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Spirituality and religiosity in medical practice at a university hospital

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Abstract

Religiosity and spirituality are pivotal in medical practice, particularly in fostering a patient-centered approach that enhances the physician-patient relationship. Despite this, many physicians still underutilize these invaluable resources, often due to feelings of uncertainty when navigating the personal aspects of patients' lives. To address this challenge, a survey involving 128 physicians, including residents, was conducted at a university hospital in Minas Gerais between August and December 2021. Utilizing the Duke Religiosity Inventory and Multidimensional Interpersonal Reactivity Scale questionnaires, alongside inquiries drawn from prior studies on health and spirituality, the goal was to assess professionals' perceptions of the significance of religiosity and spirituality in clinical practice and their interplay with ethical and humanistic attitudes. The findings unveiled a significant correlation between the two scales, underscoring a positive connection between religiosity, spirituality, and empathy.

Keywords: Spirituality. Empathy. Physician-patient relations.

Resumo

Espiritualidade e religiosidade na prática médica em um hospital universitário

A religiosidade e a espiritualidade desempenham papéis cruciais na medicina, especialmente na abordagem centrada no paciente, melhorando a relação médico-paciente. Apesar disso, muitos médicos ainda subutilizam esses recursos, muitas vezes devido a insegurança ao lidar com a esfera pessoal da vida dos pacientes. Para abordar essa questão, conduziu-se pesquisa com 128 médicos, incluindo residentes, em um hospital universitário de Minas Gerais, entre agosto e dezembro de 2021, mediante aplicação dos questionários Inventário de Religiosidade de Duke e Escala Multidimensional de Reatividade Interpessoal, além de questões levantadas em estudos anteriores sobre saúde e espiritualidade. Com isso, buscou-se avaliar de que forma profissionais percebem a importância da religiosidade e da espiritualidade na prática clínica e sua relação com posturas éticas e humanistas. Os resultados revelaram correlação significativa entre as duas escalas, indicando associação positiva entre religiosidade e espiritualidade e empatia.

Palavras-chave: Espiritualidade. Empatia. Relações médico-paciente.

Resumen

Espiritualidad y religiosidad en la práctica médica en un hospital universitario

La religiosidad y la espiritualidad desempeñan un papel clave en la medicina, especialmente en el enfoque centrado en el paciente al mejorar la relación médico-paciente. Muchos médicos aún no utilizan este recurso, debido a la inseguridad a menudo de enfrentar la vida personal de los pacientes. En este estudio se aplicó a 128 médicos y residentes de un hospital universitario de Minas Gerais (Brasil) los cuestionarios Índice de Religiosidad de Duke y Índice de Reactividad Interpersonal Multidimensional entre agosto y diciembre de 2021, así como preguntas planteadas en estudios anteriores sobre salud y espiritualidad. Se pretendió evaluar la percepción de los profesionales sobre la importancia de la religiosidad y la espiritualidad en la práctica clínica y su relación con las actitudes éticas y humanistas. Los resultados revelaron una correlación significativa entre las dos escalas, lo que indica una asociación positiva entre la religiosidad y espiritualidad y la empatía.

Palabras clave: Espiritualidad. Empatía. Relaciones médico-paciente.

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The relationship between physician and patient is commonly strengthened when there is vulnerability on the part of the individual assisted. Therefore, patient-centered medicine signifies a change in basic assumptions in clinical methodology, aiming to explore the health-disease continuum through biological, psychological, and social dimensions, transcending the confines of the biomedical model, which focuses exclusively on the illness [1]. Consequently, religiosity and spirituality (R/S) often surface as crucial components in treatment, frequently noted by patients [2].

As defined by Koenig [3], spirituality pertains to an individual's quest to comprehend life events and their connection with the sacred, not necessarily involving religious rituals. On the other hand, religiosity concerns the extent of an individual's religious involvement and its impact on daily life, habits, and worldview. It can be categorized as intrinsic (where religion manifests through the individual's greater good) or extrinsic (where religion serves as a means to other ends) [4,5].

Despite ample scientific evidence supporting the benefits of integrating R/S into the physician-patient relationship, few healthcare professionals employ this approach. This deficiency is often attributed to inadequate preparation in medical education regarding these matters, leading to professional insecurity. Moreover, a common challenge arises in the form of a religiosity gap—a disparity in R/S levels between the physician and the patient—hindering effective empathy and connection in patient care [2].

Given the significance of this realm in the adopted approach, adjustments are essential in the actions of professionals to align with patient needs. This is because coping, the process by which individuals seek to understand and manage the significant demands of their lives [6], may yield positive or negative outcomes when it comes to R/S. It tends to be positive when characterized by benevolent religious reevaluation, but negative when individuals perceive God as punitive, for instance.

This correlation can be assessed using the religious-spiritual coping scale [7]. In cases of negative coping mechanisms, the healthcare team should intervene to propose alternative interpretations.

The extent to which patients are willing to address intimate issues such as R/S depends on their level of rapport with the physician and how comfortable they feel with the care team. Hence, it is advisable to document the patient's spiritual history from the initial encounter. Moreover, understanding these details is crucial for distinguishing spiritual experiences from mental disorders outlined in the *Diagnostic and Statistical Manual of Mental Disorders*, as noted by Tostes, Pinto and Moreira-Almeida [2].

Another pivotal aspect in the interaction between the healthcare team and patients is empathy, regarded as one of the physician's paramount people skills [8]. In clinical practice, empathy comprises cognitive, emotional, and behavioral components, encompassing *the ability to recognize emotions in others, empathize with these emotions, and respond appropriately* [9].

Physicians' empathy correlates with transparent and candid communication, facilitating better alignment between patient needs and the treatment plans proposed [10]. Diagnoses become more accurate, treatment adherence rates increase, leading to enhanced therapeutic outcomes, and a decrease in legal disputes [11].

According to Lacombe [8], levels of empathy exhibited a positive correlation with the perception of well-being concerning spirituality, religiosity, and personal beliefs among medical students.

Given this context, the objective of this study is to assess the significance attributed by physicians at a university hospital to R/S, alongside examining the correlation between empathy and R/S in the practices of health professionals.

Method

This study was subject to review by the research ethics committee and received approval following Resolutions 466/2012 [12] and 510/2016 [13] of the National Health Council regarding research involving human subjects.

The investigation took place at a university hospital located in the Brazilian countryside, where the medical staff comprises 835 professionals, including 274 residents. Due to the COVID-19 pandemic, hospital visits were curtailed as part of the biosafety measures. Nonetheless, physicians from various departments were invited to partake in the study and completed self-administered paper questionnaires.

Data collection happened from August to December 2021. In adherence to public health

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guidelines during the pandemic and recognizing that social distancing measures demand a reduction in non-essential physical interactions, researchers employed personal protective equipment (PPE) and staggered schedules to mitigate overcrowding in hospital areas.

Consequently, researchers provided the participants with the necessary materials, including the informed consent form and questionnaires, allowing them sufficient time to respond at their convenience. Upon the expiration of the designated time limit, researchers retrieved the completed questionnaires. The research instruments were:

1. A questionnaire designed to gather data on age, gender, educational level, marital status, self-reported race, years since graduation, occupation, and religious affiliation.
2. A questionnaire exploring opinions regarding the integration of R/S in clinical practice, adapted from previous studies conducted by Borges and collaborators [14] and Santos and Oliveira [15]. This instrument aims to assess a professionals' ethical and humanistic perspectives and their interpretation of issues related to health and spirituality.
3. The Duke Religiosity Inventory (P-Durel), a brief questionnaire consisting of five items designed to measure three dimensions of individual religiosity: organizational religiosity (OR), non-organizational religiosity (NOR), and intrinsic religiosity (IR) [16]; and
4. The Davis Multidimensional Interpersonal Reactivity Scale (MIRS), a questionnaire evaluating empathy across multiple dimensions. It comprises three subscales with a total of 21 items, assessing empathic concern (EC), perspective taking (PT), and personal distress (PD). This scale was originally developed by Davis [17,18] and subsequently translated into Brazilian Portuguese, being validated by Koller, Camino and Ribeiro [19].

Following data collection and administration of the questionnaires, descriptive analyses were conducted to identify variables of interest. Data were stored and analyzed using the IBM SPSS software. Descriptive analysis employed methods such as frequency, percentage, median, and interquartile deviation. For metric variables, the Kolmogorov-Smirnov normality test was applied.

In comparisons involving two proportions, Fisher's exact test and the Chi-square test (χ^2, α=5%) were utilized. Pearson's significance test was employed to evaluate correlation coefficients, with gender being dichotomously categorized as 0 for males and 1 for females. The significance level adopted was 5%.

Results

The final sample comprised 128 physicians, with 54 being residents and 74 non-residents. Table 1 illustrates that 58.5% of respondents are male, 77.4% identify as white, and 49.2% are married. Regarding religious affiliation, 44.5% identify as Catholic, while other beliefs and religious identifications include spiritualists (18.8%), spiritual individuals without a specific religion (20.3%), protestants (10.2%), and atheists (5.4%).

Table 1. Sociodemographic characteristics, median religious beliefs, and interquartile deviations for the P-Durel and MIRS scales of 128 resident and non-resident physicians at a university hospital.

	Residents	Non-resident physicians	Total
	54 (100%)	74 (100%)	128 (100%)
Age	27.00±3	39.00±21	31.00±16
Gender	51(100%) *	72 (100%) *	123 (100%) *
Male	26 (51%)	46 (63.9%)	72 (58.5%)
Female	25 (49%)	26 (36.1%)	51 (41.5%)

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Table 1. Continuation

	Residents	Non-resident physicians	Total
	54 (100%)	74 (100%)	128 (100%)
Marital Status	**54 (100%)**	**74 (100%)**	**128 (100%)**
Single	41 (75.8%)	21 (28.4%)	62 (48.4%)
Married	11 (20.4%)	52 (70.3%)	63 (49.2%)
Divorced	1 (1.9%)	1 (1.3%)	2 (1.6%)
Other	1 (1.9%)	0 (0%)	1 (0.8%)
Ethnicity (self-reported)	**54 (100%)**	**74 (100%)**	**128 (100%)**
White	38 (70.3%)	61 (82.4%)	99 (77.4%)
Latino	11 (20.4%)	11 (14.9%)	22 (17.1%)
Black	4 (7.4%)	1 (1.35%)	5 (3.9%)
Asian	1 (1.9%)	0 (0%)	1 (0.8%)
Other	0 (0%)	1 (1.35%)	1 (0.8%)
Religion/faith	**54 (100%)**	**74 (100%)**	**128 (100%)**
Atheist	3 (5.6%)	4 (5.4%)	7 (5.4%)
Agnostic	13 (24.1%)	13 (17.6%)	26 (20.3%)
Catholic	20 (36.9%)	37 (50%)	57 (44.5%)
Protestant	9 (16.7%)	4 (5.4%)	13 (10.2%)
Spiritualist	8 (14.8%)	16 (21.6%)	24 (18.8%)
Other	1 (1.9%)	0 (0%)	1 (0.8%)
Believes in God	**54 (100%)**	**74 (100%)**	**128 (100%)**
Yes	48 (88.9%)	65 (87.8%)	113 (88.2%)
No	4 (7.4%)	3 (4.1%)	7 (5.5%)
No opinion	2 (3.7%)	6 (8.1%)	8 (6.3%)
After death, is the soul still alive?	**54 (100%)**	**74 (100%)**	**128 (100%)**
Yes	38 (70.3%)	56 (75.7%)	94 (73.4%)
No	9 (16.7%)	12 (16.2%)	21 (16.4%)
No opinion	7 (13%)	6 (8.1%)	13 (10.2%)
Believes in reincarnation	**54 (100%)**	**74 (100%)**	**128 (100%)**
Yes	17 (31.5%)	33 (44.6%)	50 (39.0%)
No	27 (50%)	27 (36.5%)	54 (42.2%)
No opinion	10 (18.5%)	14 (18.9%)	24 (18.8%)
Is the human being made up of body and soul?	**54 (100%)**	**74 (100%)**	**128 (100%)**
Yes	50 (92.5%)	64 (86.5%)	114 (89.1%)
No	3 (5.6%)	8 (10.8%)	11 (8.6%)
No opinion	1 (1.9%)	2 (2.7%)	3 (2.3%)

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Table 1. Continuation

	Residents	Non-resident physicians	Total
	54 (100%)	74 (100%)	128 (100%)
How religious do you consider yourself to be?	**54 (100%)**	**73 (100%) ***	**127 (100%) ***
Very	5 (9.3%)	10 (13.7%)	15 (11.8%)
Quite	27 (50%)	36 (49.3%)	63 (49.6%)
A little	17 (31.4%)	20 (27.4%)	37 (29.1%)
Not at all	5 (9.3%)	7 (9.6%)	12 (9.5%)
P-Durel			
Organizational religiosity	3.00±2	3.00±3	3.00±2
Non-organizational religiosity	5.00±3	5.00±4	4.00±3
Intrinsic religiosity	13.00±4	13.00±4	13.00±4
MIRS			
Empathetic consideration	28.00±5	26.00±8	27.00±7
Perspective taking	25.00±5	27.00±6	26.00±5
Personal distress	18.00±5	17.00±6	17.00±5
Total	71.00±12	71.00±14	71.00±13

**In this section, some responses were left blank, leading to variations in the total responses for the specified items.*
MIRS: Davis Multidimensional Interpersonal Reactivity Scale; P-Durel: Duke Religiosity Inventory

Of note, 88.2% of respondents express belief in God, 73.4% believe in the persistence of the soul after death, and 89.1% agree with the concept of humans being comprised of both body and soul. A significant difference was observed solely in the marital status of physicians and their status as residents or non-residents (FET=33.051; p<0.01 – data not shown). Table 1 also presents the median values and interquartile deviations for the religiosity and empathy scales. The findings suggest comparable levels of religiosity and empathy among resident and non-resident physicians.

Table 2 delineates physicians' viewpoints on the R/S topic and its influence on clinical practice. Most (51.9%) associate spirituality with the "Search for meaning and significance in human life."

Table 2. Opinions of 128 physicians from a university hospital regarding religiosity and spirituality and their impact on clinical practice.

	Resident physicians	Non-resident physicians	Total
What do you understand by spirituality?	**54 (100%)**	**73 (100%) ***	**127 (100%) ***
Ethical and humanistic stance	16 (29.6%)	29 (39.7%)	45 (35.4%)
Search for meaning and purpose in human life	28 (51.9%)	38 (52%)	66 (51.9%)
Faith and relationship with God/religiosity	16 (29.6%)	29 (39.7%)	45 (35.4%)
Belief in something transcendent to matter	23 (42.6%)	25 (34.25%)	48 (37.8%)
Belief in the existence of the soul and life after death	4 (7.4%)	25 (34.25%)	29 (22.8%)

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Table 2. Continuation

	Resident physicians	Non-resident physicians	Total
What does this relate to the subject of health and spirituality?	**54 (100%)**	**74 (100%)**	**128 (100%)**
Humanization of medicine	29 (53.7%)	47 (63.5%)	76 (59.3%)
Quality of life	16 (29.6%)	28 (37.8%)	44 (34.3%)
Total/holistic health	29 (53.7%)	32 (43.2%)	63 (49.2%)
Positive or negative interference of religiosity on health	21 (38.9%)	24 (32.4%)	45 (35.1%)
Interference of the transcendent/immaterial in health	21 (38.9%)	18 (24.3%)	39 (30.4%)
Approach to living and dying	25 (46.3%)	28 (37.8%)	53 (41.4%)
R/S reflects on patient health	**54 (100%)**	**74 (100%)**	**128 (100%)**
Very much	20 (37%)	24 (32.4%)	44 (34.3%)
Quite	25 (46.3%)	40 (54.1%)	65 (50.8%)
More or less	8 (14.8%)	6 (8.1%)	14 (10.9%)
A little	0 (0%)	3 (4.1%)	3 (2.4%)
Little or nothing	1 (1.9%)	1 (1.3%)	2 (1.6%)
R/S repercussions are positive or negative	**54 (100%)**	**74 (100%)**	**128 (100%)**
Generally positive	41 (75.9%)	59 (79.7%)	100 (78.1%)
Generally negative	2 (3.7%)	1 (1.3%)	3 (2.4%)
Both positive and negative	11 (20.4%)	12 (16.3%)	23 (17.9%)
No influence	0 (0%)	2 (2.7%)	2 (1.6%)
Does a physician's R/S interfere with the understanding of the health-disease process and the physician-patient relationship?	**54 (100%)**	**74 (100%)**	**128 (100%)**
Huge intensity	3 (5.6%)	13 (17.6%)	16 (12.5%)
Great intensity	24 (44.4%)	27 (36.4%)	51 (39.8%)
Moderate intensity	23 (42.5%)	23 (31.1%)	46 (35.9%)
Little intensity	3 (5.6%)	9 (12.2%)	12 (9.4%)
No interference	1 (1.9%)	2 (2.7%)	3 (2.4%)
Do you feel like discussing the topic of faith and spirituality with patients?	**54 (100%)**	**73 (100%)**	**127 (100%) ***
Yes, rarely	16 (29.6%)	26 (35.7%)	42 (33.0%)
Yes, often	28 (51.9%)	25 (34.2%)	53 (41.7%)
No	10 (18.5%)	22 (30.1%)	22 (17.3%)
Do you feel prepared to address spiritual aspects with the patient?	**54 (100%)**	**74 (100%)**	**128 (100%)**
Very prepared	0 (0%)	5 (6.8%)	5 (3.9%)
Quite prepared	4 (7.4%)	7 (9.5%)	11 (8.6%)
Moderately prepared	24 (44.4%)	22 (29.6%)	46 (35.9%)
Little prepared	23 (42.6%)	29 (39.2%)	52 (40.6%)
Unprepared	2 (3.7%)	6 (8.1%)	8 (6.3%)
Not applicable	1 (1.9%)	5 (6.8%)	6 (4.7%)

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Table 2. Continuation

	Resident physicians	Non-resident physicians	Total
How relevant do you think this approach is?	**54 (100%)**	**74 (100%)**	**128 (100%)**
Truly relevant	8 (14.8%)	10 (13.5%)	18 (14.1%)
Quite relevant	24 (44.4%)	30 (40.5%)	54 (42.1%)
Moderately relevant	16 (29.6%)	22 (29.7%)	38 (29.7%)
Little relevant	5 (9.3%)	7 (9.5%)	12 (9.4%)
Irrelevant	1 (1.9%)	5 (6.8%)	6 (4.7%)
When is it appropriate for the professional to pray with the patient?	**54 (100%)**	**73 (100%) ***	**127 (100%) ***
Never	4 (7.4%)	11 (15.1%)	15 (11.8%)
Only if invited by the patient	37 (68.5%)	53 (72.6%)	90 (70.9%)
Whenever the professional considers it appropriate	13 (24.1%)	9 (12.3%)	22 (17.3%)
Have you ever asked about patients' R/S?	**54 (100%)**	**74 (100%)**	**128 (100%)**
Yes	42 (77.8%)	50 (67.6%)	92 (71.9%)
No	12 (22.2%)	24 (32.4%)	36 (28.1%)
How often do you ask?	**50 (100%) ** **	**61 (100%) ** **	**111 (100%) ** **
Rarely	16 (32%)	23 (37.7%)	39 (35.2%)
Sometimes	22 (44%)	22 (36.1%)	44 (39.6%)
Often	10 (20%)	12 (19.7%)	22 (19.8%)
Always	2 (4%)	4 (6.5%)	6 (5.4%)
How often do patients seem uncomfortable when asked about R/S	**50 (100%) ** **	**63 (100%) ** **	**113 (100%) ** **
Never	15 (30%)	16 (25.4%)	31 (27.4%)
Rarely	21 (42%)	34 (54%)	55 (48.7%)
Sometimes	14 (28%)	12 (19%)	26 (23.0%)
Often	0 (0%)	1 (1.6%)	1 (0.9%)
Always	0 (0%)	0 (0%)	0 (0.0%)
Factors that discourage you from discussing R/S with patients	**54 (100%)**	**74 (100%)**	**128 (100%)**
Lack of knowledge	11 (20.4%)	14 (18.9%)	25 (19.5%)
Lack of training	20 (37%)	19 (25.7%)	39 (30.4%)
Lack of time	28 (51.9%)	27 (36.5%)	55 (42.9%)
Discomfort with the topic	7 (13%)	14 (18.9%)	21 (16.4%)
Fear of imposing religious views on patients	24 (44.4%)	38 (51.4%)	62 (48.4%)
Religious knowledge is irrelevant in medical treatment	0 (0%)	4 (5.4%)	4 (3.2%)
It is not part of my job	3 (5.6%)	4 (5.4%)	7 (5.4%)
Fear of offending patients	15 (27.8%)	23 (31.1%)	38 (29.6%)
Fear that my colleagues will disapprove	3 (5.6%)	3 (4.1%)	6 (4.7%)
Other	1 (1.9%)	7 (9.5%)	8 (6.3%)

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Table 2. Continuation

	Resident physicians	Non-resident physicians	Total
Spiritual tools and treatments that could be recommended to patients	**54 (100%)**	**74 (100%)**	**128 (100%)**
Prayer	41 (75.9%)	53 (71.6%)	94 (73.4%)
Religious reading	28 (51.9%)	34 (45.9%)	62 (48.4%)
Fluidized water/energized water/holy water	4 (7.4%)	8 (10.8%)	12 (9.3%)
Disobsession/exorcism/ “purification”	2 (3.8%) g	0 (0%)	2 (1.6%)
Laying on of hands/*reiki*/energy healing/Johrei	12 (22.2%)	9 (12.2%)	21 (16.4%)
Charity work in religious temples	17 (31.5%)	17 (23%)	34 (26.5%)
Other	5 (9.3%)	9 (12.2%)	14 (10.9%)

**In this section, some responses were left blank, leading to variations in the total number of responses.*

***These items were answered only by participants who indicated “yes” in the previous question.*

R/S: religiosity and spirituality

Approximately 85% of resident physicians and 70% of non-resident physicians expressed interest in discussing the topic of faith and spirituality with patients, with 71.9% of them having already broached R/S with their patients at some point. The main factors deterring physicians from discussing R/S with patients include “Lack of time,” cited by 42.9% of respondents, and “Fear of imposing religious views on patients,” mentioned by 48.4% of the total.

Despite these barriers, “Prayer” emerges as the most commonly recommended spiritual tool, with 73.4% of physicians endorsing its use. This recommendation underscores the perceived significance of prayer in physician-patient interactions within the context of spirituality.

Correlation analysis (Table 3) identified significant associations between certain variables and MIRS components. Remarkably, there was a significant correlation between the gender variable and “MIRS empathic consideration” (r=0.483*), “MIRS personal distress” (r=0.278**), and “MIRS total” (r=0.404**), with female participants presenting higher scores in these components. Additionally, NOR correlated IR showed a significant correlation with “MIRS empathic consideration” (r=0.236**), “MIRS perspective taking” (r=0.206*), and “MIRS total” (r=0.234**).

Table 3. Spearman correlation analysis between empathy, religiosity, age, gender, and training time among 128 physicians from a university hospital.

Variable		Age	Gender	Time since graduation	OR	NOR	IR
MIRS empathetic consideration	*r*	-.001	.483*	.004	.132	.264**	.236**
MIRS perspective taking	*r*	.175	.028	.171	.010	.050	.206*
MIRS *personal distress*	*r*	-,132	.278**	-,153	.048	.088	.055
MIRS total	*r*	.055	.404**	.056	.071	.163	.234*

MIRS: Davis Multidimensional Interpersonal Reactivity Scale; OR: organizational religiosity; NOR: non-organizational religiosity; IR: intrinsic religiosity; r: correlation coefficient; *p<0.05; **p<0.01

Discussion

In addition to emphasizing the significance of spirituality in clinical practice, this study underscores the disparity between the recognition of the importance of this aspect and physicians’ perceived readiness to address it.

Despite acknowledging the impact of R/S on health, 82.8% of physicians expressed feeling not at all, little, or moderately prepared to broach

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the topic. The primary deterrents to discourage this type of discussion are lack of time, fear of imposing religious views on patients, and lack of training. This aligns with findings from other studies, exposing a pervasive issue within Brazilian medical education [20,21].

Costa and collaborators [22] reveal that while medical students acknowledge the importance of the topic, they feel discouraged from addressing it due to limited exposure during academic training. Similarly, most physicians interviewed in this study reported feeling underprepared to tackle the subject. This discrepancy underscores the imperative to enhance students' qualifications by incorporating R/S themes into medical curricula [23,24].

Understanding physicians' perceptions and practices regarding R/S is vital for fostering holistic, patient-centered medical care [25]. The findings of this study underscore that a considerable proportion of physicians acknowledge the influence of R/S on patients' health. This points to the need to integrate R/S into medical curricula to equip professionals with the skills to address these topics both sensitively and respectfully [26].

Moreover, given that many physicians express interest in discussing issues of faith and spirituality with patients but feel uncertain or unprepared to do so, it is crucial to provide adequate training and resources to support them in this endeavor [23]. An informed and empathetic approach to R/S has the potential to enhance the physician-patient relationship, fostering open communication and personalized care [8].

The positive correlation observed between empathy and participants who identify as females aligns with trends documented in the literature, particularly among medical students [27]. The gender-based differences in empathy are attributed to both intrinsic factors (such as evolutionary characteristics) and extrinsic factors (including interpersonal caregiving, socialization, and gender-related expectations) [28].

The significant correlation between items on the P-Durel scale and those on the MIRS scale indicates a positive association between R/S and empathy. This suggests that physicians who engage in practices such as prayer, spiritual readings, meditation, and regular attendance at religious services are more likely to recognize and respond to the needs of others.

This correlation aligns with previous studies [8,29] that suggest greater involvement with R/S—entailing a pursuit of existential questions and attributing transcendental meaning to existence—could serve as an effective means of coping with human suffering, fostering an empathetic stance towards patients.

However, it is important to acknowledge the limitations of this study when interpreting the results. Firstly, the sample primarily consisted of physicians from a single region, potentially limiting the generalizability of perceptions and practices to professionals from other areas. Additionally, the cross-sectional design of this study precludes the analysis of changes in attitudes and practices over time.

Thus, longitudinal studies are warranted to examine how physicians' attitudes and practices regarding R/S evolve, particularly following specific interventions or training programs. Investigating the effectiveness of training programs aimed at enhancing physicians' competence in addressing R/S issues within clinical practice could be a valuable experience.

Final considerations

R/S holds considerable significance in medical practice, with most interviewees emphasizing its relevance and recognizing its predominantly positive influence. However, a significant gap exists between the importance attributed to these topics and physicians' perceived readiness to address them with patients. This incongruity underscores the necessity for a more comprehensive and integrated approach to R/S in the curriculum of medical courses in Brazil.

Moreover, the correlations observed between the P-Durel and MIRS scales suggest that physicians with a stronger religious inclination tend to demonstrate higher levels of empathy, highlighting the potential interplay between R/S and patient-centered care.

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