Clinical Research and Methods

Spiritual Perspectives and Practices of Family Physicians With an Expressed Interest in Spirituality

Frederic C. Craigie, Jr, PhD; Richard F. Hobbs III, MD

Background and Objectives: *Among a growing number of articles about spirituality and medicine, there are no open-ended empirical inquiries about family physicians' understanding of spirituality and what it might mean to incorporate spirituality into family practice. We used a qualitative methodology to investigate family physicians' perceptions of spirituality in clinical care, the roles of their own personal spirituality, and implications for medical education.* Methods: *We used qualitative content analysis on transcripts of semi-structured interviews that had been conducted with 12 family physicians, in three regions of the country, with an expressed interest in spirituality.* Results: *This group of physicians reported 1) taking a vital clinical role as encouragers of patients' spiritual resources, 2) a vital role of their personal spirituality as an underpinning of the vocation and practice of family medicine, and 3) the key roles of respectful dialogue and mentoring in medical education about spirituality.* Conclusions: *Results affirm the significance of spirituality in clinical family practice for the subjects interviewed and support a tripartite model that embraces clinical approaches to the spirituality of patients and families, the spirituality of caregivers, and the qualities of spirituality in health care organizations.*

(Fam Med 1999;31(8):578-85.)

A growing and significant consideration of spirituality has occurred in the family medicine literature in the past 10 years. Articles have included summaries of research about religious commitment and health,[1-3] meta-analytic reviews about the consideration of religious variables in family medicine research,[4-5] and surveys of spiritual beliefs, experiences, and behaviors among physicians and patients.[6-13] Other publications have presented original research about spirituality and health status,[14] paradigms and curricula,[15-17] research about spirituality and family practice residents,[13-19] and commentary.[20-22] This literature reveals that spirituality is an important dimension of human experience, particularly in the settings of illness and adversity, and is typically associated in a beneficial way with measures of health status, coping, and well-being. The literature also reveals that there is a substantial level of interest on the part of both patients and family physicians about incorporating spirituality into family medical care.

What it means to incorporate spirituality into family medical care, however, remains an open question. While there are questionnaire data about the beliefs and practices of family physicians,[8-13,17] there are no open-ended empirical inquiries about family physicians' understanding of spirituality and what it might mean to incorporate spirituality into family practice. There are also only limited data on the personal spirituality of family physicians and on the ways in which physicians' spirituality affects their provision of clinical care. There is, finally, only a single study that provides data about spirituality education in family medicine, reporting curricular preferences and needs of family practice residents and faculty.[17]

The present study uses a qualitative interview methodology for investigating the perceptions and practices of a small group of family physicians about the incorporation of spirituality in clinical family practice and in family medicine education. We chose a qualitative methodology[23-25] because the understanding of spirituality in family practice is still in its early stages, and a qualitative methodology might generate additional hypotheses and directions about what it means to incorporate spirituality into family practice.

Specifically, this project seeks to expand the understanding of 1) ways in which family physicians successfully incorporate spirituality into their professional work, 2) ways in which physicians experience spirituality as a resource for themselves as caregivers, 3) obstacles that family physicians perceive as hindering

From the Maine-Dartmouth Family Practice Residency, Augusta, Me (Dr Craigie); and the Central Maine Medical Center Family Practice Residency, Lewiston, Me (Dr Hobbs).

the integration of spirituality into their professional and personal experience and how they attempt to address those obstacles, and 4) reflections of established family physicians, in light of their professional experience, about how a sensitivity to issues of spirituality can best be instilled or encouraged in family physicians in training.

Methods

Interview Format

We conducted semi-structured interviews with practicing family physicians. Subjects were asked about demographic information, practice characteristics, and questions from the list presented in Table 1. The interview format was conversational and flexible, allowing for probing of individual descriptions and meanings. Interviews were conducted by one of the authors, lasted an average of 45 minutes, and were recorded by audiotape.

Subjects

Key informants, or subjects, in qualitative research are deliberately selected in a non-random fashion.[26] The principal goal of qualitative sampling is not "representativeness" but "information richness," the "desire to illuminate the questions under study and to increase the scope or range of information exposed—to uncover multiple realities."[27] Qualitative researchers ask, "Who are the people whose life experiences and interests would give them something helpful and illuminating to say about the subject at hand?" Subjects in the present study were recruited by word of mouth among colleagues seeking to identify family physicians with significant community practice experience and an interest in discussing the incorporation of spirituality into family practice.

Twelve physicians were identified by the aforementioned process, and all agreed to participate and were interviewed. All were board-certified allopathic family physicians. Six were male and six female. They practiced in the South Central, Midwest, and Northeast regions of the country. Nine were in full-time community practice, and two were full-time residency faculty members with significant community experience. The final subject, who also had significant community practice experience, was semiretired and involved in part-time teaching. Although the latter three subjects were not currently in full-time community practice, we felt that the nature and extent of their community practice histories would contribute toward the sampling goal of information richness.

Subjects ranged in age from early 30s to early 70s; most subjects were in their late 30s and 40s. All were Caucasian. They represented a broad range of religious affiliations, including "Christian," Protestant, Catholic, Jewish, Unitarian/Universalist, Seventh-Day Adventist, Buddhist, and Society of Friends.

Table 1

Interview Questions

- What are your areas of interest and expertise within clinical family practice? On what do you pride yourself in your work?
- What is your understanding or definition of spirituality? Has this understanding changed during or as a result of your professional career?
- In what ways have you been able to incorporate spirituality into the clinical work you do?
- What is an example of a clinical situation in which you have been able to incorporate spirituality into your clinical work?
- What obstacles do you perceive that hinder the integration of spirituality into your professional experience, and how do you attempt to address them?
- In what ways has spirituality been a resource for you, personally, as a physician?
- What is an example of a situation in which your own experience of spirituality has made a difference for you as a caregiver?
- What obstacles do you perceive that hinder the integration of spirituality into your personal experience as a physician, and how do you attempt to address them?
- What would be helpful to you in terms of education, resources, or other assistance to support your incorporation of spirituality into your work?
- In light of your own experience, what reflections do you have about how sensitivity to issues of spirituality can best be instilled or encouraged in physicians in training?

Data Management and Analysis

Audiotapes of interviews were transcribed by an undergraduate research assistant. Questions about content were resolved with the interviewer, leaving only rare, isolated words or pieces of text unintelligible.

Data analysis procedures were based most closely on the phenomenological model described by Colaizzi.[28] This approach was chosen because of its use in somewhat analogous research, investigating the nature of caring,[29] the components of courage in adolescents with chronic illness,[30] and the experience of transcendence in patients with breast cancer[31] and AIDS.[32]

The process of analysis and interpretation consisted of seven steps:

1) Reviewing all of the subjects' descriptions. Transcripts of each of the interviews were read several times to get a sense of their total content, along with listening again to sections of audiotapes themselves.

2) Extracting significant statements. Phrases, sentences, or paragraphs bearing on the questions at hand were extracted from the interview transcripts and pasted to separate pages. This process was designed to err in the direction of "over-inclusion" of significant statements, with the result that little material of any substance was omitted.

3) Creating formulated meanings. For each significant statement, a brief description of underlying meaning was put into words. Formulated meanings were intended to answer the question, "What is the substance of what the physician is saying here?" Typically, meanings were edited or truncated versions of what physicians had said, using the original language as much as possible. The process of creating meanings was done independently by both authors, with the wording of the final meaning being that of the first author, as modified in dialogue with the second author. Examples of the transition from statements to meanings are shown in Table 2.

4) Aggregating the formulated meanings into categories. Nine categories of interpretation were developed. Several categories arose directly from the original research questions, including categories pertaining to definitions of spirituality, approaches to incorporating spirituality in the care of patients, and the personal spirituality of caregivers. Additional interpretive categories emerged from an iterative process[33,34] of reviewing the text, expanding the framework of categories to accommodate new classes of information, rereviewing the text, and so forth. Examples of categories developed through this process were those pertaining to spirituality in the context of the health care organization and to vocation, mission, and values in being a physician.

Each of the 249 formulated meanings was assigned to one of the nine categories by the first author. There was a range of between 10 and 60 meanings per category. Four months after the assignment of meanings to categories, the process was repeated to provide a test-retest estimate of the reliability of category assignment. Percent agreement was calculated as the percentage of the 249 meaning statements that were assigned to the same category each time. Percent agreement was 89.9.

5) Developing themes within categories. This step involved development of interpretive themes within each of the nine categories. Themes, at this level, provide succinct summary statements of meaning in the physicians' understanding and incorporation of spirituality. The authors independently drafted themes within each category and then met to arrive at consensus in their delineation and phrasing. Draft themes that were conceptually similar between the two authors were retained in the analysis and named with mutually acceptable language and phrasing. Draft themes with no consensus between the authors were dropped from the analysis.

6) Creating a summary narrative description. The authors together identified key elements from the data to generate a summary narrative description of the spiritual perspectives and practices of these physicians. A narrative description, in Colaizzi's methodology,[28] is intended to provide, as much as possible, a succinct and unequivocal statement of the findings. A draft description was created by the first author and modified in a subsequent dialogue with the second author.

7) Returning to subjects for validation. All subjects were provided with preliminary results of the study and invited to offer comments and reactions. Subjects were asked to respond within 1 month.

Table 2

Illustrative Significant Statements and Formulated Meanings

Significant Statements	*Formulated Meanings*
I think it's important, I think there's a lot of healing that happens just by connecting spiritually with people. It's not about what's in a pill or even the length of time that you spend with the person. It's finding the energy in them that wants to keep going—the musician who wants to keep playing or the athlete who wants to get back on the court and the mother who loves to cook and wants to get her family back together for a big meal. Just connecting with the real life force in that person.	Healing happens as we connect spiritually with another person . . . finding the energy in them that wants to keep going . . . connecting with the real life force in that person.
I don't always understand the psyche, but the spirit is even less comprehensible than that. It's so intangible sometimes. You know it's there, but sometimes I don't know it's there until after I've had the encounter, and I think, oh yeah, that's what happened.	Experiential aspect of spirituality . . . I may sometimes recognize after encounters that the spirit had been involved.
God has brought them here to do this thing. They have a purpose to interact with, I mean, medicine's gotta be more than just a job. If it's just a job, frustration level is high. If it is a vocation, they can gain inner strength and also affect their patients in ways that are much beyond the diseases they are treating. I think the potential for satisfaction is much higher.	Seeing medicine as a vocation, not a job . . . gives doctors inner strength and enables them to affect patients in ways that go beyond treating disease, leading to personal satisfaction.

Results

Nine interpretive categories and themes were identified (Table 3):

1) Definitions of Spirituality

Spirituality was viewed as a broad aspect of human experience having to do with meaning and purpose and with enlivening and sustaining relationships with spirit, eg:

> Spirituality as the life force, what motivates and inspires people, what it means to a person to really live.

2) Spirituality as Experience

Each of these subjects told stories about patients, office practice, or about themselves as a way of illustrating what spirituality meant to them. Five of the physicians expressly commented that spirituality was more a matter of experience than linguistic description, eg:

> Experiential aspect of spirituality . . . it's not easy to talk about apart from the context of how spiritual experiences are a part of our lives.

3) Qualities of Viewing and Relating to Patients

Nine subjects offered comments about honoring patients, learning from them, and seeing in them qualities of sacredness.

> Spirituality is seeing people as unique human beings whom God has created.

4) Personal Spirituality of the Caregiver

All 12 subjects spoke at some length about the significance of their own personal spirituality. Taken together, in fact, they spoke almost as much about this subject (with 55 meaning statements) as they did about clinical approaches (60 statements). They suggested that their personal spirituality helped to promote a sense of spiritual centeredness . . .

> Cultivating my own spiritual wholeness really makes a difference . . . in how I feel about people and medicine and in how I deal with frustrating patients and situations. I gain strength, remain at peace, and sometimes experience inner joy when things don't look so good.

. . . and helped the physicians be more available as instruments of healing in the lives of their patients.

> The kind of intimate work we do as doctors demands a real presence . . . our care of people can be technically competent but spiritually impaired if our heart, mind, and focus are divided.

Table 3

Interpretive Categories and Themes*

1. Definitions of spirituality
   - Relationship with spirit or force that enlivens and sustains
   - Connectedness with community
   - Higher meaning, life purpose
   - Universality
2. Spirituality as experience
   - Experience of the presence of spirit
   - Awareness of spirit in encounters with other people
   - Legitimacy of experiences beyond our intellectual understanding, expression of language, or theological basis
3. Qualities of viewing and relating to patients
   - Honoring patients, treating them with respect, seeing qualities of sacredness
   - Open to learning from patients and their life experiences
   - Presence, genuineness, advocacy
4. Personal spirituality of the caregiver
   - Spirituality as a source of personal peace, meaning, and centeredness
   - Being enriched and inspired by patients
   - Importance of spiritual well-being for healthy and healing relationships
   - Spiritual practices, relationship with higher power/God
5. Vocation and mission in being a doctor
   - Medicine as vocation, mission, ministry
   - Sense of meaning, privilege, and personal satisfaction in significant relationships
   - Being an instrument of higher power/God
6. Clinical: incorporating spirituality in the care of patients
   - Being a facilitator and encourager of patients' spiritual values and resources
     a. Meaning, purpose, and energy
     b. Relationship with spirit
     c. Spiritual community
   - Quality of presence and relationship
7. Obstacles and challenges
   - Time and energy
   - Challenge of conflicting beliefs with patients and colleagues
8. Spirituality in the context of the organization
   - Spirit and wholeness of the organization
   - Shared mission and values
   - Supportive and caring community
   - Valuing and empowering in collaborative work relationships
9. Supporting the understanding of spirituality in medical education
   - Dialogue: forums and teaching moments
   - Mentoring relationships
   - Affirming the value of each person's spiritual journey

* An expanded version of this table, including representative statements of meaning for each theme, is available from the corresponding author.

5) Vocation and Mission in Being a Doctor

Eight of the subjects expressed a clear sense of calling or vocation about being a physician, . . .

> Seeing medicine as a vocation, not a job . . . gives doctors inner strength and enables them to affect patients in ways that go beyond treating disease.

. . . which led them to a spirit of privilege about their work . . .

> It is a great privilege to be close to issues of life and death and the meaning of someone's life . . . how they have lived their life and, sometimes, how they will die.

. . . and, sometimes, to the experience of being an instrument of a higher power or God in patients' lives.

> . . . bringing the presence of God into that encounter.

6) Clinical Incorporation of Spirituality

The clinical incorporation of spirituality into the care of patients, for these physicians, primarily meant acting as a facilitator and encourager of patients' spiritual values and resources. Dimensions of this facilitator role included:

1) helping patients apprehend meaning and purpose,

> Working with patients . . . finding out what motivates and excites and inspires them . . . connecting with the things that make them 'them' as an individual.

2) helping patients identify sustaining values and perspectives in the face of illness,

> . . . gently raising questions about meaning in the experience of illness and death.

3) directing patients to the healing qualities of spiritual relationships,

> . . . great interest in patients' relationship with God, a significant potential resource for them . . . which may or may not have to do with religious involvement.

4) supporting patients in cultivating community-based spiritual resources.

> . . . connecting people with their spiritual resources . . . who can they really talk with, who affirms them?

Each of the physicians, in a variety of ways, made the point that his/her role was not to provide answers to spiritual questions but to draw out spiritual values and perspectives that come from patients.

> If you perceive a void in patients' lives, respectfully ask questions that lead them to think through issues of who they are, their purpose and future . . . answers to these questions need to come from them.

Only one physician reported routine spiritual history-taking in an organized way, although several others indicated that they attempt to understand sources of meaning, purpose, and joy for most of their patients. For the rest, spiritual discussions were more ad hoc and were prompted by a variety of concerns typically having to do with illness, death, stress, and change. Ten of the physicians made the point that discussions of spiritual issues were only a part of the picture and that spirituality was also visible in their work in the qualities of presence and relationship with patients.

> It is not easy to talk about my perceptions of spirituality with patients . . . occasionally I do, when they ask about what it might mean that they are sick, for instance . . . but the majority of what I do is nonverbal, it is how I am with people.

7) Obstacles and Challenges

The limitations of time and energy were the principal challenges for most of these physicians, both in the context of their own personal development and the context of clinical work with patients.

> When I am feeling rushed and overwhelmed, I lose focus and tend to take less good care of myself . . . this feels hypocritical when I talk with patients about wellness and caring for themselves.

The most common response to these challenges was to look to the development of collaborative and fruitful relationships over time . . .

> Being freed from the notion that I need to do it all today . . . recognizing, in fact, that patients can connect more about spiritual values as I develop relationships with them over time.

. . . and to attempt to insert various reflective and centering practices in their daily routines.

> . . . discipline of standing at the door before I go in, remembering why I am there and why I want to take care of this patient.

8) Spirituality and the Organization

Six of the physicians spoke about the life of their affiliated health care organizations in spiritual terms.

> There is an amazing spirit here in spite of the fact that everybody feels stretched in terms of the workload.

They expressed the view that qualities of the mission and culture of their health care organizations were associated with healing.

> The atmosphere in the office sets a foundation for healing . . . treating office staff with respect, seeing staff as core parts of the office and empowering them to contribute all they can, helping both the patients and the health care providers feel this is a safe and comfortable place to be a patient and to work.

9) Spirituality in Medical Education

Most subjects thought that the key to addressing spirituality in medical education was to create more opportunities for dialogue.

> . . . single biggest step is just talking about it more often . . . providing venues for physicians and students to talk about things that are spiritually nurturing and important.

Given the personal nature of spiritual beliefs and values, however, it was considered crucial to make this dialogue respectful and safe.

> Creating a safe environment where you don't have to apologize for who you are and what you bring.

The safety of discussions was less an issue of subject areas than it was of the climate and spirit of discussions. Two subjects, for instance, spoke of the importance of inclusive language . . .

> Making dialogue about spirituality in medicine less scary by not requiring a certain vocabulary.

. . . and of respect.

> Creating a climate where learners are respected, not ridiculed.

Six physicians also spoke about the significance of mentoring relationships and teaching moments . . .

> Teaching young physicians about spiritual issues in medicine . . . being able to be there with them in the wake of intense experiences, helping them not to run and hide but to sit there and experience them, soak it up, and learn from it.

. . . and of opportunities for learning by example.

> Learn by observing, seeing what people value, even in the absence of organized conversations.

Summary of the Study Physicians' Views About Incorporating Spirituality Into Family Practice

Subjects viewed spirituality as a significant dimension of human experience that embraces sustaining and enlivening relationships with spirit and the pursuit and expression of meaning and purpose. The personal spirituality of these physicians enables and empowers them to experience qualities of sacredness in patient encounters, to view medicine as vocation and mission, to maintain a spirit of peace and centeredness, and to be available as instruments of healing. Clinically, they see their role as facilitators and encouragers of patients' spiritual values and resources. They also associate healing with qualities of spirituality in the life, mission, and culture of health care organizations. They believe that medical education about spirituality demands the respect and honoring of learners' values and life experiences and takes place through formal and informal dialogue and through mentoring relationships.

Follow-up Interventions

At the time of follow-up of interview subjects, 3 of the 12 physicians had moved from their original practice locations. Of the remaining nine, eight responded within 1 month. They uniformly indicated that the results captured what they had wished to express and said that they had no suggestions for change. Several subjects indicated that the organization of data was "validating" and "a nice way to say what I try to do with my life."

Discussion

Content analyses of transcripts of interviews with 12 family physicians revealed a broad view of spirituality and a number of themes about ways in which spirituality, for them, is incorporated in clinical family medicine. With respect to the goals of the study, the data revealed that these subjects perceive 1) a vital clinical role of physicians as encouragers of patients' spiritual resources, 2) a role of the personal spirituality of physicians as an underpinning of the vocation and practice of family medicine, 3) the ubiquitous challenge of time and energy, which is addressed with some degree of success through longitudinal relationships, and 4) the key roles of respectful dialogue and mentoring in supporting the understanding of spirituality in medical education.

The perceptions and perspectives of this group of physicians affirm the growing interest in spirituality as an important clinical consideration in family medicine. The ideas and language of these physicians also affirm the importance of meaning as a cornerstone of spirituality in medicine[35] and affirm the movement toward what has recently been described as "inclusive spirituality."[22]

Beyond these affirmations, however, there were a number of themes from this group of subjects that open up additional perspectives on the ways in which spirituality is viewed and approached in clinical family medicine.

Personal Spirituality

These physicians spoke at length and with passion about the significant role of their own spirituality for the practice of medicine. Their personal spirituality was seen as a foundation for their own coping with and satisfaction from medicine and for their ability to facilitate healing in the lives of their patients. While the family medicine literature reveals some references to the significance of the personal spirituality of family

physicians in the contexts of coping[36] and curriculum development,[17] it may be observed that the preponderance of the family medicine literature has to do with paradigms for addressing the spirituality of patients. The present results would appear to encourage greater attention in both clinical practice and medical education to the values and spiritual well-being of caregivers and to the role of the person of the doctor in the healing process. Indeed, two recent questionnaire surveys[12,13] help to advance this area.

Spirituality in Relationships

For the subjects in this study, spirituality was often experienced in the context of relationships with patients. These physicians frequently conveyed insights in narrative form, telling stories about patient encounters that had somehow touched on qualities of the sacredness of life. They spoke of the commitment to honor patients' values and life experiences, and they spoke of learning from and being enriched by patients. These observations are consistent with Frank's recent consideration of narrative and illness,[37] in which he argues that meaningful and healing encounters have to occur within the context of a genuine relationship.

It may be observed that much of the recent literature about spirituality in family practice focuses attention on the development of structured paradigms and clinical techniques for understanding and working with patients' spirituality. The present results support the continuing work in these areas but would offer the view that, for these subjects, incorporating spirituality into family practice is rooted in relationship and requires more than the definition and application of paradigms and techniques.

In a similar way, comments of these physicians about medical education focused less on content than on qualities of relationships and interactions that supported the process of learning about spirituality. These physicians thought that the essential ingredients in teaching about spirituality were dialogue, respect, mentoring, and teaching moments. They spoke less about particular curricular content areas, such as faith traditions, religious practices, and counseling techniques. Of course, this lack of emphasis on educational content should not be taken to discourage curricular development about spirituality. It does, however, offer a reminder that much of the learning in this area will take place in interactions and relationships outside of a formal medical education setting.

Organizational Spirituality

Half of the physicians in this sample volunteered that healing was also associated with qualities of spirituality in the life, mission, and culture of their health care organizations. While there is presently a growing literature in the business and management community about spirituality and organizational life,[38-40] little writing is noted about spirituality in health care organizations. As an exception, Silverman's recent delineation of a spirituality curriculum for family medicine[17] begins with the goal of creating a "supportive (healing) environment . . . that values and nourishes the spirituality of patients, residents, staff, and faculty." Physicians in the present study would certainly agree with this goal and would consider it an essential aspect of spirituality in clinical family practice.

The relationships among clinical, personal, and organizational aspects of spirituality in family practice are intriguing. Indeed, recent articles in the hospital management[41] and psychology[42] literature suggest a tripartite paradigm for incorporating spirituality into health care. This paradigm, which is consistent with results of the present study, argues on behalf of mutual influences among 1) clinical approaches to the spirituality of patients and families, 2) the spirituality of caregivers, and 3) the qualities of spirituality in health care organizations. This appears, as well, to be a fruitful area for further development of spirituality and family practice.

Limitations

Like all qualitative research, the present study is limited in claims to generalizability. Although this subject group reflects gender balance and considerable spiritual/religious diversity, our results do not permit inferences about differences within subjects (eg, comparing religious affiliations). Because subjects were selected specifically because of their interest in discussing spirituality, the results do not purport to represent the wider world of family physicians (which would include, for instance, those for whom religious and spiritual issues hold a different level of interest.

Implications for Future Research

The themes elicited from this group of physicians merit further exploration. The themes present opportunities for additional qualitative and phenomenological research that would extend this methodology to other samples of physicians, including those who have less interest in spiritual issues. There are also opportunities to investigate the meanings and behaviors associated with the themes identified in this study and to examine parallel patient perspectives. Given the significance for these physicians of personal spiritual well-being, qualitative research might explore what the essential components of spiritual well-being are for physicians. Is spirituality captured adequately by objective measures such as that recently used by Ellis et al,[13] or does it encompass additional elements? How do physicians cultivate their own spiritual well-being? In what ways does spiritual well-being matter in patient care? What are patient perspectives on spiritual well-being? Do patients notice these qualities in physicians? How do they tell? What difference does it make to them?

Finally, given the significance for several of these physicians of organizational spirituality, what are the qualities of organizational life and culture that are thought to contribute to a spirit of healing? How are these qualities cultivated, and how are they experienced by patients?

A more general direction for both research and curriculum development, suggested by these results, would simply be to collect stories about physicians' experiences of spirituality. It is noteworthy that these subjects, when asked to give examples about the incorporation of spirituality into their professional work, provided a remarkable collection of stories about their patients or about themselves, and several of them made the point that the experience of spirituality was significant in a way that transcended any language that might be used to describe it. Stories have meaning, or perhaps the hearers of stories create meanings, even when storytellers (or researchers) do not attempt to capture and analyze what stories convey.

A number of these themes suggest directions for quantitative research. What spiritual "facilitation" behaviors of physicians might be visible in a wider sample? What are the relationships among physician or organizational well-being and patient perceptions? Are there any associations in patients between the experience of meaning and purpose and morbidity/mortality? With the emergence of refined measures of spirituality,[22] quantitative research can more readily examine the interplay among spiritual beliefs and practices, physician and patient perceptions, and measures of health care use and health status.

Corresponding Author: Address correspondence to Dr Craigie, Maine-Dartmouth Family Practice Residency, 15 East Chestnut Street, Augusta, ME 04330. 207-626-1894. Fax: 207-626-1902. E-mail: f.craigie@dartmouth.edu.

References

1. Matthews DA. Religion and spirituality in primary care. Mind/Body Medicine 1997;2:339-49.
2. Matthews DA, McCullough ME, Larson DB, Koenig HG, Swyers JP, Milano MG. Religious commitment and health status: a review of the research and implications for family medicine. Arch Fam Med 1998;7:118-24.
3. McKee DD, Chappel N. Spirituality and medical practice. J Fam Pract 1992;35:201-8.
4. Craigie FC, Larson DB, Liu IY. References to religion in the *Journal of Family Practice:* dimensions and valence of spirituality. J Fam Pract 1990;30:477-80.
5. Craigie FC, Liu I, Larson DB, Lyons JS. A systematic analysis of religious variables in the *Journal of Family Practice*, l976–l986. J Fam Pract 1988;27:509-13.
6. Daaleman TP, Nease DE, Jr. Patient attitudes regarding physician inquiry into spiritual and religious issues. J Fam Pract 1994;39:564-8.
7. King DE, Bushwick B. Beliefs and attitudes of hospital inpatients about faith healing and prayer. J Fam Pract 1994;39:349-52.
8. King D, Sobal J, Haggarty J, Dent M, Patton D. Experiences and attitudes about faith healing among family physicians. J Fam Pract 1992;35:158-62.
9. Koenig HG, Bearon LB, Dayringer R. Physician perspectives on the role of religion in the physician-older patient relationship. J Fam Pract 1989;28:441-8.
10. Maugans TA, Wadland WC. Religion and family medicine: a survey of physicians and patients. J Fam Pract 1991;32:210-3.
11. Oyama O, Koenig HG. Religious beliefs and practices in family medicine. Arch Fam Med 1998;7:431-5.
12. Daaleman TP, Frey B. Spiritual beliefs and practices of family physicians: a national survey. J Fam Pract 1999;48:98-104.
13. Ellis MR, Vinson DC, Ewigman B. Addressing spiritual concerns of patients: family physicians' attitudes and practices. J Fam Pract 1999;48:105-9.
14. McBride JL, Arthur G, Brooks R, Pilkington L. The relationship between a patient's spirituality and health experiences. Fam Med 1998;30(2):122-6.
15. Maugans TA. The SPIRITual history. Arch Fam Med 1996;5:11-6.
16. Onarecker CD, Sterling BC. Addressing your patients' spiritual needs. Family Practice Management 1995;May:44-9.
17. Silverman HD. Creating a spirituality curriculum for family practice residents. Alternative Therapies 1997;3:54-61.
18. Manusov EG, Carr RJ, Rowane M, Beatty LA, Nadeau MT. Dimensions of happiness: a qualitative study of family practice residents. J Am Board Fam Pract 1995;8:367-75.
19. McKee D, Worby M. Comparing a Christian physicians' support group with the Balint group. J Fam Pract 1990;30:65-8.
20. Foglio JP, Brody H. Religion, faith, and family medicine. J Fam Pract 1988;27:473-4.
21. Magaletta PR, Duckro PN, Staten SF. Prayer in office practice: on the threshold of integration. J Fam Pract 1997;44:254-6.
22. Thomason CL, Brody H. Inclusive spirituality. J Fam Pract 1999;48: 96-7.
23. Crabtree BF, Miller WL. A qualitative approach to primary care research: the long interview. Fam Med 1991;23(2):145-51.
24. Crabtree BF, Miller WL, eds. Doing qualitative research. Thousand Oaks, Calif: Sage Publications, 1992.
25. Searight HR, Young R. Qualitative research and family medicine: a natural fit. Family Systems Medicine 1994;12:117-31.
26. Gilchrist VJ. Key informant interviews. In: Crabtree BF, Miller WL, eds. Doing qualitative research. Thousand Oaks, Calif: Sage Publications, 1992:70-89.
27. Kuzel AJ. Sampling in qualitative inquiry. In: Crabtree BF, Miller WL, eds. Doing qualitative research. Thousand Oaks, Calif: Sage Publications, 1992:31-44.
28. Colaizzi PF. Psychological research as the phenomenologist views it. In: Valle RS, King M, eds. Existential-phenomenological alternatives for psychology. New York: Oxford University Press, 1978:48-71.
29. Reimen D. The essential structure of a caring interaction: doing phenomenology. In: Munhall P, Oiler C, eds. Nursing research: a qualitative perspective. Norwalk, Conn: Appleton-Century-Crofts, 1986:85-108.
30. Haase J. Components of courage in chronically ill adolescents. Advances in Nursing Science 1987;9:64-80.
31. Coward DD. The lived experience of self-transcendence in women with advanced breast cancer. Nurs Sci Q 1990;3:162-9.
32. Coward DD, Lewis FM. The lived experience of self-transcendence in gay men with AIDS. Oncol Nurs Forum 1993;20:1363-8.
33. Knafl KA, Webster DC. Managing and analyzing qualitiative data: a description of tasks, techniques, and materials. West J Nurs Res 1988;10:195-218.
34. Crabtree BF, Miller WL. A template approach to text analysis: developing and using codebooks. In: Crabtree BF, Miller WL, eds. Doing qualitative research. Thousand Oaks, Calif: Sage Publications Inc, 1992:93-109.
35. Dossey L. Meaning and medicine. New York: Bantam, 1991.
36. Post DM. Values, stress, and coping among practicing family physicians. Arch Fam Med 1997;6:252-5.
37. Frank AW. Just listening: narrative and deep illness. Family Systems Health 1998;16:197-216.
38. Chappell T. The soul of a business. New York: Bantam, 1993.
39. Fox M. The reinvention of work: a new vision of livelihood for our time. San Francisco: Harper, 1994.
40. Conger JA, ed. Spirit at work: discovering the spirituality in leadership. San Francisco: Jossey-Bass, 1994.
41. Craigie FC. Weaving spirituality into organizational life: suggestions for processes and programs. Health Prog 1998;March-April:25-8,32.
42. Craigie FC. The spirit and work: observations about spirituality and organizational life. Journal of Psychology and Christianity 1999;18:43-53.