

# The Patient's Perception of the role of Prayer in the Family Practice Consultation.

**Liddle, A.S.**

M.B., Ch.B., M.Phil (Family Medicine & Primary Care)

A qualitative study accepted as part of the requirements for the degree M. Phil (Family Medicine & Primary Care) University of Cape Town, 1997

**Address for correspondence:**

Dr. A.S. Liddle  
P.O. Box 2045, Sarepta, 7582  
Telephone: +27 21 906 1880  
Facsimile: +27 21 904 1559  
E-mail: drlidl@ananzi.co.za

**Keywords**

Prayer, Spirituality, Religion, Qualitative, Patient-centeredness.

## Abstract

Prayer and spirituality are aspects of patient care that are not often addressed in modern medical practice. Controversy surrounds the family practitioner's role regarding prayer. The patient's belief system and religion are neglected psychosocial variables. Prayer is accepted as an integral aspect of therapeutic counselling, by pastoral counsellors. The issues, that this study address are, whether prayer is appropriate in the family practice consultation and if so, the effective dosage, in the range between homeopathic and overdose. All the participating doctors practise in the "township" areas of the Cape Peninsula. The intention is to gauge the patients' opinion on the family doctors' role regarding prayer and to assess whether differences in religion between doctor and patient affects the patients' choice of doctor or their religious enquiry or discussion. The results compare favourably with other studies, viz. that there is a lack of religious inquiry, initiated by doctors. Most respondents felt that they would not discuss religious or spiritual matters with practitioners of different religious persuasions. Others had felt that doctors of different religions, who had discussed religion, enriched the experience of the consultation. None of the respondents had expressed that they would not attend doctors on the basis of their religion. The positive reinforcement of the doctor patient relationship, for respondents who shared spirituality or prayer with their practitioners, is a significant finding. This positive reinforcement is displayed through Venn diagrams. Suggestions that would facilitate the introduction of spirituality into the family practice consultation are presented.

*S A Fam Pract 2002, 25(4): 9-14*

## Introduction

This study aims for a deeper understanding of patients' views on prayer in the family practice consultation. Family practice patients have diverse religious beliefs and practices.<sup>1,2</sup> Relating religion to medicine is, on the one hand, considered an unusual occurrence,<sup>3,4</sup> and a sensitive almost taboo subject.<sup>5,6,7</sup> On the other hand, religion is considered to form an integral part of medicine, not only by divine authority but by virtue of factual knowledge<sup>8</sup> and reason.<sup>4</sup> Reticence, to research prayer, based on the potential of divine punitive reaction is rejected since it confuses the spiritual action of prayer with its consequences.<sup>9</sup> Lay press articles,<sup>10-13</sup>

books written by doctors<sup>14-18</sup> and medical publications<sup>7,19-21</sup> have brought these issues under the spotlight. A review of the literature (PRE-1995), reveals two studies<sup>6,22</sup>, which assessed patients' expectation of prayer and discussion of religion.

## Methods

This is a qualitative study of a purposeful sample of 10 adult patients, selected by the author and three family practitioners of different religious persuasions. Consent for participation and publication was obtained. Potential problems, of supercession, were avoided by selecting practitioners, who practise in different areas. Any risk, to the doctor patient rela-

tionship, was nullified by allowing the respondent freedom of expression. Respondents were assured that the confidentiality and anonymity applied throughout. Feedback interviews facilitated understanding and allowed respondents' final approval. All respondents said that they enjoyed participating. One feedback interview was concluded with a prayer, at the request of and, by the respondent. Data was collected by tape recording and written field notes. Each respondent was allocated a three letter alpha code. The first letter indicating the sequence of respondent, the second letter indicating the respondent's gender and the third letter, the respondent's religion. For interview AFC, we can therefore conclude;

A= the first interview, F= female respondent, C= Christian. All lines of transcripts were numbered by an alpha numeric number, the alpha prefix being the interview code and the numeric suffix, the line number. The editing style allows for analysis and data collection to occur simultaneously. Phrases were grouped using the cut and paste method. Venn diagrams facilitated a concise display of the data of individual respondents. An individual understanding is considered essential by Stewart.<sup>23</sup> The individual display also allows demonstration of the diversity of beliefs and practices found in the small sample of respondents.

Themes were compared and re-organised. Data was further reduced and recorded in a matrix as described by Huberman.<sup>24</sup> The matrix, enabled integration of the individual interviews into collective themes. Further summarizing and reduction led to the results, as recorded. The themes' reliability was checked by utilizing the formula of Huberman,<sup>24</sup> viz, reliability = number of agreements/total number of agreements plus disagreements. Internal consistency of interview AFC was calculated by double coding and applying the above formula. Double coding sharpened the definitions<sup>24</sup> and served, very effectively, to check the correctness of categorizing. Discussion with colleagues and supervisors counteracted my bias and prioritized the primary aim of the study, i.e. the respondents' perception. I actively attempted reflexivity during the literature review, interview, analysis and during writing up.

## Findings

The eight collective themes identified are presented below with supporting direct quotations from the individual interviews. The demographics of the sample are summarized in Table I.

**Beliefs:** Respondents' beliefs, expectations and past experiences, more than their demographic criteria, seem to direct their attitudes and actions, as one respondent says, "I was brought up, religion doesn't sit on your head, it is what is inside of you as a person." FFM048-050. Group functioning is expressed as an issue of prime importance, since "the church ... is the means of getting people together to become a worshipping community, a worshipping family." BMC108-110 A monotheistic belief is shared by all respondents, irrespective of religion or denomination, as is the belief in a benevolent God. All respondents confirmed a role for, and belief in, prayer. The degree of belief varies from "one day I may get an answer" EMC121 to "prayer is in everything that we do." CFM204 I did not inquire directly about the frequency of the practice of prayer. Some respondents indicated that they, are "very prayerful", HFC023 endeavoured not to make themselves "too busy" AFC250 and even to "sometimes... just get the urge" AFC252 to pray. Religion and prayer holds people or families together during these troubled times" KMC496-497. Religion is so important that, "I don't think that any family can be a family if ...they haven't got

the Lord, or if they don't make the Lord a part of their lives." AFC159-162 The tendency to "forget there is a Lord" DMC181 or to "leave God on the outside" JMC421 is thought to be encouraged by an over dependence on bio-medical science. All respondents indicated that "Prayer is involved in medicine". EMC345

**Speaking about the doctor.** The vocation of medicine is recognised by many respondents as "a calling from God." HFC424 Physicians are identified as "the hands of God and the science of God" BMC156 with "the gift and the talent under the controlling hands and direct supervision of God and of the angels." BMC156-159 Almost all respondents expressed excellent relationships with their GP's. The only two who did not express this did not mention their GP at all. A concern was expressed in that some patients "idolise" JMC432 their doctors. One doctor was identified as a "super power." EMC151 However, "doctor are also only human." KMC346 The religious doctor who "knows the source of his strength", KMC418 seems to facilitate communication. One respondent clearly expresses, "if ...you don't speak about God, it doesn't mean I won't go back to you. But ...God comes into the conversation, then I'm open. I'll talk to you." GFC230-235

Comfort and trust is generated by the awareness that "this is a man of God, believes in the same principles, that I believe in." KMC700-702 One respondent had "a prayer together"

**Table I:** Demographics of sample.

Interview	Denomination	Language	Age	Occupation	Dr's religion
AFC	Anglican	English	48	Housewife	Anglican
BMC	Anglican	English		Priest	Anglican
CFM	Moslem	Afrikaans	26	Clerk	Anglican
DMC	SDA#	English	63	Foreman	Agnostic humanist
EMC	Anglican	English	37	Teacher	Agnostic humanist
FFM	Moslem	English	39	Childcare worker	Hindu
GFC	Docks Mission	English	42	Housing Assistant	Moslem
HFC	Anglican	English	49	Housewife	Moslem
JMC	Anglican	English	50	Senior Operator	Anglican
KMC	VGK*	Afrikaans	46	Clerk	VGK*

# Seventh-Day Adventist - \* Vereenigde Gereformeerde Kerk - *Italics indicate that the information was obtained from the family doctor*

JMC263 with a doctor, that he had consulted. It was "quite a surprise... to hear a doctor ask..., if he could pray" JMC296-297 but he felt elevated and "on the same level" JMC306 The GP who appreciates God is viewed, "as a confidant. ...on the same wavelength." GFC286-288 The respondent who did not experience any spiritual interaction during the consultation, similarly, felt that his GP has a very "compassionate nature." EMC158 Another respondent, if she should notice her doctor praying quietly, would consider him "a sweet person ... would probably make my heart glad" AFC352-354

**Prayer.** Prayer is generally recognised as communication with God. All, except one, expressed satisfaction with prayer. Prayer, for the dissident voice, is "obviously a one way conversation". EMC103 He questions where "faith comes in" EMC124 and almost wistfully concludes, that "maybe one day I'll get an answer." EMC121. All respondents felt that there is a role for prayer in the family practice consultation. The doctor has a specific talent and duty "because we're all gifted ...with the gift of being able to talk and to listen... (i.e.) the gift of prayer." BMC236-240 "Prayer... goes hand in hand with medical" JMC382 and the doctor cannot achieve anything without divine guidance and intervention. The timing of the prayer, as well as its implementation, is "a difficult choice" KMC531 and the doctor will need to know his patients and be sure that the patient really wants to pray. Prayer in the consultation seems to have a "soothing" FFM236 effect, that "fills us again with His power... and with His love". JMC502 Prayer is, therefore suggested as, appropriate in times of "emotional trauma", AFC302 "and when you're deeply troubled." AFC299

**Feelings about prayer in the consultation.** The need for prayer in the consultation is repeatedly addressed. Respondents "encourage the doctor to pray" BMC263 and "would love to see doctors... [pray] more often". DMC179 A "Moslem gynae" FFM183 prays for all his patients. The patient "feel great" FFM244 and is assured of "extra strength" FFM245 as she is

"petrified of operations." FFM162 "The prayer of a faithful believer is very powerful". KMC598 Consequently "if patients ...idolise" JMC439 the doctor and he "prays for you, it will be fantastic". KMC599 It is "strange" AFC333 that prayer becomes more important when one fear that "something may happen" AFC341 or if "you don't know if you're going to come out". FFM225. Care should be exercised with patients who are unaware or unsure of their diagnosis. Prayer at such a time, may cause "psychological hurt", BMC221 "simply because... it's a medical doctor", BMC216 who is being seen. Doctors who pray at inopportune moments or without gaining the patients' trust and permission may discourage some patients. "If it's not a situation that calls for prayer, it's not going to go down looking well. They're going to say, 'Don't go to that doctor.'" AFC315-318 Prayer is suppressed by "big-headed" JMC482 attitude, verbosity or "empty words". HFC188 Respondents also, are wary of "window-dressing" HFCR and of doctors, "not being sure of themselves" EMC296 or who are "trying to impress". EMC298 A great difficulty is that "doctors are so busy." JMC456

**Difference of religion between doctor and patient.** There is general consensus of respect for other religions, even where "there is a world of difference" KMC662. Patients attended doctors because of the doctors' skill, honesty, level of care, attitudes and respect. When the GP "cares... then ... religion doesn't matter" CFM397 Doctors of different religions who demonstrated and shared their beliefs with the respondents caused the respondents to admire those doctors. This encourages patients "to feel... equal, ... understand each other and ... (to) communicate." GFC126 Most respondents expressed a difficulty with cross religion prayer. Somewhat of a paradox, since all respondents agreed that "we serve one God." JMC329 and some would, "still ask God [for] a blessing." JMC373 The differences in religion and even of church denomination, could result in communication to be "not on the same level" JMC322 or that "we will

talk past each other". KMC441 One respondent felt that where even the "religious principles" KMC673 differs, he would have great difficulty co-operating with that practitioner.

#### **Doctor asking about religion.**

Only one respondent said that her GP asked about her religion. She considered this, an expression of "his interest" CFM329 and "respect for my religion" CFM331 Another indicated that not "one doctor asked and I'm 48 years old." AFC343 One "made it known to the doctor what religion we are." DMC208 Two respondents "will try and bring it (religion) in". GFC290 One says, "if he don't respond, I won't force the issue". GFC291 The other "will always infer from my conversation, ... where do I stand with this doctor. How does he view things, what is his religious ideology?" KMC685-687

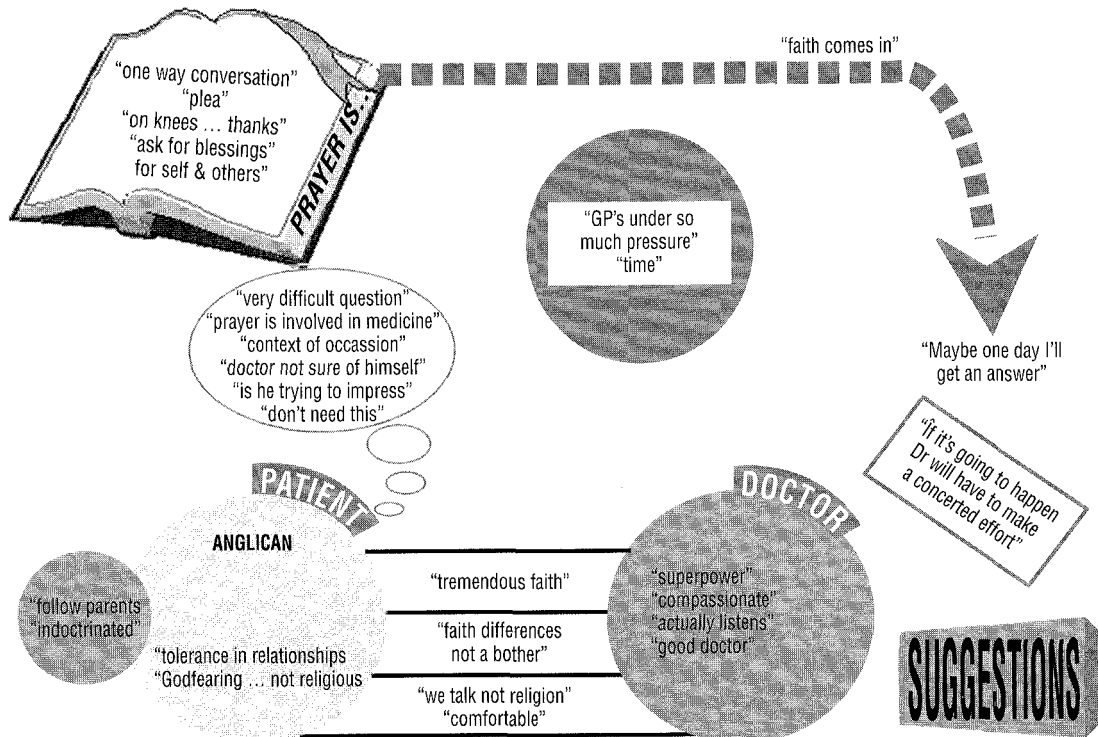
#### **How to pray in the consultation.**

Respondents' suggestions on the means of implementation of prayer are based on a good doctor-patient relationship. Doctors should know their patients, not surprise the patient with sudden "out of the blue" AFC320 prayer and ascertain that the patient is fully aware of the reasons for the prayer. The relationship between clergy and family practitioners, "was fantastic. Today that disposition has been neglected and estranged, ... it must be picked up again". KMC582-584 "That the doctors also will realize, 'I am not master over human lives.'" KMC619-624 All believers are urged to fulfil their "evangelical mission" GFCR and share their beliefs with patients. Prayer sessions or prayer rooms at surgeries "will be flooded by people who would eagerly want to pray there." KMC566

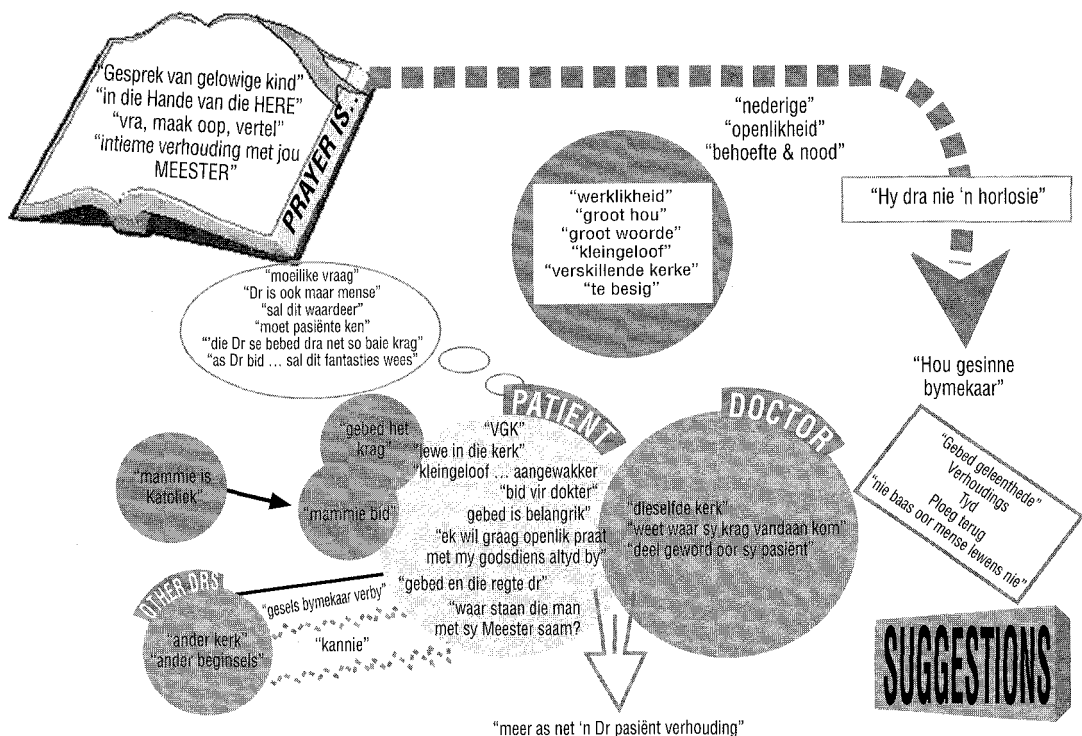
#### **The doctor-patient relationship**

appeared to assume greater importance when it was associated with shared spirituality. The venn diagram (figs 1 & 2) and its explanation, depict these relationships and summarize each interview. The two larger circles represent the respondent to the left (blue) and their own family practitioner (pink) to the right. Other smaller circles, represent other doctors (pink) or people that the respon-

**Figure 1:** Diagram of consultation of respondent EMC. This diagram does not show any episodes of shared spirituality.



**Figure 2:** Diagram of consultation of respondent KMC. This diagram shows episodes of shared spirituality, at the intersections of the circles, between the patient and the doctor and also with his wife and others.



dent discussed. The intersections of the circles indicated episodes of shared prayer or spirituality. Unbroken straight lines between the circles represent good relationships and jagged lines represent poor or hostile relationships. The open book display the respondent's understanding of prayer. The bubble indicates thoughts and/ or feelings. The "no entry" sign depicts any inhibitions or impediments to prayer in the consultation. The suggestions are being deposited into the box for that purpose. Quotes and arrows are inserted to complete the flow.

## Discussion

The population studied, is characterized by a wide diversity in a multicultural society and many different religions and religious denominations. This study, despite the small sample, has demonstrated some differences and touch upon some of the effects that relate specifically to doctor-patient religious differences. Reliability calculations, according to his formula, fitted Huberman's expectations.<sup>24</sup>

The study has several limitations. The sample is small, even for a qualitative study. The religious diversity cannot be fully addressed without input from more denominations and religious affiliations. e.g. Roman Catholics, Apostolics, Atheists, Hindus et al. "Extreme case"<sup>14</sup> sampling might have enriched the study. All respondents in this study do pray. The views of atheists or people who do not pray, may differ. The context of the interviews, specifically relating to issues of gender and respondent expectations and view of the interviewer, is thus not adequately addressed. The need for prayer does not necessarily refer to prayer by the doctor but could also be prayer by or for the patient and by or for any other individual or institution.

Respondents have warned how not to and suggested how to introduce prayer into the family practice consultation. These warnings should be heeded as part of a patient-centered approach and the processes of reflexivity and bracketing during the consultation. An awareness of self is crucial to enable reflexivity and

bracketing. Much have been said about what we pray for. One respondent mentioned that prayer is a "one way conversation". EMC104 It is important to consider what kind of divine intervention we are awaiting. This is especially important when we are evaluating trials that investigate the efficacy of prayer.

This study confirms the results of previous research,<sup>1,18</sup> that doctors do not ask patients about their religion, but is contrary to the results of a non-random study of 49 general practitioners 35 all members of the Medical Association of South Africa where 83% of the respondents said that they inquired about religion in the consultation. Further study into the reasons why doctors do not ask patients would be useful. Respondents wish to know their doctors' religious standing. Their inquiry is inhibited by respect for the doctor. A respondent viewed her GP's inquiry about her religion as a sign of respect. Schreiber<sup>34</sup> wrote that the lack of doctors' inquiry might indicate disrespect to the patient.

This study was initiated to assess the respondents' perception of the role of prayer. "Prayer goes hand in hand with medicine" JMC381 and "prayer is involved in medicine" EMC345 are replies that reflect the feelings of all the respondents. The in-depth interviews have, true to the expectations of qualitative research, revealed a rich depth of feelings and a myriad of opinions. The most important findings are that the respondents expect respect for their beliefs and a patient-centred approach. The exact role of prayer need to be determined for each patient in every consultation. Doctors should continuously be aware of their own feelings and conscious of patient cues. Prayer is not a substitute for clinical competence. Prayer and the personal spiritual orientation of each individual are part of the doctor-patient interaction, with or without the awareness of the respective individuals. Episodes of spirituality, shared between the doctor and patient, as expressed by some respondents, lead to the opening of communication, equality and im-

proved relationships. The association between the two variables i.e. the doctor patient relationship and prayer, needs further investigation. We are not expected to fulfil all the expectations of our patients but we are expected to be aware of those needs and to address those needs when possible.

## Conclusion

Respondents made appropriate, plausible and acceptable suggestions regarding the incorporation of prayer and religious inquiry into the doctors' armamentarium. Respondents have showed sensitivity when they attempted to establish the religious or spiritual ideology of their medical providers. I think that all family practitioners should consider such discussion as part of the usual patient history. We should handle this discussion with similar sensitivity. Maugans<sup>21</sup> has develop excellent guide-lines to a spiritual inquiry based on the mnemonic "SPIRIT".<sup>21</sup>

Barnard,<sup>1</sup> during 1995, reported that 13 American medical schools had a required course in religious studies and 24 other schools offered the course as part of another course. Such a course should be introduced at our medical schools so that all medical students could appreciate the rich and varied forms of religious life, expression, and practice. The resulting awareness will motivate the students to practise genuinely person-centred medicine.

## Acknowledgements

I acknowledge and thank all who have contributed and assisted in varying degrees and apologise to those not mentioned here. Thank you, the ten respondents who willingly shared their time and their homes, Drs J. Dhansay, F. Frantz and E.V. Rapioti for the selection of your patients, my supervisors (Dr B. Schweitzer & Dr Anthonnisen), Prof Pierre de Villiers and Dr Dave Whittaker for his patience, advice and assistance with the research and preparation of this article.

## References

1. Barnard David. Toward a Person-Centered Medicine: Religious Studies in the Medical Curriculum. *Academic Medicine* 70:9; 806-813
2. Mckee D.D., Chappel J.N. Spiritual, Medicine and Practice. *J Fam Pract* 1992;35:2:201-208
3. Craigie F.C., Liu., Larson D.B., Lyons J.S. A Systematic Analysis of Religious Variables in the Jnl of Fam Practice, 1976-1986. *J Fam Pract* 1988;27:5:509-513.
4. Foglia J.P. Religion, Faith, and Family Medicine. *J Fam Pract* 1988;27:5:473-474.
5. Sherril Kimberely. Adult Burn Patients: The Role of Religion in Recovery. *SMJ*. 81:7:821-825.
6. Van Hoorn G.C. Goddiens in Algemene Praktyd. M. Fam Med Thesis. US.1989.
7. Jones. T.L. What's God Got To Do With It? *Texas Medicine*. December 1995;91:12:26-29.
8. Albutt Sir Clifford. Reflections on Faith Healing. *BMJ*. June 18,1910:1:1453-1457.
9. Joyce C.R.B. and Weldon R.M.C. The Objective Efficacy of Prayer. *J. Chron. Dis.* 1965:18:367-377.
10. Dossey L. The Healing Power of Prayer. *Readers Digest*. 148:889; 69-71. May 1996.
11. Wallis C. Healing. *Time*. 147;126; 44-47. June 1996.
12. Kaplan M. Ambushed by Spirituality. *Time*. 147;126;48. June 1996.
13. Doheny K. inshape. The spiritual side of medicine. *Shape*. May 1997. page31.
14. Dossey L. Healing Words. The Power of Prayer and The Practice of Medicine. Harper. San Francisco.
15. Siegal B. Love, Medicine and Miracles. Rider. London. 1986.
16. Chropa D. Perfect Health. Bantam Books. Toronto. 1990.
17. Weil A. Spontaneous Healing. Little. London. 1995.
18. Wasserman H.P. Geneeskunde in die Bybel. J.L.van Shaik. Pretoria. 1997.
19. Van Deventer Claire. Spiritual Care. *SA Fam Pract* 1995;16:12:786-790.
20. Johnson R. Chemo, Guts, Prayers and Small Mercies. *SA Fam Pract*. Oct 1996;17:10:458-460.
21. Maugans T.A. The Spiritual History. *Arch Fam Med* Jan 1996;5:11-16
22. King D. E. Bushwick B. Beliefs and Attitudes of Hospital Inpatients about Faith Healing and Prayer. *J Fam Pract* 1994;39:4:349-352.
23. Miller W. J., Crabtree B.F. Tools for Primary Care Research, Ed.Moira Stewart. Ch. 16; Depth Interviewing. *The Long Interview Approach*.
24. Miles M.B., Huberman M.A. Qualitative Data Analysis. A Source book of New Methods. SAGE Publication. Newbury Park. London. New Delhi.
25. Meyer M. Goddiens en die pasient – hoe sien die algemene praktisyn dit. 'n Studie in Bellville. *S Afr Med J* 1993;83:907-910.
26. Schreiber K. Religion in the Physician-Patient Relationship. *JAMA* 1991;266:21:3062-3066.

**University of Stellenbosch**

Faculty of

**Health Sciences**

Department of Obstetrics and Gynaecology

Stellenbosch University



### UPDATE IN FAMILY PLANNING AND REPRODUCTIVE HEALTH CARE SATELLITE SYMPOSIUM – 23 AUGUST 2002

*A country-wide satellite-linked one-day update in Family Planning and Reproductive Health with interactive lectures by the world-renowned expert Prof John Guillebaud and other local presenters*

#### Update and improve your knowledge in Family Planning and Reproductive Health.

A wide range of topics will be discussed with special reference to management problems, including:

- Combination oral contraception – prescribing guidelines/ controversies
- New developments and frequently asked questions covering - high and low BMI, migraine, heart disease, osteoporosis, emergency contraception, sterilisation guidelines
- Contraception at the extremes of reproductive life
- Intra-uterine contraception today – less risky than the pill and better than sterilisation?
- Postnatal contraception following disease in and of pregnancy
- Pre-conception counselling

**This meeting is accredited for 7 CDP points.**

Address your questions directly from the satellite-linked lecture room in: East London, Port Elizabeth, Queenstown, Bloemfontein, Randburg, Midrand, Durban, New Castle, Pietermaritzburg, Nelspruit, Witbank, Klerksdorp, Vryburg, Polokwane, Kimberley, Springbok, Upington, Bellville, George, Stellenbosch, Vredendal

**Enquiries/ Registration: Me Madaleine Schultz-du Toit**  
Phone: 021 9389217, Fax: 021 9322455, E-mail: mms1@sun.ac.za