RELIGION AND SPIRITUALITY IN SPECIFIC CLINICAL SITUATIONS IN MEDICAL PRACTICE; A CROSS-SECTIONAL COMPARATIVE STUDY BETWEEN PATIENTS AND DOCTORS IN A TERTIARY CARE HOSPITAL IN MALAYSIA

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SUMMARY: In recent years there has been growing awareness regarding the role of religion and spirituality (R/S) in the practice of clinical medicine. We aim to assess the beliefs and practises of physicians regarding the role of R/S in clinical practice. Concomitantly, we aim to assess the beliefs of our patients and whether they like to address such issues. Questionnaire based cross sectional study among hospitalized patients and their treating doctors. The majority of patients were male (62.9%), Malay Muslims (75.4%) and had primary (32.5%) or secondary (48.6%) education. Nearly all patients and doctors believed in the existence of God and life after death. Although significant majority of both patients and physicians agreed that religious involvement is associated with improved health, only half of doctors discussed such issues in clinical situations. Three quarters of patients noticed an increase in faith due to illness and similar proportion wanted a religious counsellor to help them rather than a psychiatrist. Only a quarter of physicians agreed with euthanasia, 68% with use of placebo and just 10% with false hope of cure, while among patients only 6.4% agreed with euthanasia and 92% had a hope of cure.

Religion is important to many patients and doctors, but more than half doctors ignore it in their clinical practice, a discrepancy between beliefs and behaviour. In conclusion, religion deserves greater attention in the practice of medicine.

Key Words: Spirituality, medicine and religion, euthanasia.

INTRODUCTION

The role of religious / spiritual practices (R/S) in clinical medicine has begun to be appreciated in recent years, largely from arguments that such activities improve human health and well-being (1-4). Remarkable advances in medicine and scientific information have made dramatic changes in health care delivery system and have changed the focus from a caring, service-oriented model to a technological cure-oriented one. This has resulted in considerable strain on the doctor-patient relationship. Health consumers from every level of society in different parts of the world express their dissatisfaction and ask to be viewed in a more holistic and

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humane manner. Many of our patients have strong R/S beliefs that often influence on decisions made by them, their families, and their careers. Many times they refuse contemporary medicine and opt for traditional methods of treatment. Until recently, assessing patient's R/S beliefs was viewed as unnecessary and inappropriate, but many recent surveys suggest that the 'religiosity gap' between therapist and patient is narrowing (5). This emphasises the need for a holistic understanding of the illness experience from the patient's point of view. This perspective has been further highlighted in a recent consensus statement that includes assessment and support of R/S well-being as core principle of professional practice and care at the end of life (6). Koenig *et al.* has suggested that even in the absence of supporting evidence, it would still be permissible for physicians to recommend R/S activities to their patients, because such activities provide comfort (7). In Malaysia, R/S beliefs among doctors and patients are not known and the requests from patients for R/S input are similarly diverse. Virtually all of the research in this area has been with Western, largely Christian, populations. Assessment and support of R/S practices vary widely among doctors and to the best of our knowledge our study is the first to address such issues in Malaysia. The present study has some promise since it samples a population of patients and physicians who are multi-racial and multi-faith. We want to ascertain the prevalent R/S beliefs among patients and doctors, their role in specific clinical situations and weather patients like to address such issues in their consultations.

MATERIALS AND METHODS

This was a questionnaire based cross sectional study among 280 hospitalized patients from Hospital Tengku Ampuan Afzan (HTAA) and their treating doctors (50) to inquire about their religious affiliation, beliefs and experiences regarding the role of R/S in specific clinical situations. Malaysia is a multi-racial, multi-religious, fast developing country where a western oriented information delivery policy is adopted in the medical curriculum. HTAA is an 800-bed, tertiary level, state hospital in Pahang- the biggest state in Peninsular Malaysia with a population of about 1.6 million people. It is also the main teaching hospital for the medical faculty of the International Islamic University Malaysia (IIUM).

Patients were selected from different wards and disciplines conveniently. They were approached in person, provided with a brief description and aim of the study. Their consent was obtained before they were administered a simple, self reported questionnaire. The questionnaire consisted of two parts, the first being questions regarding patients' demographic parameters, to look at the background of the study population and the second part dwelled on information given by the patients. Each question had various responses such as yes or no and agree/disagree depending on the context of the question. Patients were also asked about their knowledge on mercy killing and their personal choice. All patients recruited in the study were fully conscious and able to give consent. Unstable patients, paediatric patients and patients from intensive care unit, coronary care unit and high dependency wards were excluded. All data were collected by a trained research nurse.

A similar self-reported questionnaire based study of doctors from the same hospital was conducted and questions were framed on similar issues. They were approached individually, provided with a brief description and aim of the study and requested to fill up the questionnaire form at their leisure. The forms were collected again after contacting the respondents. The Questionnaire had a cover page on confidentially issues and also acted as a consent form for the participants. Fifty doctors responded by filling the questionnaire out of 80 approached.

Doctors' and patients' responses were compared on individual items and composite scores were derived from subset of items relevant to R/S medicine. Statistical analysis was done using the Statistical Package for Social Sciences (SPSS), Version 12 available at the faculty of medicine IIUM. Chi-square (χ^2) test was used to compare the proportions between the doctors and patients and a p-value of less than 0.05 was taken as statistically significant.

This study was approved by the pertinent ethical committees of Kulliyyah of Medicine and HTAA.

RESULTS

Table 1 summarises the grades and gender of responding doctors. Almost all doctors believed in the existence of God, life after death and healing power of

Table 1: Gender and grades of responding doctors.

	N=50(%)
Gender	
Male	38(76)
Female	12(24)
Grade	
Consultants/Professor	4(8)
Specialists/Registrar	28(56)
Senior Medical Officers	18(36)

Table 2: Belief of doctors.

Beliefs	Yes (%)	No (%)
Existence of God	49 (98)	1 (2)
Existence of life after death	49 (98)	1 (2)
Healing power of prayer/meditation	49 (98)	1 (2)
Benefit of prayer/meditation	48 (96)	2 (4)

prayer/meditation (Table 2) however only 52% discussed religious issues with their patients and they would discuss it irrespective of R/S beliefs of their patients. Two third of the doctors said they do encourage R/S practices (Table 3). Table 5 lists the demographic profile and diagnosis of the patient population. A total of 280 patients responded by filling up the questionnaire. The religiousness of doctors and patients was comparable (Table 9). Majority of patients could not recall any inquiry by physicians about religious issues. Among patients 79% noticed increase in faith due to illness and wanted religious counsellor to help them rather than a psychiatrist (Table 4). A quarter of doctors agreed with euthanasia, 68% with use of placebo and 10% with false hope of cure while among patients only 6.4% agreed with euthanasia and 92% had a hope of cure (Table 6).

DISCUSSION

A number of published empirical studies suggest that R/S involvement is associated with better outcomes in physical and mental health. For example most physicians believed that R/S often helps patients to cope, gives them a positive state of mind and provides emotional and practical support via the religious community (1). Similarly R/S involvement is associated with improved quality of life and reduction in anxiety, depression, and substance abuse (3). American researchers into college wellbeing, and Engebretson's work in Australia, prove that there is a link between spiritual awareness and reduction in self-destructive behaviour and a more positive, even optimistic, attitude towards life. 87% of our patients who used prayer for their health concerns reported high levels of perceived helpfulness as it has

Table 3: Doctor's clinical practices/experiences.

Issues	Yes	No	Never try
Do you enquire/discuss about patient religious/ spiritual life	32 (64)	9 (18)	9 (18)
Like other health-related patient issues like quite smoking, do you encourage religious/spiritual practices?	32 (64)	9 (18)	9 (18)
Do you discuss irrespective of background religious/spiritual beliefs?	27 (54)	13 (26)	10 (20)
Do patients like to address religious issues?	24 (48)	19 (38)	7 (14)
Do you think it strengthens the bond?	32 (64)	16 (32)	2 (4)
Do you respect religious/spiritual beliefs in treatment?	49 (98)	1 (2)	0 (0)
If patients refuse treatment, do you involve family members?	45 (90)	3 (6)	2 (4)
If patients refuse treatment on religious beliefs, do you think religious counsellor can be of help?	35 (70)	15 (30)	0 (0)

Table 4: Doctor's attitude towards euthanasia and other related issues.

Issues	Agree (%)	Disagree (%)
Attitude to euthanasia	12 (24)	38 (76)
Placebo	34 (68)	22 (44)
False hope of cure	5 (10)	45 (90)

been reported by earlier studies (8). When faced with disease, disability and death, many patients like physicians to address their R/S needs. R/S practices are statistically significant in coping with a terminal illness (9). Several surveys have documented patients' desire to have spiritual concerns addressed by their doctors and their benefit from such discussions (10-12).

Illness brings a patient closer to God and 79% of our patients noticed increase in faith and wanted religious counsellor to help them rather than a psychiatrist. The desire for a religious counsellor may explain why every year, millions of patients seek counselling from clergy/religious people. Doctors are an integral part of the public health system, not only in disease control, but also in patient health education. There is inherent power they hold by virtue of possessing a specialised knowledge of diagnosis, prognosis, and treatment. Beyond their technical task of diagnosing and treating disease, they are also obliged to being attentive to their patients' social milieu. They have an important role of promoting positive health behavior and appropriate coping strategies. For example a patient with heart disease is asked to restrict his physical activity and avoid fatty food. The advice is likely to be followed because the patient accepts the doctor's authority. The same influence can be exerted when a doctor inquires about drug abuse, promiscuity or alcoholism and persuades his patients to change their personal behaviour by recommending rehabilitative activities.

Religion serves an important preventive role, as most religions discourage or in the case of Islam altogether ban alcohol and drug abuse. Many studies have found inverse relationship between religiosity and substance abuse (13, 14). It was interesting to note that patients in HIV/AIDS category, 88.3% of whom were young intravenous drug abusers with mean age of 34 years (± 7), were least religious as depicted by their religious activities (Table 7) ($p<0.001$).

Candid exchanges about diagnosis and prognosis, especially when the answers are grim, are a relatively recent phenomenon. According to Hippocrates, doctors should "comfort with care and attention, revealing nothing of the patient's present or future condition." Hope and expectation live inside a patient and brings him to see the doctor. Nearly all of our patients had a hope of cure. The power of a doctor's saying is profound. When a doctor enumerates side effects and merely pronounces dim statistics, thus offering a hopeless prognosis, patients experience despair. It invokes emotional and sometimes violent responses from family. The basis of their act is love and concern for the patient. The patient may continue to hope about cure right up to death. They are also in denial, unwilling to accept the truth. Until the moment of death, families pray for a mir-

Table 5: Demographic profiles and case selection of all the patients in the study.

Characteristics	N = 180 n (%)
Gender	
Male	176 (62.9)
Female	104 (37.1)
Ethnic group	
Malay	208 (74.3)
Chinese	44 (15.7)
Indian	16 (5.7)
Other	12 (4.3)
Religion	
Islam	211 (75.4)
Christian	25 (8.9)
Buddhist	30 (10.7)
Hindu	9 (3.2)
Others	5 (2.2)
Education	
Primary	91 (32.5)
Secondary	136 (48.6)
Tertiary	16 (5.7)
Illiterate	37 (13.3)
Occupation	
Professional	22 (7.9)
Executive	11 (3.9)
Administrative	11 (3.9)
Non professional	105 (37.5)
Unemployed	131 (46.8)
Diagnosis	
Advanced malignancy on palliative care	50 (17.9)
Chronic renal failure on haemodialysis	50 (17.9)
HIV positive/AIDS cases	77 (27.5)
Patients undergoing surgical procedures	50 (17.9)
Admissions for other diseases	53 (18.8)

Table 6: Belief of patients.

Beliefs	Yes (%)	No (%)	Not sure (%)
Existence of God	271 (96.8)	9 (3.2)	0 (0)
Existence of life after death	250 (89.3)	26 (9.3)	4 (1.4)
Are you comfortable with your spiritual life?	246 (87.9)	32 (11.4)	2 (0.7)
Spiritual/ religious beliefs respected by staff	276 (98.6)	2 (0.7)	2 (0.7)
Did your physicians inquire about religious issues?	139 (49.6)	114 (40.7)	27 (9.7)
Healing power of prayer/meditation	255 (91.1)	21 (7.5)	4 (1.4)
Perceived benefit of prayer/meditation	239 (85.3)	33 (11.8)	8 (2.9)
Increase in faith due to illness	220 (78.6)	50 (17.8)	10 (3.6)
Do you think it is punishment by God?	190 (67.9)	89 (31.8)	1 (0.4)
Are you depressed?	174 (62.1)	103 (36.8)	3 (1.1)
Ever have a suicidal thought	45 (16.1)	232 (82.9)	3 (1.1)
Like to have a religious counsellor	212 (75.7)	66 (23.6)	2 (0.7)
Like to have a psychiatrist help	146 (52.1)	133 (47.5)	1(0.4)
Hope of cure?	258 (92.1)	18 (6.4)	4 (1.4)
Know about mercy killing (euthanasia)	61 (21.8)	216 (77.1)	3 (1.1)
Attitude towards euthanasia	18 (6.4)	259 (92.5)	3 (1.1)

Table 7: Religiosity among HIV/AIDS patients compared to all other patients.

Performance of Salat/meditation	HIV/ AIDS patients	Other patients
Never	17 (22.1)	4 (1.9)
Daily	19 (24.7)	176 (86.8)
Weekly	9 (11.6)	8 (3.8)
Occasionally	32 (41.6)	13 (6.5)
Total	77 (100)	203 (100)

Table 8: Belief of patients.

HIV Status	Drug Abuse		Total
	Yes	No	
Yes	68 (98.6)	9 (4.3)	77 (27.5)
No	1 (1.4)	202 (95.7)	203 (72.5)
Total	69 (100)	211 (100)	280 (100)

acle to happen and then at the moment of the death, they say, 'This is God's will' and 'God will get us through this.' Doctors in many third world countries and modernised nations, including Italy and Japan, still believe in withholding a bad prognosis from the patient, on the request of family members (15). Telling the truth is an ethical obligation, as patients have a legal right to be fully informed about their medical condition and treat-

Table 9: Comparison between doctors and patients.

	Yes (%)		No (%)		p value
	Doctor	Patient	Doctor	Patient	
Existence of God	49 (98.0)	271 (97.8)	1 (2.0)	9 (2.2)	0.478
Existence of life after death	49 (98.0)	250 (89.9)	1 (2.0)	30 (11.1)	0.064
Healing power of prayer/meditation	49 (98.0)	255 (91.1)	1 (2.0)	25 (8.9)	0.146
Benefit after prayer/meditation	49 (98.0)	239 (85.3)	1 (2.0)	41 (14.7)	0.015
Attitude towards euthanasia	12 (24.0)	21 (7.5)	38 (76.0)	259 (92.5)	< 0.001

ment options. Doctors should understand the patient's beliefs including any religious beliefs and use their best judgment in disclosing unfavorable diagnosis (16). The extent, depth, timing, and technique of truth disclosure must be tailored to the individual patient's wishes. This is necessary to protect them from the anxiety and distress associated with the knowledge of impending death. Doctors must identify key people of the family and restrict their communication with them initially, and correct unfounded expectations. One in ten doctors in our study believed in false hope of cure. This centuries-old belief is no longer true. All patients need hope, and doctors are obligated to offer it in some form. Because nothing is absolutely determined, there is no reason to fear but also reason to hope. Doctors should explain and reframe the patient's and family's hope for something more realistic and achievable by providing spiritual, psychological, and social support, and offering palliative care. Interventions that fail to change the course of disease may only harm the patient. Such discussions are always sensitive but it must be communicated in a way that facilitates acceptance and understanding.

Placebos are a surprisingly widespread practice even today and 68% of our doctors believed with their use (17, 18). Their use remains a controversial issue and has been criticised on ethical grounds, as it violates the fundamental principle of trust and faith that the doctor-patient relationship is based upon.

Euthanasia and physician-assisted suicide (PAS) are most controversial and emotive issues. The term euthanasia means, the physician intentionally ends the patient's life at the patient's request and with the patient's full informed consent. In PAS, the physician provides the patient with the means to end his or her own life. In the United States, this is currently legal only in the state of Oregon. A quarter of our doctors were in favour of euthanasia, while only 6.4% of patients were in its favour. The doctors should not take interest in or explicit request for euthanasia or PAS as final. They should enquire about what motivates the request. Physical symptoms such as pain, fatigue, and dyspnoea, should be evaluated and treated as part of high-quality end-of-life care. Depression and anxiety should be specifically addressed. Hospice and palliative care services may be very helpful in addressing such patients. Euthanasia is not legal in any state in the United States. According to Jewish religious law, any intervention to hasten death is viewed as unethical even if the outcome is ethically desirable. In Islam, there are strong religious prohibitions against PAS or direct actions that hasten death. This is related to a verse from Holy Quran. 'That one who takes a life as if he has taken the life of all mankind' (19). Extraordinary measures that are likely to result in no substantial change in the patient's clinical course are to be avoided. One may withdraw the life support equipment from such patients after talking to the family. In an attempt to prolong life without quality, one must not prolong the misery at a high cost (20).

Two third of our doctors said they do encourage R/S practices, however majority of patients could not recall any inquiry by physicians about such issues. Why do physicians resist discussing R/S issues? Many possible explanations have been given. Lack of time to discuss, lack of training in obtaining a R/S history and

difficulty in identifying patients who want to discuss R/S issues, are some of the reasons put forth (21,22). Many doctors are also uncertain about whether, or how to address such issues. Often they are trained to diagnose and treat disease and have little or no training in obtaining the R/S history of the patient. But it seems more likely that R/S practice is a psychosocial taboo, as most of our physicians had never tried it. To reduce the impact of such taboos, a number of commentators have argued that medical training should include R/S issues, including knowledge of major religions and skills (such as teaching students to include the R/S dimension in history-taking) (23, 24). Various organizations including the American Psychiatric Association, American Academy of Family Physicians, American College of Physicians and Association of American Medical Colleges have stressed the need for addressing R/S issues, in patient care as well as in training of healthcare professionals (25). The American Counselling Association (ACA) Code of Ethics (2005) provides ethical guidelines for the integration of spirituality into the counselling process in a variety of aspects. More than 80 US medical schools now offer courses on R/S as part of their curriculum (26). A recent initiative from the Scottish executive health department makes spiritual care a central element of the way their National Health Service cares for people (27). However the doctor must avoid imposing his own values on the patient and let the patient act in a way consistent with his or her belief systems.

There are limitations to our data. Most importantly they are cross-sectional, so no causal statements can be made. Also, we did not observe doctors behaviour, but relied on self-report, raising the possibility of reporting bias. Finally, it is difficult to know how well the current findings generalise to various populations of doctors. However the findings reported support other similar studies on the importance of doctor's belief/attitude in the area of R/S and medicine. Among the patients, results presented rely on assessment of R/S at a single time point, limiting our ability to infer the causal nature of the observed relationships. Future research is needed to validate our findings with other doctor groups and different patient populations.

CONCLUSION

Physicians in the 21st century are encouraged to work in partnership with their patients, informing, guiding, advising, and helping them to make appropriate choices about how to deal with their illness. Doctor is not just a dispenser of medicine but a value maker, ethicist, social force and political influence in the life of his patients. There is no such thing as value free medicine, nor has there ever been. In conclusion, R/S clearly deserves greater attention in professional practice, as it may also go a long way in making the practice of medicine more holistic, ethical and compassionate. It will also strengthen medical students in their commitment as caring doctors.

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