

Prayers in the Clinic: How Pediatric Physicians Respond

Wendy Cadge, PhD, and Elaine Howard Ecklund, PhD

Background: Physicians and researchers have recently paid increased attention to prayer in physician-patient interactions. Research focuses more on attitudinal questions about whether physicians and/or patients think prayer is relevant than on actual data about when and how prayer comes up in the clinic and how physicians respond. We focus on pediatric physicians to investigate: 1) how prayer enters clinical contexts and 2) how physicians respond.

Methods: We examined in-depth interviews with 30 academic pediatricians and pediatric oncologists. All of these physicians were employed by the most highly ranked hospitals according to *US News and World Report*.

Results: In close to 100% of cases when the subject of prayer came up in clinical contexts, it was patients and families who raised it. Patients and families mostly talked about prayer in response to a seriously ill or dying child. When it was raised, pediatric physicians responded to prayer by participating; accommodating but not participating; reframing; and directing families to other resources.

Conclusions: Physicians wanted to respect patients and families around the topic of prayer. They negotiated between patient/family requests, the specific situation, and their own comfort levels to respond in one of four ways. Their four responses allowed researchers to generate hypotheses about the independent variables that influence how pediatric physicians respond to prayer. Asking how prayer actually came up in clinical situations rather than how patients and/or physicians thought it should be raised, better informs ongoing conversations about the significance of prayer in physician-patient interactions.

Key Words: pediatric physicians, provision of healthcare services, religion/spirituality

I ncreasing numbers of physicians acknowledge that religion and spirituality help some patients and families cope with illness, especially difficult and life-threatening illnesses.¹⁻⁵ Patients pray, consult religious/spiritual teachers, attend religious gatherings, and rely on personal religious/spiritual beliefs.⁶⁻⁸ Recent surveys of pediatric physicians describe their *attitudes* about religion and spirituality and how these might influence patient care.⁹⁻¹² Much less is known about the *behaviors*, self reported or otherwise, of pediatric physicians around religion and spirituality in clinical contexts. We asked how pediatric physicians say they behave when prayer enters clinical situations. Previous studies have not explored how physicians act in these situations.^{9,10}

The empirical study of pediatric physicians' self-reported behaviors around prayer in clinical contexts respond to three ongoing discussions. First, there is debate about whether patients want physicians to pray with them.¹³⁻¹⁸ Second, there is an ethical discussion about whether it is appropriate for physicians to pray with patients and how such prayers should be approached.¹⁹ Third, there is research that shows more than half of Americans pray for their own health or the health of their loved ones and three-quarters believe prayer can have

Key Points

- In close to 100% of cases, when the topic of prayer is raised in clinical situations, it is patients and families, rather than pediatric physicians, who raise it.
- Patients and families most often talk about prayer in response to a seriously ill or dying child.
- Once raised, physicians respond to prayer by: participating in prayers, accommodating prayers but not participating, reframing prayers, or directing patients and families to religious/spiritual resources.
- Pediatric physicians' four responses allow researchers to generate hypotheses about the independent variables that may influence how pediatric physicians respond to prayer.

From the Department of Sociology, Brandeis University, Waltham, MA and Department of Sociology, Rice University, Houston, TX.

Reprint requests to Wendy Cadge, PhD, Department of Sociology, Brandeis University, 415 South Street, MS 071, Waltham, MA 02454. Email: wcadge@brandeis.edu

Supported by funding from the Robert Wood Johnson Foundation Scholars in Health Policy Research Program at Harvard University (to W.C.) and by Grant No 11299 from the John Templeton Foundation (to E.H.E.).

This project was approved by the Institutional Review Board at Rice University.

Accepted May 14, 2009.

Copyright © 2009 by The Southern Medical Association

0038-4348/0-2000/10200-1218

a positive effect on those who are ill.* Surveys of religion and spirituality among pediatric physicians, however, have stopped short of analyzing physicians' perceptions of their own behaviors when prayer enters clinical settings.

Materials and Methods

After obtaining approval from the Rice University Institutional Review Board, we conducted this study in two phases, both focused on pediatric physicians randomly selected from thirteen *US News and World Report* honor roll hospitals.† Rather than studying physicians at a single hospital, we selected physicians from thirteen hospitals to maximize the reliability and generalizability of the findings.²⁰ We focused on pediatric physicians at highly ranked honor roll hospitals as leaders in their fields.^{21,22}

Honor roll distinction was determined by combining hospital reputation, mortality data, and patient-care related factors. When six or more specialty areas showed "exceptional breadth of excellence," the hospital placed greater than two standard deviations above the mean and was granted honor role status. The following hospitals were included: Stanford Hospital and Clinics, the Johns Hopkins Children's Center, UCLA Medical Center, the University of Michigan Medical Center, Duke University Medical Center, University of Washington Medical Center, Mayo Clinic, Cleveland Clinic, New York-Presbyterian Medical Center, Massachusetts General Hospital, Hospital of the University of Pennsylvania, University of California San Francisco Medical Center, and Barnes-Jewish Hospital.

In phase one of the study, 209 faculty level general pediatricians were randomly selected from departments of pediatrics at hospitals in the sample. Similarly, 122 pediatric oncologists were randomly selected for participation. During May and June 2005, a contact letter was sent to each respondent inviting participation in a short web-based or telephone survey about religious identity, beliefs, practices, ethics, and the intersection of religion and medicine. Overall, 116 general pediatricians completed the survey (110 via web and 6 by telephone), yielding a response rate of 56%. Also, 74 academic pediatric oncologists were recruited, yielding a response rate of 60% (71 online, 3 by telephone). These survey data were published in other articles.^{23,24} Researchers have not yet studied how prayer comes up in clinical situations and how pediatric physicians actually respond. For this reason we did not include a question about it on the survey. Instead, and because little is known about how prayer is introduced, we asked about the subject in in-depth interviews, a protocol that is recommended by medical researchers when little is known about a topic.^{25,26}

Interviews with 30 pediatric physicians (14 pediatricians and 16 pediatric oncologists) comprise phase two of this

project. Interviewees were randomly selected from those who completed the survey. The interview response rate for pediatricians was 47% and for pediatric oncologists it was 53%. There was no bias of selection in choosing potential interview respondents. For methodological triangulation, each of the two authors conducted a portion of the semi-structured interviews, in person and by telephone. Much of the data presented here was gathered in response to questions:

- When, if at all, does the issue of prayer come up in your interactions with patients and families?
- Who brings it up?
- Do patients/families ever ask you to pray with them? If yes, how do you respond?

We stopped hearing new themes after completing 30 interviews, evidence that we reached saturation and a reliable sample size.²⁰ Interviews were digitally recorded and transcribed by trained transcriptionists.

The authors triangulated the data in the analysis, identifying common themes and systematically coding all of the transcripts inductively using a grounded theory approach.²⁷ As is common in qualitative research, initial codes were refined as new themes became evident. Themes and codes were considered independently by each of the authors, in consultation with a research assistant. This process of triangulation strengthens the interpretations and conclusions. Representative quotes were selected to illustrate the conclusions presented below.

Results

Study Population

The thirty physicians interviewed included equal numbers of women and men. Sixty percent were white and just over one-quarter were Asian American. They ranged in age from 31–65, average 46. The majority were married and just over half had children under age 18. They had been in their current position between 2 and 32 years, average 10.3 years. Eighty-six percent said they were spiritual, 34% said they were religious, and 41% belonged to a religious organization. When asked about their religious affiliation, 43% (n = 13) said none, 23% (n = 7) said Jewish, 13% (n = 4) said Protestant, 10% (n = 3) said Catholic, and the remaining 10% (n = 3) report another religion or had no answer.

When Prayer Comes Up, How Do Pediatric Physicians Say They Respond?

Prayer is not a regular subject of discussion with patients and families, but it does come up, more often for pediatric oncologists than pediatricians. Patients and families usually raise the subject. When patients and families raise the topic, physicians describe responding in one of four ways: they

*Data from a survey conducted by Newsweek dated November 1, 2003. Available through Polling the Nation.

†*U.S. News & World Report*. July 12, 2004 edition, "Honor Roll Hospitals."

participate in the prayers; they accommodate the prayers, not participating; they reframe the prayers; or they direct patients and families to other religious and spiritual resources. The immediate context in which families raise prayer and the physicians' own personal backgrounds influence their response with no discernable patterns according to personal, religious, or demographic characteristics of the physicians.

One set of physicians participated in prayers with patients and families. A pediatric oncologist said that patients and families frequently mentioned spontaneously that they were praying for certain outcomes. He responded, "I'll tell them that I will join them in their prayers" (Int21). Sometimes families asked physicians to pray with them. Another pediatric oncologist said, "Some of the families I'm very close to . . . say, 'do you mind praying with us?'" He always responded by praying with them (Int6).

Physicians are often invited to participate in religious ceremonies in the hospital where prayers are offered, such as at baptisms. In the words of one physician, a Catholic, "In my life on a few occasions, I had the parents ask me to be there for the baptism given to the baby because the baby was dying, or I stayed when they called the priest to give the benediction to the infant. I stay at the bedside myself because, I felt like, you know they're part of my family, so . . . I love to share that" (Int6).

Rather than praying with patients and families, a second group of physicians accommodated prayers by being present for them but not participating. Physicians described standing quietly with families bowing their heads and even speaking at funerals in ways they felt benefited families. A pediatric oncologist explained, "I participate [in prayers]. I mean in the sense that I generally sit quietly and listen to their prayer in what I hope is a respectful manner" (Int28). A pediatrician echoed, "I remember a case where everyone was standing around a bed and the family wanted everyone to bow their heads with them and I did it out of respect for the family" (Int22). And another pediatric oncologist explained, "I will bow my head and close my eyes and listen. I will sometimes say a quiet amen. I won't fake it, but I am respectful of their desires. I've often had a strongly religious grandmother or somebody offer to pray for me in various situations, and if somebody tells me they're going to pray for me, I say, 'Thank you'" (Int29).

Pediatric oncologists also reported sometimes speaking at children's funerals. After explaining that she accommodated families' prayers by "stand[ing] in a circle and hold[ing] their hands because [she] thinks that could be a sign of comfort and solace to them," one pediatric oncologist explained that she goes to most kids' funerals and when asked to speak tries to be "quiet about my own personal viewpoints" and "very general" in the comments (Int20).

Different from those who accommodate prayer silently, a few reported speaking directly with families about how they

interact with prayer. When families asked her to pray, one pediatric oncologist said she prays in her own way.

"In my agnostic way, I do pray. People say more general things like, 'You know, would you please pray for my child,' and I answer 'Of course – in my way I will, absolutely, my prayers are with you.' And that's a true statement . . . and whether I translate it to good thoughts or to dialogue with God. It may not be the way they pray, but it's the way I pray (Int26)."

Another pediatric oncologist also wants to accommodate people's requests for prayers but makes clear that he is only comfortable doing so to a point. "If somebody wishes me to lead a prayer, I say 'I don't think that's appropriate or I would prefer not to but I'll be happy to be here with you.'" Beyond that he feels it is "manifestly unfair of patients to demand something so personal of their physicians" (Int27).

A third group of physicians reframed the prayer requests families make in ways they perceive to be more realistic and appropriate. A pediatric oncologist explained that families will say "'Will you pray for him [patient's name]?' kind of in a general sense." This physician reframes the request in her answer to families saying, "Of course, everybody will be praying for them." She explains, "I try not to bring myself into it, because I don't want this to be about me, and I don't want them [the family] to think that I have more quote-unquote power to cure their child than I actually have. And I don't want them to think that because I'm praying with them that I will be more likely to cure them than if I didn't pray with them" (Int16).

A final group of physicians responded to prayer by referring patients and families to other resources, such as the family's religious and spiritual leaders or hospital chaplains. A pediatrician remembered working in a pediatric emergency room several years ago and asking families "who they wanted to have come be with them as far as their priest or minister or other spiritual person" (Int3). Similarly, a pediatric oncologist responded to family requests by saying that she would keep people in her prayers but also referred families to chaplains. She explains, "If I don't feel comfortable, if I feel that their religion is something that I have a hard time understanding, I often ask if they would like to have some spiritual guidance. I'm happy to call someone that might be better able to address it" (Int25).

Discussion and Conclusion

Studies of prayer in pediatric physician-patient interactions focus on attitudes and preferences—whether patients want physicians to pray with them, how physicians feel about praying, and the ethics of physician prayer—rather than empirically documenting what is actually taking place in clinical encounters.^{1–12} This article is the first to focus on how physicians describe actually behaving.

We find that prayer is more commonly relevant for the pediatric oncologists interviewed than for pediatricians. When

families raise the topic of prayer in the clinic, it is rarely a simple matter of families directly asking physicians to pray and physicians saying yes or no. One previous study showed that 90% of pediatricians at an urban medical center said they thought it appropriate to pray with patients and 76% said they would feel comfortable praying with patients.¹⁰ Our study found that the request is often not as direct as survey questions assume. The situations that gave rise to requests and physicians' behaviors in response are more complex than simply praying or not praying.

All of the physicians interviewed had a desire to be respectful of families' prayers, even if they did not share their beliefs or feel comfortable participating in them. While some did participate in prayers as people of faith or members of the same religious tradition, others silently accommodated. Some pediatric physicians put their personal beliefs aside to support a family while others gently let families know of their personal comfort levels. Others refer requests to religious leaders or hospital chaplains, those who pediatricians think have more expertise to be with patients and families in their prayers.

This study is limited by its small sample size, and its findings cannot be generalized statistically to all pediatricians/pediatric oncologists or to all pediatric physicians in academic medical centers. The qualitative research methods used here are valuable for generating detailed descriptions of behaviors from the perspective of the people involved in them and hypotheses for larger quantitative study. This paper points to the importance of studying physicians' self-reported behaviors in addition to their attitudes, in order to understand how prayer is present in pediatric clinical contexts. If these results are replicated in larger quantitative studies, they suggest that medical schools might add sections about how to respond to prayer to courses about religion/spirituality, cultural competency, and/or patient-physician relations.

References

1. Robinson MR, Thiel MM, Backus MM, et al. Matters of spirituality at the end of life in the pediatric intensive care unit. *Pediatrics* 2006;118:e719–e729.
2. Chibnall JT, Brooks CA. Religion in the clinic: the role of physician beliefs. *South Med J* 2001;94:374–379.
3. Curlin FA, Roach CJ, Gorawara-Bhat R, et al. How are religion and spirituality related to health? a study of physicians' perspectives. *South Med J* 2005;98:761–766.
4. Koenig HG, Bearon LB, Dayringer R. Physician perspectives on the role of religion in the physician-older person patient relationship. *J Fam Pract* 1989;28:441–448.
5. Steinhauer KE, Christakis NA, Clipp EC, et al. Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA* 2000;284:2476–2482.
6. Mansfield CJ, Mitchell J, King DE. The doctor as God's mechanic? Beliefs in the Southeastern United States. *Soc Sci Med* 2002;54:399–409.
7. Levin JS, Larson DB, Pulchalski CM. Religion and spirituality in medicine: research and education. *JAMA* 1997;278:782–793.
8. Friedman T, Slayton W, Allen L, et al. Use of alternative therapies for children with cancer. *Pediatrics* 1997;100:e1–e10.
9. Armbruster CA, Chibnall JT, Legett S. Pediatrician beliefs about spirituality and religion in medicine: associations with clinical practice. *Pediatrics* 2003;111:e227–e235.
10. Siegel B, Tenenbaum AJ, Jamanka A, et al. Faculty and resident attitudes about spirituality and religion in the provision of pediatric health care. *Ambul Pediatr* 2002;2:5–10.
11. Barnes LL, Plotnikoff G, Fox K, et al. Spirituality, religion, and pediatrics: intersecting worlds of healing. *Pediatrics* 2000;106(4 suppl):899–908.
12. Sikand A, Laken M. Pediatricians' experiences with and attitudes toward complementary/alternative medicine. *Arch Pediatr Adolesc Med* 1998;152:1059–1064.
13. MacLean CD, Susi B, Phifer N, et al. Patient preference for physician discussion and practice of spirituality. *J Gen Intern Med* 2003;18:38–43.
14. Ehman JW, Ott BB, Short TH, et al. Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill? *Arch Intern Med* 1999;159:1803–1806.
15. King DE, Bushwick B. Beliefs and attitudes of hospital inpatients about faith healing and prayer. *J Fam Pract* 1994;39:349–352.
16. Monroe MH, Bynum D, Susi B, et al. Primary care physician preferences regarding spiritual behavior in medical practice. *Arch Intern Med* 2003;163:22:2751–2756.
17. Maugans TA, Wadland W. Religion and family medicine: a survey of physicians and patients. *J Fam Pract* 1991;32:210–213.
18. Daaleman TP, Nease DE Jr. Patient attitudes regarding physician inquiry into spiritual and religious issues. *J Fam Pract* 1994;39:564–568.
19. Curlin FA, Hall DE. Strangers or friends? A proposal for a new spirituality-in-medicine ethic. *J Gen Intern Med* 2005;20:370–374.
20. Denzin NK, Lincoln YS. *Handbook of Qualitative Research*. Thousand Oaks, CA, Sage, 2000.
21. Dye T. *Who's Running America?* Englewood Cliffs, NJ, Prentice-Hall, 2001.
22. Rado I. Cultural elites and the institutionalization of ideas. *Soc Forum* 1987;2:42–66.
23. Ecklund EH, Cadge W, Gage EA, et al. The religious and spiritual beliefs and practices of academic pediatric oncologists in the United States. *J Pediatr Hematol Oncol* 2007;29:736–742.
24. Catlin EA, Cadge W, Ecklund EH, et al. The religious identities, beliefs, and practices of academic pediatricians in the United States. *Acad Med* 83:1146–1152.
25. Shortell SM. The emergence of qualitative methods in health services research. *Health Serv Res* 1999;35:1083–1090.
26. Sofaer S. Qualitative methods: what are they and why use them? *Health Serv Res* 1999;35:1101–1118.
27. Strauss A, Corbin J. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, CA, Sage, 1990.