A survey of general practitioners' attitudes to the involvement of clergy in patient care

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SUMMARY. A questionnaire was sent to a sample of general practitioners in the Avon health district asking whether they perceived a role for the clergy in patient care. Doctors were questioned about both their theoretical attitudes to and practical involvement of clergy in relation to some 20 specific concerns of patients (for example, bereavement, divorce, depression, chronic illness) and to explain from a series of options their reasons for referring or failing to refer patients to clergy. The responses of the 228 respondents showed that they perceived a significant role for the clergy in theory which was not matched in practice. The reasons for the gap between theory and practice are analysed and discussed and suggestions are made as to how the positive responses may be more effectively developed towards improving patient care.

Introduction

IN recent years interest in whole person medicine — recognizing that health care involves treating people as body, mind and spirit — has greatly increased both within and outside the medical world. Ministering to the spirit has traditionally been left to the clergy and has generally been seen as separate from the treatment of body and mind, which has increasingly become the preserve of the health care professionals.

Last year saw the publication, after two years of meetings, of a joint working party report of the Royal College of General Practitioners (RCGP) and the Churches' Council for Health and Healing (CCHH) entitled *Whole person medicine*.[1,2] Seven recommendations were made in the report, including one which said:

> 'that both the College and the Council should encourage closer cooperation between general practitioners and ministers of religion in the day-to-day care of patients.'

This recommendation is supported by an approved statement of the British Medical Association, issued as long ago as 1947, which accepted:

> 'There is no ethical reason to prevent medical practitioners from cooperating with clergy in all cases [concerned with the treatment of patients] and more especially those in which the doctor in charge of the patient thinks that religious ministrations will conduce to health and peace of mind or lead to recovery.'[3]

The BMA statement concluded by declaring, 'we welcome opportunities for discussion and cooperation in the future'.

In the light of these reports and the increasing attention now being given to whole person medicine,[4-8] a survey has been carried out to discover the attitudes of general practitioners towards involving the clergy in patient care and their actual practice of referring patients.

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As both the RCGP/CCHH report and the BMA's approved statement were concerned with the involvement of Christian clergy, this survey was similarly restricted.

Method

Questionnaire

A questionnaire was compiled and pilot tested in the Swindon health district. It invited responses based on the theory and practice of involving clergy in patient care.

To look at the theoretical aspects 20 concerns were listed (for example, terminal illness, abortion, depression, retirement) and respondents indicated if they considered clergy could help in caring for the patient and for the person closest to the patient. This list was based on a similar one originally compiled at a course organized by the British Postgraduate Medical Federation, when 18 'rites of passage' were identified where it was felt clergy involvement would be beneficial.[9] In a second section four statements were presented about different degrees of relationship between religion and human illness and respondents were asked to tick one.

To look at practical aspects of referral to the clergy, respondents estimated the number of times in a year in which they referred patients and/or involved clergy in patient care. They were also asked to indicate which of the 20 theoretical concerns they had made referrals about. Next, a series of options was presented, reflecting possible positive and negative reasons for referral and respondents indicated why referrals were or were not made. These statements were compiled as a result of discussion with a number of doctors and clergy and were amended for the final survey to reflect additional factors which emerged from the pilot study.

Finally, the general practitioners were asked to state how many clergy they knew on first name terms.

Survey

An area within the Avon health district was chosen for the survey, consisting mainly of greater Bristol and including a cross section of social classes in the population. All active general practitioners in the area were mailed a questionnaire in the early spring of 1988 with a covering letter from the Bishop of Bristol's advisory group on health and healing (who wished to make use of the results).

Results

A total of 228 questionnaires were returned from the 410 mailed, a 55.6% response.

Clergy involvement: in theory

Table 1 reveals a very positive acceptance by general practitioners of the usefulness of clergy in theory in dealing with patients' concerns. In answer to the same question about the person closest to the patient, the responses were almost identical, except that clergy were deemed to be marginally more helpful to patients than to their partners. This positive response is underlined by the fact that 65 doctors (28.5%) recognized the potential of clergy for helping with all 20 concerns. The highest scoring concerns were those related to two of the issues traditionally associated with the clergy—marriage and death. The traditional

Table 1. Number of respondents believing that the clergy could be of help in caring for patients' concerns.

Patients' concerns	Number (%) of GPs responding positively ($n = 228$)
Terminal illness	225 (*98.7*)
Bereavement	223 (*97.8*)
Marriage	215 (*94.3*)
Chronic illness	214 (*93.9*)
Divorce	214 (*93.9*)
Attempted suicide	205 (*89.9*)
Depression	200 (*87.7*)
Physical disabilities	195 (*85.5*)
Alcohol/drug dependence	193 (*84.7*)
AIDS	192 (*84.2*)
Big disappointment	184 (*80.7*)
Abortion	182 (*79.8*)
Getting older	182 (*79.8*)
Major accident	174 (*76.3*)
Unemployment/retirement	173 (*75.9*)
Infertility	154 (*67.5*)
Major surgical operation	152 (*66.7*)
New employment	118 (*51.7*)
Childbirth	114 (*50.0*)
Going on the 'pill'	103 (*45.2*)

AIDS = acquired immune deficiency syndrome.

'hatch, match and dispatch' role was not, however, confirmed in 'hatch' concerns: abortion, infertility, childbirth and going on the 'pill' were not so frequently seen as areas in which clergy could help. While all the concerns were related to events which could radically affect people's lifestyle, a role was not easily perceived in new employment or after a major surgical operation. However, even here over 50% of respondents thought the clergy could be of help.

These positive attitudes are reinforced by 163 respondents (71.5%) confirming that religion has a specific contribution to make to the cure of illness for some patients and another 41 (18.0%) that it is of general relevance to the experience of illness and its treatment in all patients.

Clergy involvement: in practice

Referral rates to clergy are indicated in Table 2. It shows that 130 of the respondents (57.0%) have some contact with clergy over patient care; this represents 31.7% of the total of 410 general practitioners in the health district. From this it is possible to define three groups of general practitioners: 43.0% who were nil referrers; 44.3% who were occasional referrers (referring one to six cases per annum; 8.8% who were regular referrers (seven to 12 cases per annum); and 3.9% who were frequent referrers (13+ cases per annum).

Table 3 takes up the issue of why, if in theory clergy can potentially be so helpful, 98 (43.0%) of the respondents never make use of their services. There was little evidence that clergy were considered professionally incapable of helping or likely to misuse a referral. Only two doctors claimed any dissatisfaction with the outcome of previous referrals. Failure to refer was based on four factors: the assumption that the religious patient will self-refer and the non-religious patient will not want referral; the need for the 'right' clergy to be available; the lack of religious belief on the part of the general practitioner; the fact that referral had never occurred to a sizeable minority of doctors who felt they would have been prepared to consider the possibility.

Some of these factors are raised again in Table 4 which records the attitude of occasional and regular referrers. Assumptions about the expectations of religious and non-religious patients are repeated. However, the claim of 41.3% of general practitioners that non-religious patients would not want to see the clergy is only partially born out in practice where fewer doctors (31.4%) find the offer actually being declined, when made. The high proportion (52.1%) who encourage patients to self-refer is an indication that, if only indirectly, many occasional and regular referrers are actually using the services of the clergy more than they realize. Furthermore, 31.4% conceded they did not consider the possibility of referral even when it might have been useful. In Table 4, the need of the 'right' clergy to be available is again acknowledged, while not knowing enough clergy acts

Table 2. Number of times per annum when general practitioners referred patients and/or involved clergy in patient care.

No. of referrals annually	Number (%) of GPs referring ($n = 228$)
0	98 (*43.0*)
1– 6	101 (*44.3*)
7–12	20 (*8.8*)
13–24	6 (*2.6*)
25–51	2 (*0.9*)
52+	1 (*0.4*)

Table 3. Reasons given for making no referrals to the clergy: responses of general practitioners who do not refer.

	Number (%) of GPs agreeing ($n = 98$)
Patients who would accept help from the clergy would self-refer anyway	69 (*70.4*)
Non-religious people would not want to see a clergyman	51 (*52.0*)
No clergy known	44 (*44.9*)
'Right' clergyman was not available	25 (*25.5*)
No religious beliefs held	19 (*19.4*)
Never considered the possibility, but will in future	17 (*17.3*)
Not GP's responsibility to make or suggest referrals	11 (*11.2*)
Clergy who are known could not help	9 (*9.2*)
Clergy would regard referrals as 'souls for saving' rather than people to be helped	6 (*6.1*)
No wish to trouble busy clergymen	3 (*3.1*)
Deterred by failure of a previous referral	2 (*2.0*)
Clergy do not possess the necessary competence to be of any help	1 (*1.0*)

Table 4. Reasons given for not making more referrals to the clergy: responses of general practitioners who occasionally or regularly refer.

	Number (%) of GPs agreeing ($n = 121$)
Usually suggest patients should self-refer, if they wish	63 (*52.1*)
Most patients who would accept clergy help would self-refer anyway	62 (*51.2*)
Only patients with known religious associations referred and few of these are seen	58 (*47.9*)
Non-religious patients would not want to see a clergyman	50 (*41.3*)
Not enough clergy known well to make referral a regular feature of patient care	47 (*38.8*)
Referral not thought about when it might have been helpful for the patient	38 (*31.4*)
Patients often decline the offer, when made, to involve a clergyman	38 (*31.4*)
More referrals possible if the 'right' clergyman had been available	37 (*30.6*)
Clergy can help positively in only a few illnesses/problems	20 (*16.5*)
No wish to trouble busy clergymen	9 (*7.4*)

as a controlling influence on the number of referrals. When doctors were asked how many clergy they knew, among the total 228 respondents only 28 (12.3%) knew four or more clergy on first name terms. This being so, referrals will inevitably be restricted.

Table 5 shows that for the nine general practitioners who refer frequently, knowing a number of local clergy is important. They are, however, also prepared to make use of clergy they do not know, a confidence based presumably on their successful cooperation with known clergy. This confidence recognizes the clergy's competence to deal with a wide range of concerns and that for some patients, including non-religious patients, such referral will be the most appropriate treatment. Eight of the group of nine considered themselves to be religious, and this must heighten their awareness of possible referral to the clergy.

The concerns for which referrals are actually made are detailed in Table 6. It can be seen that those referring regularly have a higher rate of referral and refer a wider range of concerns than those who only refer occasionally and this trend is further extended by the frequent referrers. When the relationship between the theory of Table 1 and the practice indicated in Table 6 is tested, there is a high positive correlation overall, the Spearman rank correlation coefficient produced being 0.72. Hence the referral pattern is not a random one, rather doctors actually refer more frequently patients with concerns for which in theory they also consider clergy best equipped to help.

Table 5. Reasons given for making frequent referrals to the clergy: responses of general practitioners who frequently refer.

	Number (%) of GPs agreeing ($n = 9$)
Clergy can be especially useful in a good number of illnesses/problems	9 (*100*)
Hold personal religious belief and believe that religion has a part to play in health care	8 (*89*)
A number of local clergy known well	7 (*78*)
Referral suggested to patients whether or not they are known to be religious	7 (*78*)
Referral to a clergyman an appropriate treatment for some patients	7 (*78*)
Clergy are competent to deal with referrals	5 (*56*)
One clergyman is known well and is worked with	4 (*44*)
Prepared to make referrals whether or not clergyman known personally	4 (*44*)

Table 6. Number of respondents who have actually referred patients to clergy for different concerns.

	Number (%) of GPs who have made referrals		
Patients' concerns	Occasional referrers ($n = 101$)	Regular referrers ($n = 20$)	Frequent referrers ($n = 9$)
Terminal illness	49 (*49*)	16 (*80*)	7 (*78*)
Bereavement	56 (*55*)	15 (*75*)	7 (*78*)
Marriage	13 (*13*)	8 (*40*)	4 (*44*)
Chronic illness	25 (*25*)	10 (*50*)	5 (*56*)
Divorce	22 (*22*)	9 (*45*)	5 (*56*)
Attempted suicide	7 (*7*)	5 (*25*)	2 (*22*)
Depression	43 (*43*)	13 (*65*)	7 (*78*)
Physical disabilities	4 (*4*)	1 (*5*)	1 (*11*)
Alcohol/drug dependence	9 (*9*)	4 (*20*)	2 (*22*)
AIDS	0 (*0*)	0 (*0*)	0 (*0*)
Big disappointment	1 (*1*)	3 (*15*)	2 (*22*)
Abortion	11 (*11*)	4 (*20*)	5 (*56*)
Getting older	3 (*3*)	0 (*0*)	0 (*0*)
Major accident	2 (*2*)	0 (*0*)	0 (*0*)
Unemployment/retirement	4 (*4*)	0 (*0*)	2 (*22*)
Infertility	3 (*3*)	2 (*10*)	3 (*33*)
Major surgical operation	3 (*3*)	4 (*20*)	3 (*33*)
New employment	0 (*0*)	0 (*0*)	0 (*0*)
Childbirth	3 (*3*)	0 (*0*)	1 (*11*)
Going on the 'pill'	6 (*6*)	0 (*0*)	2 (*22*)

Discussion

The fact that 44.4% of the general practitioners did not reply must be remembered in interpreting the responses of this survey. However, the data do indicate some of the trends in the thinking and practice of a not insignificant number of general practitioners within a prescribed area. The pilot survey in the Swindon health district produced a 65% response rate from a total of 210 doctors and the results there were similar to those reported here.

The views of this sample of general practitioners reveal that a role for the clergy could be envisaged across a wide range of life events, but that in practice referrals are mainly restricted to those situations associated with a more traditional view of the clergy's role and, perhaps, those concerns where doctors regularly find themselves at the limits of their own medical abilities. No reason is evident as to why involvement of clergy should not be across a broader spectrum of concerns and on a greater number of occasions. Almost one quarter of the total respondents conceded they did not think about involving the clergy even when the latter's help might have been useful. Over half of this sample (57.0%) made at least one referral a year, so for them positive contact with the clergy already exists. Other doctors suggested that patients will self-refer and 71.5% of respondents accept that religion has some specific contribution to make to the cure of illness for some patients. In practice, Table 6 shows that the regular referrers and the frequent referrers refer over a wider range of concerns than do other doctors.

Knowing the 'right' clergyman matters across each of the referral groups. This is possibly the key to more doctor–clergy cooperation. 'Would like to meet local clergy' sums up a number of comments on the survey and indicates a need for a practical means of identifying clergy with whom doctors could work confidently. Better communications might accrue from joint meetings, professional lunches and any other opportunities for the professions to meet. Indeed these already happen in some areas, while the Institute of Religion and Medicine, founded in 1964, exists particularly to foster links between doctors and clergy.†

More cooperation would inevitably bring its own problems. Doctors may declare they do not limit referral because of a fear of troubling busy clergymen but greater calls on limited clergy time would be inevitable. Awareness of the possibility of health centres where clergy too would have consulting times could be explored. Such centres already exist, as far afield as Scotland, the north east and the south west of England, building on the pioneering work of Dr Anthony Bird in Birmingham.[10]

One questionable assumption prevailing among general practitioners was the idea that clergy involvement would only be worthwhile for patients who have religious beliefs. A case against this assumption is offered in an editorial in the *Canadian Medical Association Journal* which also justifies the need to treat

†The Institute of Religion and Medicine has its headquarters at St Marylebone Parish Church, Marylebone Road, London NW1 5LT.

the whole person.[11] Personal experience, both in hospital and the community, leads the author to challenge the idea that only the religious will benefit. Some people who claim not to be religious are quite open to receiving the ministrations of a clergyman. As they get to know him better their attitude becomes more positive towards sharing a wide range of needs and concerns. Such a claim is supported by the pattern of referrals of the frequent referring group. If they were more confident about using clergy, general practitioners could advise patients who claim not to be religious of the possibilities of benefitting in some circumstances from referral to a clergyman.

The evidence of the survey indicates that the BMA approved statement of 1947 and the recommendation of the RCGP/CCHH working party would be acceptable to the sample of general practitioners surveyed. There is in theory a wide acceptance of the potential benefits of involving the clergy, but equally in practice a reluctance to test them. One respondent commented:

> 'Not being a Christian myself, I don't feel it my place to initiate such referral, but I'm very aware of the almost universal need for emotional and spiritual support in all sorts of life's problems.'

It may be that doctors need to be more aware of the potential for using the clergy alongside other professionals, such as psychologists, psychiatrists, health visitors, social workers and surgeons. This is well accepted in parts of the United States of America where in some medical schools the role of religion in medicine is given a high profile which allows for the clergy to be recognized as representing one piece in the health care jigsaw.[12] The apparent willingness of general practitioners in the UK to consider greater involvement with the clergy suggests that greater cooperation between the two would lead to improvements in patient care within the context of the patient's whole person.

References

1. Churches' Council for Health and Healing and the Royal College of General Practitioners. *Whole person medicine — a Christian perspective.* London: Churches' Council for Health and Healing, 1989: 20.
2. Sheldon MG. The Christian approach to whole person medicine. *J R Coll Gen Pract* 1989; **39:** 166.
3. Anonymous. Medicine and the Church. *Br Med J* 1947; **2:** 112.
4. Green R. Healing and spirituality. *Practitioner* 1986; **230:** 1087-1093.
5. Hunt JH. Religion and the family doctor. *J R Coll Gen Pract* 1969; **18:** 199-206.
6. Martin EEJ. Healing and the Christian doctor. *Update* 1989; **38:** 179-184.
7. Simsen B. The spiritual dimension. *Nursing Times* 1986; **82:** 41-42.
8. Swaffield L. Religious roots. *Nursing Times* 1988; **84:** 28-30.
9. Pietroni PC. Without religion, science is lame. *Health Healing* 1985; **9:** 5.
10. Bird A. *The search for health: a response from the inner city.* Birmingham: University of Birmingham, 1981.
11. Anonymous. Clergy and physicians. *Can Med Assoc J* 1968; **99:** 1205-1206.
12. Shriver DW. *Medicine and religion.* Pittsburgh: University Press, 1980, 49-76.

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