THE PATIENTS' PERCEPTION OF THE ROLE OF PRAYER IN THE FAMILY PRACTICE CONSULTATION.

A QUALITATIVE STUDY CONDUCTED IN THE WESTERN CAPE

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Submitted in partial fulfilment of the requirements for the degree M.Phil. (Family Medicine/Primary Care) in the Faculty of Medicine at the University of Cape Town.

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SUMMARY/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.

This is a qualitative study of a purposeful sample of 10 adult patients, selected by the author and three other family practitioners of different religious persuasions. 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 determine whether differences in religion between the doctor and patient affects the patients' choice of doctor or their religious enquiry or discussion.

The individual semi structured interviews are summarised in Venn diagrams. Results, after analysis, are presented collectively. The results confirm other studies and literature, viz. that there is a lack of religious inquiry, initiated by doctors. All respondents had, however, indicated that they would attend doctors of different religious persuasions. Most respondents felt that they would not discuss religious or spiritual issues and would only attend those practitioners for biomedical needs.

The positive reinforcement of the doctor patient relationship, for respondents who shared spirituality or prayer with their practitioners, is a significant finding. A sample spiritual inquiry and respondents' suggestions to facilitate the introduction of spirituality into the family practice consultation are presented.

1. INTRODUCTION

1.1 Religion and spirituality in medicine

Family practice patients have diverse and sometimes vastly different religious beliefs and practices.[1,2.] Relating religion to medicine is, on the one hand, considered an unusual occurence,[3,4.] and a sensitive almost taboo subject.[5,6,7.] 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[8] and reason.[4] 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.[9] Recent lay press articles,[10-13] books written by doctors[14-18.] and medical publications[7,19-21.] have brought these issues under the spotlight.

1.2 Motivation for the study

Prayer and faith shared with patients in times of absolute hopelessness, specifically during terminal care or bereavement counselling, has always served to alleviate my distress. Prayer at these times also appeared beneficial to most patients and their families. Cards and words of thanks attest to this. I had hesitated to discuss or offer prayer at other times since I did not want to impose my beliefs on the patients. I was also scared that patients may consider themselves beyond assistance, since prayer is more commonly used in severe or terminal illnesses. I had however freely accepted patients' prayers or thanked them for mentioning prayers that were raised for me.

I discussed pastoral psychology with a priest, who was planning to pursue studies in that field. I had mentioned how well a family practitioner colleague with a theological degree managed counselling without imposing his religious beliefs. This colleague, I said, only used religion when the patient raised that issue. The priest was incensed. He argued that one could not turn one's beliefs on or off depending on circumstances. He felt that he would study and use pastoral psychology with the emphasis on the pastoral in patient care.

A patient shared an experience after suffering a panic attack in her car. She immediately presented to a specialist physician known to her. She had appreciated the immediate consultation. The internist prayed and read from the Bible for "a solid hour". She only realized, after I had discussed his report with her, that he had diagnosed chronic obstructive airway disease. She was spiritually turned off and had difficulty attending church services for a long time thereafter.

I was faced with a variety of choices between the two extreme situations. On the one hand the issue of prayer and religion could be left entirely to the patient to raise and on the other, the practitioner could bombard the patient with prayer irrespective of the patient's wishes.

A review of the literature, reveals two studies[6,22] which assessed patients' expectation of prayer and discussion of religion. I have not found any study which focussed entirely on the perception of the patients. In this

study, I aim for a deeper understanding of the patients views on prayer in the family practice consultation.

1.3 Religion as a variable in family medicine research

McWhinney,[23] widely recognized as the father of family medicine, discusses the religious basis for, and spirituality of, "Illness, Suffering, and Healing." I feel that religion is inherent in many of McWhinney's principles of Family Medicine . Religion plays a role in;

the commitment and interest to the patient, that transcends the illness (1st Principle),

the context of the illness (2nd Principle),

community support and pastoral counselling (5th & 9th Principles) and,

the awareness of self and visible presence in the community (6th & 8th Principles).[23]

1.4 Aims of the study

The primary aim is to explore the opinions and expectations of the respondents, regarding their doctor's role in prayer during and after the consultation.

The secondary aim is to assess the effect of differences of religious denomination or belief, between doctor and patient, on discussion relating to spiritual matters and whether such differences affect their choice of doctor.

1.5 Qualitative research

Qualitative research enables the investigation of beliefs and attitudes on sensitive topics and allows detail not accessible by quantitative means.[24,25] Qualitative investigation assists an "empathetic"[26] understanding of meanings of human behaviour in natural settings.[25,27]. McWhinney,[23] long before qualitative research was accepted in family medicine, has described qualitative research as an appropriate method for family medicine.[28] McWhinney feels that the "rich texture of the world of experience" is to be found by "dialogue with patients about feelings."[23]

Interviewing serves as an effective tool to reveal things that we cannot directly observe, as Patton,[26] in describing qualitative research, concisely summarizes;

" The purpose of interview is to allow us to enter the other person's perspective"

We have the range, from an unstructured approach, which gives greater depth of information but requires much more time, to a structured approach, which has a high risk of prioritizing the researcher's concerns into responses and not learning the respondents' own perception and understanding.[26] Semi structured in depth interviewing was selected as the tool since it combines the practical advantages of structure with an open ended response.

2. LITERATURE REVIEW

2.1. Introduction

A ten year analysis of family medicine articles[3], between 1976 and 1986, showed that very little has been published on religion and spirituality in the practice of medicine. Most of the research on this impact of religion comes from the allied health fields such as sociology, psychology and epidemiology.

Sir William Osler, at the turn of the century, wrote that the attention to the role of faith and prayer "has done the profession good in awakening an interest in a too much neglected section of rational therapeutics". He urged that "our attitude as a profession should not be too hostile."[29]

The last decade showed a similar rarity of literature regarding the role of religion and prayer in family medicine.[2,30,31]. The discomfort of doctors, a concern not to impose their own beliefs and the belief that medicine is a science, and religion is not, have been offered as reasons for this paucity of religious variables in the family medicine literature.[2,3,21]. Practitioners' lack of insight into their own difficulties with religious belief, further limit the use of religion in their practices.[32]

2.2. Research into the Role of Religion in Medicine

The need for more research of religion and spirituality in medicine is widely supported.[2,31,33-36.] Levin, however, warns against drawing definitive conclusions.[37] He feels that the numerous variables, often associated with religion, are frequently not identified or measured. He presents 12 hypotheses as alternative explanations for the "salutary religious effect". He advocates religious variables that are more specific than attendance and religious affiliation.[37]

Galton, a nineteenth century president of the British Association of Anthropologists, identified "The objective efficacy of prayer ....to be a very suitable topic for statistical inquiry."[38] This challenge has, to date, evoked a paltry response. My literature search has identified three studies.[9,39,40.]

I have located two South African studies on religion in General Practice (GP).[6,35.] Meyer,[35] during his final year of medical studies, published his study on the general practitioners' view of religion. Van Hoorn[6] considered patients' opinion in an analytical cross-sectional study on Religion in General Practice.

King and Bushwick,[22] questioned American hospital in-patients on their views about faith healing and prayer. Koenig et al investigated family practitioners' belief about the role of religion and prayer in the lives of

older patients.[41] I have not found any study that focussed on the patients' perception of the role of prayer in the family practice consultation.

2.3. Expansion of the Biopsychochosocial Model

Some authors feel that the biopsychosocial model should be redesigned to include the spiritual dimension, viz. "The Biopsychosocial-spiritual Model" [2,35,42]. Hiatt[42] adds that healing originates from within the patient by processes that "ultimately derive from the spiritual impetus for unity".

Wilson[33], reviewing the role of faith and religion in healing, emphasizes that we should, in the true application of holism, "throw away prejudice, expand our knowledge and enlarge our therapeutic armamentarium". He urges, "not only a change in the way we think, but also more research on the role of religion in healing."[33] Meyer[35], during his final year of medical studies, questioned the lack of attention shown by educators and researchers toward this important variable.

2.4. Religious inquiry by doctors

Several authors comment on the failure of doctors to question their patients about their religious beliefs.[1,21,30,22,43]. King and Bushwick,[22] in a study of 203 hospital in-patients, reported that 68% of patients said that their doctor never discussed religion and 12% said their doctor rarely did.

Maugans and Wadland[30] found that 40% of patients would have liked their doctor to discuss religion with them and 21% felt that it was the

doctor's responsibility to inquire about religious issues. The majority of the 146 patients could not recall any inquiries by doctors about religion. The authors commented that patients would prefer, and responded best to an inquiry initiated by the doctor. Doctors focussed on religion most often during serious situations like abortion counselling (52%), major illnesses (45%), near death (68%) and counselling for terminal illness (69%).[30]

Meyer[35] recorded that 83% of the GP's said that they asked patients about spiritual matters. Although the biopsychosocial model was applied by 90% of these practitioners, only 68% viewed religion as part of this model. The study was restricted to members of MASA (Medical Association of South Africa) who had a Bellville postal address. The inclusion criteria were strictly applied and only 31 out of 49 questionnaires were evaluated.[35]

2.5. The importance of religious inquiry

Schreiber[44] discusses the timing of religious discussion and feels that the decision should be left with the individual doctor and patient. It is acknowledged that many patients bring their religious concerns along with their illness into the consulting room.[44,45] Schreiber[44] warns that lack of appreciation of the importance of religion in a patient's life will lead to an inadequate understanding of a patient's reactions. She feels that this may unintentionally indicate disrespect for a patient's privately held beliefs. She concludes that the doctor, in understanding how a

patient's faith can influence their health, will value this awareness of the patients' beliefs and improve the doctor-patient relationship.[44]

Maugans,[21] an eminent family physician, encourages each physician to develop their own approach to incorporating spiritual and religious aspects that would "produce generally positive, relationship-building results." He further presents a method to introduce spirituality and religion into the social or lifestyle history.[21]

Galanter, Larson and Rubenstein,[46] conducted a study to familiarize the mental health field with Christian Psychiatry. Their conclusions also suggested the need for a greater sensitivity to religious issues by psychiatrists. Their study showed that doctors who were more religiously committed, were more inclined to recommend prayer to their patients.[46]

Illich[47] indicates prayer and compassion to be means to allow pain to be borne with dignity. He further states that the term "pain" has no simple equivalent. "The term, taken over by doctors," he writes, "covers grief, sorrow, anguish, shame and guilt." He further extends the meaning to include "illness, tiredness, hunger, mourning, injury, distress, sadness, trouble, confusion and oppression."[47]

The lack of primary care practitioners' consideration and respect of patients' spiritual and religious beliefs has been labelled as "unethical or even negligent" by Stephen Post.[31] He suggested that spirituality should be incorporated in a therapeutic regime. The healing effect of prayer and

doctors' negligence in exploring this spiritual area of life was also addressed at the "First conference on Spiritual Dimensions in Clinical Research."[31]

Larson's conclusions[31] on the important health benefits of spirituality and religion and the need for more detailed studies is widely supported[2,33-36]. and he concludes:

"The question today is not whether there are health benefits, it is how these benefits can be obtained. We can no longer afford to neglect this important clinical variable."

2.6 Patients' expectations

Rahman[48] writes about patients requesting prayer in her oncology practice. She accepts the value of faith and shared prayers. Doctors are warned against stereotyping in which they assume religious beliefs that the patient may not have.[1,48.]

King and Bushwick[22] conducted a survey of 273 hospital in-patients on their views about prayer. They found that 48% of the patients would have liked their doctor to pray with them and 77% said that doctors should pay more attention to their spiritual needs. Their study was conducted at two hospitals and involved only family practice and obstetric patients.[22]

van Hoorn[6] in an analytical cross-sectional study of 617 patients, found that 75% of the respondents accepted religious discussion in the General Practice consultation. The sample comprises all the patients that attended

his practice over a 4 to 5 week period, patients selected by 3 other GP's, respondents selected by different priests and anyone else that displayed an enthusiasm to participate. He excluded his patients who he felt had too many problems and included only those patients who appeared spiritually mature. All respondents were given the questionnaire to complete. He presented 5 patient studies to demonstrate his use of religion in the consultation.[6]

2.7. The beneficial effects of prayer and religion

The beneficial effects of prayer have been recorded as a personal experience by Davis[49], who reported, that for him, personal prayer resulted in greater benefit than 9 years of psycho-analytical therapy.

Byrd[40], in a double blind study, showed that patients in a coronary care unit (CCU), who were specifically prayed for, experienced an improved post infarction course. 393 patients admitted to the CCU (over a ten month period), were randomized to an intercessory prayer group (192 patients) or to a control group(201 patients). No statistical differences were found between the groups at entry and it was concluded that results would be valid. While hospitalized, each patient of the first group was assigned to between three and seven intercessors. The patients' first name, diagnosis and updates of their condition were given to the intercessors. Each intercessor was asked to pray daily for a rapid recovery and for prevention of complications and death. Prayer was done outside the hospital until the patient's discharge. The patients, the doctors and staff of the CCU and the author, remained "blinded" for the duration

of the study. The control group was not assigned to any intercessors. It was assumed that both groups may have had people, not involved with the study, praying for them. This was not controlled for obvious reasons and any potential bias was considered to favour the control group.

Fewer patients in the prayer group required ventilatory support ($p<0.002$), antibiotics ($p<0.005$) or diuretics ($p<0.005$). 85% of the prayer group had a good hospital course vs 73% in the control group and a bad hospital course was recorded for 14% in the prayer group vs 22% of the controls. ($p<.01$).[40]

It has further, also been documented that attention to the patients' religious beliefs and experiences, enhances physical healing and general well-being[35,50].

2.8. The effect of doctor-patient differences of religion

The consequences of differences of religious orientation and beliefs between doctors and their patients, have been neglected in the medical literature. Maugans and Wadfield[30] showed that doctors and patients differed in their consideration of the importance of the doctor's religion or religious beliefs. The degree of importance in selection of the doctor and in maintaining the professional relationship was measured. They found that 29% of doctors against only 8% of patients agreed that religion was important in the choice of their doctor. Seventy five percent of patients and 44% of doctors felt that religion had no role in the choice. The question regarding the role of religion in maintaining the doctor patient

relationship showed similar results. Forty eight percent of doctors and only 7% of patients felt that religion was important in the doctor-patient relationship and 35% of doctors and 77% of patients felt it played no role at all. They explained this discrepancy on the basis of the patient's expectation that the consultation would be limited to biological issues. These findings are summarized in Table 1.

Table 1. Perceptions of the Role of Religion in the Physician-Patient Relationship

Belief	Number	Agree (%)	Disagree (%)	Undecided (%)
Choice of physician				
Physician	114	29	44	27
Patient	134	8	75	17
Maintenance of relationship				
Physician	114	48	35	17
Patient	134	7	77	16
Right of physician to inquire				
Physician	115	89	11	
Patient	126	52	45	
Responsibility of physician to inquire				
Physician	113	52	48	
Patient	127	21	79	

from; Maugans & Wadfield. J Fam Pract 32:2:211

2.9. The scope of family medicine

Belief, spirituality and religion are important psychosocial variables. The importance of attention to all the concerns of the patient is expressed in

the patient centred approach which is accepted and well documented as a principle of family medicine.[23,51-54].

Schwenk[55] noted that the skill to enquire about psychosocial aspects and to utilize the responses to the benefit of the patient is part of "the principles of compassionate, accessible, accountable family medical care, originally described by the founders of family practice". He feels that a psychosocial orientation is not necessarily a matter of learning or acquiring a specific counselling skill, but rather a matter of adopting an attitude. The practitioner has the freedom to continue with counselling or to refer the patient to an appropriate counsellor, once a need has been identified.[55] The practitioner's comfort and skill in dealing with the matter should influence this decision. Peabody[56] included the whole of the doctor-patient relationship as the basis of the practice of medicine. "It is an art," he said, "based on the sciences, but comprising much that still remains outside the realm of any science." He concluded, that "the secret of the care of the patient , is in caring for the patient."[56]

2.10. Prayer

Prayer is infinite in quality[57] and for these reasons difficult to define.[58] Prayer is a natural activity and a fallback for many people when they are in a severe crisis.[57,59,60] Fosdick[57] states that prayer is useless without divine fellowship. This opinion is also expressed in Isaiah[61] "when you make many prayers, I will not hear" because, "your hands are full of blood." and in Matthew[62] "Not every one that saith unto me, Lord, Lord, shall enter the kingdom of heaven; but he that doeth the will of my Father, which is in heaven." Faith was, however, not considered a prerequisite for healing by Jesus.[18,63]

The differentiation, between spiritual healing and biomedical healing, is important.[18,48] Bearon and Koenig,[64] in a study of 40 elderly patients, suggested that "prayer and medical health-seeking are not mutually exclusive." They interviewed respondents about prayer on their symptoms experienced in the preceding 3 weeks. They found that respondents had most often reserved prayer for serious symptoms.[64]

2.11. The view against incorporating prayer/ religion into medicine

There are several reasons why people cannot or will not pray viz.,

They may feel that certain of their past actions rule out the possibility of prayer and that their disgust at the act does not allow redemption.[58]

Their exasperation with themselves may be so complete that they are convinced that they cannot be helped.[58]

They fear a "surrender" and see prayer as a form of servility in which man loses his dignity.[58]

They may feel that previous prayers have not been answered.[57]

Prayer is seen as too available, easy and common[57] and thus difficult to believe that prayer could work.

They do not believe in prayer.

They fear the scorn of their peers if they cannot show that their prayers have been answered.[65]

A practitioner may, to the patient's detriment, use prayer to avoid talking about or listening to issues that may be painful or threatening to the practitioner.[66] There may also be times even during pastoral counselling when prayer is not fitting.[66]

Attention to the spiritual aspects of ill health are placed outside the scope of doctors by several authors.[19,51,67,68.] van Deventer[19] emphasizes that the point of view, convincingly stated at medical conferences, against "a spiritual dimension" and against "a need for sensitivity in this area has remained unchallenged in a conspiracy of silence". Sheldon[67] warns about the potential dangers and difficulties when faith and prayer are included in the healing process. He stresses the ethical difficulties and the cross cultural problems. Maugans[30] study also showed that 48% of doctors felt that the differences in religion affected the maintenance of the relationship. (Table 1) No reasons for this opinion are expressed.

Problems arise when religious healers seek to substitute prayer and faith for proven medical treatments.[69,70] This led the Committee on Bioethics of the American Academy of Pediatrics to call for state intervention when parental religious practices have potentially harmful consequences for their children.[71]

James[68], commenting on the article on faith healing by King[34], writes that religious faith requires no scientific evidence. He expresses the concern that the patient, "acting on faith", would view medicine and religion with distrust when their health deteriorates. He believes that patient trust in the clinician is achieved only by clinical knowledge, skill and a reputation of success. He welcomes the patients' faith as a bonus.[68]

3. METHODS

3.1 Selection of method

I first learnt about qualitative research as part of the course work. Patton[72] lists 20 questions to decide whether qualitative methods are appropriate. This study fulfils the following criteria addressed in his questions;

A focus on diversity,

a need for unobtrusive observations,

a need for personal, face to face contact,

an approach that is sensitive to collecting descriptive data,

a lack of proven quantitative instrumentation,

a need to add depth and meaning to documented statistical findings, and

a need for a goal-free evaluation that would gather information about feelings, rather than accurate measure of effects.

Qualitative research was shown to permit depth and detail of the researched topic without the constraints of predetermined categories. I liked this and felt that open ended questions would allow respondents to give full vent to their feelings, whether positive or negative. Semi-structured in-depth interviewing was selected as the tool since it combines the practical advantages of structure with an open ended response.

3.2 Definition of Terms

Bracketing: Putting the self aside so that a phenomenon can be experienced as it is.[73]

Double coding: Coding of an uncoded copy of a transcript that has been coded previously.[74]

Field notes: collective term for records of observation, development of research, as well as the researcher's own reactions, feelings and opinions of the process.[27]

Pray/Prayer: A dynamic form of communication with the Deity or transcendent Other, often with an element of petition or desire.[57,42,66.] Also described as an act of devotion and a presence in fellowship from which peace and strength could be derived.[57]

Purposeful sampling: A deliberate choice of subjects[27] for specific reasons.

Rapport: The ability to convey empathy and understanding without judgement.[26]

Reflexivity: The awareness of the inevitability of bias on the part of the researcher and to actively take it into account during the research process.[75]

Reliability: the extent to which repeatable results are produced.[76]

Religion: Belief in superhuman controlling power especially in a personal God or gods, entitled to obedience and worship.[66] Alternatively, an institutional aspect of society based on beliefs in a supernatural realm.[77]

Religious denomination: A group or sect within a specific religion.[78]

Spirituality: "a belief system focussing on intangible elements that impart vitality and meaning to life's events,..... typically expressed through formalized religions."[21]

Triangulation: use of three or more method in combination, as a check for validity.[27]

Validity: the extent to which a measurement measures what it sets out to measure.[76]

Venn Diagram: a diagram using overlapping and intersecting circles etc. to show relationships between them.[78]

3.3 Study Design

3.3.1 Qualitative semi-structured interviews

I collected data by means of in-depth, semi-structured interviews of selected respondents. I was concerned that recording may inhibit free dialogue. I thus tried to put the respondents at ease and encouraged them to talk about the topic. I acknowledged their responses by frequent non verbal (head nodding, leaning forward and empathetic attitude) and verbal (saying, "Yes," and "Mmmmm") manoeuvres. I also used summarizing and probing techniques to achieve clarity and to gain depth.

3.3.2 Sampling

Respondents were selected by purposeful sampling since it was considered the most appropriate way of encountering information rich cases. The main criteria for selection was that the respondents should be older than 16 years of age, who talk easily and spontaneously. The age of entry was set at 16 years since I had conducted an adequate interview, off tape, with my 16 year old daughter to test the interview guide.

I requested three family practitioners, all with post graduate family practice qualifications, to select respondents for the study. I selected these practitioners since I felt that we served similar populations. I also respect their work and identify with their styles. My letter of request included a guide-line to explain the study to prospective respondents. I also requested that they select at least one Christian and one Muslim

respondent and respondents of opposite gender. This, I felt, would enable the exploration of the attitudes of patients who attended doctors of different religions. Only patients who spoke either English or Afrikaans were interviewed.

I interviewed three of my own patients. I had intended this as a pilot study to test the interview guide and to practise interviewing techniques. The respondents' responses however persuaded the inclusion of the pilot study into the full study.

A total of 7 patients of the three family practitioners were interviewed. Two of the doctors selected only two patients each. I had at that stage decided to include the pilot interviews. I therefore asked them not to select their remaining respondent. The study consists of ten individual interviews.

3.3.3 Pre-interview contact

I phoned each respondent as soon as possible after obtaining their names. I first introduced myself as a family doctor who is a registered postgraduate U.C.T. student. I discussed my interest in people's opinions of the role of prayer in general family practice. I explained qualitative research as valuing the understanding of their thoughts and feelings. I stressed that there are no right or wrong answers and explained the need to record the discussion.

I stressed confidentiality and anonymity and revealed that even our telephone conversation is covered by the same principles. I advised that their own doctor had also agreed to this. I assured them that I would not personally discuss the details of the interview with their GP but indicated that their GP may identify them in the thesis. I informed them that their involvement was entirely voluntary.

After answering all questions, we agreed to meet at a time and place to suit the respondent. All respondents displayed a keen willingness to help.

3.3.4 Interviewer

I conducted all the interviews myself. I had no prior practical experience of qualitative interviewing. Lack of finance and an eagerness to learn were however strong motivating factors. I practised interviewing off tape before engaging in the pilot study. Transcripts were subjected to critical analysis of interviewing technique by Drs B. Schweitzer, F. Christians and M. Navsa. Other interviewing errors, were identified and noted when I was transcribing. I then attempted with varied success, to incorporate this learning into subsequent interviews.

3.3.5 Interview guide

An interview guide was prepared as a basic check-list to ensure that specific topics were covered during the interview. The sequence of questions was also considered at length and the guide was reviewed initially, after the pilot interviews and subsequently, after each interview.

Patton[72] labels demographic questions as basically boring and potentially discouraging to the respondent. The demographic answers during the pilot interviews were also quite lengthy. I spent much time transcribing answers that were basically not very relevant to the study. I however felt that the respondents tended to relax when they discussed themselves. This also allowed them an opportunity to familiarize themselves with the interviewer and recording equipment. Subsequent interviews also showed that the open ended nature of the initial question, allowed respondents to discuss their spirituality as part of that response.

The interview guide was intended to be used solely as a guide and not intended to restrict. I therefore introduced additional questions in order to elaborate on or to clarify responses. Minor changes to the guide were intended to allow greater focus on the subject matter. The interview guide is appended. (Appendix I)

3.3.6 Ethics

The participating family practitioners were requested to identify respondents, to inform them of the nature of the study and to request their consent to forward their names.

On initial telephone contact, I explained the study and requested consent to interview. I again explained the study and obtained consent for tape recording before the interview. I only started the interview when respondents had indicated that they fully understood and gave their consent freely.

I attempted to avoid the potential problems of supercession by selecting practitioners outside the geographical area of my practice.

To ensure the principle of non-malevolence, I remained behind after tape recording was discontinued. I then allowed respondents to express feelings and to allow their retraction of consent. I also again assured them of confidentiality and anonymity. Each respondent is identified in the transcription only by a 3 letter code. All proper names mentioned in the transcriptions were also substituted with letters of the code.

I also obtained consent to conduct the feedback interviews. One feedback interview represented an anxious moment. The respondent expressed concern that the initial interview made him realize that he was not aware of his doctor's religion. We discussed his concerns. The respondent felt reassured. I assured all respondents that the confidentiality and anonymity applied throughout the study. I had also informed the respondents that the study, on being accepted, would be reserved in the medical library and that extracts may be published.

All respondents said that they enjoyed participating. One feedback interview was concluded with a prayer, at the request of, and by the respondent.

3.3.7 Recording of interviews

Data was collected by tape recording the interviews and taking field notes. I used a tape recorder in tandem as well as a dictaphone, each with a new cassette, for all (except the pilot study) the interviews. All the original recordings are available for inspection. Field notes were recorded before, during and immediately after the interviews.

3.3.8 Transcription

I initially transcribed the audio-tapes by hand and presented these transcriptions to an experienced typist. We soon discovered that it was easier to type directly onto the word processor. Where audibility or language presented a problem to the typist, I dictated the audio input to her. All recorded material was transcribed and areas of inaudibility recorded in the transcripts. I then personally checked and corrected typing errors, until I was convinced that the transcripts were correct. I followed this process irrespective of whether I or an assistant typed the initial transcription. This long and tedious process led to inevitable delays and on occasion, I had interviewed the next respondent, before the transcription of the previous interview had been completed.

3.3.9 Coding

Each respondent was allocated a three letter alpha code. The first letter indicating the sequence of respondent per doctor, the second letter

indicating the respondent's gender and the third letter, the respondent's religion.

For interview AFC, we can conclude;

A= the first pilot 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. This would facilitate identification of the origin of quotations and subsets of themes.

3.3.10 Feedback interview

I contacted each respondent to arrange for a follow-up interview. I advised that it should be much shorter than the original interview. The aim was to ensure that I did not misunderstand anything. I also advised that the follow-up interview would allow them to approve the use of the information and serve to validate my research.

The feedback interviews were not recorded. Short notes were jotted when indicated. I wrote notes of all the feedback interviews on the same day that they were conducted.

I showed all respondents their transcripts and the allocation of a code. I assured them that confidentiality and anonymity will be maintained.

3.4 Analysis

The time consuming nature of analysis is unanimously accepted by several authors. I managed to fulfil this essential need, by chiefly using an editing style of analysis. The editing style allows for analysis and data collection to occur simultaneously.

I read the coded transcripts of the interviews and identified comments and phrases that were directly and indirectly related to my research question. I attempted to group these phrases and comments under specific categories. At subsequent readings, I underlined these phrases, colour-coding them to categorize themes. I found phrases often fitted into a number of different categories and put them into all the themes into which they fitted. I endeavoured to understand the meanings and concepts that respondents were trying to transmit. Categories that were identified stimulated my use of probing in subsequent interviews. It is thus no coincidence that the number of different themes increased until the last 2 interviews. My word processor was used to "cut and paste" the underlined text under theme headings for each interview. This data was then printed. Only then, did I recognize a way of displaying the data. The venn diagram facilitated a concise display of individual respondents. Stewart considers the individual understanding essential in order to compare and contrast.[79] The individual display also allows demonstration of the diversity of beliefs and practices found in my small sample of respondents.

Themes were compared, re-organised and data was further reduced. I then designed a matrix as described by Huberman.[74] The matrix enabled integration of the individual interviews into collective themes. I recorded the themes in the first column and the text in corresponding horizontal columns. Maintaining their exhortation to keep the matrix on a single sheet led to my substituting my study wall for a sheet. Further summarizing and reduction led to the results, as recorded.

3.5 Reliability and internal consistency

A reliability check on the themes has been performed by utilizing the formula of Huberman[74] viz,

$$\text{reliability} = \frac{\text{number of agreements}}{\text{total number of agreements plus disagreements}}$$

I checked internal consistency by double coding interview AFC and, applying the above formula to check the reliability of the themes. I categorized the first 14 pages of interview text. The application of the formula is tedious and difficult, especially where single lines of text have been coded into several different categories and where disagreements consisted of parts of lines. Double coding did, however, sharpen the definitions as indicated by Huberman. Double coding also served, very effectively, to check the correctness of categorizing. I did not apply the formula to the other interviews. I double coded all other interviews in order to gain greater accuracy.

The external reliability check was done on two interviews (BMC and EMC) by Dr Schweitzer. I calculated external reliability, of the themes, according to Huberman's formula. The results are recorded in the section for the collective results.

3.6 Bias

I was aware of my bias toward the subject of the research at the outset. I believe in the power of prayer and my Christian faith decrees "Pray on every occasion,"[80] and more specifically, "Is there anyone who is ill? ... pray for him"[81]

Discussion with colleagues and supervisors facilitated my focussing on the primary aim of the study, i.e. the patients' (or respondents') perception. I was left with a concern that I may over correct for this bias during the interviews. I applied the processes of reflexivity and bracketing allowed to encourage the respondents. I also looked at views that directly conflicted with my own, during the literature review, the interviews, the analysis and during the writing up.

4 RESULTS

4.1 Introduction

The results are presented under the respective headings. I have first presented the collective themes and results and then the individual themes and results. The categorized quotations are presented under the collective results but not in the individual interviews. The identified themes for the individual themes are listed under the respective sections. The venn diagram and the explanation thereof summarises each of the individual interviews.

All Afrikaans quotations are italicised and followed by the translation, enclosed in "{}" brackets. I have attempted to keep the translations as close as possible to the original. Italicised superscripts refer to the line number of the respective interview.

4.2 Collective results

4.2.1 Themes

The following collective themes were identified;

i Demographics
ii Beliefs.
iii Speaking about the doctor.
iv Prayer is...
v Feelings about prayer in the consultation.
vi Differences of religion between doctor and patient.
vii Doctor asking about religion.
viii How to pray in the consultation.

4.2.2 Results

i Demographics

The demographics of the sample is summarized in Table 2. The second letter of the respondents' code indicates gender, the third letter indicates religion. All respondents are married, one has separated from her spouse. Religious denominations are separately indicated, where applicable. Information printed in italics has been obtained from the participating doctors. All other information has been extracted from transcriptions of the interviews.

Table 2: Demographics of sample.

INTERVIEW	DENOM	LAN	AGE	OCCUP	DR'S RELIGION
AFC	Anglican	Eng	48	Housewife	*Anglican*
BMC	Anglican	Eng	*44*	Priest	*Anglican*
CFM	Moslem	Afr	26	Clerk	*Anglican*
DMC	SDA#	Eng	63	Foreman	*Agnostic humanist*
EMC	Anglican	Eng	37	Teacher	*Agnostic humanist*
FFM	Moslem	Eng	39	*Childcare worker*	Hindu
GFC	Docks Mission	Eng	42	*Housing assistant*	Moslem
HFC	Anglican	Eng	49	Housewife	Moslem
JMC	Anglican	Eng	50	Senior Operator	*Anglican*
KMC	VGK*	Afr	*46*	Clerk	VGK*

Seventh-Day Adventist.
* Vereenigde Gereformeerde Kerk.

ii 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 not the building..... the building, that 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 *"gebed is in alles wat ons doen."* {"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. Muslim respondents had expressed their belief to pray at least five times during each day as part of their religion. One of several short Muslim prayers, *"Bismillah... is baie kort en kragtig. So dit wil se, niemand het 'n verskoning om nie te bid nie, aangesien dit nou net so kort is."* {"Bismillah... is very short and powerful. It shows that

there is no excuse not to pray, since it is so short."}*CFM249-250* Muslim prayer times and basic Islamic principles are noted in APPENDIX II.

"Godsdiens en gebed is... die iets wat mense of gesinne in die moeilike tye bymekaar hou" {"Religion and prayer holds people or families together during these troubled times"}*KMC496-497* The importance of religion is of such a degree that one respondent says, "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* The extent of this involvement and "the context of the occasion"*EMC285* is further discussed in a subsequent theme.

iii 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. That person has been given the gift and the talent to do that study and to do that work. ...at the same time that person will be able to do that 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 Another recognizes that *"dokters is maar ook net mense."* {"doctor are also only human."}KMC346

The doctor who is very religious or who *"weet waar sy krag vandaan kom"* {"knows the source of his strength"},KMC418 seems to facilitate communication for most of the respondents. One respondent clearly expresses this feeling, "If I come to you and you don't speak about God, it doesn't mean I won't go back to you. But the thing is, ... I like to talk. You talk to me now and God comes into the conversation, then I'm open. I'll talk to you."GFC230-235 Another respondent experiences greater comfort and trust, when he knows that *"die is 'n man van God, hierdie man, is 'n man wat aan dieselfde beginsels glo, waaraan ek glo."* {"this is a man of God, this man, is a man who believes in the same principles, that I believe in."}KMC700-702

One respondent, in fact, gives the experience of having had "a prayer together"JMC263 with a doctor, that he had consulted. The respondent admitted to having felt "quite a surprise ... to hear a doctor ask .., if he could pray".JMC296-297 This made him feel that they were speaking "the same language ... on the same level"JMC306

Another respondent reports that her GP will always advise her to appreciate God and will frequently express thanks in Arabic. This allows her to experience him, " Not as a doctor not as a friend, as a confidant.

Then I can talk to him even about my problems and so. We're on the same wavelength."[GFC286-288]

The respondent who, however, 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 ... it would probably make my heart glad but I wouldn't honestly be able to say it to him. I would think it."[AFC352-354]

Respondents notice the demeanour and actions of their practitioners. One respondent concludes that "he is a clean doctor,... because he is religious."[HFC378] Another is convinced of her doctor's empathy when she saw *"dat die dokter trane in sy oe het."* {"that the doctor had tears in his eyes."}[CFM397] The respondent clarified that she had thought that her GP had said a silent prayer during the consultation because *"jy kan sien, die uitdrukking op hulle gesig as jy met hulle praat. Dan kan jy sien die gebed le daar."* {"you can notice, their facial expression as you're talking to them. Then you can see the prayer there"}[CFM375-376]

The sharing of spiritual matters elevates the relationship to *"meer as net 'n dokter pasient verhouding"*. {"more than just a doctor-patient relationship"}[KMC648] Some respondents, in appreciation of their doctors, regularly pray for them. This prayer as one respondent says, is "for guidance, for God to keep him and thank God for the right doctor you're with."[GFC107-109]

iv Prayer is...

Prayer is generally recognised as a communication with God. All, except one respondent, identified the communication as eliciting some form of response. 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. One respondent feels that the doctor has a specific talent and duty. He says, " I don't believe that the doctor should say, 'No I can't do that', because we're all gifted in that same respect umm with the gift of being able to talk and to listen. If we've been gifted to talk and to listen then we've been gifted with the gift of prayer." Other respondents firmly believe that "prayer,.. goes hand in hand with medical"*JMC382* and that the doctor cannot achieve anything without divine guidance and intervention.

The timing of the prayer, as well as it's implementation, is considered to be *"'n moeilike keuse"* {"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*

Potential impediments or feelings of discomfort could be generated by prayer in the consultation. These negative feelings and comments are included in discussion of the next theme.

v Feelings about prayer in the consultation.

The need for prayer in the consultation is repeatedly addressed. Some respondents would "encourage the doctor to pray".*BMC263* Another "would love to see doctors, doing it [prayer] more often".*DMC179* Episodes of prayer and spiritual expressions during the consultation are discussed in a previous theme. It is, however, interesting to note that another respondent had chosen a "Moslem gynae".*FFM183* This specialist had informed the respondent that he prays each morning for all his patients and for all surgical procedures to be performed that day. Indeed, before he enters the theatre, he performs "two extra salaah patterns."*FFM209* This makes her "feel great"*FFM244* since she is assured of his "extra strength"*FFM245* and as she is, herself, "petrified of operations."*FFM162*

Most respondents believe that *"die gebed van 'n gelowige het baie krag"* {"the prayer of a faithful believer is very powerful"}.*KMC598* Consequently *"as jou dokter vir jou bid, dan sal dit fantasties wees"* {"if your doctor prays for you, it will be fantastic".}*KMC599* Saliently more so as another respondent expresses, "if patients would idolise you, in that sense, uhmm how great won't it be if you would tell your patients uhmm, 'Come let's have a prayer together. Before I do the necessary thing.' ... and we, you will find sometimes how God responds".

It is however considered "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]

A dependence on modern science perpetuate the idea that *"als wetenskaplik reggestel kan word."* {"scientifically, everything can be made right."}[KMC343] Patients frequently attend for relatively minor problems or may be in a hurry and *"wil nie ... tyd mors... om te bid nie"* {"doesn't want to waste time ... to pray."}[KMC511-512]

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. One respondent feels, "the patients is going to walk out there and they're going to think, 'Daai dokter preek.' You know. If its not a situation that calls for prayer, it's not going to go down looking well. They're going to say, 'Moenie na daai dokter gaan nie. That doctor actually, just want to pray for you."[AFC314-318]

Prayer in the consultation 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]

Many respondents consider that a great difficulty to the implementation of prayer in the consultation is that "doctors are so busy." *JMC456* The effect of differences in religion or church denomination, is further discussed under the next theme.

vi Difference of religion between doctor and patient.

There is general consensus of respect for other religions, even where *"die verskil is hemelsbreed."* {"there is a world of difference"}*KMC662* A respondent is very comfortable with her gynaecologist who "dua [prays] for all his patients, being Christian or Moslem."*FFM251*

The question regarding attendance of a doctor of a different religion attracted varied answers. We are reminded that some patients, insured through certain managed care financiers, do not enjoy the benefits of freedom of choice. One respondent felt that although he would prefer to go to a Christian doctor, he would not have any objection to attend a doctor of a different faith. He admitted that he had not always felt that way. He, however, appreciates that he has "grown in understanding".*BMC346*

Those respondents who either attended or who had no objections attending doctors of different faiths, admitted that their choice was not based on religion. They attended doctors because of the doctors' skill, honesty, level of care, attitudes and respect.

Doctors of different religions who demonstrated and shared their beliefs with the respondents caused the respondents to admire those doctors. Such action encourages patients "to feel... we're equal, we understand each other and can... communicate."[GFC126] Most respondents, however, felt that different faiths may have some difficulty with cross religion prayer. This presents as somewhat of a paradox, since all respondents agreed that "we serve one God."[JMC329]

One respondent, who was satisfied with her GP and felt that *"hy gee om vir my. Dan maak die geloof nie saak nie."* {"he cares about me. Then the religion doesn't matter"}[CFM397] Another respondent indicated that he would attend a doctor of another faith for medical treatment, since he would, "still ask God [for] a blessing."[JMC373] Differences of religion should not inhibit prayer for some, because "if you say a prayer, it doesn't matter who you are."[FFM287] For others the differences in religion and even of church denomination, results in communication to be "not on the same level"[JMC322] or that *"ons sal bymekaar verby praat."* {"we will talk past each other"}.[KMC441] One respondent had admitted that where even the *"godsdiens beginsels"* {"religious principles"}[KMC673] differs, he would have great difficulty co-operating with that practitioner.

vii doctor asking about religion.

Only one respondent said that her GP asked about her religion. She viewed the inquiry as *"hy toon sy belangstelling"* {"he shows his interest"}.[CFM329] She appreciates the demonstration of *"respek vir my geloof en dit is wat ons verwag."* {"respect for my religion and that is

what we expect"}CFM331 Another respondent indicated that she "never had one doctor that asked and I'm 48 years old."*AFC343* One respondent feel that "We don't hide, we don't have to"*DMC216* and have "made it known to the doctor what religion we are."*DMC208*

Two respondents, indeed feel that religion is important and they "will try and bring it in".*GFC290* The inquiry will be indirect and gentle since the respondents feel that the doctor has a right to confidentiality. The one respondent says, "if he don't respond, I won't force the issue".*GFC291* The other respondent however feels, *"Ek sal altyd deur my gesprek lei, ... waar staan ek met hierdie dokter. Hoe is sy siening, wat is sy Godsbegrip?"* {"I 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*

viii How to pray in the consultation

Respondents' suggestions on the means of implementation of prayer is 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. One respondent advised that the best approach would be to ask the patient about their faith and religion and then ask to pray. The doctor's honesty and sincerity are essential values that would further facilitate the request. A lack of these values will cause the patient to think, "Would he then maybe tend to be not sure of himself, ... or is he trying to impress."*EMC296-298.*

We should endeavour to restore the relationship between the clergy and the family practitioners. One respondent reminisces, *"die ou styl van lewe. Dit was fantasties gewees. Vandag het daar 'n vervreeming gekom oor hierdie gesindheid, ... dit moet weer opgetel word".* {"the old style of life. It was fantastic. Today that disposition has been neglected and estranged, ... it must be picked up again"}.*KMC582-584*

All doctors who believe are urged by one respondent, as part of their belief, to fulfil their "evangelical mission"*GFCR* and share their beliefs with patients. To this end, the hope is expressed that opportunities for prayer sessions or prayer rooms would be provided at our surgeries. The respondent indeed foresees that *"sulke plekke sal oorstroom word deur mense wat graag daarso wil bid."* {"such places will be flooded by people who would eagerly want to pray there."}*KMC566*
He appeals that *"hierdie studie wat u maak, weer sal teruggeploeg word in die gemeente en in die gemeenskap. ... Dat dokters ook sal besef, 'Ek is nie baas oor mense lewens nie."* {"this study that you are doing, will again be ploughed back into the congregation and into the community. ...That the doctors also will realize, 'I am not master over human lives."}*KMC619-624*

4.2.3 Venn diagram

The doctor-patient relationship appeared to assume greater importance when it was associated with shared spirituality. I therefore elected to depict these relationships, as well as other themes on a venn diagram. The venn diagram and its explanation, also serve to 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 respondent 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 (line numbers have been deleted to preserve space) and arrows are inserted to complete the flow.

4.2.4 Validation, Reliability and Internal consistency

Reliability of the themes derived from transcript BMC, was calculated according to the following formula[74];

$$\text{reliability} = \frac{\text{number of agreements}}{\text{total number of agreements plus disagreements}}$$

My colleague (BS) and I, agreed on 7 themes and disagreed on 6. External reliability is thus;

$$7/13 \times 100 = 53{,}8\%$$

This is an acceptable figure, since the independent coder was not actively involved in the research. Huberman[74] indicates that initially, one shouldn't expect better than 70%. Subsequent discussions also, resulted in more agreements.

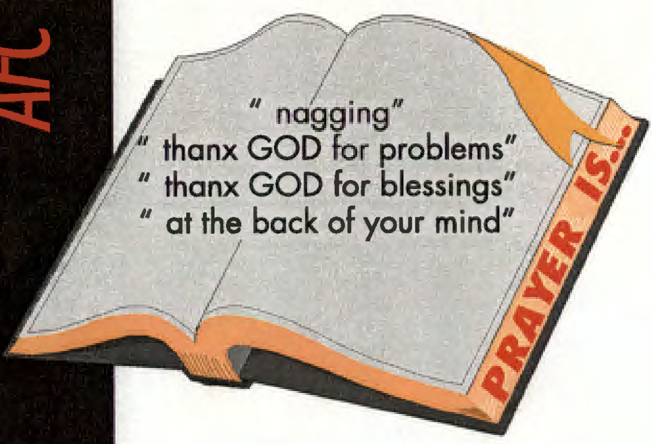
I double coded the first 14 pages of transcript AFC. Internal reliability (consistency) of the themes, was 100%. I found 26 disagreements and 90 agreements, on comparing the coded transcripts. Internal consistency is thus calculated as;

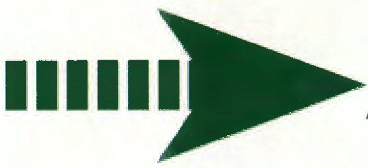
$$26/116 \times 100 = 77{,}6\%$$

"A figure closer to 80%", for initial internal consistency, is advised.[74]

VENN DIAGRAM

AFC





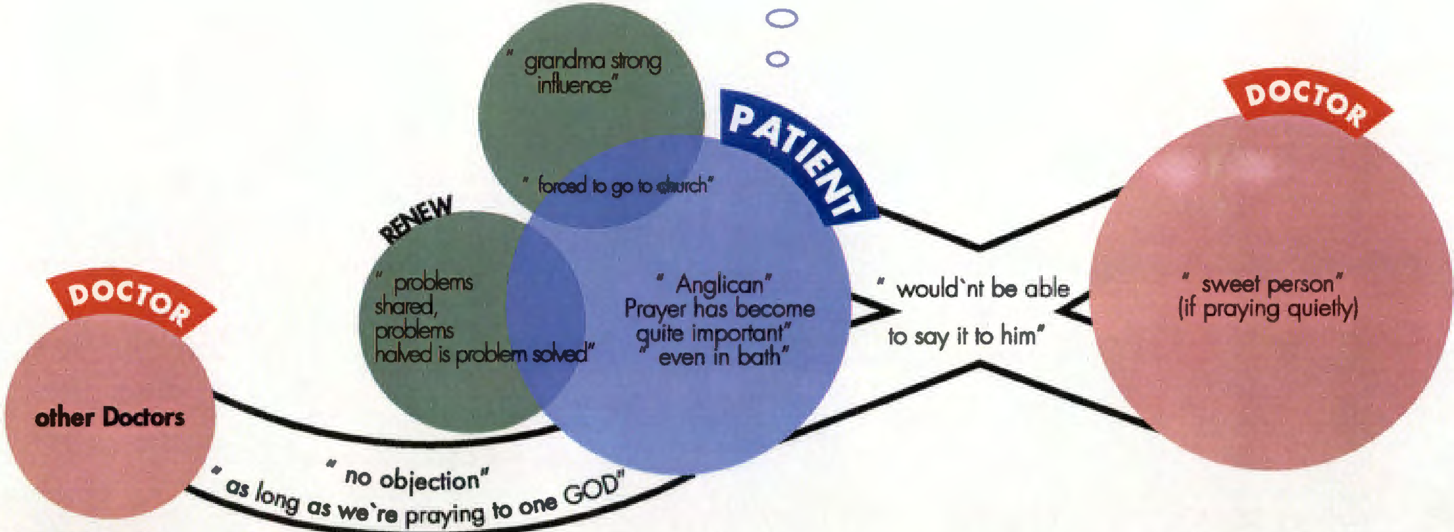
" very ill"
" major problems ... (e.g.) AIDS
" big operation"
" you know you' re not going to get better"
" deeply troubled"
" emotional trauma"

" moenie na daai Dr gaan nie"

" it's not a situation for Prayer"
" out of the blue"
" you're not used to something

" Doctor' s prayer would help"

" strange"
" weird,almost like the Dr... who became a priest"
" funny"
" uncomfortable"
" embarrassing"



" a family is not a family without GOD"
" gentle, quiet prayer"

SUGGESTIONS

4.3 Interview AFC

4.3.1. Pre-interview contact.

This interviewee is a close relative. The purpose of the interview was initially only to serve as a practice for my interviewing technique. I had prior discussion with the respondent regarding the research proposal and the theme of the research. She had readily agreed to be interviewed. She admitted to being intrigued by the possible questions and was also eager to assist. We had agreed to do the interview on 22 September, 1996.

4.3.2 Transcript and field notes.

The interview was conducted, on a Sunday afternoon, in the bedroom of the respondent. I was sitting on the bed and the respondent was lying on the bed. The tone of the interview was easy and relaxed. Unfortunately, we were interrupted both by the telephone and my bleeper. After the interview, the respondent expressed her surprise at how good it had felt, and admitted to a degree of anxiety preceding the interview.
The interview was transcribed within 10 days. The cassette and transcriptions are available for inspection.

4.3.3 Themes

The following themes were identified;

(i) Demographic data

(ii) "We were forced to go to church."

(iii) "I believe..."

(iv) "God answers my prayers"

(v) "...strange if a doctor must..." pray during the consultation.

(vi) "As long as we're [the doctor and I] praying to one God,"

4.3.4 Venn diagram

The venn diagram displays an Anglican respondent, who believes that prayer is so important that she will pray anywhere irrespective of how busy she would be or whatever she would be doing. She admits, "Sometimes I get the urge so bad that I must say a prayer before I go to the kitchen,...".

She feels that prayer "strengthens.. at many times, gives.. a sense of direction" and "...calmness that...sort of slows me down". She appreciates the "very strong influence" that her grandmother played in forming the basis of her religious beliefs. Her faith sharing church group ("Renew") also functions as emotional support. She believes that, "a problem shared is a problem halved, is a problem solved." The sharing within the group,

she feels, "doesn't only enrich you spiritually,... it enriches you to handle many things..".

She believes that "a family is not a family without the Lord". She, almost paradoxically, expresses "weird", "strange", "funny" and "embarrassing" feelings when asked about prayer during the consultation. Her discomfort is so great that, even though, she would enjoy quiet prayer by the doctor, she "would not be able to say it to him".

She does identify specific occasions when "doctor prayer would help" viz;

> "when a person is very ill",
> "A big operation, you may not come out there",
> "when you're deeply troubled", and
> "when you know you're not going to get better".

She, however, warns that "if it's not a situation calling for prayer, it's not going to...look well.". She feels that the doctor may, in fact lose patients, since patients will advise one another, *"daai dokter preek...Moenie na daai dokter gaan nie"*. {"that doctor preaches...Don't go to that doctor"}.

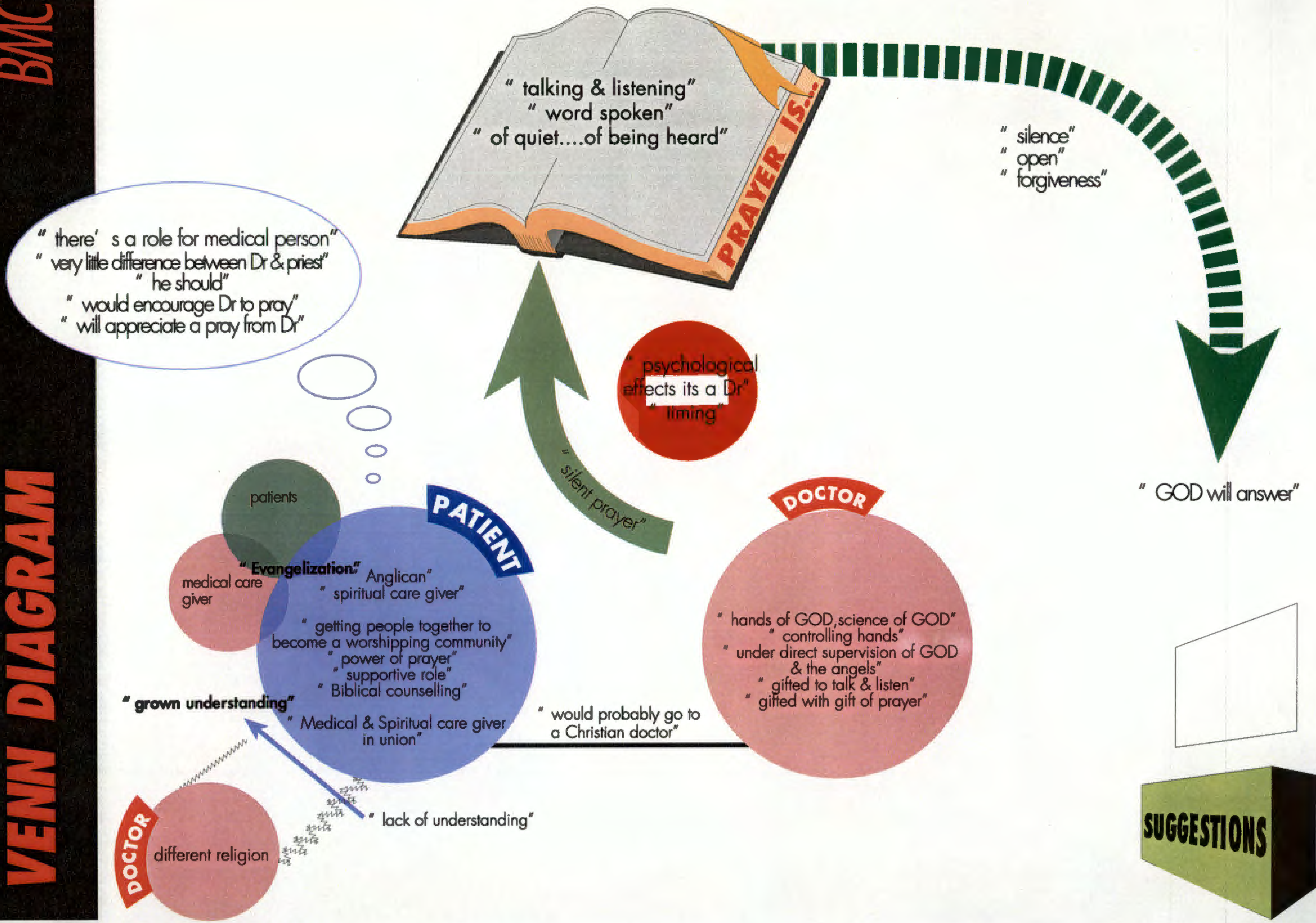
4.3.5 Feedback interview

The feedback interview was conducted at the same venue on 8 June, 1997. Consent was confirmed.

I showed and explained the Venn diagram to the respondent. She accepted it as a true summary of our original interview. I questioned her about what appeared to me as a paradox, viz; her absolute joy at noticing a doctor, praying quietly, contrasted against her discomfort of prayer during the consultation.

She validated this answer by replying that "gentle quiet prayer", always meant much more to her than a "loud preaching", kind of prayer. She added that she would hate the doctor to "sort of pray down" to her, in a "judgemental" way. She felt that, especially if she should present in an emotionally disturbed manner, the doctor would best handle it by asking for a short period of quiet. The doctor should find it much easier to ask to pray together after that period of quiet. Prayer would then bring about an "immediate calm" and would "work much better than tablets."

The interview was not recorded. Short notes were kept. The interview was written up within an hour of it's completion.


VENN DIAGRAM
BMC
" there' s a role for medical person"
" very little difference between Dr & priest"
" he should"
" would encourage Dr to pray"
" will appreciate a pray from Dr"
" talking & listening"
" word spoken"
" of quiet....of being heard"
PRAYER IS...
" silence"
" open"
" forgiveness"
" GOD will answer"
" psychological effects its a Dr"
" timing"
" silent prayer"
patients
PATIENT
medical care giver
" Evangelization" Anglican"
" spiritual care giver"
" getting people together to become a worshipping community"
" power of prayer"
" supportive role"
" Biblical counselling"
" Medical & Spiritual care giver in union"
" grown understanding"
" would probably go to a Christian doctor"
DOCTOR
" hands of GOD,science of GOD"
" controlling hands"
" under direct supervision of GOD & the angels"
" gifted to talk & listen"
" gifted with gift of prayer"
DOCTOR
different religion
" lack of understanding"
SUGGESTIONS

4.4 Interview BMC

4.4.1. Pre-interview contact.

This respondent is a patient of mine. I had discussed pastoral counselling with him, since I knew of his intention to do further studies on pastoral counselling. We had previously discussed the study. As a newly ordained priest, he had also expressed tremendous interest. He displayed an eagerness to be interviewed. We experienced some difficulty at setting up a date that was mutually convenient. An appointment was eventually arranged for 1 October, 1996.

4.4.2 Transcript and field notes

I arrived at the respondent's house at the previously arranged time. His son welcomed me, apologised that his father would be late and settled me in the lounge. The respondent arrived twenty minutes later with his wife. He explained that he had done a house visit and was also delayed by some family matters that required attention. He prepared tea for us. At that stage his wife excused herself to allow us to continue with the interview.

He assured me that he fully understood the nature and ethics of research. I explained the procedure of recording, he confirmed consent and assisted in setting up the tape recorder.

The respondent appeared nervous. This is shown at relevant places in the transcript as laughter, sighs and frequent use of "umm". The interview was interrupted by my pager bleeping and my need to respond.

After the interview, the respondent said that he felt good since a lot of things had had to come out. He had expressed concern that "the church has moved away from a biblical base of understanding care". He admitted that the interview was somewhat therapeutic.

The interview was transcribed within 3 weeks. Recordings and transcripts are available for perusal.

4.4.3 Themes

The following themes were identified from the transcript;

(i) Demographic data
(ii) "I believe..."
(iii) Prayer is "a word of quiet, of being heard."
(iv) Doctors are "The hands of God and the science of God."
(v) Prayer in the consultation may have "psychological effect..it's a medical doctor."
(vi) "who am I to challenge ...another [dr's] religion"?

4.4.4 Venn diagram

The venn diagram depicts an Anglican minister who believes in the "power of prayer." He as part of his work, encourages patients to pray for themselves and also for "the medical care giver and the spiritual care giver in union."

He understands prayer as, "listening to God and prayer is talking to God. It's a communication." He feels that you should " listen in the quiet of your heart. It doesn't necessarily mean that it needs to be a quiet place. There can be a hustle and bustle around you. If you can maintain a kind of silence within your heart, and be prepared to accept your heart to be opened to God, then God will speak to you, when you talk to God."

He considers doctors as "the hands of God and the science of God." They function "under the controlling hands and direct supervision of God and of the angels." He feels that since, as doctors, "we've been gifted to talk and to listen..., we've been gifted with the gift of prayer." Every doctor should thus be able to pray. He warns that the timing of prayer should be carefully considered. He is concerned about "the psychological effect,...to that particular patient ...simply because ....its a medical doctor you're seeing...".

He admits to having had difficulty with attending doctors of a different religion to himself. He felt that that difficulty was as a result of his "lack of understanding." He respects the right of all people to practise the religion of their choice. He acknowledges that other people's faith may be

just as strong. He feels that he has now "just grown in understanding" and although he would prefer to go to a Christian doctor, he wouldn't have a problem if the only doctor available, was not a Christian.

4.4.5 Feedback interview

We met for a feedback interview on 3 July 1997. The respondent had been transferred since our initial interview. We therefore met at his new residence. I explained that I had decided to include the interview in the study. Since I had previously informed him that the initial interview was a pilot I required his consent for including it in my research study. Consent was confirmed.

I showed him the venn diagram. He nodded in agreement. He felt that all the missions of the church were important. I had only inserted the evangelical mission in the venn diagram. I advised that I felt that the evangelical mission related more to the consultation. He said that he has realized the importance of the sacramental mission in serving others. Since we are created in God's image, we should indeed pay homage to one another. He believes, and he says that he preaches regularly, that we should pay more attention to the good in others. He says that we too regularly focus on the demons in others.

He appeared unhappy when I pointed at the warning against the inappropriate use of prayer in the consultation. He indicated that he had referred to the psychological effect on the patient not as a result of the doctor as a person but as a result of the consultation. He felt that the

image and understanding of the set-up of the the consultation may cause the patient to question the reason for prayer. He however felt that patience needs to be exercised in any relationship, even in pastoral counselling. The counsellor should not use prayer until the relationship has been cemented and the patient is ready and open to prayer. The building of "a trusting relationship" is absolutely essential. He validated and restated that there is no reason why a doctor should not pray during a consultation with a patient. Even if prayer is not used aloud in that consultation, the doctor could still say a silent prayer during or after the consultation. This concept has been added to the venn diagram in the form of a green arrow that by-passes the circle denoting the impediments to prayer.

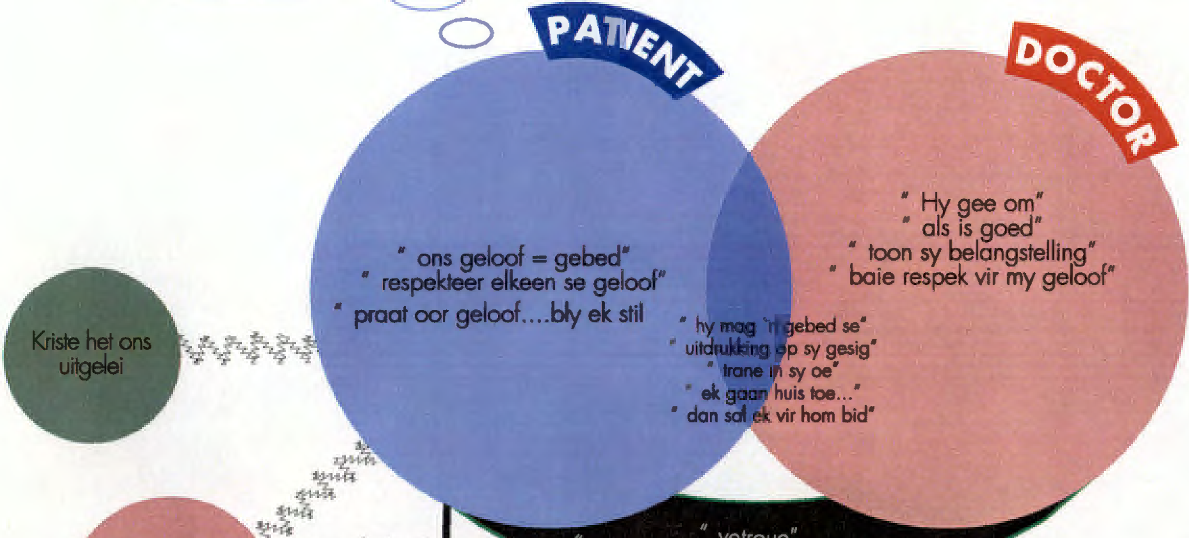
He felt that medicine should not work in isolation, nor should prayer be considered to totally substitute medicine.

VENN DIAGRAM

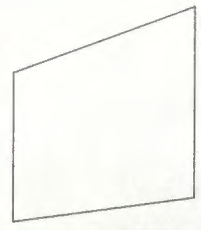
CFM

" ek sal....solank albei gelukkig is"

" niemand het 'n verskoning"



" Hoe meer gebed, hoe meer seeninge"



4.5 Interview CFM

4.5.1 Pre interview contact

This respondent is one of my patients. I had not seen her since I had diagnosed her current pregnancy. She was attending an Obstetrician for management of her confinement. I contacted her on 8 October, 1996. I explained my research proposal and requested to interview her. She was at first surprised at my request and also that I would be doing a "house visit" to conduct the interview. After I explained the reasons for asking her, she readily agreed. An appointment was set for 10 October, 1996.

4.5.2 Transcript and field notes

I arrived at CFM's home at 20h25. She apologised for the lack of furniture and offered the choice of sitting on her bed in the main bedroom or on the floor in the lounge. She said that she was quite comfortable and usually sat on the floor. Her husband was lying on the bed, watching television. I greeted her husband and also explained the nature of and reason for the interview.

We settled on pillows on the lounge floor. I again explained the process and assured her of confidentiality and anonymity. Consent was confirmed and the tape recorder started. She was very relaxed and spoke without any inhibitions. Her husband remained in the bedroom for the duration of my visit. Her son walked in and out and on an occasion attempted to conduct a conversation with me.

I felt rather guilty since she appeared to have a great need to talk and be heard. Although her consultations had always been longer than average, I felt that I had not given her sufficient opportunity to be heard in previous consultations. I was also concerned about the ethical problem that she had touched on. She had felt that she was being subjected to unnecessary pelvic examinations. I remained behind to discuss this. It appeared that the examinations were appropriate and I reassured her.

After the interview she again expressed her appreciation for being asked and said that she could have spoken much more. My bottom, at that time, was groaning. We, nevertheless, did speak for about another 40 minutes at the door.

Transcription was very difficult because of the poor quality of recording, the speed at which the respondent spoke and the language, interspersed with Islamic terms. After several attempts I gave up. I felt that I had learnt the lessons regarding recording equipment viz., to use good quality cassettes and to duplicate recording.

The quality of the responses, however, remained, hauntingly with me. I again attempted transcribing 4 months after the interview. I have noted the inaudible tracts in the transcript. The transcriptions and cassette are available for perusal.

I have compiled a glossary of Islamic terms. (APPENDIX III)

4.5.3 Themes

(i) Demographhics

(ii) *"ons geloof is gebed...in alles"*

{"our belief is prayer..in everything"}

(iii) Prayer is *"baie kort en kragtig"*

Prayer is {"very short and sweet."}

(iv) *"hoe meer gebed, hoe meer seeninge"*

{"more prayer, more blessings"}

(v) *"dan maak die geloof nie saak nie"*

{"then the belief doesn't matter"} in chosing your doctor.

(vi) *"ja, hy het al gevra"*

{"yes, he did ask already"} about my religion.

4.5.4 Venn diagram

The venn diagram indicates a Muslim respondent, who states that *" in ons geloof is gebed, is in alles wat ons doen. Jy moet bid, ten minste 5 maal 'n dag."* {"prayer in our faith, is in everything we do. You must pray at least 5 times daily."} Shortened prayers can be said at any time and removes any excuse for not praying. She believes in the power of prayer, *"dit is kort en kragtig"* {"it is short and powerful"}. She indeed does not hesitate to pray for anyone and *"sal saam met die dokter bid, whether dit nou in sy geloof is of in my geloof....., so lank ons albei gelukkig is."* {"will pray with the doctor, whether in his faith or in my faith.....,as long as we're both happy."} She admits to an inhibition to discuss religion with certain people since she remembers an experience

where her faith had been ridiculed. This experience strengthened her resolve to respect the religious beliefs of others.

She values the respect that her GP shows for her religion. She rejects any biomedical limitation to the consultation; *"soos ek na die dokter kom, ...ek voel baie, baie tye, ek wil nie net praat oor siekte met die dokter nie. Ek wil praat oor my probleem, huishoudelike probleme en so."* {"as I attend the doctor, I would not only want to talk about my illnesses. I want to talk about my domestic and other problems as well."} She is satisfied with her doctor's concern, interest and management. The confidentiality of the relationship facilitates free communication.

She is quite willing to pray with her GP. She admits that they have never prayed together but feels that the doctor's attitude and empathy indicated that *"kan jy sien die gebed le daar. Trane in sy oe ..., die gebed le daar"* {you can see the prayer is there. Tears in his eyes ..., the prayer is there"}. This appreciation of a shared unspoken prayer is shown in the intersection of the two circles on the venn diagram. She also thought that her doctor may very well have prayed for her after the consultation, as she would also pray for him.

She has no objection to attending a doctor of a different religion to hers. She feels that a Christian practitioner may experience difficulty with a Muslim prayer but she would respect the practitioner's belief and she would listen. Qualifications, attitudes and mutual respect are more important deciding factors in her choice of doctor. She feels happy attending her present practitioner since she receives good service and

treatment. She feels that if the doctor is trained and she finds what she wants then religion does not play a role.

4.5.5 Feedback interview

We met on 18 June, 1997. I showed her my understanding of the interview, using the venn diagram. She confirmed that my description and understanding was correct. She corrected my spelling of some Arabic terms.

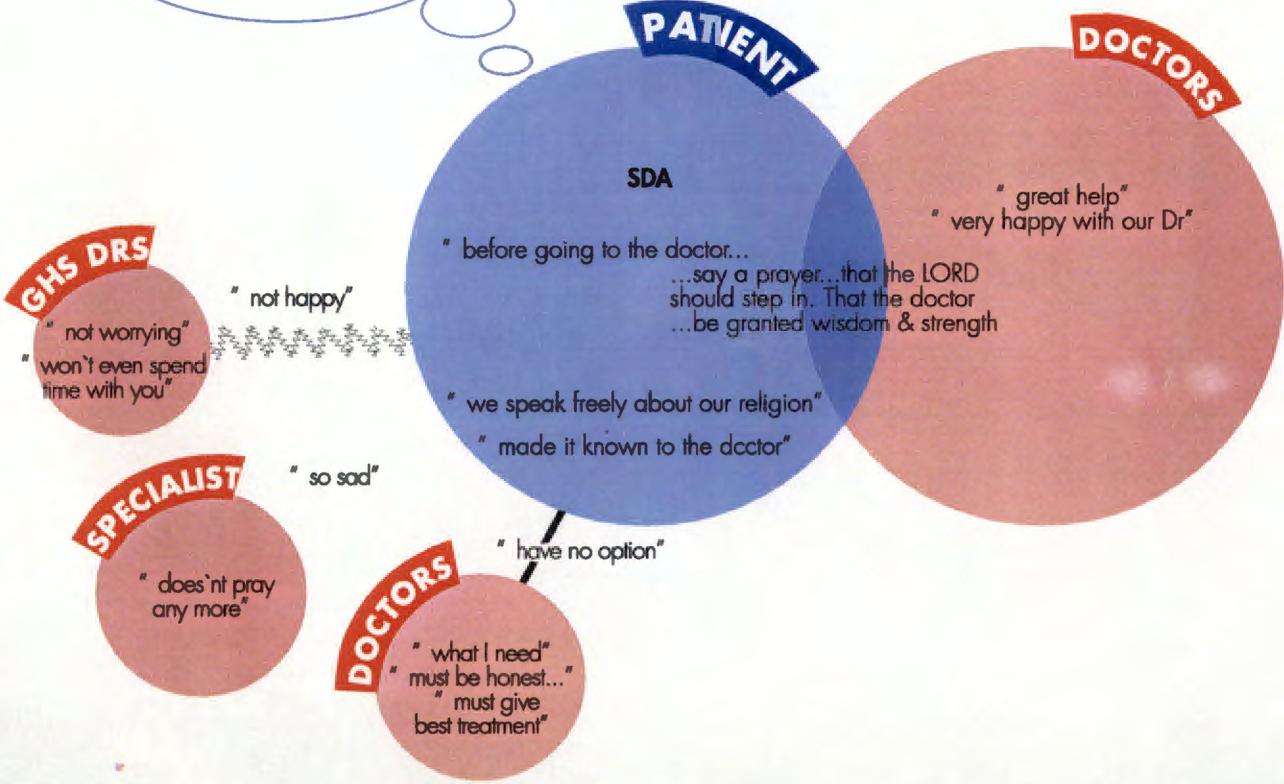
I specifically questioned her about my demonstration of the doctor's non-verbal expressions as a spiritual interaction. She agreed and said that she accepted the interaction as being prayerful. She arrived at this conclusion not only as a result of *"die lyding en saamvoel"* {"the suffering and empathy"}, but also since *"die hele atmosfeer, se dit is wel so."* {"the whole atmosphere was indicative."}

VENN DIAGRAM

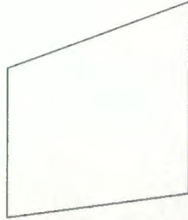
DMC

" they forget there is a LORD"

" quite comfortable"
" if Dr should ... pray...would love to see Drs do it more often"



" Prayer helps a lot"



4.6 Interview DMC

4.6.1. Pre-interview contact.

This respondent's name was given to me on 3 December, 1996. Despite all my good intentions, I only contacted him telephonically on 14 January, 1997. He recalled the request by his family doctor and was more than willing to assist in anything that involved further study. An appointment was set for Sunday, 19 January, 1997.

On arrival, I was welcomed into the lounge by the respondent. I again explained my research, demonstrated the dual recording equipment and assured him of confidentiality. Consent was confirmed and the tapes were started.

4.6.2 Transcript and field notes

The respondent appeared comfortable and relaxed throughout the interview. His wife joined us after we had started. He indicated that she could also reply. I did not respond and she did not participate. I was grateful for that, as it would have complicated the transcription.

After the interview, we informally discussed my research and other non related issues.

4.6.3 Themes

(i) Demographics
(ii) "I strongly believe.."
(iii) "Prayer helps a lot."
(iv) "This is your prayer"
(v) "You [doctors] love your jobs"
(vi) "I would love to see doctors" praying.
(vii) "we have no option" of choice of doctor.

4.6.4 Venn diagram

The venn diagram displays a Seventh-Day Adventist respondent, who believes that "prayer helps a lot". He however considers "sincerity and belief" to be major co-factors.

He indicates that they "made it [religious denomination] known" to their doctor. He does not mention any other episodes of spiritual or religious discussion with medical providers. He enjoys a good relationship with his GP and would usually before the consultation, "say a prayer ..., that the Lord should step in. That the doctor should be granted wisdom, strength and whatever the findings, we leave it in the Lord's hands." He says that he "would feel quite comfortable if the doctor should say, 'Let's sit down and pray.' He would love to see the doctors praying in the consulting rooms. He feels that "some people forget that there is a Lord." He refers to a relative who has emigrated after achieving a high academic status. He feels that it is "so sad, he does not even pray anymore".

He was unhappy with the provincial doctors who, he feels don't give the proper treatment and "the doctor won't even spend time with you". His medical benefit fund, in the choice of doctor, gives him "no option." They are given doctors to attend and most of them are of different religions. He does not have any difficulty attending doctors of different religious beliefs and remarks: "to be quite honest I have never attended a Seventh-Day Adventist doctor. If I get the proper service, the satisfaction that I got proper treatment. This is what I need from a doctor,....he must be honest with me and he must give me the best treatment."

4.6.5 Feedback interview

A follow up interview was arranged. The respondent sounded very pleased and readily agreed to the request for another interview.

The feedback interview was conducted at the same venue on 4 June, 1997. His wife was again present and this time participated in the discussion. The interview was not recorded but I jotted down some notes. I showed and explained the venn diagram to them. They agreed that it described what he had said. They then discussed the healing of a family member, resident in the USA, after he was diagnosed with a brain tumour.

I asked about his understanding of an action as being prayerful. He confirmed, his belief, that such action also occurs in the doctor patient interaction.

His wife assisted him in explaining how they had told the doctor what of their religion. She said that the doctor had commented on "her smart appearance", when they attended for a consultation on a Saturday. She had replied that they had come from church. They had then explained why they attended church on a Saturday.

The interview lasted 30 minutes and was written up on the same day.

VENN DIAGRAM

EMC

" very difficult question"
" prayer is involved in medicine"
" context of occasion"
" doctor not sure of himself"
" is he trying to impress"
" don't need this"

" GP's under so much
pressure"
" time"

" faith comes in"

" Maybe one day I'll get an answer"

PATIENT

ANGLICAN

" follow
parents"

" indoctrinated"

" tolerance in relationships"

" Godfearing ...not religious"

" tremendous faith"

" faith differences
not a bother"

" we talk not religion"
" comfortable"

DOCTOR

" superpower"
" compassionate"
" actually listens"
" good doctor"

" if it's going to happen
Dr will have to make
a concerted effort"

SUGGESTIONS

4.7 Interview EMC

4.7.1. Pre-interview contact.

This respondent's name was given to me on 3 December, 1996. Despite all my good intentions, I only contacted him telephonically on 14 January, 1997. He replied that he had waited for my call and had been prepared to do the interview during the school holidays. I apologised for the delay and explained that the interview should not last much more than an hour. The modus operandi, absolute confidentiality and anonymity was stressed. He agreed to avail himself for an interview on 23 January, 1997 at 20h00.

I was rather nervous and set off early, dressed rather formally. I was warmly welcomed by the respondent, dressed in shorts and a sweater. The mode of communication was easy and relaxed and I felt free to remove my jacket and tie.

The equipment was demonstrated, consent confirmed and the recording started.

4.7.2 Transcript and field notes

The interview took place in his lounge. His two toddler children were running in and out through the lounge to the open-plan kitchen. The respondent spoke freely. However, whenever we discussed prayer relating to health, he would stutter, pause or use repetitive "uh's".

After thanking him at the conclusion of the interview, he apologised for talking too much. I reassured him that that was exactly what I wanted. I expressed appreciation for his responses.

4.7.3 Themes

(i) Demographics
(ii) "A one way conversation"
(iii) Faith is "a problem in this day and age"
(iv) Patient will say, "...I don't need this"
(v) My doctor "actually listens to you"
(vi) Doctor's religion "doesn't play a role."

4.7.4 Venn diagram

The venn diagram displays an Anglican respondent, who feels that religion was forced upon him by his parents. He is ambivalent of the role of the church and admits that he "is a God-fearing man, but.. not a religious man".

He understands prayer as "a conversation, obviously one-way." He recognizes the difficulties to maintain faith in the face of modern day factors. He muses that, "maybe that is where faith comes in .. maybe one day I'll get an answer .... I've got faith that I am praying to a real person...". He believes that we should be tolerant of one another but experiences difficulty in being tolerant without being considered weak.

When asked about prayer in the consultation, he appeared very uncertain, as indicated by a lengthy pause. He answered that he has never even considered prayer in the consultation. He however believes that his GP has been granted "superpower" status by God. He consequently enjoys a good relationship not only because of the "tremendous faith" but also "...because of his compassionate nature. .... He takes his time and actually listens to you." He believes that "prayer is involved in medicine" but considers the "context of of of the the occasion, I would uh have uh uh I would have to...... What is the point of it uhmmmm. It is actually a very difficult question, ...To really take that idea uhhh into a consulting room". He does not "think it would bother" him but worries that the doctor "may tend to be not sure of himself...or is .. trying to impress". He thinks that "most people will say, 'No man, but I don't need this. I don't have time for this." The practice of prayer in the consultation is difficult since, "GP's are under so much pressure, long surgery hours and all of that *and*.. how many of them actually have the time... So ...if it's going to happen in that period, then that particular doctor will probably have to make a concerted effort to introduce that ".

Religion is not a consideration in the choice of doctor. "Tolerance", however, is more important. He refuses to judge anyone by "Whether he goes to church or to a mosque,... Because it is easy to be pious and .....and it doesn't mean anything really. So the fact that .. GP is not of the same faith or religion ..., it doesn't really bother .. at all."

4.7.5 Feedback interview

A follow up interview was arranged. The respondent, at first, did not appear too eager to be interviewed again.

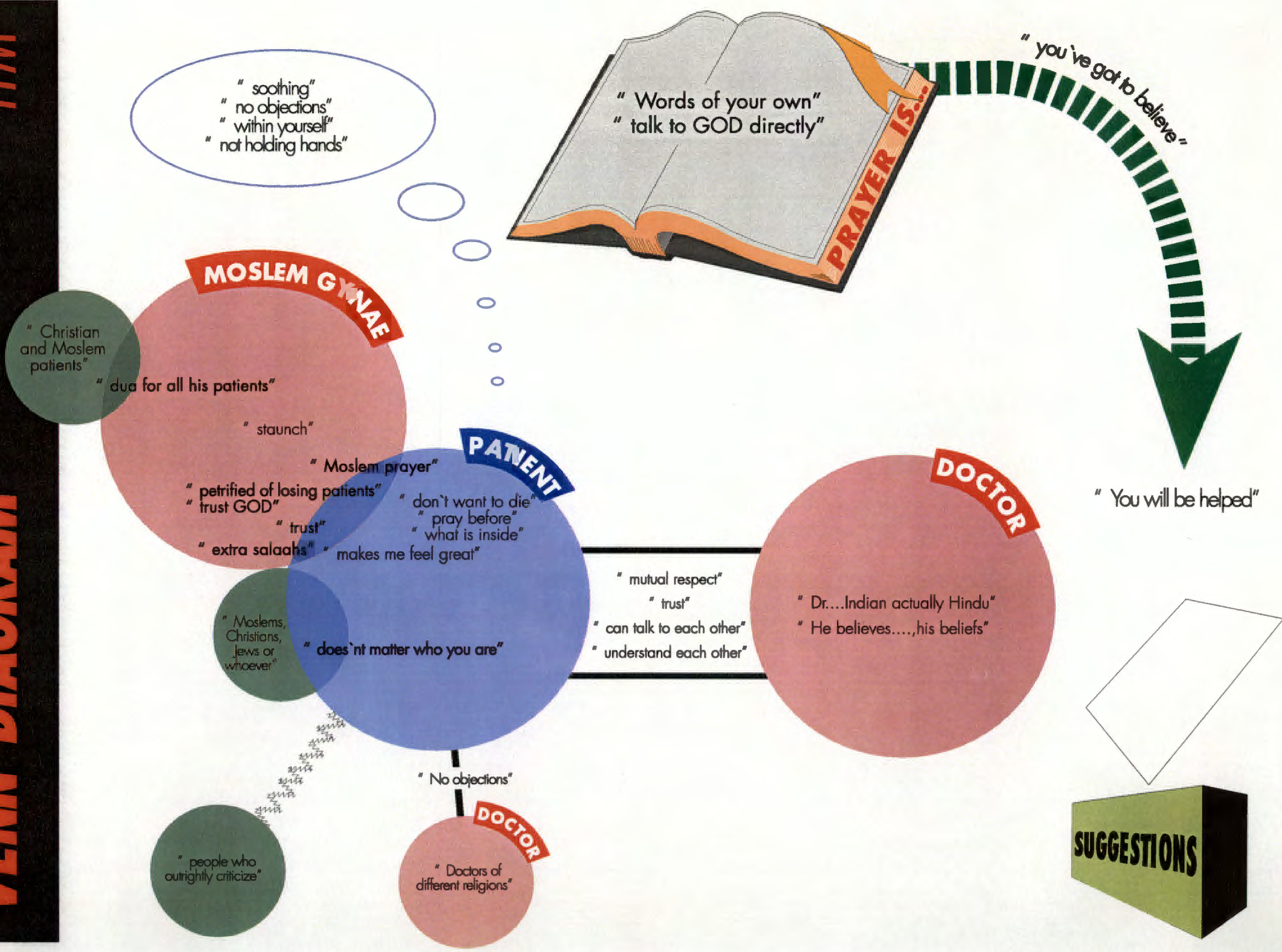
The feedback interview was conducted at the same venue on 4 June, 1997. I shared my understanding of what he had said by means of the venn diagram. He appeared baffled. I questioned him about this and he replied that he was trying to recall. He then denied any confusion and agreed that the diagram adequately summarized our first interview.

I asked him to elaborate on, what appeared to be "major" for him, viz, "tolerance". He then seemed to relax and discussed tolerance in general. I requested that he relate it to the doctor patient interaction. "Tolerance of the patient or tolerance of the doctor?", he asked. I allowed him freedom to discuss either.

A doctor should allow himself time and space not only to manage the physical ailments, but also to explore the emotional needs of the patient. He felt that a lack of tolerance could cause the real reason for the patient's attendance to be missed. A "period of reflection", would allow the doctor to be "guided by God". He said that he appreciated his doctor's management and availability. He repeated that his doctor had identified his work place as "his temple". He admitted to having felt a concern and surprise that he was unaware of his doctor's religion. He only became aware of this after the first interview. I was concerned that I had possibly crossed an ethical boundary. I probed this concern of his. He had felt that

others to whom he would recommend his doctor may find it, "strange that he did not know". "How would you handle that question?", I asked. "It doesn't affect our relationship at all. He is a good doctor.", he replied. We discussed his general practitioner's commitment to their relationship. He believed that his doctor's constant availability was a measure of his doctor's faith. He felt reassured that there was no need to know his doctor's religion.

I wrote up the feedback interview immediately afterward. I was embarrassed at one stage, during the feedback interview, when I could not immediately find a specific quotation in the transcript. The respondent was nevertheless pleased at the work involved in recording his words exactly and commented on the accuracy of the summary by means of the venn diagram. The interview was not recorded, but I made brief notes.



VENN DIAGRAM
FFM
" soothing"
" no objections"
" within yourself"
" not holding hands"
" Words of your own"
" talk to GOD directly"
PRAYER IS...
" you've got to believe"
" You will be helped"
MOSLEM GYNAE
" Christian and Moslem patients"
" dua for all his patients"
" staunch"
" Moslem prayer"
" petrified of losing patients"
" trust GOD"
" trust"
" extra salaahs"
PATIENT
" don't want to die"
" pray before"
" what is inside"
" makes me feel great"
" Moslems, Christians, Jews or whoever"
" does'nt matter who you are"
" mutual respect"
" trust"
" can talk to each other"
" understand each other"
DOCTOR
" Dr....Indian actually Hindu"
" He believes....,his beliefs"
" No objections"
DOCTOR
" Doctors of different religions"
" people who outrightly criticize"
SUGGESTIONS

4.8 Interview FFM

4.8.1. Pre-interview contact.

This respondent's name was given to me on 3 December, 1996. I only contacted her telephonically, a month later. Equipment failure forced me to delay the interview until after the month of Ramadaam.

The interview eventually took place on 23 February, 1997. She welcomed me into her lounge/ dining room. Her husband was busy outside, working on a car and her children were playing around the pool. They were within earshot but did not disturb us at all. I explained the research and recording equipment. I assured her of confidentiality and anonymity. She assisted in the setting up of the equipment.

4.8.2 Transcript and field notes

The respondent appeared very guarded at first. I explained my background, the reason for the research as well as the fact that the protocol had been approved by the ethical committee of UCT. She accepted my bona fides and reaffirmed her consent. She remained eager to discuss the specific questions that I would be covering. I advised that it would be better if we started recording and promised that if she was not satisfied, the recorded material could be destroyed.

As the interview progressed, she spoke with greater freedom. I thanked her at the conclusion of the interview. Her comment, "That's it?", showed

a measure of surprised relief. She then spontaneously shared more of her beliefs and religious practices. She readily agreed to my switching on the recording equipment again.

4.8.3 Themes

(i) Demographics
(ii) Your religion " what's inside of you"
(iii) "Pray all the time"
(iv) Prayer is "Talking to God"
(v) "I trust him [GP]"
(vi) "It doesn't matter what religion you are"
(vii) Prayer by the doctor "Makes me feel great"

4.8.4 Venn Diagram

The venn diagram indicates that the respondent enjoys a very good relationship with her family practitioner. This relationship is characterized by "trust", respect and mutual understanding.

She has "no objections" to attending doctors of different religions and points out that her own GP is "actually Hindu. I have no objections. Because if he believes and what he does, *is* his beliefs." Although she has also attended doctors of other religious orientation, she specifically requested referral to a "Moslem gynae". She trusts him implicitly because he is "staunch", and "he has put his trust into God". The specialist had

admitted to her that "he was at the beginning very petrified" that a patient may die. He therefore, regularly before surgery, says extra prayers for all his patients. This causes her to "feel great because I know that he is getting extra strength."

Prayer is "talking to God directly" and "using your own words". She feels that faith is the catalyst that would ensure a response. She feels that prayer can be shared among all people irrespective of their religion. She would share prayers with any doctor who asks but "wouldn't say a prayer, like you sit there and I sit here and we keep hands and we pray, not that kind. Within yourself, you can sit and do it..... You don't have to like broadcast it ......because all people don't take it the same way. It must be silent, within yourself."

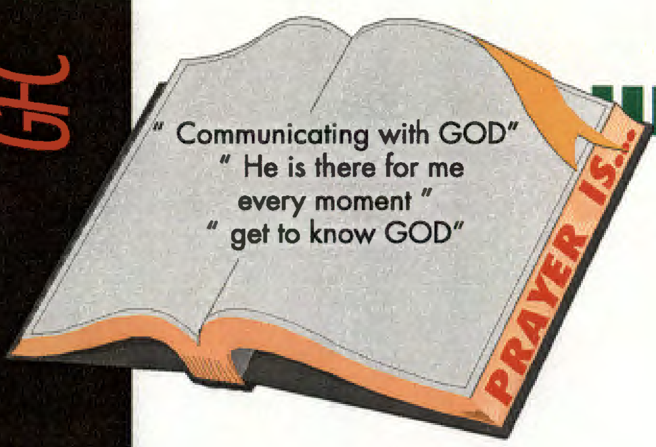
4.8.5 Feedback interview

We met on 22 June, 1997. I showed and explained the venn diagram to her. She felt that I had understood her correctly.

I asked about the similarity in her fear of operations and her gynaecologist's fear of losing patients. She replied that any similarity was entirely coincidental.

VENN DIAGRAM

GFC

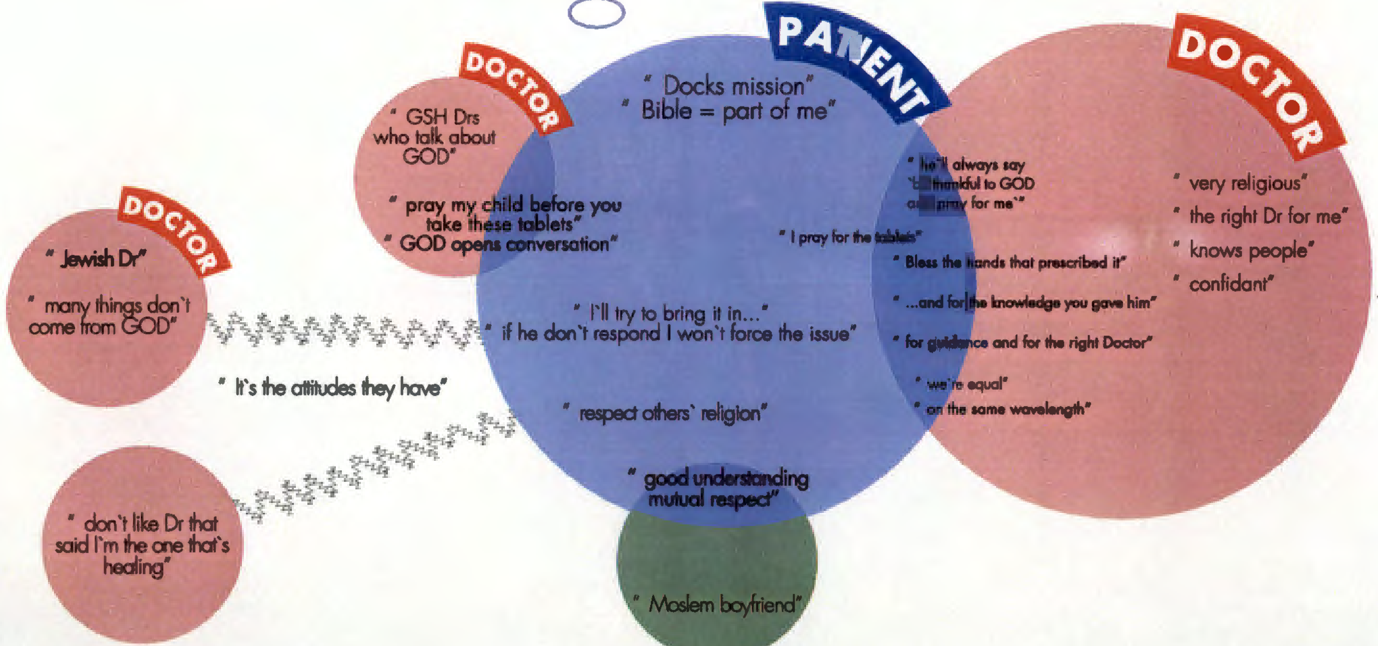


" the plain us, " " not out of duty"

" we`re equal, understand each other & can communicate the minute they mention GOD"
" would be nice if Dr must ask me"

" some Drs"
" think...I don`t know I can speak to you"

" a lot I get out of my prayers"



" any Dr who truly believes must share his beliefs with others"

4.9 Interview GFC

4.9.1. Pre-interview contact.

This respondent's name was given to me on 26 January, 1997. I contacted her telephonically a week later. I explained the study and requested permission to interview her. She agreed and an appointment was set for 8 February, 1997.

I arrived, slightly early since I was afraid that I would get lost. The agreed venue was her third floor flat. It appeared that my arrival had been well advertised among the neighbours. My fears of losing my way was thus unfounded since I was jovially directed directly to her house. I was introduced to her flatmates and shown into her bedroom. The recording equipment was demonstrated and consent confirmed.

4.9.2. Transcript and field notes

The respondent was casually dressed and entirely relaxed. She was lounging on her double bed. I indicated that I would rather sit on the bedroom stool and place the recording equipment on the bed. This also facilitated explanation of the use and need for the recording equipment.

She did admit that she had been rather excited at the prospect of being interviewed. As a result she had only gone to bed at 05h00 that morning. She apologised for using the bedroom but informed me that it was the only room she was renting and thus the most private place.

4.9.3 Themes

(i) Demographics
(ii) "Respect other people's religion"
(iii) Believe "there is a God"
(iv) Prayer is "communicating with God"
(v) Prayer gives "my strength"
(vi) "the right doctor for me."
(vii) "we're equal" in the doctor-patient relationship
(viii) "Some doctors, it's the attitudes they have."
(ix) Asking the doctor.

4.9.4 Venn diagram

The venn diagram displays a Christian respondent, who believes that the "Bible is fascinating." She has a boyfriend of a different religion. Their relationship is characterized by a "good understanding" and mutual respect for one another's beliefs. This has led her to have "respect for anybody's religion." She consequently, has no difficulty in consulting a doctor of a different religious background. She however would avoid some doctors because of the "attitudes they have." These attitudes specifically relates, not to their lack of faith, but to their assumption of their own greater than divine power. She mentions, on the other hand, that if "God comes into the conversation, then I'm open."

Prayer, for her, is "communicating with God." She finds that prayer, "strengthens" her and allows her to "get to know God." Prayer also fulfils a therapeutic role in helping, "when I'm depressed."

She describes her family practitioner, as "a very religious man" who "knows people." She prays for her doctor, "for guidance, for God to keep him." She also regularly says a prayer of "thanks for the right doctor." Her doctor frequently mentions prayer to her. The circles intersect to indicate their spiritual sharing. She, similarly at Groote Schuur Hospital, "met some doctors there who talked about God, 'pray my child before you take these tablets" These discussions and prayers makes her feel, "we're equal, we understand each other and that way I can sort of communicate".

She considers that faith in God is very important during medical consultations. She thinks it would be nice, if a doctor were to ask, "Will you pray for me or can I pray with you?" She feels that, "some doctors just think, 'Oh no, you're a Christian and I dunno if I can speak to you". Her own GP "knows people and he sort of will say, 'Thank you, Allah.' ...in Arabic." This encourages her to discuss even personal problems since she feels that they are "on the same wavelength." When she consults another doctor and she doesn't know his religion, she says, "I will try and bring it in. If he don't respond, I won't force the issue".

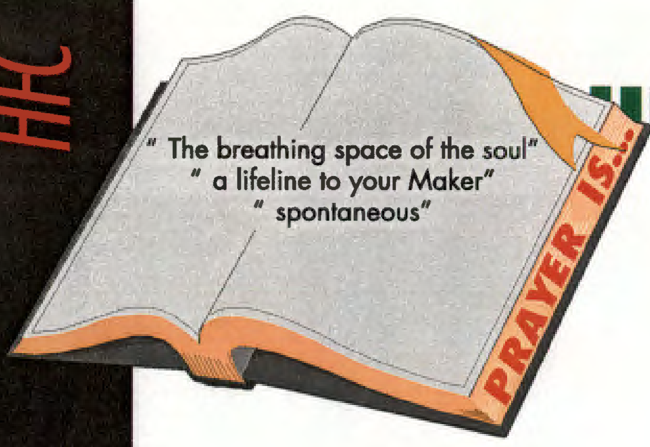
4.9.5 Feedback interview

At the feedback interview I explained my understanding of what she had said, by means of the venn diagram. She felt that the diagram adequately outlined the interview. She commented on her employers continual antagonistic disagreements regarding her beliefs. She admitted to feeling, "very guilty", since she considers this to be "unchristian". I showed her a scrap copy of the venn diagram. I explained that I had elected not to include her references to her employers, since it did not impact on the doctor patient relations. I asked whether she considered the "evangelization" a duty of the doctor as well. She replied, that it is, "but only, if they really believe." She added that it was incumbent on "any doctor who truly believes", to share such belief with others. She added that this would apply irrespective of the doctor's religion. She felt that such sharing would relax the patient and allow freer communication. She was convinced that any subsequent therapy would be "more effective." She compared this with her own feelings when doctors that she consulted discussed religion with her.

I asked whether the intersection of the two circles correctly reflected the spiritual interaction between herself and her doctor. She replied that although they had never shared prayer, she felt that the "action was prayerful". Her doctor also regularly adds to his good bye, "I'll pray for you."

VENN DIAGRAM

HFC

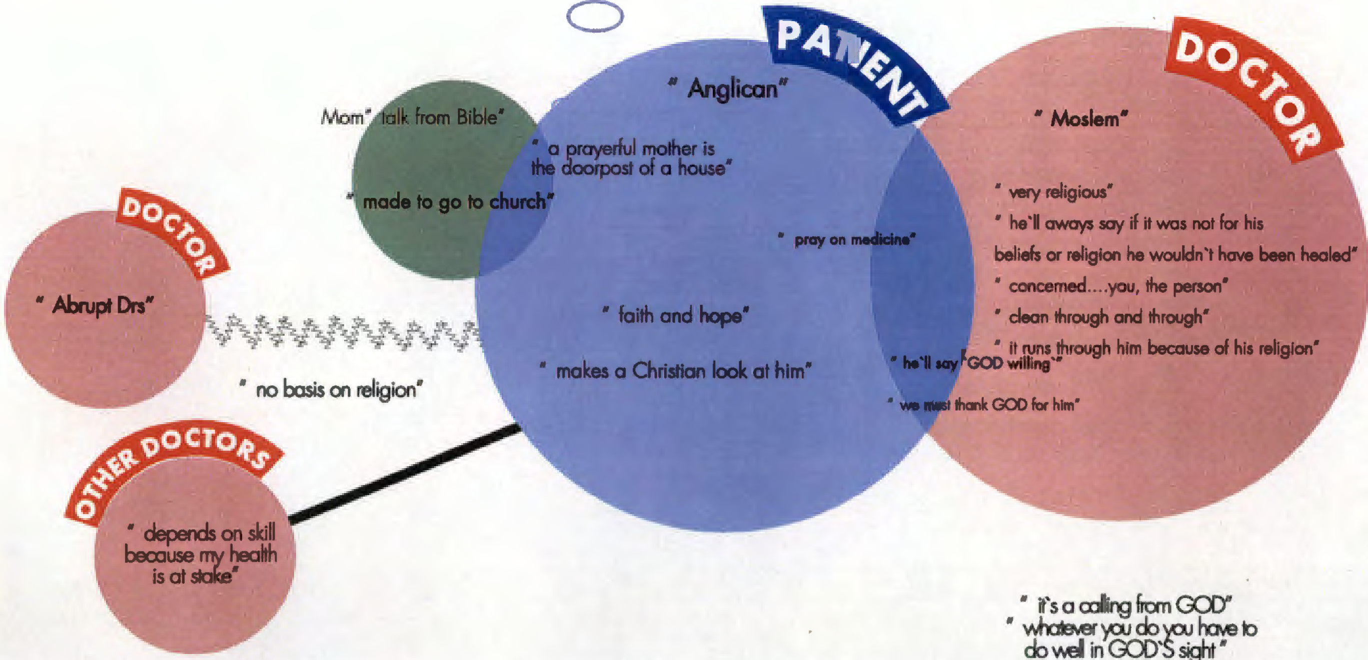


" A thousand years is a wink in GOD'S eyesight"

" He`ll answer"

" empty words"
" window dressing"

" do believe in prayer...in consultation... if Dr is religiously inclined"
" if patient says...,`let's pray` ...then why not"
" even if Dr ask ...I'll not have any objection"



SUGGESTIONS

" it's a calling from GOD"
" whatever you do you have to do well in GOD'S sight"

4.10 Interview HFC

4.10.1 Pre interview contact

This respondent's name was given to me on 26 January, 1997. I contacted her telephonically, a week later. I explained the study and requested permission to, interview her. She agreed and an appointment was set for 16 February, 1997.

I arrived at the arranged time. The respondent said that she understood the nature of the research and was entirely agreeable to participate. I nevertheless, repeated the explanation and stressed the elements of confidentiality and anonymity. The re-explanation was also for her husband's benefit. I demonstrated the recording equipment and requested permission to initiate recording.

4.10.2 Transcript and field notes

The interview occurred in their dining room with both the respondent and her spouse present. She communicated easily, occasionally looking at her husband for confirmation. After I thanked her, she apologised for being such "a chatterbox". I reassured her that, that was exactly what was required for this type of research.

The spouse was as silent as a mouse for the duration of the interview. Only after the conclusion of the interview did he speak. He discussed his work as a traffic officer and the emotional trauma associated with motor

accidents. He shared episodes of roadside prayer that resulted in miraculous recoveries. He also confirmed much of his wife's responses specifically regarding their children and the excellent relationship they shared with their family doctor. I requested permission to report on what we had shared. He confirmed permission.

4.10.3 Themes

(i) Demographics
(ii) "great belief in prayer"
(iii) "pray on medicine"
(iv) "help" from prayer
(v) Prayer is "A life-line to my Maker"
(vi) "A calling from God"
(vii) "Not because of his religion..(or) his race"

4.10.4 Venn diagram

The venn diagram displays an Anglican respondent, who believes that " a prayerful mother...is the door-post of a house, ...and ..feel that if you are prayerful, things should go right in your heart." Her belief has been instilled by her mother who forced them to attend church.

Her Muslim GP is "a very religious man". She feels that "because he is a religious person, he carries him over the way he does. It runs through him because of his religion.....That is why, he is the person he is." His manner is "clean, in personality, in person, clean through and through". His post consultation greeting, "God willing.", causes her as a Christian to admire

him. She attends him because he is a very good doctor and "thank God for him". She "believes in ...prayer... because you can get ill and if you don't pray on that medicine that the doctor is given to you, what's the use that he is giving it to you."

She believes that our profession is "a calling from God...., whatever you have to do, you have to do well in God's sight.". She does not base her choice of any doctor, on religion. "Abrupt" attitudes drive her away. The doctor's skill and care are factors that determines her selection.

She views prayer as "a life-line to your Maker". She believes in the power of prayer and that "He'll answer it". She advocates patience since "a thousand years, is a wink in God's eyesight". She will accept a doctor's request to pray during the consultation, since as she says, "I do believe in prayer, ... if the doctor is religiously inclined and if he feels lets pray about the matter, why not. If the patient feels and say to the doctor, 'Let's pray about the matter.', then why not. ..., you get strength from it, guidance from it and ...without God's help, is, will the doctor be able to, you know what I mean, be able to diagnose, be able to, how can I say, be the person he is."

4.10.5 Feedback interview

The feedback interview was conducted on 22 June, 1997. Both the respondent and her spouse were present. They both accepted the venn diagram as a true description of what we had discussed.

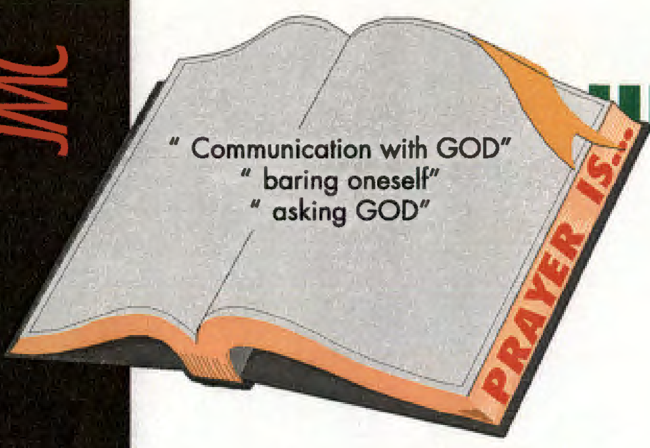
I asked the respondent about the proviso that the doctor should be "religiously inclined" prior to the conduct of prayer in the consultation. She confirmed my understanding by criticizing the "window dressing" of certain people. She feels that the insincerity of "empty words" would detract from prayer in the consultation.

She also confirmed that religion does not factor in her choices of doctor since "we're all from the same thread" in that we all originate from one creation.

I asked her spouse to elaborate on his definition of prayer. He explained that he considered "the soul as the medium of contact" with God. Prayer is thus that free communication that occurs in "the breathing space of the soul".

VENN DIAGRAM

JMC



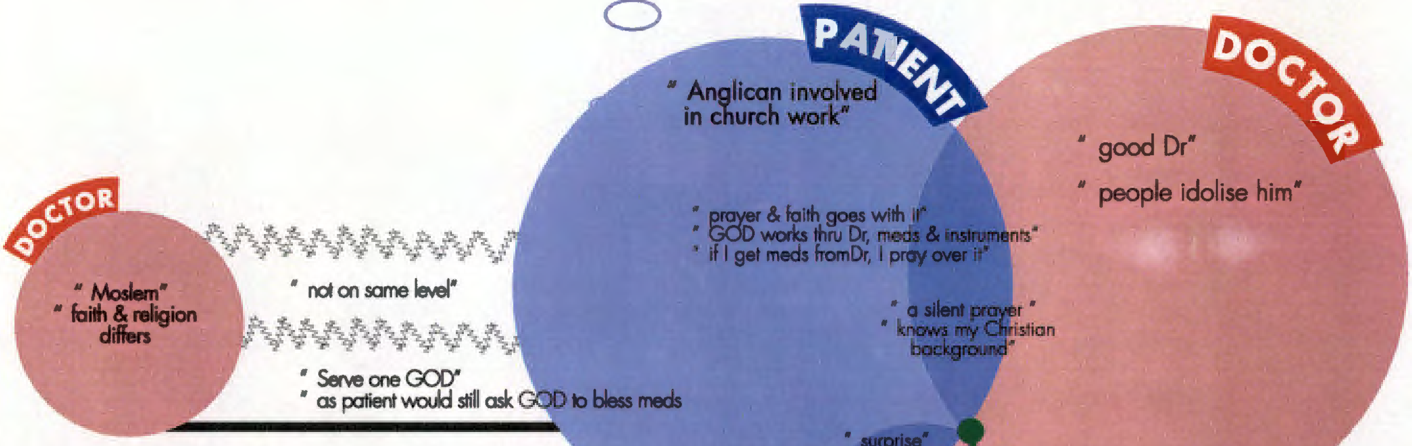
" faith"
" scripture"
" humble"

" religion"
" big headed"
" GOD outside"
" time"

" His time, His way"

" Power and Grace"
" Blessings"

" very important"
" prayer should be related to medical because it "
helps"
" what a joy won't it be"



SUGGESTIONS

" seminars"
" Dr patient way"
"Spiritual inquiry
ask GOD""

4.11 Interview JMC

4.11.1. Pre-interview contact.

This respondent's name was given to me on 3 December, 1996, by the doctor's receptionist. She informed me that she is married to the respondent and that he was actually looking forward to the interview. This facilitated introductions. I telephoned him on 14 January, 1997. He was quite prepared to cancel other appointments to accommodate me. I resisted that and we agreed to meet on 2 February, 1997.

He was waiting outside for me at the appointed time. He welcomed me into the lounge. After I had summarized my research, explained the recording equipment and confirmed consent, he assisted in setting up the equipment.

4.11.2 Transcript and field notes

His daughter and grandchild were at home. His wife was busy working and only arrived while the interview was taking place. The respondent indicated that we were busy recording. His wife joined us for the informal post interview chat.

4.11.3 Themes

(i) Demographics
(ii) "very much involved with church work"
(iii) "My understanding of prayer"
(iv) "This is our faith"
(v) In prayer "Be humble, be ourselves."
(vi) "What a joy won't it be!"
(vii) "Doctors are there for help."
(viii) "a prayer together" with a doctor.
(ix) The choice of GP "depends on the religion."
(x) Difficulties to pray in the consultation "we can so easily leave God outside."
(xi) Incorporation of prayer in the consultation "The doctor patient way."

4.11.4 Venn diagram

The venn diagram displays the respondent as an "Anglican layminister" who is very active in the church. "Prayer is basically communication between yourself and God". He considers humility, faith and scripture, as essential catalysts to effective prayer. The converse serves as impediments to the practice of and response to prayer. He believes that "God answer.. in His time and His way." However, "sometimes a miracle happens" when the response occurs immediately or without satisfying the above criteria.

"Prayer goes hand in hand with medical.......because I ....don't think there is anything that, that he or she [the doctor] can do uhmm without prayer..." He therefore regularly says, "a silent prayer,.......Even just before ... medicine and tablets ... even if you pray silent, He knows every word that you say. He knows it. Because He knows our inner most secrets, He knows our minds, He knows the very next word that we are going to say. So, it's only for us then to available ourselves to Him, and allow Himself to direct and rule our hearts and minds, in the way that He wants it to be. You know that God will, surely, He will bless us in that way."

He believes that prayer during the consultation is "very important". This prayer by or for the doctor harnesses the power, so that "God works through the instruments, through the tablets, through medicine, *and* through the doctor." He is concerned that patients idolize their doctors. He is however convinced that "if patients would idolise you, in that sense, uhmm how great won't it be if you would tell your patients uhmm, 'Come let's have a prayer together. Before I do the necessary thing.' And, and and, and we, will find sometimes how God responds". He experienced "quite a surprise" when a doctor that he attended asked to pray with him. This shared prayer with the Christian doctor he had attended, made him feel that they were "talking ... the same language ... being on the same level". He would, however, experience "a clash" in spiritual sharing with a doctor of a different religion. He admits that it "actually shouldn't be,......because scripture says there is just one God." He would not have any difficulty consulting the doctor professionally because he "would still ask God to to have a blessing over the the

medicine that I got, and so that it can work, it can, it can form its duty and heal."

He gives ideas on how the doctors might learn to conduct prayers in the consultation and to help doctors to combine "prayer with medicine". It is easy, he says, just to "ask the patient ....their faith...or the religion ...and what a joy won't it be? I mean if, if a doctor should ask a patient, don't you think we should pray together, and ask, 'God to help, ask God to come in."

4.11.5 Feedback interview

We met on 22 June, 1997 for the feedback interview. I explained the venn diagram to the respondent. He confirmed the accuracy of the summary and was extremely impressed with the diagram.

I asked how his GP had acquired the knowledge of his "background in Christian life." He explained that this usually occurred through informal discussion when he would collect his wife at work and not during the consultation.

He reaffirmed his suggestion that we, as doctors should "become, be little before God. Humble ourselves as the little child and then He..will heal". He added that we should also remember, to thank Him and give "all glory and honour to God" for whatever we achieve.

KMC

" nederige"
" openlikheid"
" behoefte & nood"

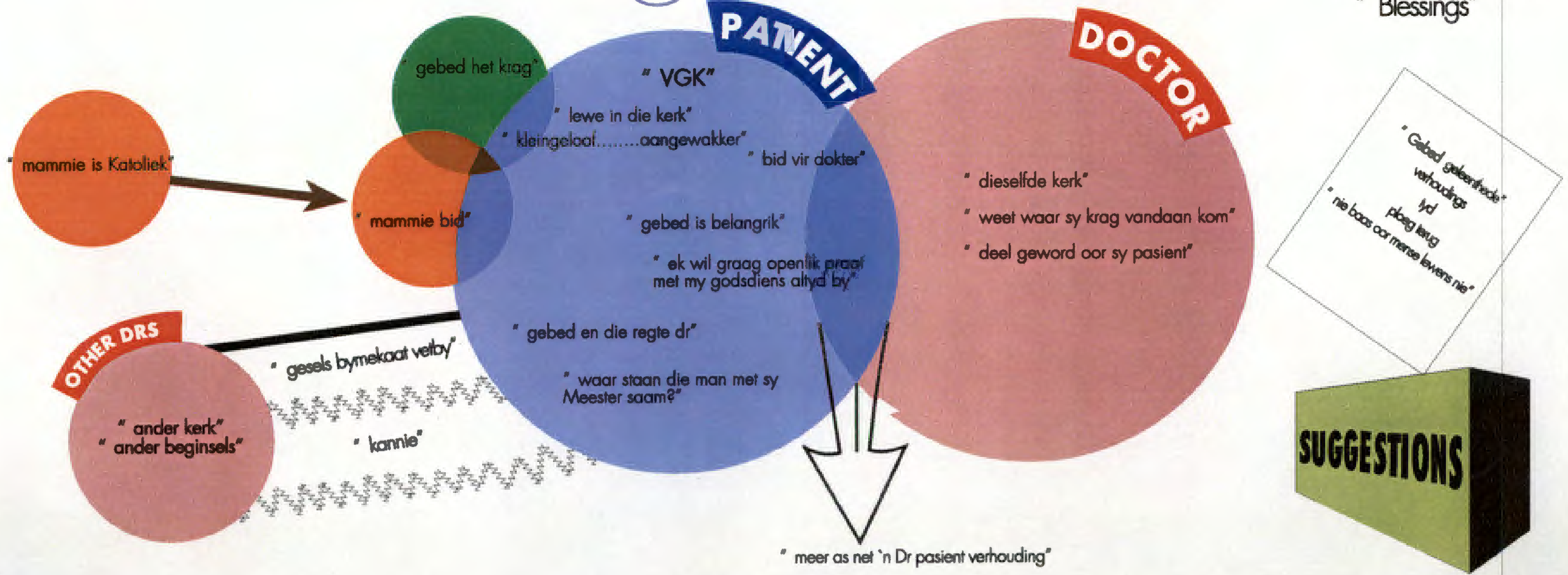
" werklikheid"
" groot hou"
" groot worde"
" kleingeloof"
" verskillende kerke"
" te besig"

" Hy dra nie n horlosie"

" Power and Grace"
" Blessings"

" moeilike vraag"
" Dr is ook maar mense"
" sal dit waardeer"
" moet pasiente ken"
" die Dr se gebed dra net so baie krag"
" as Dr bid... sal dit fantasties wees"

VENN DIAGRAM



" meer as net 'n Dr pasient verhouding"

4.12 Interview KMC

4.12.1 Pre interview contact

I telephoned the respondent on 25 February, 1997, the day after I had received his name from his doctor. We discussed the nature of the study. The respondent raised numerous questions regarding my course of study, the reasons for the research and the exact modus operandi. I answered all his questions and assured him of total confidentiality and anonymity. He expressed eagerness to participate and we arranged an appointment for 8 March, 1997.

4.12.2 Transcript and field notes

Unfortunately, I lost my way and arrived 15 minutes late. On my arrival, the respondent was waiting for me at his gate. He welcomed me and introduced me to his wife and son. We were then left alone to continue with the interview. The respondent had been under the impression that I was a minister of religion, with a doctorate in Theology. He could not quite believe that a doctor of medicine was doing research that involved religion. We again discussed my research proposal and my studies. He said that he was very interested and had in fact taken time off from the building operations that they were conducting at the church.

We were at a real risk of conducting part of the interview without recording, so I explained the instruments to the respondent and requested permission to start recording.

4.12.3 Themes

(i) Demographics

(ii) Religious roles *"Taak wat Here op jou voorle"* {"Task appointed for you by the Lord"}

(iii) Beliefs *"daar is 'n Hoer Gesag"* {"there is a higher authority"}

(iv) Facilitating prayer *"Jy word weer bemoedig"* {"You are encouraged again"}

(v) *"kannie werklikheid weg redeneer nie"* {"You cannot reason against reality"}

(vi) *"daai intieme verhouding met jou Meester"*

Prayer is {"that intimate relationship with your Master"}

(vii) *"Fantasties ..as dokter bid"* {"Fantastic... if doctor prays"}

(viii) Timing of prayer *"Here dra nie 'n horlosie nie"* {"The Lord doesn't wear a watch"}

(ix) *"Waar staan die man [dr] met sy Meester?"*

{"What is this man's [dr's] relationship with his Master?"}

(x) Doctor-patient religious differences. *"Verskil hemelsbreed"* {"World of difference"}

(xi) Suggestions for implementation.

(xii) *"Meer as net 'n dokter pasient verhouding"*

{"More than just a doctor-patient relationship"}

4.12.4 Venn diagram

The venn diagram displays a respondent who spends a lot of time, being involved in and doing church work. He has, despite his big role in the church, often accepted the pessimistic prognoses of doctors. He berates himself and says, *"die klein geloof was weer deur my seun aangewakker. Ons moet telkemaal, ongeag van die probleem, na die Meester toe gaan en daar kon ons weer bid."* {"this small faith was reawakened by my son. We should always, irrespective of the problem, go to the Master where we could pray again."}

He describes the advantages of having a doctor of the same denomination as himself. He says, *"wanneer ek met hom [dokter] openlik praat, dan kom my godsdiens altyd by. .... En daarom het ek geweldige respek en agting vir my huidige huisdokter, omdat hy ook uit dieselfde kerk denominasie kom. ....wanneer ek en hy dan gesels oor kerkelike en godsdienstige sake, dan weet ons waarvan ons praat."* {"when I speak frankly to him [doctor], my religion always comes in ... And that is why I have a tremendous respect and regard for my present GP since he comes out of the same church denomination. ....we thus know what we're talking about when we talk about the church and religious issues."} The frank communication, further encouraged by his GP's empathy results in their relationship being *"nie net 'n dokter pasiente verhouding nie, dit is 'n bietjie meer as dit."* {"not only a doctor-patient relationship, it is a bit more than that."}

He feels that doctors are dependant on, and are appointed by God. He would, on consulting a doctor, probe to discover, *"Waar staan hierdie man met sy Meester saam?"* {""What is this man's position with his Master""}

He respects the beliefs of others, and does attend doctors of different religions. He experiences difficulty to communicate or to cooperate with a doctor that belongs to a different church or that does not share his *"godsdiens beginsels."* {"religious principles."} He has *"meer vertroue in 'n Christelike of 'n Godsdienstige of 'n Christen dokter, wat jy weet, wat ook maar weet, waar sy krag vandaan kom".* {"more trust in a Christianly or a religious or a Christian doctor, that you know, knows the origin of his power"}. The effect of religious differences, is highlighted by the initial reluctance of his wife, who had previously celebrated as Catholic, to join in family prayer.

He thinks that prayer in the consultation would be inhibited by; verbosity aimed at impressing, pride, differences of religious denominations, patients who consider the problem too small and who are in a hurry and the doctors being too busy. *"Maar daar is ook die werklikheid wat jy nie kon weg redeneer nie."* {"Then you are also faced with the reality that you cannot argue against."}

He considers the question of prayer in the consultation as a *"Moeilike vraag weereens. Omdat 'n mens lewe in hierdie, hierdie moderne wereld waar als wetenskaplik reggestel kan word."* {"Difficult question. Since we live in this modern world where everything can be corrected

scientifically."} He however accepts that *"dokters is maar ook net mense en hulle kan net doen, dit wat deur die Here aan hulle verleen word; daai kennis, daai insig en daai wysheid, en daai manier om met mense te werk."* {"doctors are only human and can only deliver what God has bestowed upon them; the knowledge, the insight and the wisdom and the manner of working with people."} He is convinced that *"geen dokter kan iemand gesond maak, simpel ou siekte, verkoue, ...nie deur net die simptome te dokter."* {"no doctor can heal anyone, even a simple cold,... through doctoring the symptoms only."} He feels that the occasion for prayer would best be identified by the doctor, who knows his patients. Patients would appreciate *" 'n dokter ...wat regtig belangstel in jou, dat daai dokter vir jou kan se, 'My suster, my broer, kom ons bid vir 'n oomblikkie terwyl ons bymekaar in die spreekamer sit met daai siek probleem', en dan kom jy...met die wete dat dit is nie net die dokter se medisyne nie maar die dokter se gebed, dra net so baie krag."* {"a doctor...that is really so interested in you, that the doctor can tell you, 'My sister, my brother, let us pray for a moment while we are sitting together in the surgery with that illness problem', and then.... you would know that it is not only the medicine, but also the doctor's prayer, that delivers the power."} He concludes that it would be fantastic if a doctor prays with him and *"wanneer jy dan 'n dokter het wat bemoeienis maak en omgee vir jou ..., dan waardeer jy hom sowaar en jy dra hom altyd na die Here op."* {"when you then have an empathetic doctor who cares about you... , then you really appreciate him and always pray for him."}

He suggested that prayer rooms would be useful at consulting rooms. He is convinced that this would result in *"oorstroming van sulke plekke deur*

mense wat graag daarso sal wil bid. Want ...dit is juis daar waar jy nader aan die Here leef, met jou nood kom jy na iemand toe." {'overflowing of such places...because that is exactly where you live closer to the Lord, when you, in times of need, or prayer go to someone."} He feels strongly that the mutual relationships between doctor and clergy and the doctor and patient, *"moet weer opgetel word."* {"must be reestablished"}.

He earnestly requested that the results of my and similar research *"sal teruggeploeg word in die gemeente en in die gemeenskap. Sodat ons kan besef en die dokters kan besef, dat ons tog iemand het wat meer mag het as ons. Dat die dokters ook sal besef, 'Ek is nie baas oor mense se lewens nie."* {"be ploughed back into the congregation and the community. So that we can realize and doctors can realize that we do have someone with greater authority than ourselves. That doctors can realize, "I am no master over human lives."}

4.12.5 Feedback interview

We met for a follow up on 24 June, 1997. I showed and explained the venn diagram to the respondent. He was impressed by the style and appropriate summary of the lengthy interview.
I asked that he elaborate on his statement;

KMC653	*"..., wanneer ek nou 'n klein dingetjie het, of 'n klein*
KMC654	*sieketjie en ek moet gou 'n dokter daarvoor sien, dan gaan ek*
KMC655	*na my Muslim dokter toe,......*

KMC653	..., when I now have a small issue, or a minor
KMC654	illness and I have to see a doctor quickly for it, then
KMC655	go to my Muslim doctor..."

He explained that he had met that doctor when she was an assistant to his present GP. He felt comfortable to attend her when his GP was unavailable. He confirmed the difficulty of open communication with doctors of different religions.

He also explained the combination of *"gebed en ook die regte dokter"*, {"prayer and also the right doctor"} by showing that prayer does not function in a vacuum. He said that prayer does not mean that you should forego *"intelektualiteit"* {"intelectuality"}. He felt that the person who prays and then attend " 'n doekom" is negating the prayer.

We spent time discussing other issues. I accepted the respondent's request to say a prayer. We concluded with a prayer of thanks, and for strength, safety and guidance.

5. DISCUSSION

5.1 Qualitative method

The practice of religion is characterized by a wide diversity. This is not only increased by our multicultural society and the many different religions, but also by the numerous different denominations and a diversity among congregants of a specific denomination. My study, despite the small sample, has demonstrated some of these differences and touch upon some of the effects that relate specifically to doctor-patient religious differences.

I found the qualitative in-depth, semi-structured interviews to be an appropriate method. The feedback interviews also served the very necessary opportunity of not only allowing respondents to "approve" the results, but also to be affirmed of the value of their contribution.

5.2 Validity and reliability

Reliability calculations, according to his formula, fitted the expectations suggested by Huberman.[74] The reliability of the analysis is also ensured by keeping records of the interviews and by documenting the process of analysis.[27]

Walker demonstrated that validity in qualitative research is progressively accomplished throughout the research process.[82] I also increased validity by;

allowing the respondent, uninterrupted responses,[83]

doing feedback interviews,[27,74].

allowing spouse participation in three interviews, and

through comparison of my findings with other quantitative studies.[6,30,35].

5.3 Limitations of the study

The sample is small, even considering that it is 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. The study may have been enriched by adopting "extreme case"[14] sampling. All respondents in this study do pray. The views of atheists or people who do not pray, may differ.

As mentioned in the methodology, I have had no prior experience of qualitative research. I regret that I did not record more meticulous and descriptive field notes as described by Patton.[72] I also, only recorded additional notes and feelings after transcription and initial analysis. The context of the interviews, specifically relating to issues of gender and respondent expectations and view of the interviewer, is thus not adequately addressed. My own bias was also not measured.

Any advantage of increased validity of the interviews by a single interviewer is overshadowed by all the potential advantages of a team of researchers. Qualitative research is facilitated by a research team. The work load is reduced and validity of the process and analysis can be improved.

5.4 My feelings and experiences

Transcription proved to be even more tedious and much more time consuming than other researchers and the literature had warned.

My illegible handwritten transcriptions caused more work and added frustrations to both myself and my secretarial assistants. I investigated other means of transcription (MRC and voice activated computer programs), but found that the costs were prohibitive.

I found both the research and the topic a very humbling experience. I had often confidently predicted deadlines, only to find that the sheer volume of work rendered these deadlines nonsensical. Analysis and discussion was complicated by the problems of developing a balance between remaining focussed and the risk of missing data or meanings that could arise from additional exploration.

Repeated listening and reading of recordings or transcripts demonstrated that there is much in what people say or mean that I do not listen or respond to. I felt in awe of the faith and belief of the respondents and their admiration for medical practitioners. I found great difficulty

maintaining the bracketing (putting the self aside) for the purposes of the research. I remember how, when I first identified my research question, I tried to persuade all my inquiring colleagues that my choice of topic did not indicate that I was very religious. This may have indicated a lack of spiritual understanding or a phase of denial. I have, since I started the research, initiated a spiritual inquiry as advocated by Maugans[21] and shared my feelings more easily with patients. This, to an extent a fulfilment of my "evangelical mission", has allowed patients to better understand the "realistic uncertainty and limitations" of medicine.[1]

5.5 Discussion of results

Religion, spirituality and indeed prayer are important parts of the lives of each of the interviewed patients. This concept is reflected in several references.[3,6,23,31,33,44]. Not one respondent totally rejected the concept of prayer associated with the family practice consultation. The different venn diagrams demonstrate the variety of responses, thoughts and inhibitions or impediments.

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. Unfortunately I have not explored this in the interviews. 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. I think that a physicist has, in the previous century, given a very appropriate answer;[8]

> "We shall not pray for things frankly material, but for the spiritual gifts, not for the setting of a bone, nor even for the renovation of a withered or poisoned film of brain, but for conformity with the divine will and for that communion with God which mould our lives."

I do not intend to suggest that prayers should not be raised for cure. Indeed I, as mentioned, have also experienced that, "sometimes a miracle happens."*JMC162*

A respondent has also urged doctors to reinstitute the relationship with priests. We need to adopt a priestly role to address the spiritual dimensions of the illness.[45] I am not suggesting that we usurp the role of the clergy, but that we recognize the clergy as a resource that we cannot afford to ignore. The parish priest who knows his congregants intimately, is an indispensable partner to the family practitioner. I have experienced the great value of the family priest as a co-counsellor in family counselling.

This study confirms the results of previous research,[1,18] that doctors do not ask patients about their religion, but is contrary to the results of a study of 49 general practitioners[35] in Bellville, where 83% of the respondents said that they inquired about religion in the consultation. That study[35] is however limited by the small, non-random sample that

was restricted to members of the Medical Association of South Africa. Further study into the reasons why doctors do not ask patients would be useful. These reasons would possibly be better evaluated by interview of family practitioners.

Some respondents have also indicated a need to know their doctors' religious standing. Their inquiry is inhibited by the respect for the doctor. I find it fascinating how they would indirectly probe and drop cues for the doctor. The one respondent who had been asked about her religion viewed the inquiry as a sign of respect by the GP. Schreiber[44] wrote that the lack of inquiry may indicate disrespect to the patient.

6 Conclusion.

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 us to respect their beliefs and to explore their feelings in a patient centred way. The exact role of prayer need to be determined for each patient in each consultation. The doctor should continuously be aware of his/her own feelings and conscious of the patient cues.

Prayer is not a substitute for clinical competence. Prayer and the spirituality of each individual form 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 improved relationships. The association between the two variables i.e. the doctor patient relationship and prayer, needs further investigation.

Patient-centredness and other family medicine principles are essential factors that facilitate exploration of the patients' spirituality and need for prayer. 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. We are not expected to fulfil all the needs of our patients but we are expected to be aware of those needs and to address those needs when possible. The incorporation of this need and the patients' related characteristics into the Bio-psychosocial model is thus long overdue.

Suggestions have been made by respondents regarding the incorporation of prayer and religious inquiry into the doctors' armamentarium. These suggestions are appropriate, plausible and acceptable. Respondents have shown a 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 has develop excellent guidelines to a spiritual inquiry. He based the inquiry on the mnemonic "SPIRIT". I have altered some of the questions for use in my practice. (APPENDIX IV)

Barnard,[1] 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-centered medicine.[1]

I pray that this dissertation will contribute to restoring the importance of the roles of religion and prayer in medicine.

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9. APPENDICES

APPENDIX I
Interview guide

Could you tell me about yourself.

[Explore birth place, age, youth, schooling, family (genogram if possible) and current employment.]

What is your formal religious affiliation?

[Explore the denomination, frequency of group worship and last attendances]

Describe the beliefs and practices of your religion (or spiritual system) that you personally accept.

{Explore the importance of beliefs, unacceptable medical practices and the respondent's position in the group or spiritual community. Specifically address prayer and the respondent's understanding and practice.}

What is your understanding of prayer?

[Explore, not only, the definition, but also, the response to prayer.]

How do you feel about prayer during medical consultations?

[Explore previous experiences or feelings and attempt to match any previous experience with reasons for attendance. Also explore respondent's perception of appropiate timing for *& style* of prayer.]

Have doctors previously inquired about your religion?

[Explore the extent and timing of past inquiry and respondent's ideas regarding this inquiry.]

How do you feel about attending a doctor who practise a religion different to yours?

[Check whether the respondent considers the difference to be a barrier to the relationship.]

APPENDIX II

BASIC PRINCIPLES OF ISLAM

1 Belief in One Creator and all the prophets, Mohamed being the last prophet.

2 Fast.

3 Zakah.

4 Pray 5 times daily, fajr, zuhr, asr, maghrib and isha.

5 Go to Haj, when by the means (physically, spiritually,socially and economically) Everything at home must be well cared for.

APPENDIX III

Glossary of Islamic Terms

alhamdullila	*Thanks to the Almighty*
asr	*prayer between midday and sunset*
batcha	*reciting the Quran*
Bismillah	*in the name of Allah*
Bismillah hir-rahman-nirrahim	*in the name of Allah all Powerful most Merciful*
dua	*prayer*
fajr	*dawn prayer*
fitra	*charitable donations specifically in the month of Ramadaan. The donation should be equivalent to the amount you would spend for your Eid meal.*
isha	*at least 75 minutes after sunset*
(i)stinja	*cleansing after toilet*
kitaab	*a book, usually containing prayers*
madressa	*muslim school*
maghrib	*sunset*
month of Ramadaan	*month of compulsory fasting, the month during which the Quraan was revealed*
muqulaf	*puberty*
sadaka	*voluntary donation (to charity or the underprivileged)*
salah	*prayer with physical ritual, usually in the mosque*
shaytan	*devil*
Quraan	*the sacred book, by which Moslems regulate their lives*
ya-habie-y-rassul	*prayer of praise and thanks*
zakah	*compulsory donation of 2.5% of your profits annually*
zuhr	*midday prayer*

APPENDIX IV

*Sample Questions for the **SPIRIT**ual History, based on Maugan's mnemonic*[21]

Mnemonic	Questions
S-Spiritual belief System	What is your formal religous affiliation? (This question should be asked as part of the demographic data. Any ignorance of the belief system could then be addressed.)
P-Personal spirituality	What does your religion mean to you? What is the importance of your religion in your daily life?
I-Integration with a spiritual community.	What is your role within your church or group? Does the group serve as a source of support? (Attention specifically to health issues.)
R-Ritualized practices & Restrictions	Are there specific practices that you carry out? Are there lifestyle activities that are encouraged or forbidden? Do you comply? Are there any elements of medical care forbidden by your belief?
I-Implications for medical care	What aspects of your religion would you like me to keep in mind as I care for you? What knowledge or understanding would strengthen our relationship as doctor and patient? Are there any barriers to our relationship based on religous issues?
T-Terminal events planning	Are there particular aspects of care that you wish to forego or have witheld because of your faith? (Discuss life support mechanisms and organ donation.)