1993; Oxman et al., 1995), lower blood pressure (Koenig et al., 1998a), lower substance abuse (Moore et al., 1990; Miller, 1998), quicker recovery from depression (Koenig et al., 1998b; McCullough and Larson, 1999), and improved ability to cope with serious illness such as HIV, cancer, and spinal cord injury (Riley et al., 1998; Brady et al., 1999; Cotton et al., 1999).

Investigating issues that prevent physicians from discussing spirituality, Ellis reported lack of time (71%), and lack of training (59%) most frequently cited. Other barriers identified by more than half of respondents included uncertainty about which patients wanted spiritual discussion, and fear of projecting personal beliefs onto patients (Ellis et al., 1999).

Physician spiritual beliefs and barriers have not yet been reported in managed care settings. A managed care setting introduces constraints that may affect practitioners' perspectives on patient care. For example, corporate policies dictating practice issues contrast with traditional health care which is identified with freedom of choice for patients and physicians.<sup>2</sup> The managed care setting is important in American health care. Despite reported dissatisfaction about managed care in the past decade, almost 60% of the population currently belongs to some type of managed care health plan (Bertram, 2003). There are current movements towards 'consumer-driven health care', however, which are aimed at giving patients more health related options within the managed care setting (Herzinger, 2003). Given the substantial evidence that discussing spiritual issues during the health care visit is of interest to both patients and practitioners, this is a relevant topic to investigate in the managed care setting.

<sup>1</sup><http://www.barna.org/cgi-bin/PageCategory.asp> (14 October 2003).

<sup>2</sup><http://www.mcareal.com/factshts/mcolfact.htm> (16 October 2003).

We studied the primary care medical staff of the managed care entity of a major academic institution. Our objectives were to understand more about our practitioners' beliefs and to identify perceived barriers to integrating spirituality into patient care.

### *Methods*

Johns Hopkins Community Physicians (JHCP), an affiliate of the Johns Hopkins School of Medicine, is a non-profit, staff model group with 18 ambulatory primary care practice offices in Maryland. Our primary care specialties are internal medicine, family practice, pediatrics, and obstetrics/gynecology. In 2001, our medical staff of 123 (52% female) consisted of physicians (85%) and nurse practitioners/physician assistants (15%). All clinicians have approximately the same outpatient clinical responsibilities. At the time of this study, 61% of JHCP patients had managed care coverage.

In November 2001, our survey was distributed at the annual, mandatory, off-campus, staff meeting. Subjects were guaranteed response confidentiality. The survey included a demographic section (six items), the Duke University Religious Index scale (DUREL) scale (five items), the Spirituality in Patient Care (SPC) scale (10 items) and the Spiritual Barriers Scale (BAR) scale (nine items). The DUREL assesses social and private religious involvement, and depth of spiritual involvement (Koenig et al., 1997). The SPC measures beliefs about spirituality specifically related to the role of spirituality in medical encounters (Tarpley, 2003). The BAR measures specific clinician barriers to using of spirituality in a patient visit. The SPC and the BAR had used standard 5-point Likert response scales. The Johns Hopkins Institutional Review Board approved the study.

### *Data analysis*

We performed univariate analysis of demographic variables, physician attitudes, and perceived barriers. We examined relationships among categorical variables using cross-tabulation arrays and the  $\chi^2$  statistics. When comparing means from more than one continuous or scale sum score, we analyzed with Student's *t*-tests and ANOVA (Nunally, 1978).

### *Findings*

Our response rate was 96% of those attending the meeting ( $n = 78$ ). The proportion of females and of physicians was representative of the total staff. The demographic characteristics are summarized in Table 1.

The mean DUREL score was  $21.1 \pm 7.17$  (subjects' range 8–31, possible scale range 6–31). The Cronbach's alpha coefficient was 0.91. All items

**TABLE 1**  
**Demographic and Spiritual Characteristics of Respondents**

<i>Characteristic</i>	<i>Percentage</i>
Age (mean; range)	44.9 ± 9 (27–73)
Gender ( <i>n</i> = 75)	Female 57
Specialty ( <i>n</i> = 75)	Internal medicine 40
	Family practice 32
	Pediatrics 24
	Obstetrics 4
Religious Affiliation ( <i>n</i> = 73)	Christian 67
	Jewish 14
	Muslim/Hindu/Buddhist 11
	Agnostic/Atheist 8
	Other 1
Attendance at religious meetings ( <i>n</i> = 73)	Once a week or more 32
	A few times a month 19
	A few times a year 29
	Rarely/never 21
Training in spirituality ( <i>n</i> = 73)	None 76
	1–2 lectures 7
	Course 17

correlated significantly with the total ranging from 0.67 to 0.82, with three of the five items correlating above 0.80 with the total. The score was lower in men than women physicians (19.3 vs. 22.4, respectively) and this approached statistical significance ( $p = 0.07$ ). There were no differences by race or ethnicity, by specific religious domination, or by specialty. The combined group of atheist/agnostics had significantly lower scores compared to those who stated a religion ( $12 \pm 4$  vs.  $22 \pm 7$ ,  $p = 0.003$ ). See Table 2 for other DUREL results.

The mean SPC score was  $33.2 \pm 4.8$  (subjects' range 25–45, possible range 9–45). Women had higher SPC score than men, ( $35 \pm 5$  vs.  $31 \pm 4$ ,  $p = 0.007$ ). Cronbach's alpha of the SPC was 0.76. There were no differences by race or ethnicity, specialty, or by any specific religious denomination. Atheists/agnostics did not have significantly lower scores than their counterparts. See Table 3 for other SPC results.

The mean BAR was  $28.9 \pm 6.6$  (subjects' range, 13–45, possible range, 9–45), Cronbach's alpha coefficient of 0.84. There were no differences in the mean scores by gender, race or ethnicity, specialty, denomination, or being an atheist/agnostic. The Barriers Scale was not correlated with the SPC

**TABLE 2**

**Response Levels and % Responding, DUREL Scale**

<i>Question / Statement</i>	<i>Response</i>	<i>Percentage</i>
How often do you spend time in private religious activities, such as prayer, meditation or Bible study? ( <i>n</i> = 74)	Once a day or more	46
	Once or twice a week	14
	A few times a month	15
	Rarely/never	26
In my life, I experience the presence of the Divine (i.e., God). ( <i>n</i> = 75)	Definitely true/ tends to be true	66
	Tends to be not true/ definitely not true	14
	Unsure	20
My religious beliefs are what really lie behind my whole approach to life. ( <i>n</i> = 75)	Definitely true/ tends to be true	69
	Tends to be not true/ definitely not true	23
	Unsure	8
I try hard to carry my religion over into all other dealings in life. ( <i>n</i> = 74)	Definitely true/ tends to be true	62
	Tends to be not true/ definitely not true	26
	Unsure	12
<i>Please circle the statement closest to your description of yourself: (n = 73)</i>		
I consider myself spiritual and I regularly participate in organized religious activities.		36
I consider myself spiritual and I occasionally participate in organized religious activities.		34
I consider myself spiritual but I am not part of any organized religious group.		16
I do not consider myself spiritual or religious.		14

TABLE 3

**Spirituality and Patient Care: Items, Response Categories and % Responding**

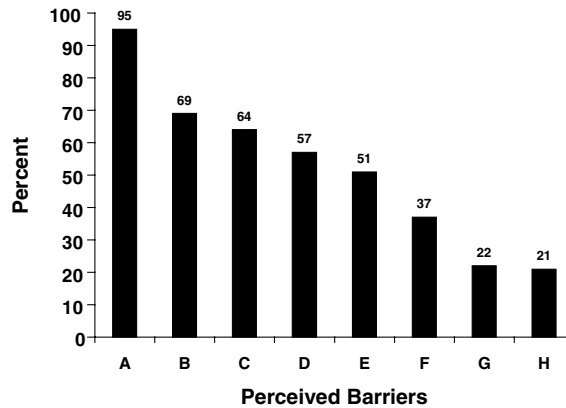
<i>Statement</i>	<i>Agree</i>	<i>Disagree</i>	<i>Unsure</i>
A patient's spiritual outlook affects how she/he handles health difficulties ( $n = 75$ ).	95%	0%	5%
Chaplains, rabbis, ministers and other faith-system professionals are integral members of the health care team ( $n = 75$ ).	64%	11%	25%
Medical students' or residents' consideration of their own spirituality is important to their role as caregivers ( $n = 74$ ).	68%	4%	28%
Spiritual/faith concerns are especially important for terminally ill patients ( $n = 75$ ).	100%	0%	0%
A physician with no personal faith system or spiritual concerns should not discuss (address) spiritual/faith questions with patients ( $n = 75$ ). <sup>1</sup>	11%	75%	15%
A physician should politely refuse to pray with any patient who requires prayer in the office or hospital room. ( $n = 73$ ). <sup>1</sup>	8%	59%	33%
The routine patient history and physical should include questions relating to faith, spirituality and/or religious affiliation ( $n = 75$ ).	47%	21%	32%
Addressing the patient's spiritual and emotional needs is a part of the physician's role ( $n = 75$ ).	68%	9%	23%
Meditation, prayer, reflection or some other form of contemplation is an important daily activity for a medical student or physician ( $n = 75$ ).	59%	23%	17%

<sup>1</sup> Disagree statement reflects stronger spiritual beliefs (Scale is reversed).

(0.09,  $p = 0.45$ ) or the DUREL (0.07,  $p = 0.60$ ). See Figure 1 for other BAR results.

### *Discussion*

The managed care setting introduces some practice constraints that might be reflected in ambivalence towards adding a new dimension to the healthcare visit. We assessed clinician spiritual beliefs and identified barriers to incorporating spirituality into medical visits in a group of primary care clinicians providing care to a majority managed care patients in a statewide system.



**FIGURE 1**

**Percent of Respondents Indicating ‘Agree’ or ‘Strongly Agree’ on Each Barrier**

Key: A, Lack of time; B, Lack of training; C, Low priority compared to medical issues; D, Personal discomfort; D, Fear of offending patients; E, Fear of projecting personal beliefs; F, Lack of reimbursement for extra time; G, Fear of opinions of colleagues; H, Fear of response from administration.

Our sample, which included a higher proportion of women than other reported surveys (Maugans and Wadland, 1991; Ellis et al., 1999) identified that women were significantly more likely to express the importance of spirituality in patient care. This has not previously been reported. Interestingly, atheists and agnostics showed SPC scores similar to clinicians identifying a religion. We interpret this as indicating that impact of personal beliefs, often cited as a concern by physicians, is not necessarily an issue to addressing spirituality with patients.

Comparing to other recent studies of spirituality among clinicians (Maugans and Wadland, 1991; Oyama and Koenig, 1998; Daaleman and Frey, 1989; Ellis et al., 1999), our providers were also majority Christian (Maugans and Wadland, 1991; Oyama and Koenig, 1998), however, a higher proportion practiced an Eastern religion (Muslim, Buddhist, Hindu). This may relate to a lower percent of weekly church attenders (32% vs. 53% in the Daaleman study) however, a higher percent (46% vs. 35%) who spent time in personal prayer daily (Daaleman and Frey, 1999). Exploring clinician spiritual attitudes, 66% of respondents reported that they experience the Divine. In another statewide study, 46% considered God as a personal entity (Maugans and Wadland, 1991) and in a national survey 77% felt ‘extremely’ or ‘somewhat’ close to God (Daaleman and Frey, 1999). It is not yet clear how to interpret these similar statements.

In our study, 95% of clinicians believed that a patient's spirituality affects his/her health, the same percentage reported by Ellis et al. (1999). A higher proportion of our clinicians (68% vs. 58%) agreed that addressing spirituality concerns is part of the physicians' role. Forty-seven percent of our clinicians think that spirituality should be a part of a routine patient history and physical, and an additional 32% were uncertain.

In our managed care group, the most frequent barriers were similar to those reported by clinicians in another statewide setting, i.e., 'lack of time' and 'lack of training' were identified as the top barriers (Ellis et al., 1999). However, a higher proportion in our group noted time pressures as the most important barrier (95% vs. 71%). We postulate that the increased time concern in our group is related to the time pressures inherent in a managed care system, where clinicians have less control of their patient schedules. 'Low priority compared to medical issues' and 'personal discomfort' were ranked third and fourth by our respondents in contrast to 'uncertainty in how to identify interested patients' and 'fear of projecting personal beliefs', which were ranked higher in another study (Ellis et al., 1999). This may relate to the wider range of beliefs reflected in our respondents. We were interested to note that the barrier least cited by our respondents was 'fear of response from administration' (21%), which we postulated as a concern within the managed care setting. Men and women noted the same barriers to incorporating spirituality into patient care.

There is evidence that several of the barriers noted (personal discomfort, fear of offending patients, concern for projecting beliefs) are concerns that need not resonate with patients. As only 24% of our respondents indicated any education in spirituality and medicine, we project that these barriers are remedial.

We have contributed to the assessment of spirituality in primary care practices through this survey of clinicians in a statewide, predominantly managed care, setting. We have used three psychometrically validated scales, which together give greater understanding of clinician spirituality. Limitations to our study are the small sample size, the lack of agreement on preferred scales used to measure spirituality in patient care and/or how to interpret similar items. The latter restricts our ability to make direct comparison to other studies (Maugans and Wadland, 1991; Daaleman and Frey, 1999; Ellis et al., 1999).

In summary, most of our primary care clinicians in managed care are spiritual themselves, believe that spirituality is important to patients in addressing health difficulties, and indicate they lack time or training to do this. Clinician education may help overcome barriers and lead to improved practitioner confidence in their own ability to manage the healthcare visit to more fully meet their patients' expressed desires in linking spirituality and health.



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