Development of a Faith-Based Clinic: Needs Assessment of the Hartford Community

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Development of a Faith-Based Clinic: Needs Assessment of the Hartford Community

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Development of a Faith-Based Clinic: Needs Assessment of the Hartford Community

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INTRODUCTION

Spirituality in medical care has traditionally been ignored in allopathic healthcare as the medical field focused on technological advances and specialty medicine. However, recent studies show that Americans would like to have more holistic healthcare and a more personal connection with their medical providers. Also, many patients would like their medical providers to discuss faith as it related to their health and pray with them. Unfortunately, physicians, as a group, tend to be less spiritual than their patients, and are ill equipped to address any spiritual needs in the medical office. Consequently, a movement in medicine has begun to help physicians provide more holistic healthcare to their patients by addressing faith during medical encounters, and a number of faith-based medical centers have been founded across the country.

Concurrently, our nation has an increasing number of medically uninsured and underserved people. Hartford, CT is no exception from this trend, and the city continues to be ranked a “Medically Underserved Area/Population” by the Connecticut Department of Health. In response to this data, in 2005, the Christian Medical Fellowship, created a planning committee to design a faith-based free medical center in Hartford, CT. The Christian Medical Fellowship Health Center (CMFHC) has a threefold mission. First, CMF seeks to provide quality primary health care to uninsured and underserved people in the Hartford community through this faith-based medical center. Second, the CMFHC will also address the spiritual health of patients and will encourage prayer and spiritual counseling at the center at patients’ request.
Third, the CMFHC seeks to be a training site for young physicians and medical
students to practice skills in spiritual history taking and to foster a holistic view of
health. Overall, the CMFHC seeks to be responsive to the physical, emotional, and
spiritual needs of the Hartford community.

The CMFHC planning committee conducted a preliminary needs assessment in
which it reviewed the state of health care for the uninsured and underserved in the
United States and in Hartford, CT. It also reviewed the literature on faith and prayer in
the context of medical visits and reviewed current models of successful faith-based
clinics in other parts of the country. The final report, by Mahooti 2006 in his master’s
of public health thesis, showed a normative need for a free health center in Hartford,
CT, based on utilization rates in the emergency rooms of Hartford’s hospital and the
availability of free services at the two federally qualified health centers. The report
also established that nationally patients’ felt a need for prayer and spiritual discussion
with their health care providers, and there were faith-based health centers around the
country that were thriving as they provided a place where patient’s spiritual health was
addressed and valued.

Based on the report cited above, the CMFHC opened its doors to the public this
year with preliminary health services. However, the CMFHC desires more information
on the perceptions in the local Hartford community regarding a need for a faith-based
medical center.

Therefore, this study was a targeted needs assessment of local church groups
and residents in Hartford. It addresses the question of whether the people of Hartford
are similar to those in other parts of the nation who have felt a need for free faith-based
medical centers in their own communities. It also assesses how well the Hartford medical community is doing at addressing faith in the context of medical care. This information will be used to generate ideas for the CMFHC to tailor its services to the needs of the community.

This thesis will first discuss background information including the faith and medicine literature, the CMFHC’s current operations, and the needs assessment literature in the context of community-oriented primary care. The methods and results of the study follow this background. Finally, a discussion of the data, including the limitations of the study and future directions for the CMF Health Center is presented.
BACKGROUND

This background section contains a more detailed review of the results of the preliminary needs assessment by Dr. Navid Mahooti, which is a summary of the faith in medicine literature and of the state of healthcare access in Hartford, CT. Also, to better understand the process of needs assessments, this section reviews Community-Oriented Primary Care and the general needs assessment literature.

Evidence for incorporating faith into medical practice

Today, the impact of faith on healthcare and medicine is extensive. Many organizations in the U.S. espouse Christian teachings, ideals and values, and seek to incorporate faith into health encounters domestically and internationally. (Mahooti, 2006)

At this time, estimates as to the number of faith-based clinics range from over 150 to well over 200, accounting for millions of patient visits annually. (Fox News, 2004; Knox, 2002) These clinics have been created out of humanitarian concerns for the health and well-being of the poor and medically underserved. Research supports the development of faith-based clinics for medically underserved populations.

Many patients express a desire to discuss faith-related beliefs and practices with their physicians, and many physicians would like to accommodate their patients’ wishes. Unfortunately, studies have revealed that while approximately 40% of physicians would like to address their patients’ faith-based needs, only 10% or so actually do so. Physicians cite time constraints and inadequate training to explain this discrepancy. (Mahooti, 2006)

Traditionally, medical schools failed to educate their students in addressing the emotional and spiritual part of their patients’ health. While technical medical advances
flourished, focus on the patient-doctor relationship declined, and in the opinion of Dr. Christian Puchalski, “doctors are ‘overtechnologicalized’ so to speak – that they focus too much on the disease and not enough on the person.” There has been a wave of complaints from patients, “that physicians are becoming too cold, too technical, and that people wanted a warmer, closer relationship with physicians” so now medical schools are adding lectures on faith to their curricula. In 2004, 84 of the 126 accredited medical schools offered at least one course in spirituality in medicine. (Greenberg, 2005; Fortin, 2004) Physicians are now trained to take a “spiritual history” at key times in a patient encounter. This simple step “can enhance patient satisfaction, improve outcomes, and personalize what can otherwise be a dehumanizing experience. Furthermore, taking a faith history can also serve to increase the patient’s trust in his/her physician, (Koenig, 2004) especially if the patients’ and physicians’ world views are congruent.” (Krupat, 2001) There are now a number of published methods for taking a faith history that have been tested and found to be beneficial in the literature – acronyms include “FiCA” and “HOPE.” (GWISH 2006, Anandarajah G and Height E, 2001) See Table 1.1 and 1.2. Dr. Navid Mahooti (2006) states, “It is clear that physicians who respectfully inquire about patient’s faith-based beliefs and practices, at a pace and comfort level dictated by the patient, create opportunities to serve their patients better.” (Ehman, 1999; Gioiella, 1998; Ellis and Campbell, 2004; Lo et al., 2002; Koenig 2004, McCord, 2004; Herbert, 2001)

While these studies have shown that patients in various parts of the country would like their doctors to inquire about their faith, there have been no studies of this type in Hartford, CT. It is likely that patients in the Hartford community would be
similar to patients previously studied or they might be even more positive about incorporating faith into medicine. Hartford, Connecticut is a community of spiritually minded individuals, with many African American and Latino individuals attending community churches. It is hypothesized that patients would appreciate a pro-active faith-based medical center that would not only to affirm an individual’s faith but also to embrace faith-related activities such as prayer, Bible reading and church attendance as beneficial for their health. Unfortunately, most physicians say they are uncomfortable taking a spiritual history during medical encounters and ill equipped to do so. Overall, there is a gap between patients’ desire for this aspect of quality care and the medical community’s ability to provide it. This needs assessment will help determine, more specifically than previous studies, if patients in Hartford have a perceived need for faith-based medical care.

To what extent should physicians be involved in patients’ spirituality?

While the studies listed above present the benefits of incorporating spirituality into medical care in some way, fewer studies have addressed the question of how this should be done. This is an important question for a few reasons and it has ethical implications. First, the percentage of patients who want to discuss faith or pray with their doctors changes depending on the situation and the patient characteristics. Second, small percentages of patients say they would not welcome “carefully worded inquiries into their spiritual or religious beliefs” in various contexts. Third, the physician risks acting as a “paternalistic ‘priestly’ figurehead,” which can erode patient autonomy, if spirituality is not addressed carefully. (Post et al., 2000)
Despite the evidence for a strong relationship between spirituality and medicine, (Anandarajah and Hight, 2001) there are nuances in patients' interpretation of spirituality and their desires for patient physicians interactions. In 1990, a Gallop poll showed that “95% of Americans believe in God.” In a study of hospitalized patients, 77% believed physicians should consider their spiritual needs as part of their medical care and 37% want physicians to inquire about their religious beliefs more. (King and Bushwick, 1994) Another study, of outpatients in a family medicine office, showed that “30% of patients felt that religion generally affected their health; however, religion was felt to be important in many specific situations: terminal illness (61%), death (60%), birth (48%), major surgery (47%), general well-being (41%), and major illness (36%).” Forty percent of patients in their sample agreed that physicians should discuss pertinent religious issues with their patients. (Maugans and Wadi and, 1991)

Concerning patients’ desire for prayer with their physicians, there is a range of study results. “One national poll found that 48% of patients want prayer with their physicians and 64% of Americans think that physicians should join their patients in prayer if the patients ask.” (Post et al., 2000) In a study of geriatric clinic patients and senior center participants, “71% said that they wished their physician to pray with them if they were sick or near death,” and in a study of family medicine outpatient 67.3% of patients would like their physician to pray with them. (Oyama and Koenig, 1998)

Of ambulatory patients in a pulmonary office, two-thirds indicated they would welcome inquiry into their spiritual beliefs if they became gravely ill. When patients were separated two groups based on their own religiosity, their responses were clearly different from each other. In the group who stated their religious beliefs would
influence their medical decisions, 94% agreed that physicians should ask gravely ill patients about such beliefs. In the group who denied having religious beliefs that would influence their medical decisions, 45% agreed that physicians should ask about these beliefs. (Ehman et al., 1999) The authors of another study of patients’ desires for spirituality in medicine found that patients’ religious beliefs and practices may affect whether patients want physicians to address religious issues. (Oyama and Koenig, 1998) These discrepancies in patients’ opinions on spiritual questions in medicine may inhibit physicians from initiating spiritual discussions during medicine encounters. Fifty-six percent of physicians said one of the barriers to discussion of spiritual issues was “difficulty in identifying patients who want such a discussion.” (Anandarajah and Hight, 2001)

The second factor to be considered in how faith and medicine should be incorporated is the small percentage of patients who may be offended by inquiry into their spiritual beliefs. Post et al. (2000) state that “One review indicates that very few patients are offended at gentle, nonjudgmental questioning or clinical inquiry about such matters.” Another study found that 16% of patients would not welcome inquiry into their religious beliefs [even] when they are gravely ill. (Ehman et al., 1999) When a group of family physicians were surveyed by King and Bushwick (1992), 16% agreed with the statement, “Discussing religion would turn patients away from my practice.” (Oyama and Koenig, 1998) For fear of offending this small percentage of patients, many physicians avoid spiritual discussion altogether. However, the provision of quality medical care has always required the discussion of sensitive and occasionally upsetting topics. Issues such as sexuality, drugs and alcohol are discussed
at the risk of offending people because the importance and opportunity for healing is
greater than the harm of asking sensitive questions. Therefore, this small percent of
patients who may be offended by inquiry into spiritual matters, should modify
physicians approach to questioning, but should not prohibit the questions.

Third, ethically, it is important to emphasize that patients are the more
vulnerable party in the patient-doctor relationship and care must be taken to preserve
their autonomy and “freedom of thought and belief.” (Anandarajah and Hight, 2001)
Therefore, there is much debate on how patients are best served when discussing
spiritual issues or praying together. Post et al. (2000) state, that if physicians “act as
pastoral caregivers” this “might result in coercion of patients or the perception on the
patient’s part of an even greater power than would occur without such religious
sanction.” In other words, patients might begin to relate to their physician as a
paternalistic “priestly” authority and this goes against the current values of allowing
“patient empowerment through autonomy and self-determination.” This concept leads
some physicians to think that praying with patients is a particularly complex issue.
First, most physicians agree that prayer should be used as an adjunct to conventional
medical therapy rather than an alternative or substitute therapy. Second, Post et al.
(2000) advise physicians not to offer prayer for a patient without the patient’s explicit
request and permission, because of the potential for patients’ to feel coerced. Post et al
(2000) also recommend that “prayer should be led by an identified religious leader
distinct form the treating medical team whenever possible so as to avoid even an
initiate requests or accept physicians’ noncoercive offers, prayer can be meaningful, especially prior to major surgery or at the time of impending death.”

In addition to prayer, discussion of religious beliefs has concerned some physicians. Out of respect for patients’ autonomy in beliefs and practices, physicians worry about “unduly influencing patients with their own beliefs” during the discussion of patient spirituality. Dr. Maugans argues that “cognizant and reflective physicians should be able to avoid overt projection of spiritual beliefs and attitudes onto patients.” In addition, “At times, revealing one’s own personal spirituality may be appropriate if it helps in building the patient-physician relationship or in breaking down barriers that have developed over conflictual belief systems. Generally this is done at the request of the patient and only if the physician feels capable.” (Maugans, 1996) Most likely this revelation of personal beliefs might blur the “boundaries” between the medical profession and the pastoral profession; a boundary which some physicians believe should not be blurred. (Post et al., 2000)

Overall, there appears to be some consensus that certain types of spiritual care might be acceptable in a medical practice. Foremost is that any discussion of spirituality or intervention must be “patient-centered.” Then, to determine if the patient’s spirituality is important to them and to their health, and to screen for any spiritual distress, physicians should take a “spiritual history” using an established tool, in a non-threatening way. This can be done all at once or in a longitudinal inquiry. (Anandarajah and Hight, 2001; Maugans, 1996; Oyama and Koenig, 1998; Post et al., 2000) Second, if appropriate, physicians can give “general spiritual care” which is “recognizing and responding to ‘the multifaceted expressions of spirituality we
encounter in our patient and their families.” This involves “compassion, presence, listening, and the encouragement of realistic hope, and might not involve any discussion of God or religion.” (Anandarajah and Hight, 2001) Also, physicians should always show respect for any responses to the spiritual history questions, and can support the patient’s own religious beliefs, particularly if they are not obviously harmful to their health. (Oyama and Koenig, 1998) Third, the patient’s spirituality can be incorporated into their preventive and adjuvant health care. Patients can “be helped to identify and mobilize their own internal spiritual resources such as prayer, meditation, yoga, t'ai chi, and walks in the country,” both as preventive activities and, in conjunction with medical treatment (saying the rosary while taking medication or listening to music before surgery). (Anandarajah and Hight, 2001) Fourth, the patient’s treatment plan can be adjusted to in response to the patient’s spiritual needs. This treatment is most often a referral to pastoral care, but it can also be teaching relaxation exercises or types of meditation. Also, after a spiritual discussion, a patient may decide to change his/her plan regarding chemotherapy or end-of-life care. Physicians should familiarize themselves with spiritual resources in the community and use them appropriately as patients desire. (Anandarajah and Hight, 2001; Maugans, 1996; Post et al., 2000) See Table 1.2 for Dr. Puchalski’s recommendations regarding taking a spiritual history.

Despite the controversies about some aspects of spirituality and medical care, “neglecting or disregarding health-related religious beliefs or needs of patients...is not an appropriate response.” (Oyama and Koenig, 1998)
Evidence for a free medical center in Hartford, Connecticut

State of healthcare for the underserved in Hartford

It is well known that the United States is one of the only developed countries without universal health care. A portion of residents go without needed health services each year. Overall, 18% of the population of the United States is uninsured and 38% of those with some insurance had difficulty accessing medical care when they needed it. (Kaiser, 2006, 2002) A great percentage of these under and uninsured individuals are from working poor families. (Kaiser, 2006) The U.S. Census estimated that 9.9% of Hartford county residents are uninsured. (U.S. Census, 2000) However, the city of Hartford is particularly underserved and is designated by the Connecticut Department of Public Health as a “Medically Underserved Area/Population” and a “Health Professional Shortage Area” specifically in the fields of primary care and mental health. (CT DPH, 2005) According to the 2000 U.S. Census, there are 121,578 people in the city of Hartford. Twenty seven percent of Hartford residents live below the poverty line, and 9% are unemployed. Also, 18.6% of residents are foreign-born, and 46.5% live in a house in which they speak a language other than English. For 20.9% of these foreign language speaking residents, their language is not Spanish – totaling 10,322 residents. (U.S. Census 2000) The Hartford Health Survey 2003 reported that almost one-third (30%) of Hartford residents receive their routine medical care from hospital clinics (21%), the emergency room (5%) or other sites (4%) instead of from a traditional primary care home (HHS 2003.) The true percentage of use of emergency rooms is likely to be even higher than estimated, because the HHS surveyed only individuals who were fluent in English and Spanish, and had a telephone and a valid
address. Most of the homeless and some illegal immigrants in the community are missing at least one of those key criteria, and were likely overlooked in this survey.

There are a few health clinics designed to meet the needs of the medically underserved in Hartford. Hartford Hospital and St. Francis Medical Center each have out-patient clinics which accept state insurance, but they do not provide free care to people without insurance. They only provide emergency and inpatient services to those without insurance. Recently, in 2007, Hartford Hospital had to close its doors to new patients enrolling in the outpatient clinics, except patients with a particular type of state insurance. There are two Federally Qualified Health Centers in Hartford: Charter Oak Health Center and Community Health Services. Both provide services to the underserved and uninsured regardless of their ability to pay. (CTPCA, 2006) The Charter Oak Health Center also targets the homeless population by sending visiting nurses to various shelters for regular health care services. (Charter Oak, 2007) Community Health Services also provides services in English, Spanish, Romanian, Haitian Creole, Bosnian, Russian, Albanian, German, and French, and can use a language telephone line for other languages. (CTPC, 2006) Despite these services, Hartford remains designated as a medically underserved area, and this is unlikely to change as the population grows and as the medical services remain stable or decline. It is likely that Hartford could use another medical clinic that could provide comprehensive primary care services similar to a federally qualified health center.

The above data on the state of healthcare for the underserved and uninsured in Hartford, CT is valuable to consider when planning a new free medical clinic. It is the first step in assessing the need for a new medical clinic. But this data represents
expressed need and normative need using secondary sources. (See definitions in the needs assessment section of the Background.) To complete the needs assessment, a study of community members’ perceived needs was required. The community has been labeled “underserved,” but how does that affect an individual living in Hartford on a day to day basis. Broad census assessments are notorious for missing groups of people who may not use mainstream social services and may not have addresses and phone numbers. Therefore, the initial assessment, by Dr. Mahooti, was followed up with this needs assessment study, an in-depth qualitative study, directed at measuring the perceived needs of people in the Hartford community for a free faith-based medical clinic.

**CMF Health Center**

The Christian Medical Fellowship Health Center is currently a free faith-based health center in inner-city Hartford. It is unique among most community medical clinics and even among some faith-based clinics, in that it “proactive” in its approach to spiritual care as well as comprehensive primary medical care. Being “proactive” means that “physicians will be encouraged to explore and address the faith-related issues related to their patients’ wellbeing. Patients will be encouraged, at their own pace and comfort, to talk about their faith, to talk about God’s role in their health, to pray and/or receive prayer, and to discuss anything else that they believe affects their wellbeing.” (Mahooti 2006) Overall, the CMFHC addresses the community’s needs in the context of these mission and vision statements, developed in early 2006. The CMFHC’s mission and vision statements are as follows: (Mahooti 2006)
Mission: The Christian Medical Fellowship Health Center is a nonprofit organization established to demonstrate the love of Jesus Christ by providing affordable, holistic and quality health care services to people in the greater Hartford community.

Vision: CMFHC will provide comprehensive women’s health services regularly and envisions a future where:
1) Comprehensive health care services are provided to men, women, and children in a spiritually-friendly environment honoring to Jesus Christ;
2) Patients have their physical, emotional and faith-related needs addressed;
3) Patients are educated about health promotion and disease prevention;
4) Patients take ownership of CMFHC;
5) Volunteers and staff are encouraged and enabled to integrate their Christian worldview into their daily interactions with others;
6) All involved discover God’s general and specific purpose for their lives.

The CMFHC also plans to encourage further research in the area of faith and medicine, and aims to train physicians in how to “engage patients in thoughtful, non-threatening conversations about spirituality, religion, and faith and their impact on health and wellbeing.” (Mahooti 2006)

Since the CMFHC opened on October 14, 2006, it has been gradually evolving to fulfill more of its vision while maintaining its mission. The current operations of the CMFHC and the estimated effect of the CMFHC on the community will be presented. CMFHC began providing health screening services initially, in a “health fair” format, as a way to bring many people into the clinic and spread the word throughout the local community. Before each event, fliers were posted in the surrounding neighborhood and the local homeless shelters were notified. At the time of each event, volunteers walked through the neighborhood, passing out fliers and directing people to the CMFHC. Occasionally radio and community newspaper advertisements were placed as funding and timing allowed. The first event in October was heavily advertised and approximately 30 patients came for health screening services on a Saturday afternoon.
The second health fair, on a Thursday night, had no patients, and it was speculated that this might be due to service duplication, since the South Park Inn shelter has regular medical clinics on Tuesday and Thursday evenings. Therefore, the CMFHC decided that further clinics would be on Saturdays and in an effort to ease advertising and help patients plan, each clinic would be on the first Saturday of every month from 1-3pm. Subsequent health fairs were more successful in attracting patients. Table 1.3 shows clinic utilization data from January through May.

In March, the CMFHC expanded to include acute medical visits as well as health screenings. This was timed following the collection of data for this research study in which at least ten church leaders heard of the CMFHC and some advertised the CMFHC to their congregations. The researcher also announced the upcoming clinic time to a church congregation the week prior to the clinic. Likely due to these community contacts, the patients attending the March clinic all came from private residences and the clinic was busy enough that volunteers did not go out into the streets on the day of the clinic to recruit patients. The April clinic followed a similar pattern, but in May, the church leaders were not reminded about the upcoming CMFHC clinic. During the May clinic hours, volunteers did go into the streets to recruit patients and therefore, the clinic filled primarily with residents of the local homeless shelters.

It is apparent that many CMFHC patients have to overcome some barriers to attend the clinic. These barriers include work schedules, transportation, and child care. The most striking example of this is two women who attended the CMFHC in March. Neither woman had transportation to the clinic, one woman was working as a babysitter during the clinic hours, so they believed they could not attend. However,
their pastor, knowing their lack of healthcare, drove them to the CMFHC himself and watched the children while the women saw the medical doctors. Listed in Table 1.3, approximately 30% of the CMFHC patients do not have a medical doctor. Also, Spanish translators have been required at four out of six CMFHC events.

Currently, the CMFHC is open on the first Saturday of every month from 1-3pm for both health screenings such as blood pressure, glucose, hemoglobin, cholesterol and pregnancy tests, and for medical consultation for acute problems. The CMFHC has Spanish translation available always and occasionally has Portuguese translation as well. As the volunteer base grows, the CMFHC will increase its hours to twice a month clinics. The CMFHC plans to expand to towards comprehensive primary care services, initially by providing women’s health care while continuing to see all adults for acute medical problems. The choice to expand to women’s healthcare first is due in part to the acquisition of a portable ultrasound machine and the particular medical interests of the CMF director and generous donors.

Needs Assessment Process

Now that the context has been described for the beginning of the CMFHC and its desire for a needs assessment of the Hartford community, this thesis will examine the needs assessment process through the lens of Community-Oriented Primary Care and the general needs assessment literature.
**CMF Health Center as a Community-Oriented Primary Care Center?**

The Christian Medical Fellowship designed the CMF Health Center through a combination of investigative studies, professional opinion and community input. They seek to provide quality primary care services at the CMFHC which are holistic and targeted to the needs of the community, and the community will be an integral part of the volunteer base in addition to utilizing services at the clinic. Overall, CMF has been combining epidemiology and community medicine to build support for the health center and to enhance its medical services. This process of linking the community to decision-making about the provision of medical services and to the evaluation of services is the cornerstone of community-oriented primary care (COPC). Therefore, here is a review of the COPC model and a discussion of its potential applications for the CMFHC.

**Overview of Community-Oriented Primary Care**

History of community-oriented primary care

The theory of COPC can be traced in the literature back to 1921 writings by John Grant, and its concepts are occasionally summarized as “population-based medicine,” the combination of personal primary care and community medicine or as the application of epidemiology to primary care (IOM, vol.I, 1984.) But it was popularized and coined “Community-Oriented Primary Care” by Dr. Sidney Kark in the 1970s, after he had been using the concepts for many years. (Boufford and
Shonubi, 1985.) Kark saw a need to combine epidemiology and community medicine as a way to strengthen and enlarge the impact of traditional primary care services. He sought to develop primary health care that would “not only respond to the expressed needs of individual patients seeking care and treatment when ill, but also functions with communities and families as a public health or community medicine practice in promoting community health.”

Theoretical Concepts in COPC

Sydney Kark’s views were developed at a time in history when most major medical advances were focused on hospital services for the very ill population, and many individuals, especially those low-income earners, began receiving their primary health care in the hospital based out-patient clinics or emergency rooms. The administrators of hospitals were rarely in direct contact with the communities that they served, and there was no place for community involvement in the development of their own health care. Despite the technological advances, the depersonalization of primary health care contributed to a net detrimental impact on the health and well-being of communities. Overall, the United States’ health care services continue to model the depersonalized hospital-based services of the 1970s. As previously mentioned, the majority of low-income families in Hartford, CT receive their primary health care from clinics or emergency rooms at Hartford Hospital, St. Francis Medical Center, and Connecticut Children’s Medical Center. While patients are receiving more of their health care from hospital based services, little relationship has been found between the amount of medical care facilities, such as the prevalence of doctors, nurses, and acute
hospital beds, and mortality rates in developed countries. It is well-accepted that, ideally, primary care services should consider "social, cultural, and behavioral aspects of the patient's history and life situation," (Kark, 1981), should focus on the families of patients' as important determinants of their health, and should provide continuity of care for patients. This may be best accomplished when the community is brought into the medical practice. Kark argued that good primary care medicine would have to be community medicine. Since the CMF Health Center seeks to provide excellent primary care, it seems that its development might be appropriately compared to the development process for community-oriented primary care practices. (Kark, 1981)

Definition of COPC

The Institute of Medicine standardized the definition and the process of development of community-oriented primary care in 1984 after examining seven medical practices that at least in part used COPC concepts. It defined COPC as

the provision of primary care services to a defined community, coupled with systematic efforts to identify and address the major health problems of that community through effective modifications in both the primary care services and other appropriate community health programs.

Therefore, a community-oriented primary care center needed three components.

1. a practice or service program actively engaged in primary care
2. a community for which the practice has accepted responsibility for health care
3. a process by which the practice, with the participation of the community, identifies and addresses the major health problems of the community; this process consists of:
a. defining and characterizing the community
b. identifying the community’s health problems
c. modifying the health care programs of the practice in response to the identified community health needs
d. monitoring the impact of the program modifications.

(Other commentaries on COPC add two more components: the complementary use of epidemiological and clinic skills and the accessibility of the primary care services. The author believes these are more appropriately addressed in the context of point 3 above, and therefore, will use only the IOM’s definitions in this description.) A conceptual model of COPC which includes the primary care practice, the denominator population (community) and the COPC process is shown in Figure 1.4. (Nutting, 1986) A second figure, Figure 1.5, by Rhyne et al. shows the COPC process and its emphasis on community. (Strelnick, 1999)

CMFHC as a model of COPC?

In reference to the definitions proposed above, we will examine how the CMF Health Center could be a good model of COPC and later address whether COPC is the best model for the CMF Health Center to adopt. Currently, the CMF Health Center is actively engaged in primary care, including both preventive and curative services. Though the scope of these services is not large, the CMFHC hopes to maintain these duel services as the health center evolves toward extended office hours and more comprehensive services. The community for which the CMFHC accepts responsibility has not yet been defined. This study will help define the community best targeted by
the CMFHC. This study also is the first step in a long-term process to determine the major health problems in the community, adjust health programs to address these problems and monitor the impact of services provided at the CMFHC.

Practical Development of COPC

The Institute of Medicine provides a guideline to further quantify a program's development toward a community-oriented primary care practice. Each of the four process components above (a,b,c,d) can be evaluated on a 0 to IV scale. (IOM, vol.II, 1984) See Table 1.6 (Nutting, 1986) for the complete definitions of each stage. Seven primary care practices, varying from large publicly funded practices to tiny 2-practitioner private practices, were evaluated on this scale. Each practice had at least one care provider dedicated to the implementation of COPC in a form fitting to the community provided by the practice. Most of the seven sites were operating at stage III and IV for defining and characterizing their community, stage III for identifying community health problems, stage III for modifying their health care program, and stage 0 for monitoring the impact of program modifications. While no site had implemented the full breadth of COPC, each showed that COPC concepts were flexible and could benefit all types of communities across the United States. (Nutting and Connor, 1986) This needs assessment in this research of the Hartford community will begin CMFHC's development as a potential COPC—a full description of the implications for CMFHC will be discussed at the conclusion of this study.
Recent Debate on COPC

Of note, the Institute of Medicine’s most recent report on primary care in 1996, did not specifically endorse community-oriented primary care as the model of primary care that deserves widespread implementation. (Donaldson et al., 1996) There have been concerns that the cost of continued epidemiologic studies and program evaluation would be overbearing in most primary care practices across the United States, and there have not been outcome studies to show definitively that community-oriented primary care changes health outcomes at a population level. The ever changing reimbursement structure for primary care services does not yet finance some of the research and clinical programs that are part of a COPC practice. “A justifiable concern persists that both the level of coordination and organizational and financial flexibility required by COPC can be achieved in the pluralistic, preponderantly private practice system of primary care in this country.” (Nutting et al., 1985) However, the IOM’s recent definition of primary care includes “practicing in the context of family and community” and the spirit of COPC is evident in this broader definition of primary care.

This committee has defined primary care as the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The committee recommends the adoption of this definition by all parties involved in the delivery and financing of primary care and by institutions responsible for the education and training of primary care clinicians. (Donaldson, 1996)

Some of the relevant recommendations of this IOM report that echo values of COPC are listed below.

Primary care improves the quality and efficiency of care and expands access to appropriate services; it also forms an important bridge between personal health care and public health, to the advantage of both.
The committee believes that the quality, efficiency, and responsiveness of primary care are enhanced by the use of interdisciplinary teams and recommends the adoption of the team concept of primary care wherever feasible. The committee recommends that public or private programs designed to cover underserved populations and those with special needs include the provision of primary care services as defined in this report. It further recommends that the agencies or organizations funding these programs carefully monitor them to ensure that such primary care is provided.”

Community-oriented primary care has not been forgotten in the literature, but rather has more recently been incorporated into a broader definition of primary care that will serve to strengthen the administration of primary care by many varied practices across the United States. Furthermore, COPC remains a viable model for the CMF Health Center since the financing structure, academic vision and altruistic purposes remove some of the traditional barriers to developing COPC practices.

Needs Assessment as part of the COPC process

As defined above, in a community-oriented primary care model, the primary care practice must have a process to identify and address the major health problems of a community. The process, previously described in four headings, could be simplified with these headings: (1) characterization the community, (2) needs assessment of the community’s health problems, and (3) program evaluation of practices or programs directed at those health problems. This change in language describing the COPC process, leads into the well established public health fields of needs assessment and program evaluation. The CMFHC has studied and characterized the community in a previous study as described above (Mahooti, 2006.) This study will focus on the current step (2) of needs assessment, which will be described below. Program
evaluation will be the next step (3) for the CMFHC, and this is addressed in another research study concerning the development of a pilot evaluation tool to be used by patients at the CMFHC. Therefore, discussion of evaluation techniques will be deferred to future studies.

Overview of Needs Assessment Literature

Definition of “Need”

The Webster Collegiate Dictionary states that a need is “a lack of something useful, required or desired.” It also can be described as a “necessity or obligation,” however, the word necessity seems to lack the emotional connotation inherent in the word “need.” The word need also implies that an urgency is present that compels action. This is an important distinction between “wants” and “would likes” because to engage in a needs assessment is to identify needs that must be acted on not merely to superficially improve people’s lives but to significantly fill a gap and contribute to bringing a person closer to his/her potential – healthier, more educated, more secure, etc… In the context of a needs assessment concerning faith and medicine, it must be shown that a faith-based medical center would fulfill something lacking in a group of people. More specifically, it would show that some people would be healthier and happier if their faith could be more incorporated into their healthcare, and that without this service they would be lacking complete, holistic healthcare.
According to McKillip (1987), a need is a “value judgment that some group has a problem that can be solved.” This definition reminds the reader that “because needs involve values, different people may perceive different needs for the same situation.” Often in the social services realm, there are discrepancies between the service providers’ opinion of what a population needs, and the service recipients’ view of what they need. (Nagle, 1995.) These two groups of people often come from different communities, socially and ethnically, and have different views of what makes a good life or a healthy person. Without an evaluation of needs from the recipients’ point of view, along with an assessment of the environmental context in which these recipients live, many seemingly needed services can go unutilized. Secondly, McKillip’s definition of need uses the word “problem” which should be something that can be measured and solved. A problem can be “an inadequate outcome that falls short of expectations.” In identifying needs, the service providers or recipients must be able to identifying an outcome, in a way that the improvement of the outcome can be detected over time. Overall, during a needs assessment the researchers must remain solution oriented. (Nagle, 1995)

Definition of “Needs Assessment”

Keeping in mind this definition of need, a needs assessment is a systematic exploration of the way things are and the way things should be. Another useful definition is “A systematic process to determine the service needs of a defined population; a definition of the extent of need, available services, and service gaps.” (Portland Area HIV Planning Services Council, 2003) A comprehensive needs
Assessment would ideally use empirical evidence from research to identify needs and solutions, instead of using intuition or isolated experiences. It should gather data from many groups, both the providers and recipients of services and also from those who make decisions about those services (ex. Policy makers or hospital administrators.) The research team should include members of the community and representatives of any major group of stakeholders. The goals of the needs assessment should include development of an action plan to solve the problems (needs) discovered and a plan to disseminate findings. (Finifter et al., 2005.)

Methods of Needs Assessment

Approach to Needs

Many methods for needs assessments will be reviewed. Assessments can be organized by the approach in defining and measuring need. Nagle describes four distinct approaches labeled “normative need, relative need, perceived need and expressed need.” “A normative need implies the presence of some norm or standard, with need being evaluated against some standard.” Standards have been set in many fields by professional bodies such as the American Medical Association, the CDC, local school boards, the EPA or other divisions of the national and state government. For example, a town could have a normative need for a particular vaccine simply because the government has mandated it for school entrance. This approach is helpful for initial program development, but can be difficult in fields in which norms and standards change rapidly.
A felt or perceived need is what "people think or perceive are their needs or expectations for services outcomes." This approach assumes that individuals in the target population have insight into their own needs. This is a helpful approach when adjusting services to be responsive to clients, though data can be variable and individualistic and it may be difficult or simply not feasible to make "needed" changes to a program. Studying perceived needs also raises the expectations of the clients and will require good communication between provider and client as possible changes are made.

An expressed need is "an estimate of the percentage of people whose perception of need has been mobilized into action." This is measured by analyzing the actual utilization of services. Long waiting lists for services or empty community seminars may be indications of the needs of a community. However, in the case of a long waiting list for primary care doctor appointments, it could be interpreted that this service is highly needed as it is, which would maintain the status quo. When in fact, the service may be needed in a different form that does not exist in the community and therefore patients cannot access it.

Last, a comparative or relative need is a "disparity existing between two groups" that are comparable due to some shared characteristic. For example, the two groups could be children of the same age who attend different schools, people of the same ethnicity who live in different geographical locations or women across the country of two different socio-economical classes. Comparisons between two groups may reveal gaps in services or in utilization of services, which may indicate some need
in one group. Evaluators have to be careful to take into account confounding differences between the two groups when making comparisons.

It may be useful to use a few of these approaches when identifying needs, since each has different pros and cons. A combination of approaches will reduce bias and will be more likely identify consensus needs that are agreed upon by multiple stakeholders, including financers, providers and clients. (Nagle, 1995)

Choosing a Research Team

For any needs assessment, a team approach usually produces the most representative and most useful data. The research team is a working group responsible for the planning, implementation, interpretation and finalization and dissemination of study results. (Nagle, 1995; Gilliam et al., 2002) Ideally, the team should be composed of a composite of stakeholders committed to the community being studied. “Stakeholders” are defined as “people who have a vested interest or stake, whose lives are affected by the program, and whose decisions can affect the future of the program.” In the setting of a community needs assessment for a faith-based free medical clinic, the stakeholders would be the financers, the volunteers and service providers, the utilizers of the clinic (community members) and those individuals affected by the health status of utilizers of the clinic (children, church leaders.) Often stakeholders have different goals and priorities, but by working together they produce program ideas that are most likely to be supported by all and implemented successfully. A neutral facilitator is useful for coordinating activities and ongoing communication between stakeholders. Engaging the full breadth of stakeholders means “fostering input, participation, and ownership sharing among those who have a stake in how the
evaluation is conducted and what will be done with the findings.” (Gilliam et al., 2002) While professional evaluators and scientists may be best suited for the implementation and analysis of the needs assessment, the community stakeholders should be active participants during the planning and design stage and also in the finalization and dissemination of the study findings. (Gilliam et al., 2002)

Types of Data Assessment

There are numerous methods for needs assessment, each with its own advantages and disadvantages. In this review, we will discuss resource inventory, social indicators, surveys, and structured groups.

A resource inventory is often quick and inexpensive, but the data is least specific. Resource inventories are a compilation of services available to the target group in a specific service area combined with an analysis of utilization patterns of these services. It usually includes a description of available services, who is providing the services and who is using the services, and what is the service capacity. This data can often be found in hospital and state agency records. The resulting utilization rates are a measure of “expressed need” and may be used if measuring “comparative need.” However, “utilization rates represent manifestations of problems that have already developed; they are not helpful in prevention planning” (Nagle, 1995.) As mentioned above, conclusions from this type of needs assessment may simply maintain or duplicate the status quo. While clearly not sufficient for a needs assessment, this resource inventory may serve as an important initial step and help direct further needs assessment.
Social indicators are also inexpensive and easy to access, and may be valuable in finding at-risk populations. Social indicators include data such as socioeconomic status, racial composition, educational levels, health status, and housing patterns. This data can be found in government publications like the census or other surveys, schools, health organizations and social service agencies. However, use of this data “presumes that need estimates can be inferred by considering selected statistics that have been found to correlate highly with service utilization.” (Nagle, 1995) There must be substantial evidence in the literature to back up these correlations to make this data useful. Also, this method is dependent on the social indicator data sources for being up-to-date and relevant for the current time. Overall, this is an indirect measurement of expressed need (utilization rates) but it may serve to direct subsequent more specific types of needs assessments.

Surveys are the most common method used in needs assessments in part due to the breadth of different kinds of surveys. Surveys can range from impersonal to ultra-personal and quick to lengthy, an appropriate survey type can be found along that continuum to suit almost any needs assessment. The researcher should consider the scope of the assessment, the technical expertise of the research team, and the resources (time and money) available to conduct the assessment. (Nagle, 1995.)

If the assessment requires gathering information from a large number of respondents, questionnaires may be the best way to collect data. They are a quick way to reach a large number of respondents and the data gathered is usually quantitative which makes analysis simpler. Questionnaires can be distributed by mail, with response cards included or they can be read over the telephone. They can be more
costly than expected due to postage or telephone costs and there can be a delayed turnaround time with mailed questionnaires. Also, the written or verbal introduction that invites a respondent to participate in a survey needs to be carefully written or else response rates can be low. In-depth interviews are an alternative to questionnaires if only a small number of respondents are needed, and qualitative data is preferred. Interviews rely highly on the skill of the interviewer to build rapport, but when that is done successfully the quality of information gathered may be very detailed and relevant. A good interviewer can gather honest answers from marginalized individuals who might be hard to reach through a phone or mailed questionnaires or hesitant to answer truthfully (McKillip, 1987.) If necessary, interviews can be conducted over the phone, but it is much harder to build rapport by telephone. Overall, interviews are more time consuming and travel costs can be expensive, but they produce rich, qualitative data. (Nagle, 1995)

Concerning all survey methods, a decision should be made about sampling, which can be random and representative, or purposeful. If the needs assessment targets a large group of clients that all use the same set of services, a random sampling of the entire community will provide the most direct assessment of their felt or perceived needs. This helps to foster community participation and can help build support for any resultant programs to meet their needs. The disadvantages of this approach include the cost of such a broad sample and the potential for a one-sided perspective of the problem or need, i.e., sometimes we do not see our own needs as well as others do. Another option is purposeful sampling, which is directed towards individuals who have a valued perspective or expertise about a problem. Their acquaintance with the
community being studied might enable them to estimate the “perceived needs” of that community. Otherwise, they will be able to describe the expressed or comparative needs of the community based on their frequent observations. These individuals are termed “key informants” and they might include community officials, parents of school children, public health officials or medical experts. “If a diverse sample of key informants is used, the needs assessor can receive a comprehensive impression of the needs of … the community.” (Nagle, 1995) This sampling technique is simple to arrange and relatively inexpensive. It also can serve as groundwork for cooperation between many agencies and individuals with common interests, as the researcher travels from group to group building connections. The major disadvantage is that the key informants may be biased from their own unique perspective and may not fully grasp the needs of the clients. Therefore, careful attention should be paid to the adequacy of number and type of informants used. Overall, key informants are a valuable first step in a needs assessment as they become key players in the future solution of a problem. (Nagle, 1995)

The final methods to be discussed here are structured groups, including focus groups, nominal groups, Delphi techniques and community forums. These group models are most often supplementary to structured models like surveys, but they can be the most informative because they involve active discussion among interested parties. When the group is a sample of the community, this method may be one of the best ways to hear directly what the perceived needs are in the community.

Focus groups are “guided discussions intended to yield information on specific topics relating to feelings and beliefs about needs from a selected population.” (Nagle,
These groups usually include six to ten participants, a moderator and a recorder. The moderator asks open-ended questions such as “What about drugs and alcohol?” or “Why violence?” which are designed to produce discussion. The focus is on the quality of information rather than the quantity. To ensure free interaction among the participants, homogenous grouping is recommended. If the community being studied is not entirely homogenous, the groups should consist of homogenous subsets of that community. However, too broad a representation will take away from the in-depth and comprehensive potential of a focus group method. Nagle states that while “focus groups may be viewed as being quite similar to open-ended interviews, research indicates that focus groups are frequently superior... because of the synergistic effect which results in more identified needs and solutions.” Focus groups are useful in delineating differences between different audiences, such as professionals and the clients they serve. (Soriano, 1995; Nagle, 1995)

Nominal group technique is designed to overcome the common problems of group dynamics and “the term nominal describes the process of bringing groups together but minimizing verbal communication.” (McKillip, 1987; Miller and Hustedde, 1987; Nagle, 1995) These groups need not be as homogenous as focus groups are because they are tightly structured and involve written responses instead of relying on quality discussion. Interaction does occur as group members write down ideas, formally share the ideas, then rank each other's ideas and a summary of the results is presented. In the end, each nominal group will produce one solution to a given problem. To ensure this solution is acceptable to all stakeholders, the group should include a member of each interested stakeholder party.
The Delphi technique was designed to develop a group opinion among experts in a particular field, and it uses successive questionnaires administered to a “panel” of experts. These “panelists” are separate in space and time. They all receive an initial questionnaire with questions about a problem situation. When the questionnaires are returned, they are summarized. This summary forms the basis for a second questionnaire which asks panelists to agree or disagree with the central tendencies of the group and then ask them to clarify this judgment. A third questionnaire again asks panelists to rank their collective opinion and the process continues until there is a general consensus among the group. This technique is most useful if the experts have a high motivation in participating and if they have well developed writing skills. It can be used to avoid confrontation if the topic is controversial. But the Delphi technique is primarily used to supplement other needs assessment methods, because it does not identify needs directly but rather summarizes the needs in order to ease future action plans. (Nagle, 1995)

The last group method to be discussed is the community forum. A community forum is a public gathering, open to all in the community, with a leader designated to present questions for the group to discuss. The meeting should be highly publicized and held at a convenient time and location to ensure that a representative sample of the community will attend. The research team should record all comments and have a sign-up sheet for participants to show how representative the meeting was of the community and for follow-up contact with participants. This method is appealing because of its ease of arrangement and inexpensive and quick collection of data. However, the validity of the data is largely dependent on the representation of the
community in the meeting and forums can easily become dominated by one particular interest group. Also, certain sub-groups of the community may be unable to attend the meeting due to work schedules, physical impairments or other constraints. Therefore, the researchers should consider providing services such as transportation, child care and food at the event, to increase the participation of all relevant sub-groups. Overall, this method can be useful if the community is proactive, available, and insightful about their own needs. (Nagle, 1995)

Best Practices

Overall, the research team’s ultimate choice of assessment method should be guided by some generally accepted principles. First, researchers must resist the urge to rely on intuition, “common knowledge” or anecdotal information when assessing a problem. Instead, the team should develop empirical evidence from research to identify a community’s needs. Second, this empirical evidence should be collected from a broad range of sources, i.e., as many different stakeholders as possible, and using both quantitative and qualitative methods. This describes a multitiered needs assessment. Data should come from the “target population itself, those who provide services to the target population and those who make decisions that affect the target population.” (Finifter 2005) Third, to avoid the lack of implementation of recommended solutions, researchers must maintain an “action orientation” throughout the assessment process. A plan for dissemination of findings and implementing solutions must be in place so that action occurs in a timely fashion while the community remains expectant and excited, and while the data collected remains up-to-date. Last, the assessment process should be inclusive of community leaders, service
providers and members of the target population, in addition to the researchers who will conduct the assessment. Each group brings different skills and the process helps to build a network for implementing the results of the assessment. These principles, though sometimes difficult to use, will guide the research team through a needs assessment process that will produce the most productive data and solutions possible. (Finifter, 2005)

**Objectives of the Needs Assessment**

1. Determine if there is a perceived need for a free faith-based clinic in Hartford, CT.
2. Determine the nature of the need.
3. Determine the extent of the need.
4. Estimate how well current providers are meeting the need.
5. Develop a body of ideas on how to best meet the need.

**Methodology of the Needs Assessment**

**Scope of the Needs Assessment**

This research study aims to determine if there is a perceived need for a free faith-based medical center in the Hartford community. This study builds upon a previous study that focused on quantitative census and hospital data which showed an
expressed need for another medical clinic to serve the urban poor and underserved in Hartford, CT. That study also established that nationally patients indicate they would like their doctors to inquire about spiritual health and/or pray with them at medical visits. This needs assessment will focus on determining if people in the Hartford community are similar to the general population in their desire for the spiritual component of health be discussed in a medical visit. This study is the first of its kind in Hartford, and therefore, will seek to establish whether a body of people exists who would approve of a faith-based medical center. It does not seek to show that a majority of Hartford residents, or a representative group of Hartford residents, would approve of a faith-based medical center.

Design of the Needs Assessment

Given the limited scope of this needs assessment, the study used a purposeful sampling method and sought rich, in-depth data through key informant interviews and focus groups. The substance of the questions focused on the felt or perceived needs of community members, either directly from those members themselves or indirectly through trusted individuals who know them well – church leaders and community volunteers. The perceived needs of individuals were viewed as the most useful type of need to assess since it is the most direct measurement of need. Since perceived needs can be variable and individualistic, interviewees were chosen who might have somewhat uniform views and at least have a similar societal perspective. Also, by directly speaking with community members and church leaders, this would form a network from which the faith-based clinic would continue to draw its patients and
which would help spread work about the clinic through the various service ministries of the churches. Church leaders were chosen as key informants because of their unique perspective on the spiritual health of the Hartford community. Also, church leaders often are privy to the personal struggles of church members since they are sought out for prayer and guidance during difficult times. Therefore, many church leaders may know details of the health status of the members of their church congregation. The focus groups were intended to add a community perspective to the assessment and make the study multitiered. Focus groups were intended to consist of congregation members who live in Hartford. Since church congregations tend to be homogenous in ethnicity and other characteristics, this would help make the groups homogenous which facilitates an open and honest discussion.

Plan for dissemination of findings

The results of this needs assessment will be presented to the directors of the CMF faith-based medical center and to any interested members of the academic medical community. Since the CMF Health Center is new in its operation, it is also flexible in its design and will consider implementation of any ideas resultant in this study.
METHODS

Recruitment of Key Informant Participants

Key informants were selected using two methods. First, a geographical map of the CMFHC area was made using the address 48 Main St. on Mapquest.com. “Church organization” was then selected on the Locate function, which produced a listing of churches ordered by distance from the CMFHC. All churches within a one mile radius from the clinic were identified, totaling 43 churches. These churches were then searched on the internet using Google.com to confirm that they were Christian places of worship. Five of the 43 listed churches were eliminated because they were not Christian places of worship. Three were Christian organizational buildings or homeless shelters, and two were Islamic centers. Two organizations were eliminated because they were part of a large church that was already included in the list. Therefore, 36 churches were identified and called by telephone to request an interview. Also, a Google.com search was used to identify the names of church pastors or administrators, so they could be asked for by name in the telephone call. Only four leaders were identified. Three were called and one was emailed and called. The remaining 32 churches were called by the researcher with a request to speak to the primary minister or priest of the church. Out of the total 36 churches, twenty messages were left with church receptionists or answering machines. Three church leaders replied to the message and consented to the interview. Seventeen church leaders did not return the phone call. One leader declined. One receptionist would not leave a message for the church leader, saying he would most likely decline to be
interviewed. At nine churches, neither an individual, nor a machine answered the telephone call. For two churches, the number listed was an incorrect number. Three church leaders accepted the telephone call and agreed to participate in the study. One had to cancel on the day of the interview due to church responsibilities and he was not able to reschedule for another time. If email addresses were available for church leaders who did not return phone messages, they were emailed approximately one week after the initial phone call. Two leaders were emailed in this manner, but did not reply to the email. Overall, five church leaders from this group (11.6%) agreed to participate in the study.

The second method for recruiting key informant participants was the use of the personal network of the researcher. The CMF director had previously attended a community breakfast at Hartford Hospital, in July 2006, regarding the state of healthcare in Hartford and focusing on new ideas for how to improve the community’s healthcare. During this event, the CMF director spoke briefly on his intent to develop the CMF Health Center. Fellow attendees at this meeting included eight church leaders, and the CMF director had a list of the names and phone numbers of those participants. Two of these church leaders were from churches within the one mile radius of CMFHC and contact with them is recorded in the paragraph above (one declined and one did not return two messages left.) The remaining six church leaders were called and invited to participate in an interview. On initial contact, one leader consented, one declined, three messages were left and one call was not answered by an individual or a machine. The researcher later repeated the call which was not answered and that leader agreed to be interviewed. One church administrator replied to the message left, passed on a
message to the leader again, and later the church leader agreed to be interviewed. Overall, three of these six leaders were interviewed (50%) (three of the eight, 37.5%, who had originally attended a community breakfast approximately eight months prior.)

Also, the researcher became aware of some small ethnic churches that did not appear on the Mapquest.com search while driving through the community on the way to the clinic, hospital or to conduct interviews. These churches were all located within one mile from the CMFHC. At one church, the associate minister was walking by as the researcher was writing down the name and phone number of the church. The minister approached the researcher and through conversation he agreed to be interviewed that day. The other three church names were searched for on google.com and the names of two church leaders and all three church phone numbers were discovered. One church was called, but it was an incorrect number. One church leader was called, a voice message was left, but the call was not returned. Another was emailed, in English and Portuguese, and he consented to participate in the study. Of this group, two church leaders (50%) agreed to be interviewed.

Figure 2.1 shows the recruitment of participants from all three methods.

Key Informant Participants

Overall, ten church leaders were interviewed. Three church leaders declined to be interviewed, one cancelled the interview, twenty church leaders did not return messages, and twelve could not be contacted due to incorrect information listed on the internet or no one answered the telephone call.
The participants included eight men and two women. Seven of the men were the senior pastor or priest of their church. One man was the associate pastor. One woman was the volunteer coordinator of the church’s social services and one woman worked at the reading room for her church. Of these ten participants, three were Caucasian, two were Caribbean American, one was African American, and one was Hispanic. Other ethnicities included one Brazilian, one Nigerian, and one Indian participant. Overall, five of ten participants had immigrated to the United States from another country. The churches they represent included seven churches within 1.1 mile distance from the CMFHC, two churches approximately 1.5-1.6 miles away, and one church 3.3 miles away. All were within the city of Hartford. Five churches served a suburban congregation with people attending primarily from the neighboring towns of East Hartford, West Hartford, Bloomfield, and Windsor. Three churches had a mixed congregation of Hartford residents and suburban residents, and two church congregations were almost entirely local Hartford residents. The ethnicities of the various congregations included Afro Caribbean, African American, Brazilian, Caucasian, French and Hispanic. All of the participants were similar in ethnicity to their congregation except for one Indian priest who ministered to Hispanic and French parishioners. The churches ranged in size from congregations of 20 to 3000 members, with the most common size being between 150-200 members. Table 2.2 shows the individual participants and the affiliated church characteristics.
Key Informant Interviews

The interviews were conducted in the church office or in a neutral location such as a local coffee establishment. The purpose of the study, and the risks and benefits of the study were explained to the participant. Verbal consent was obtained and the participant was given the research cover letter including the principal investigator’s name and contact information. The interview was audio recorded directly onto the researcher’s password protected laptop using the Audacity program. The researcher also hand wrote notes on the printed interview questions and the papers were labeled “Interview 1, 2 or 3” etc… The interview questions were qualitative in nature and were adjusted during each interview to enhance the conversational quality of the interview. There were twelve questions. The interviews lasted approximately one hour (range 30min. to 1 ½ hours) including time for comments and questions from the participant. No compensation or incentive gift was given to the participants. This method was in accordance with the approval given by the University of Connecticut Health Center Institutional Review Board.

Recruitment of Focus Group Participants

Focus groups participants were recruited through the contacts of the key informant participants. Key informants were asked if they would post a flier in their church advertising focus groups on “Faith and Medicine.” Five church leaders took the flier and agreed to post it in a visible location. Occasionally, when the interviewer felt the church congregants would be particularly valuable focus group participants, the interview asked the key informant how to arrange a group discussion at his/her church.
Two informants provided options for recruitment. One pastor suggested that the interviewer attend a Sunday evening service, introduce herself to the congregation and then he would help gather some people for a discussion during the coffee hour after the service. The priest of one church requested that the interviewer and her colleagues to speak to the children and youth group about the dangers of drugs and alcohol from a Christian medical student perspective. It was agreed that some colleagues could speak to the youth while the interviewer concurrently conducted a focus group with the parents of those youth in another room.

The researcher also decided to adopt a participatory research model due to the lack of success in recruiting focus group participants. One church ran a soup kitchen for the community out of the church basement. The researcher volunteered at the soup kitchen with a colleague, with the intention to both serve and casually discuss the idea of a faith based free medical clinic with the fellow volunteers who primarily came from the church hosting the soup kitchen.

Focus Group Participants

Overall, the interviewer received no inquiries about the focus groups as a result of the fliers posted in five churches. The informant who recommended a focus group event concurrent with a youth group meeting was not able to coordinate the event with his church staff. One focus group was conducted at a church in Hartford after the Sunday evening service. Ten people out of a congregation of approximately 40-50 people volunteered to join the focus group. (response rate of approximately 22.5%) The participants in this group included nine immigrants to the United States and one
first generation American. They were Brazilian and Hispanic in ethnicity. It was a fluid group of people, since they joined as they could and left as they needed to. There were never more than six people sitting together at one time.

Focus Group

The focus group occurred following an evening church service. First, the interviewer spoke briefly during the church service, through a translator, about the CMFHC and invited all present to attend the upcoming CMFHC clinic. Also, the interviewer requested the help of the congregation in making the clinic the best it can be, especially in the area of faith and medicine, by asking them to sit together as a group following the service for a discussion of faith and medicine (the focus group.) Following the service the interviewer socialized with the parishioners and then waited at a table in the fellowship hall for people to gather for a discussion. Participants voluntarily approached the interviewer and her Portuguese translator, primarily to ask questions about the CMFHC. Each participant stayed long enough to answer about two questions asked by the researcher. There was minimal group discussion, and the researcher had to ask more focused questions, rather than the open-ended statements written on the focus group guide (Appendix 2.) The sum of the encounters lasted approximately 30 minutes.

Participatory Research

The researcher had little success recruiting focus group participants from the various churches. Therefore, the researcher chose to attend some church related
community activities where there would be opportunities to converse with parishioners. One church had a biweekly soup kitchen which served the poor and homeless in the community. The researcher volunteered to pass out food and listened and learned from the fellow volunteers about the community’s needs. Fellow volunteers were casually asked to give opinions about the prospect of a faith-based free medical clinic in their community. Other topics of conversation included the adequacy of current services, the immediate needs for health care, the pressures of inner-city life, the values of people in the community, and the state of spiritual health in the community. CMFHC fliers were posted at the soup kitchen entrance.

Participatory Research Participants

At the soup kitchen event, the researcher spoke in depth with two volunteers and briefly described the CMFHC to about 5 other volunteers present. The majority of volunteers were from the church hosting the soup kitchen, which was a predominately African American church at the southern edge of the North End of Hartford. Of the two volunteers with whom the researcher spoke most, one was a young man who lived on “gun alley” in Hartford, and the other was an older woman who grew up in Hartford, but lived in Bloomfield, CT at the time of the conversation.

Analysis of the Data

Key Informant Data

The data from each interview was reviewed by reading the handwritten notes and listening to key parts of the audio recordings for further clarification. One to two
page summaries of each interview were made, with the data separated by question
headings. Then the summaries were coded by highlighting key words and key ideas.
These highlighted sections were then groups together according to common themes.
The common themes across interviews became individual paragraphs. No themes were
left out from the data analysis, even if only a single informant identified a theme. The
data is reported on under the question heading it was gathered under, unless an
informant repeated one theme multiple times in multiple questions. Quotes were added
to the report directly from the audio tapes with the permission of each informant.

Focus Group Data

The researcher wrote hand-written notes during the focus group session. No
audio recording was made. Immediately following the focus group, the researcher
wrote a more comprehensive summary of the event and the opinions of the participants
using the notes taken. This summary is provided in its entirety. Since there was only
one focus group, general themes highlighted represent that small subset of people.

Participatory Research Data

Through the community experiences had by the researcher, her thoughts were
periodically written down following any events of educational value. These thoughts
are summarized, without using any formal coding method. The data is organized to
highlight key themes emphasized by the community members.
RESULTS

Key Informant Interviews

As previously mentioned, the key informant interviews consisted of eleven questions which can be viewed in Appendix A. The first question prompted the informants to provide a demographic description of their church and these demographics were previously discussed in the Methods and are shown in Table 2.2. In this section, the responses to the remaining ten questions will be described in detail. Quotes from the informants are referenced by interview number (see Table 2.2.)

Spontaneous Comments

Before beginning the results description, it is important to describe some comments by the key informants that were given in response to the question: Tell me about your congregation. While most described the congregation in terms of demographics, some key informants spontaneously gave statement about their theology or their view of faith and medicine. These statements are summarized here because the spontaneity of these unprovoked comments may hold some significance.

Two informants emphasized the plight of their congregations upfront in the interview. One explained immediately that his parishioners were mostly illegal aliens and had no access to healthcare because they were afraid of medical institutions. He volunteered for this study because he wanted to be an advocate for his congregation and help connect them to potential safe medical services. Another informant added to his demographic description of the parishioners, that many were migrants and seasonal
workers with little stability in their life, and they were transiently involved in the
county at different times of the year. Three informants emphasized that despite their
suburban congregation, they were dedicated to the Hartford community. These
parishioners could choose a church in the suburbs, but instead they choose Hartford to
worship because they are “community-oriented” and share an ethnic identity with
Hartford residents, or simply because their beliefs lead them to a “commitment to
urban ministry” and a “desire to want to help the Hartford community.” Last, two
informants immediately mentioned their church’s theology in relation to medical care.
One of the church denominations was founded in part to draw people away from faith
in herbal medicine or tribal medicine and refocus them on faith in God and Jesus Christ
for all their needs. The other informant described that they believe Jesus Christ is the
source of all things we need in life, and they go to Him first for all their holistic needs
—including physical and spiritual needs. In all circumstances they believe “The Lord
will make a way somehow” and all things are possible.

Church Health Programs

Before embarking on questions to explore the personal opinions of the key
informants, they were asked to describe current health programs at their respective
churches. The responses revealed a wide array of health services provided at churches
which can be described as denomination centered or local church centered, and
education focused or access focused. Overall, these churches provided a mixture of
programs designed for parishioners and programs designed for the outside community,
and 8 of the 10 key informants described some kind of faith-based health program.
Two informants acknowledged that their Christian denomination provided some access-focused health services to those who need it through various programs. One informant described a mobile clinic which operates out of St. Peter’s church parking lot, run by the Catholic Archdiocese’s “Knights of Malta.” This is an access focused service because it provides free medical care to individuals without medical insurance. His own local church does not have any local health programs, but he would be interested in bringing some health education seminars to the congregation. The other informant belonged to a Christian Science church which operates its own health system by training its own medical treatment providers and visiting nurses, and by maintaining facilities similar in function to nursing homes or sanatoriums. They also provide literature on the theology of science and health, and in doing so, overall, address both access to care and education.

The majority of informants interviewed described health programs financed and supported by the local church and its volunteers. The extent of health programs was roughly proportional to the size and history of the church. The largest church developed a “Wellness Center” which is a partnership with a local college’s nursing student program. Together they provide education and access to medical care, through seminars for parishioners at the church on “Wellness Sundays” and health services at the church or at the church’s outreach ministries. These health services include health screenings, health and nutrition education, and social work services. The church is able to support many outreach ministries such as a “Sandwich ministry” which provides sandwiches daily to the community’s poor, a housing program titled “Catherine’s Place” which houses homeless women with concurrent substance abuse problems, and
a high school diploma program for teenage mothers titled “Julie Education.” This shows that the church views wellness as including spiritual, physical, mental and emotional health. The breadth of services also show this church’s belief that it is their responsibility to help both the church members and the entire community.

Four medium to large size churches also provide health programs at their church, but these are primarily education focused. Two churches conduct health fairs with health booths or a mobile van on their property. These fairs offer some medical care, but also a large amount of health education. One of these churches is considering having a free health clinic, for parishioners and for the community, which would operate in the church building on Saturdays. For now, their focus remains health education. Health seminars are the most common way for one church to disseminate health information to the congregation. These seminars occur about one to three times yearly, usually during Sunday School hours or special events, such as Men’s or Women’s luncheons. One church is participating in the Go Red campaign (American Heart Association) for women’s heart health and another has a Healthy Heart Ministry which is a partnership between many churches to promote healthy lifestyles in their congregations. Only one of these medium-sized churches plans to address access to healthcare for their members, though they will do it through an educational format. They are having a seminar on how to navigate the health system and how to access services currently available in the community. They also have a “sick list” which lists homebound ill members who will receive visitation from the pastor once per month. Overall, these medium sized churches recognize the need for health care access and
information, but they are more equipped to provide medical education rather than expensive health care services.

There was one church with a medium size congregation but a large church endowment, and consequently their health programs were primarily financial in origin. They focused on access to care and had a “Hartford Hospital bed fund” through which any parishioner who received services at Hartford Hospital could be financed in full for the medical costs incurred. They had a second fund for “health and housing” which could help with outpatient costs such as prescription drugs. This informant hoped to bring more health education and health fair activities to the church.

Only two informants said there were no health programs at their church. One stated that any extra money the church has is sent to the families of parishioners who live in foreign countries, so there is little left for any extra events at the church. However, he does emphasize the importance of physical health to his congregation and seeks to help them access healthcare. He hoped that the meeting with the researcher could lead to a new partnership to improve access to healthcare for his congregation.

Overall, it is apparent that the spiritual community has embraced physical health as important in the lives of their parishioners, and they have welcomed medical providers into the spiritual setting of churches. While it remains to be seen if they have thought about faith and medicine as related ideas, they have been participating in faith-based medical activities in their own buildings. Those churches with the resources to do so, address physical health in their congregation and in the community, and those without the resources hope to find creative ways in the future to help parishioners, and the community at large, become physically healthy and stay healthy.
Access to Healthcare

When asked about the challenges their congregation has in accessing healthcare services, three groups of participants emerged based on their common experiences. The informants from four suburban churches estimated that their congregations have full access to healthcare and can pay for prescription drugs, although they may use various foundations to help with these costs. The second group, three congregations with a mix of Hartford and suburban residents, had access to healthcare but they may be underinsured and unable to access certain special services. They also have trouble paying for prescriptions. The third group, two congregations serving primarily Hartford residents, did not have access to healthcare for a number of different reasons. Finally, there was one large inner city church that could not fit into a particular group because of the breadth of experiences of its church members. It had members who were fully insured, some who were underinsured, and a significant part of the congregation had no insurance or “zero healthcare.” (10)

In the first group of informants, whose congregations had access to healthcare, only one informant said access to healthcare was simply not a problem. The other three informants all qualified their responses by saying some parishioners need more help than their health insurance can provide to receive adequate health care. These parishioners receive additional financial help directly from the local church, or they use church related financial services such as the “Benevolent Fund” in the Christian Science Church. (3) Also, some ministers help parishioners find additional financial help through local private foundations. The combined efforts of the private and
government health insurance programs combined with the generosity of the churches, leads to adequate healthcare services for these congregations.

In the second group, there was a common theme of discontent with the healthcare services the parishioners receive. Specifically, lack of money for prescription medicines was the biggest complaint, with two individuals saying that “some [parishioners] have to choose between food and medicine” (8) or “between rent and medicine.” (7) Also, one complained that dental care is lacking in most of the parishioner’s health insurance coverage, so they depend on a mobile clinic that offers dental services. One informant spoke from her experience working with women in the church shelter and from speaking with many people served through the various church programs. She said,

“They are highly underserved. The programs that are in place with the state involve long lines and no education. … There is not a continuum of care for them. … That is one of the main reasons for the Wellness Center, that this is such a poorly served group… I know a lot of people and places who won’t take SAGA [state health insurance] and that eliminates you out of care. … The services are really lacking, but the problem is that the population is accustomed to being disappointed.” (5)

Overall, she suspects that these needy people are difficult to identify and may remain hard to reach because they distrust the medical system and their distrust is bigger that their perceived need for medical care. So, a good service provider should go into the community to make herself known, and then be very consistent and reliable in meeting the community’s needs.

Finally, the third group of informants reported that some people do not have any access to healthcare in Hartford, CT. Two spoke on behalf of these people who are primarily new immigrants and may be illegal residents. One informant said “Access is
the main problem people have with healthcare” and they end up paying out of pocket for many services when they are in dire need of healthcare. “People are afraid of getting sick… [Access to health care] is the main problem.” (4) The other informant described access as a “big problem” since many in his congregation have no health insurance. The complete lack of insurance is typical for his ethnic community, and he estimated that this community totaled about 7,000 to 10,000 people in Hartford. These people do not know how to get healthcare or where to get healthcare. There are no services to help them navigate the health system. He lamented that the wealth of services available to Spanish-speaking people is of no use to his own community. He was frustrated that they remain hidden and possibly forgotten in Hartford. “They do have a hard time getting to a clinic and getting healthcare. Ninety percent [in this community] do not have health insurance. Also, they are working two or three jobs.” (2) Most people are trying to work as much as possible, so they can send money home and eventually return to their home countries. Consequently, their health is not a priority for them.

Overall, four of the informants believed their congregations were accessing adequate healthcare, but there were six inner-city churches that stated most parishioners have great difficulty accessing healthcare or they have no healthcare at all. There appears to be a correlation between place of residence and access to healthcare, and those informants who have Hartford residents in their congregation or who work closely with inner-city ministries may have the best insight into the state of access to healthcare in Hartford, CT. The new immigrants may be the most underserved
population in Hartford; however, other people with only state insurance still come up short in their attempts to access comprehensive quality healthcare.

Faith and Health

In response to a question about faith and health, the key informants uniformly agreed that there is a relationship between faith and health, and responded using eight themes which describe that relationship. The themes range from deep theological concepts, to practical concerns, or to a sense that faith and health are just connected somehow. Interestingly, these themes did not each come from separate individuals, although this could be possible given the diversity of Christian denominations represented by the informants. But rather, many themes were mentioned by all individuals interviewed, and their respective ideas overlapped quite naturally. The themes are described below along a continuum from limited to integrated concepts. See Table 3.1.

The most tangible theme described by the key informants was that faith in God compels people to do good things for others. That is, helping people heal physically is “an exercise of faith.” One informant described serving others physically as “living out the Gospel promises.” (5) By exercising faith through service, the giver receives much benefit as s/he discovers her/his own gifts and passions, and it can be a very fulfilling activity. This theme follows easily from the Christian concept that to love God is to “love your neighbor as yourself.” (Matt. 22:39) (5)

The second theme is that faith and health are connected because faith in God affects any decision people make about their life. This theme is most obvious when
people are making personal health decisions about end-of-life care or abortion, for example, but faith also plays a role in common medical treatment and health maintenance decisions. One informant said that “true faith would affect decisions.” (9)

The next three themes all represent ways in which God or faith in God can indirectly improve the health of people. First, God gives us biblical principles that command us to be good stewards of our bodies, and faith helps us know to take care of ourselves. (2) In the words of one informant, “we are responsible to God for all of our being [because we were bought with a price, Jesus Christ], so we are to take care of our bodies, our spirits and our minds... therefore, we approach eating well and exercising, differently... our bodies belong to God [and are for His glory].” (1) Another informant cited that a large part of Jesus’ ministry was healing the sick, so he inferred that “God’s intent is for us to be well.” Therefore, we should take care of our bodies and “keep [ourselves] healthy.” (10) Second, God is viewed as the one who gives scientific knowledge to people. He created us with a capacity to learn about the human body and then gave the gift of medical knowledge so doctors can improve our health. This counters the idea that God and science are in opposition to each other, instead, God can work through science. Two informants stated, “God does not condemn science,” instead, “science is a gift of God.” (6,4,9) One informant emphasized that “God uses doctors and uses medicines to help people, and heal them or make them well,” so we should seek those services. (10) This comment takes the idea a step further. Not only did God give doctors intelligent brains through their genetics, but He continues to direct and guide their actions in their efforts to heal people. Third, the most abstract of these three themes, is that there is power in faith and that “faith in a
divine power offers hope," and this gives a "good environment" for physical healing and health. (5) This concept was also termed "positivity" or "belief cures" by a number of informants. (9,7) Positivity, even without religion, was viewed as beneficial to any patient's health, and this was cited as the reason parents encourage their children with a "you can do it" attitude. Specifically, faith in God can impart a special healing hope. Participants cited medical studies that show that patients who have "a faith base... they seem to heal quicker and they seem to be discharged quicker" [from the hospital.] (8) They recounted stories of healing, when doctors were amazed at the speed of recovery of certain individuals who had a strong faith in God and who maintained a positive outlook.

“There is a lady from the church who had a stroke, and she has stuck on her television screen... a post-it saying 'by His stripes you were healed'... and every time you visit her, she encourages you more than you can encourage her... because her outlook is positive... I'm going to be better, there's a purpose in this... so, her faith in God plus her entire attitude towards life... yes, [she will heal better]... her speech has been restored and her ability to continue her thoughts has been restored. Her grip is getting a lot firmer... I believe she's going to be restored, and I said 'when you return you are going to be able to run around the sanctuary.' I am giving her a goal to work for.” (1)

“I had one member who had a stroke. The doctor told her you will never walk again. I told her not to listen. God has the final word. You will walk. [And one day she told me] ‘I walked’, because she kept in her mind my encouragement to her. She walked until the day she died.” (8)

The participants took this concept of spiritual, though indirect, healing and went one step further asserting that God can heal people directly. This sixth theme is that a divine God can heal people and He does heal people. As one informant said, “we believe in miracles.” (10) The informants viewed God as not limited to working through the confines of science or the medical system. He can work through many other things, such as personal prayer, public prayer with the laying of hands on the ill person, anointing of oil, or quoting scripture. One informant described scientific
studies that show that “prayer is effective in the healing process.” He is “a firm believer that prayer helps.” (9) One informant said that once when he prayed for a man he saw “that he was psychologically completely relieved. He [the patient] felt some healing power that [came] over him.” (4) They recounted stories of miraculous immediate healings, both from the Bible and in people they know currently. But more often, they emphasized times when people prayed for a particular patient who later became well despite critical medical conditions. When the doctors were amazed, they knew that God is the one who did the healing. One informant was quick to say he is not against medicine, but he believes, “the doctor’s report is not the final report.” Another said, “There is another power involved in the doctor’s success.” (4,6,7,8)

The seventh theme, expressed by only two of the participants, was that some illness may have a spiritual cause. One informant stated that he and the people of his church first pray when they are sick, not just to ask for healing, but to ask God what has caused the illness. The cause could be spiritual, and if so, the spiritual problem must be addressed in addition to seeking medical treatment. He emphasized that not all illnesses have a spiritual component. However, the other informant believed that health is purely spiritual. She believed that people’s medical conditions do not truly exist in reality, but rather, they are faulty beliefs that need to be conquered mentally. Therefore, health is an activity of the mind, and the effective treatment for illnesses is a correction in the way the individual is thinking. (3,6)

Last, some informants summarized that faith and health are related to such an extent that they cannot think of these two concepts separately. They described faith and health as “going hand in hand,” and being “twins.” (8) They described how in the
Bible, Jesus addressed the whole person, both spiritual and physical concurrently, when he ministered to people. They emphasized that faith and health should be merged in the minds of people and that this merging would change lives for the better. People would be better able to deal with medical issues knowing that God works all things for good. One informant described his “Doctor-patient faith motif” as a theory in which optimal health occurs when patients have faith in their doctors [because patients should do what doctors say] and faith in God [because doctors are fallible and God ultimately is the caretaker of their body.] Both faith and medicine are important – “they both travel down the same road” in the words of one informant. Another simply said, “I don’t believe you can separate the two [faith and health].” (1,7,8,9)

Did any of the informant characteristics predict where their opinions on faith and health might be on the continuum? On the surface, that does not appear to be the case. The opinions on faith and health of each informant were usually spread over the entire continuum, not grouped to one side or the other. Tables 3.1b and 3.1c show the faith and health continuum themes divided by church denomination and type of community respectively. Table 3.1b shows the data when informants are grouped by church denomination and this data includes the focus group participants who were from a Baptist church. There are only a few differences between the groups. The Christian Science Church informant notably viewed health as purely spiritual and therefore, she did not express any other opinions on faith and health. The Baptist (focus group) and Catholic informants were the only groups to mention that faith leads them to do good to others. The protestant congregation informants viewed faith and health as most integrated, as “twins.” Overall, the beliefs that “positivity” improves
health and that God can heal people directly was represented in all major church denominations.

Table 3.1c shows the faith and health data when informants are grouped by their community. Informants were divided into two groups – first, those whose church is primarily filled with new immigrants and Hartford residents, (informants 2, 4, 6, 10), and second, those whose church is primarily filled with long-term residents in the U.S. and suburban residents, (informants 1, 3, 5, 7, 8, 9.) These groups were made using the researcher’s judgment, and they are not precise due to the mixed congregations of most churches. The focus group data is included in the “new immigrant” group. The two groups are not very different in their ideas about faith and health. Both groups believe that faith leads them to do good to others, that God gives their doctors knowledge and directs their hands, that “positivity” is good for health, that God can heal people, and that faith can determine health. The new immigrants also believed that faith leads them to take care of their bodies. The suburban, long-term residents believed that faith affects their decisions and faith and health are inseparable “twins.”

Overall, the differences between groups in both Table 3.1b and 3.1c, are not great enough that they can be considered significant predictors of a person’s views of faith and health.

Congregation’s belief in a relationship between faith and health

Key informants estimated that their parishioners generally were aware of the relationship between faith and health either because this relationship was taught from the church pulpit or because they saw parishioners acting out the belief that faith and
health are connected. Two of ten informants thought their parishioners would agree in theory that faith and health are connected, but it is not talked about in church, and they do not see the parishioners acting out that belief. One informant believed his parishioners were not aware of a connection between faith and health at all, so he planned to introduce the concept to them as a result of the interview.

Five out of ten informants were confident parishioners were aware of faith and health because this is a common topic in preaching, teaching and spiritual counseling. One informant described how he “preached a whole series on health including goals to bettering yourself, going to the gym and eating well.” (10) The church that was most proactive in teaching about faith and health was the Christian Science church, in which they have an entire book written on the subject that is considered a supplement to the scriptures. There is also a common devotional book containing daily readings on spiritual topics, one of which is faith and health. Also, every church newsletter contains a testimony of a person’s healing from illness. (3) More commonly, other churches discuss faith and health at ministry fairs which encourage people to serve the health needs of the community. At one church, their yearly ministry fair focuses on testimonies of “where they find God in their experiences [while serving the community].” (5) In other churches, parishioners frequently describe, in “testimonies” at church services, how miracles happened and God restored their health, and parishioners routinely encourage one another to “keep the faith” through trying health circumstances. (8,10) Also, some churches support medical missionaries overseas and parishioners regularly hear the stories from the mission field. For instance, the
Assembly of God denomination has a sending mission organization called “Convoy of Hope.” (1)

The second way in which parishioners show they are aware of a relationship between faith and health, is that they exercise this relationship through their actions. This concept was mentioned by six of ten participants. First, parishioners were said to pray regularly for their health needs and the health needs of others. They also actively call their pastor for prayer when they know they need surgery or when they end up in the hospital. “I go to the hospital and I see him [church member] praying…. I pray over him and he is very happy to see me… when someone is sick, they call for me to visit.” (4) Second, parishioners also exercise this belief by volunteering for health ministries and generally helping people in practical ways – such as giving rides to church or bringing meals to a sick family. Third, parishioners generally “keep the faith” during times of personal illness or illness in their friends or family. Parishioners will frequently say, “I’ve got faith in God that he’s going to bring me through surgery”… and later they give God credit saying, “He did” [bring me through surgery.]” (8) Fourth, one congregation recently had their yearly 21-day fast and they made it a “fruit and vegetable fast.” The fast was designed to help them be more spiritually and physically healthy. (10) Overall, these actions of parishioners, witnessed by their pastors or spiritual leaders, seemed to demonstrate that parishioners are keenly aware of a relationship between faith and health.

As previously mentioned, not all parishioners are viewed to be as aware of faith and health as their church leaders are. One informant acknowledged that those who are serious about their faith will be serious about faith and health. However, many
parishioners are not focused on faith outside of their regular Sunday service. They have other priorities such as working and earning money, so faith and health are both neglected. “Most of them, because they work this many hours, church is not a priority for them… but the ones that are involved in the religious community, most of them have a connection between health and faith.” (2) Another informant thought his parishioners would agree that faith and health are related, but since he does not see them acting on this belief, he questioned how significant it was to them. Unlike other informants, his parishioners do not approach him for prayer. (7) The last informant speculated that his congregation has fallen into the common thought that medicine is scientific only and faith is unrelated to healthcare. (9) These providers plan to continue introducing the relationship between faith and health to their congregation, because they believe that knowledge could improve their health overall.

Congregation’s practice of faith and health

Every key informant attested that individuals in his/her church exercise their faith in relation to their health in at least one way. The most common use of faith in healthcare settings was prayer – either for healing, comfort, encouragement or guidance. However, there were many other ways people exercised faith, which ranged from anointing the sick with oil to simply taking care of their bodies as they believe the Lord would want them to.

Prayer was mentioned by 8 out of 10 informants as a way their parishioners combine faith and health. Parishioners routinely pray for their own illnesses and for their family and friends when they are ill. Occasionally, parishioners come to the
pastor of the church or to a specific prayer group to ask for prayer for themselves or their family and friends. The most frequently mentioned setting for prayer was prior to surgery – whether at church the Sunday before or at the hospital that day. Informants mentioned three different goals that people had when they pray for illness, surgery or a dying friend. First, some people pray for healing because they believe God can heal and hasten recovery. One informant mentioned the “Miracle Room” at the church in which their Monday night prayer meetings are held. It was so named because they saw so many people healed after the church had prayed for them during those meetings. (1) An informant quoted a parishioner of his, saying “I can tell when people are praying for my parents” because their health improves. (9) Informants also acknowledged that prayer can bring comfort and encouragement to people when they are ill. One informant said that when he visits people in the hospital, they request prayer for the sake of encouragement even though they might not believe in any particular religion. He said prayer can bring “psychological relief” in times of stress, even to non-believers. (4) Last, people pray when they need guidance in making difficult medical decisions. One informant emphasized the desire for guidance as well as healing, saying “they pray for healing and guidance, [because] maybe they need a miracle or maybe they need a doctor.” (2) This kind of prayer takes people towards medical care, not away from it.

Second, some parishioners also seek anointing with oil when they are sick or when a person’s condition is considered terminal. They believe that this anointing, in which their pastor or priest sprinkles some blessed oil onto their heads usually combined with a prayer for them, may provide a healing power or a blessing on that person. These anointing may occur in church services, but it can also be brought to the
bedside of patients in the hospital. One informant described that anointing “brings about God’s grace and healing touch.” (4) In some ways, an anointing with oil is a reminder that Jesus also suffered in life, and it brings comfort to people who are ill. This practice was common in mostly Catholic and Pentecostal congregations.

Third, in times of illness, one group of parishioners will consult prophets. These prophets are individuals who receive direct revelations from God and can speak God’s word to others. The prophets are able to direct people’s decisions about healthcare and give general advice. They are viewed as an added resource that can be used when individuals would like to hear what God’s says about a health situation. (6)

Fourth, the practice of reading the scriptures was viewed as bringing healing both directly and indirectly. One informant described that people can be healed by quoting scripture. Though more specifically, it is the faith in the scripture that brings about the healing. This informant recounted a story about his father in-law: “He had severe pain and he just quoted scriptures, I think it’s Isaiah … saying that Jesus said, “By His stripes we are healed” and he just laid in his bed and he felt something move in his side and [then] the pain was gone.” (7) Another informant believed reading scriptures brought improved health in a more indirect way. The act of regularly reading the scriptures kept the mind healthy. She believed that the mind is so important for health and well-being that having a healthy mind would help keep the physical body healthy. (3)

Fifth, in at least one congregation, they primarily exercise faith and health by serving others less fortunate then themselves. They seek to help others practically, through hands-on service, just as Jesus did. For instance, one informant stated that the
parish nurses focus as much on the conversation they have with patients as they do on getting a correct blood pressure reading. Their faith gives them a desire to serve and as they serve, they believe they are ministering to more than just the physical body – but also to the emotional and spiritual body. (5)

Sixth, some parishioners are inspired by their faith to take better care of themselves physically. As discussed earlier, the Bible teaches people to be good stewards of their bodies and it teaches that health is valuable. So, at least one informant saw his parishioners improving their own health after being inspired to do so by their faith in God and the scriptures. (10)

Last, some informants re-emphasized that their parishioners are not “naïve” enough to disregard allopathic medicine altogether in favor of spiritual healing only. Every informant encouraged the use of traditional medical care, (or in one case, Christian Science medical care) and said that faith encourages people to seek medical treatment. In the words of one informant, they believe “the truth will set you free.” So parishioners learn truths about their illness from their doctors, and then they act on those truths with faith that they can be free from illness. (1,2,3,10)

Overall, prayer was clearly the most common practice which combines faith and health, though the way in which people prayed and their beliefs about prayer were varied. Apart from prayer, each informant mentioned a practice specific to their congregation that used faith to improve health. Only one informant said that prayer was the only way parishioners combined faith and health.
Experience with healthcare providers

The key informants had mixed opinions about the receptiveness of medical providers to speaking about faith in a healthcare setting. Most informants saw subtleties in the way doctors approach faith, and saw wide variation between different doctors. Only three informants said doctors and patients simply do not discuss faith at all, and only one informant knew a dentist that prayed with the staff in his office and openly talked about faith with patients. The majority of informants had faith come up in healthcare conversations at least once, and had mixed responses from different providers – some listened politely, but did not really hear them, others generally encouraged them to act in accordance with their own faith, and some participated in prayer at their request. Only when the doctor and patient shared the same faith, did they really speak openly about faith in a healthcare setting. We will discuss the breadth of these experiences on a spectrum entitled “faith-friendly,” (see Table 3.2) and then compare the experiences in the United States with the informants’ stories of healthcare encounters in other countries.

Three of the ten key informants could not think of a time that faith was ever addressed in a healthcare setting in their experience. They generally agreed that doctors just don’t talk about faith and since they, as patients, had never brought faith into the conversation, it never was discussed. They, and three other informants, speculated on why most doctors do not address faith during medical care. First, they thought that doctors do not want to talk about faith. One informant said, “I don’t think people would mind [if a doctor asked them about faith,] but I don’t think doctors are willing to do that.” (2) They mentioned that there are cultural boundaries that dictate
appropriate times for discussing sensitive topics such as faith. Generally, since doctors are providing a service to patients with many different backgrounds, it is taboo to ask about faith since it may affect the quality of the working relationship between the doctor and the patient. “Here, they don’t talk about faith at all, because they consider it their duty to just practice medicine.” (6) One informant stated that our current culture is very focused on being polite and ethical in all encounters, so doctors and patients are concerned about what should or should not happen in a medical care context. “Culturally, there are a lot of shoulds and should nots about sharing faith, about belief systems, and a lot has to do with... how much of a crisis something is, as to whether or not those cultural boundaries get broken down.” (5) Another reason doctors do not talk about faith is that faith may be an intimate part of people and many doctors do not have an intimate enough relationship with their patients for patients to be open about faith. Although one informant works full time for a church, she only discusses her faith with one of her medical care providers, because the others have not built a significant relationship with her. (5) Last, one informant stated that doctors are generally taught that “faith and medicine do not mix.” (9) And when patients believe that doctors are taught this, they also do not mention faith. For some patients, their entire experience with faith in medical settings is checking the religion box on the hospital admission forms. (2)

Some doctors are willing to take one step further in the “faith-friendly” spectrum. They create an environment where patients feel comfortable talking about faith and the doctors listen politely (10) – but “they don’t really hear what patients are saying.” (1) These doctors may or may not recognize that faith is important to their
patients, but they prefer not to actively participate in any encouragement of faith. Patients do feel they are treated with respect by their doctors, but they do not really connect personally with these doctors. These informants felt that though the doctors listened, they did not fully understand the significance of faith in their lives.

Further along the faith-friendly spectrum, there are some doctors who will both listen and understand, though they do not initiate any discussion of faith. One informant sees a doctor regularly whom she has found very considerate of her faith. He encourages her to take care of her health in a way that is congruent with her faith, and he will tailor his recommendations and/or prescriptions so that she need not compromise her faith. Overall, she believes this type of relationship is so valuable that she always seeks this kind of provider. (3)

Then, there are some doctors who will participate in faith activities with patients. Three of the participants had encountered doctors [or dentists] who pray with patients, though this was considered rare. One informant, a pastor, visits parishioners in the hospital and some doctors will accept his invitation to pray together for the patient’s well being and the doctor’s success in treating the patient. In this instance, the pastor is the one praying, but by participating with his presence, the doctor affirms the patient’s faith and acknowledges the health benefits of faith. Doctors have previously thanked him for taking the time to pray for them and the patient. The informant notes that this kind of encounter did not happen even a few years ago. But he believes that “lately [doctors] have deduced that prayer helps heal quicker and now doctors know that we need something bigger than themselves.” (8) Other doctors will not only participate and show appreciation, but they will initiate prayer by asking patients if
they would like to be prayed for. This often catches patients by surprise, but it was appreciated by the informants in this study. (1,9)

Overall, four informants found that their most open conversations were with doctors who shared their faith. Then each could be open and free to discuss how faith impacts their health and their overall life situation. One informant viewed doctors of similar faith as better able to listen receptively to him when he speaks about faith, and they might pray with him also. For this informant, any doctor with a Jewish or Christian background had a similar enough faith to his that it changed [improved] the way they talked about his faith and health. (1) Another informant said that only doctors who were religious themselves would care to broach the subject of faith during medical care, and it is with these doctors that patients are more likely to be open about their own faith. (6,9) The last informant appeared to have a close relationship with his own physician. He recounted that his discussion of faith during a medical visit varies greatly depending on the doctor’s personal beliefs. “My doctor, we talk about faith every time I go because he is a believer. And I know that when people go to him... he is able to minister... beyond the physical. His office is a ministry... [he says to his patients] ‘there’s faith, there’s God, there’s other things you can tap into that will help you.’ ” (10) The experience of this informant appeared to be similar some informants’ experiences in other parts of the world.

Many Hartford residents are immigrants from places like Africa, South America and the Caribbean, and some of the study participants were immigrants as well. These key informants described how their medical providers in their home countries integrated faith and medicine quite naturally.
One informant stated that faith is discussed in medical encounters in his home country because of the particular cultural beliefs of the people. He said, “Doctors will ask [patients] about [their] church [and will ask if] people are praying for the patient… because there might not be a natural cause for the illness.” Doctors will frequently pray with patients. They will ask God for help in general and specifically for a successful treatment. They will also actively seek out family members to encourage them to pray for the patient. Although the country is divided between Christians and Muslims, in the healthcare setting, prayer and spiritual encouragement occurred regardless of the different beliefs of providers and patients. Both groups valued faith and doctors desired for patients to gain the benefits of that faith for their own personal health. (6)

Another informant reported that faith was integrated into some medical education since the Catholic Church had its own medical college in his native country. The teachers of that college were priests, and they taught from a spiritual point of view. Consequently, he believes that those doctors were much more comfortable discussing faith with patients, and they might have developed ethical views that were more congruent with their patients’ views. (4)

Also, one informant had spent time in Panama and Puerto Rico where they had faith-based health clinics in churches. These clinics were staffed by Christian doctors who would pray with patients and occasionally sing with patients, and these actions improved people’s health. While treating a dying man, “they noticed that when they would sing to him, there was recuperation, and when they would pray, there was a difference. To the point that one of the hospitals now puts Christian music through the
hallways, and they've seen a difference [in patients' health] ... I have seen the models out there and what it does.” (10)

The last story of medical care in another country came from a pastor from Trinidad and Tobago. He described a free medical clinic located in a church staffed by volunteer physicians and supported in part by the government which provided medicines. Evangelism was a well-known part of the clinic’s mission and the community embraced this clinic, along with its mission, gladly. He speculated that people in his country defined health for themselves as “body, soul and spirit,” and it was natural, even preferred, for medical doctors to address spiritual health as well as physical health. For them, having a doctor ask about their faith and general spiritual health was just part of good medical care. (1)

Overall, as a summary of the informants’ experiences with healthcare providers, doctors can fall anywhere along the “faith-friendly” continuum, but most in the United States tend to separate any discussion of faith from their provision of medical care. A few physicians are asking about faith and encouraging faith activities, mostly when they share a similar faith with their patients. The informants had experiences in other countries which integrated faith and medicine to a greater depth than what people in the United States usually imagine. In the next section, we examine where along this faith-friendly spectrum parishioners in Hartford might want their physicians to aspire to.

Congregants desires for faith-based health care

Key informants were asked to estimate how their parishioners might want to have faith incorporated into their healthcare. Nine of ten informants had ideas of how
faith could be included in medical care, and only one informant thought people in her church would like medical care to remain entirely secular, just as it is now. Some informants thought that, as a minimum, having a Christian doctor would be beneficial, because it would strengthen the doctor-patient relationship. Others emphasized that people would be thrilled if their doctors also prayed with them, discussed faith in relation to their personal health, and some would even be receptive to words of encouragement and Christian instruction. Overall, the suggestions from informants went far beyond simply having Christian be part of the name of the clinic; instead, they wanted physicians to be pro-active and Christian in their healthcare. These results are shown in Table 3.3.

One informant believed allopathic medical care could remain exactly as it is, but this was not because she did not want faith and medicine to be integrated. Instead, quite the opposite, she believed faith and health are connected, according to her theology. However, her faith seemed incompatible with allopathic healthcare, and she preferred to use the healthcare practitioners affiliated with her Christian Science Church. She was content, and felt she was being cared for holistically through her own practitioners. Therefore, she did not seek holistic medical care from any allopathic doctors. (3)

Three of the ten informants believed that patients would welcome having a Christian doctor, regardless of whether there was any prayer or mention of faith during medical care. One informant said, “I think if the doctor, or the healthcare provider, is a person of faith that would definitely be a plus. That would be a great plus!” (7)
Another informant said that somehow, parishioners might be more trusting of Christian doctors, believing them to be more honest and thorough in their medical care. Also, the relationship between doctor and patient might be stronger when both have the same faith. When a patient knows that their doctor is a Christian, they can be more honest about their faith if they choose, and there is a greater level of intimacy, “a closer relationship” which leads to improved medical care. (2, 6)

Three informants asserted that their parishioners would like faith discussed during medical care, especially at those times when serious health problems or ethical questions arise. “They [his parishioners] would welcome breaking the taboo and bringing up faith in the doctor’s office.” (9) “As a culture, we say faith is not something you should talk about. But it is something we should talk about, because faith is part of the whole being. If you are spiritually sick, it’s going to manifest itself in other ways. ... I think that by ignoring the spiritual element, the healing is not as deep as is designed.” (5) Informants speculated that even a brief reference to faith, such as saying “I guess God had a hand in that,” changes the medical interaction. (5) It breaks down barriers, because it communicates to the patient that their faith is ok. The patient then feels more acceptable to the provider. An informant gave this example: “If the provider acknowledged that science and faith can go together, that would be powerful. I would leave the office with more peace knowing I can put my faith in medicine and in God, instead of having to choose one or the other.” (9)

Informants, five of ten, most commonly mentioned that prayer during medical care would be desired by their parishioners. Informants were quite certain that their parishioners desire prayer, because when medical providers do pray with them, they are
so excited that they report it to their pastors and friends. “They find it quite exciting… they wouldn’t think that a doctor would embrace that at all.” (8) They believed parishioners would benefit greatly from a doctor who could perceive that a patient needed encouragement and prayer, and then would pray at that very moment with the patient. Prayer could be used effectively at strategic moments in a medical office, as in this example. “Let’s say for instance, I go to the doctor and don’t look too good, or my case might be terminal, and if the doctor [said] to me, ‘You know what, let’s pray about this right now’… or ‘Your faith can help you through this right now’…” (7) Another informant said, “If I went to a doctor and he/she offered to pray with me – it would have a profound effect on me.” (9) The general consensus was summarized by one informant who said, “Prayer is always awesome in the healthcare setting.” (10)

Two informants believed people would welcome their healthcare providers taking a step further than prayer and also including some biblical words of encouragement or some indirect moral instruction during medical care. They recognized others might see these kind of actions as stepping over an ethical boundary, but they believed patients would receive it well and be comforted. One informant said, “It is fine to reinforce with patients that God loves them and to give them indirect moral instruction. Patient’s often have a ‘guilt complex’ [when they are sick they think they did something wrong] and saying God loves them will console the patient.” He described a Catholic nurse who worked in a hospital of mostly Hindu patients, and she spoke openly about God’s love to the people she cared for. “The Hindu doctors said this lady used to do 50% of the cure, because the way she used to talk about God, the way she used to care for them, her approach irrespective of who they were – that in
itself had some sort of healing effect on people.” (4) Another informant suggested that
doctors should ask about faith, and then encourage religious activity if it seems
appropriate for that patient. They could make simple statements such as “You should
think about religion…Do you have a church home?” and if so encourage, “Maybe your
faith in God will help you.” (8) Underneath these recommendations is the premise
that patients really do need God, and doctors, since they are trusted and respected, are
in a good position to direct patients to what they really need – God and God’s love in
their life.

Table 3.3b and 3.3c were created in an effort to show any relationships between
the informants’ church denomination, or their parishioners’ residency status, and their
desires for faith-based medical care. The tables do not show any relationships which
might help a physician predict which spiritual activities a patient might desire in the
medical encounter. In Table 3.3b, there were some minor differences between church
denominations. Every denomination represented desired prayer and/or discussion of
faith during the medical encounter. However, only those informants from Baptist and
Pentecostal churches desired a Christian doctor. These two denominations may have
more evangelical Christians in their congregation and they may be looking for an
evangelical doctor. In Table 3.3c, there was only one difference. The informants from
churches of primarily new immigrants and Hartford residents, did not explicitly
mention that they wanted discussion of faith during medical encounters. This may not
be significant, since this group did desire Biblical encouragement and moral instruction,
which would most likely occur during a discussion of faith.
Table 3.4 shows the individual responses of each informant concerning their view of faith and health and their congregations' desire for faith-based medical care. Most informants believed a number of different things about faith and health and therefore, they can not be characterized clearly as having either a “limited” or entirely “integrated” view of faith and health. There is no particular pattern in the data that would also the researcher to correlate a view of faith and health with a particular desire for faith-based medical care. However, of those who listed prayer as a desire for faith-based care, all but one informant also said he/she believed God heals people. It seems logical that people who believe God could heal would value the prayers of their healthcare provider more than other individuals. Further commentary on the significance of these tables is included in the discussion section titled “How should healthcare providers address spiritual needs?”

Would parishioners attend the CMFHC (or any free faith-based medical center?)

Eight of ten participants said that people in their community would certainly use a free faith-based health center like the CMFHC. All believed that people needed the type of healthcare that CMFHC would provide. However, they recognized challenges and barriers that might keep people from attending the CMFHC, despite their great need and desire to come. Participants also suggested factors that would make a free faith-based health center more appealing and possibly overcoming some barriers to use. There were two participants for whom the benefits of a faith-based health center were appealing, but they believed their community would be no more likely to use a faith-based health center than a traditional medical center.
First, within the context of a generally positive reaction to news of a local free faith-based health center, participants predicted challenges ahead for the new CMFHC. While they agreed that the need for the CMFHC is great, they also acknowledged many barriers that might keep people from attending the CMFHC. The barriers mentioned were quite different for those people who already had health insurance and who would be seeking the faith-based component of the CMFHC versus those without access to health care who might be attending for the free care component of the CMFHC.

The most frequently mentioned barrier among church members who already had health insurance and a regular doctor was inertia. Most people do not change health care providers unless they move geographically or are incredibly dissatisfied with their care. It can take many years to build a good working relationship with a doctor, and there are medical benefits of going to a doctor who knows you well. One informant said, “The only barrier is, I think, if they have a primary care doctor presently, I don’t think they would want to separate from that person and go to another because they are a Christian.” (1) Therefore, despite the prospect of finding a doctor who may be better in the long-term, changing doctors does not seem wise to people unless they are forced to do this through other circumstances. The second significant barrier for those people with health insurance was that their insurance may not cover this particular health clinic. Despite the argument that the clinic would be free and therefore, insurance is not needed, participants felt that people would try to stay within their insurance plan. “The other [barrier] is, I think that those who have insurance may be connected to certain groups of doctors that are approved by that HMO... So possibly, they might not want to change doctors.” (1) It is possible that since
participating in a health insurance plan may be mandated by an employer, the beneficiaries might feel obligated to use it, or they might fear that their insurance would not pick up their hospital or laboratory bills if they are not using a doctor within the health plan.

People who do not have health insurance or health care may be exempt from the barriers listed above, but they have barriers to attending a free faith-based clinic that are equally as significant. The reasons they might not attend a free clinic are the very same reasons that they do not have health care. They may be illegal residents of the United States or they might be poor, unemployed or in transition in society for multiple reasons. First, for those who are undocumented residents, they are constantly wary of any organization that might discover their illegal status. They will avoid contact with any governmental organization, or with any institution that could report information to the government or be visited by immigration authorities – this includes hospitals and doctors offices. A number of participants emphasized that people who are in the country illegally will have to be assured multiple times that it is safe for them to visit the clinic and to accept free services. “They are sick, but they are afraid to come forward... They will not seek help, because they are afraid if they come forward, they could be deported.” (1) Their privacy must be protected and trust must be built up in the community. Second, for other individuals dealing with unemployment, homelessness, poverty or other life transitions, their health is simply not a priority in their life. When they are struggling to find employment or to feed and clothe themselves and their families, they will sacrifice their health temporarily for more immediate needs. An informant stated “the level of need is ‘Do I have a safe place to
sleep tonight?' Then the next one is 'Is there something to eat?' … Healthcare is one of the lower items on the list. And there’s a lot sacrificed before you get to healthcare.”

They may have been brought up in a community that did not have access to care or did not value health care until they were very sick. There are other reasons for health care being a low priority, but these observations came from the informants who care for the community and observe this phenomenon. A few informants actively work to provide other types of services to this community, and they have seen a pattern where people will ignore their own health while they meet other needs and desires.

Despite the barriers listed above, most participants believe that people in their community would still be attracted to a free faith-based health center. They believed a health center like the CMFHC had enough positive characteristics to overcome the common barriers to people seeking health care. For two participants, any Christian health center would draw them in, since they value the Christian perspective on healthcare so much. They believed a Christian would have providers who are “more honest, trust-worthy, transparent in dealings, not only after money, and [who] would do everything based on God.” “They would choose it over anything else.” Also, they believed patients would receive more “complete care...[because] they would get an idea of how to face their illness... and they would welcome this type of medical care.”

However, most informants believed there are certain things a free faith-based health center must do well to make it even more appealing to the community.

First, the physicians should be active members of the local community. One informant emphasized that it is the relationship patients have with their doctors that keeps them coming back, and for a new clinic, it will be much more successful if
patients know the doctor is dedicated to the community because he/she is an active participant locally and has already built relationships with others in the community. When asked what would make community members come to the clinic, another informant said, “Relationship... having a connection with somebody affiliated with it” would be the strongest draw. (5) Second, this informant mentioned that the clinic will have to earn people’s trust. Having true relationships with patients is one way to earn trust, but also the clinic needs to be consistent in living up to its promises. Since the clinic is free, patients will be skeptical, and the clinic needs to show through consistency that there are “no strings attached.” She believed that before people attend the clinic, they would require “having trust and confidence that you are going to be there when you say you are going to be there, and having trust and confidence that it is free.” (5) Third, any faith-based health center would have to be equal in quality to traditional medical care. To be equal means the clinic must offer comprehensive services, good medical equipment and well trained doctors who give quality medical advice. When asked if his congregation would attend a faith-based clinic, one informant said “I think if it has everything that they need... [comprehensive]... exactly. If they are equal... services... I definitely think people would go to the Christian [doctor].” (10) A faith-based health center does have additional benefits, but those benefits may not be worth giving up better quality medical care elsewhere. One informant thought patients would end up just going “wherever the best healthcare is provided” and then they would continue to use their church and spiritual counselors elsewhere for their spiritual health. (6) But, most informants thought, if the clinic is
equal in quality to other medical care, “these doctors will have something to offer which is greater than the typical doctor.” (10)

Overall, the informants concluded that the CMFHC would be attractive to many people, particularly those with a personal faith history and those without current medical care. A “personal faith history” can mean they are currently a Christian active in the church community, or it can mean that they were brought up with general Christian values and they may most identify with Christianity versus other religions. One informant said, “if they [the doctor and patient] share the same belief, it would be a positive part of their healthcare.” He estimated that most people in the Hartford community have at least a vague faith history. He said “they haven’t given up on doctors or religion” and even these people would find the clinic beneficial and would feel comfortable in a Christian facility. (8) For those who hold tightly to Christian values, a faith-based health center would be especially beneficial when patients want to discuss “topics like abortion, the morning after pill, etc…” These people would also like to have clergy or Christian counselors available in the office, so they “could help at any time, not just when people have terminal conditions.” (7)

Informants also were convinced that people without healthcare would attend a free faith-based clinic. Their main motivation to attend would be the free healthcare more than the spiritual aspect. One informant said, “I think the underserved would [attend the CMFHC.] I don’t know that the motivator would be [faith.]” (5) However, the spiritual aspect would not keep them away and as stated above, most people in the Hartford community have a Christian faith history anyway. Another informant thought the elderly especially might attend, because they have both financial need, and they
might be more likely to have a personal faith. That informant also said, “I would absolutely” attend the clinic if I had no doctor. (9)

The two participants who did not think the members of their community would attend a free faith-based health center, were unique compared to the other informants. One informant was from a Christian Science Church and members of that church already have medical providers who practice medicine guided by the Christian Science Church doctrine. Therefore, that community already has “faith-based healthcare” and they do not need a parallel model in the allopathic medical world. Overall, her assessment that parishioners would not attend the CMFHC was not a rejection of the “faith-based” healthcare idea. The other informant in this group was Nigerian and his church community was a group of Nigerian immigrants who aimed to integrate into American life. They had many spiritual practices, but he did not think they would seek out a faith-based provider. He believed people wanted to abandon this combination of faith and medicine (which they experienced in Nigeria) and instead, they wanted to adopt the American model of allopathic healthcare. He believed the community could continue to “just call their pastor for the spiritual aspect” of medical care. (6)

Informants’ awareness and opinions of CMFHC

None of the informants remembered hearing of the Christian Medical Fellowship Health Center before, and only one informant knew of the organization Christian Medical Fellowship. (The three informants who were listed as attendees at a community breakfast eight months prior could not recall that breakfast at the time of the interview.) While all participants were generally positive about having a free faith-
based health center in Hartford, 6 participants made their excitement very clear. Others went on to describe the CMFHC as needed, and then expressed their expectations for how successful the clinic would be in Hartford.

Eight of the ten informants believed the CMFHC clinic was a good idea and they used phrases such as “great idea,” (twice), “welcomed proposal,” “absolutely a good idea,” “I hope I have shared my enthusiasm and excitement,” “I am excited,” “awesome idea,” and “it’s a blessing to the nth degree.” (1, 2, 4, 5, 9, 10) One informant went on to say that he would choose the CMFHC for his medical care if he did not have a doctor. Three went on to confirm again that the combination of faith and medicine at the CMFHC is acceptable and “fine.” Though the interview questions did not address sharing the Christian faith with patients, an informant stated, “I do not think it’s sneaky to share the good news in the healthcare setting. It is not a negative thing to take advantage of this opportunity [to share faith with others.]” (9)

Two other informants stated that the CMFHC was interesting or a “fascinating idea” and they acknowledged that combining faith and medicine is a growing trend. The CMFHC is an obvious example of the combination of faith and medicine, however, they believed “as it is now, doctors and patients are using faith because they have traumatic situations that require trust.” (3) They also reiterated that not only is medicine embracing more faith, but the faith communities are embracing more medicine, by teaching health and nutrition in their churches. (6)

Beyond simply acknowledging a growing trend, some informants said the CMFHC was very much needed in the Hartford community for three main reasons. First, most informants spoke of the need for access to medical care for the people of
Hartford. They believed that Hartford does need free and affordable medical clinics. (1, 2, 8, 9) None were opposed to the idea of free medical care, since they describe healthcare as a universal need. They reemphasized that many people do not have insurance and "it [CMFHC] will fill a great need for people without insurance or those with high co-pays." (9) Healthcare is the "main thing [people need] in this area." (8)

Second, CMFHC would meet a need for quality healthcare. This idea came from their conviction that Christian doctors would provide better quality healthcare in two ways. They would be more "Christ-like... non perfect [doctors], but [ones who] believe in aiding the poor and sick and ... comforting people." (7) People would choose these doctors because they assume they might emulate Christ’s compassion. Also, doctors at a faith-based health center might be more thorough in their examinations and assessments. One informant said, "They [his parishioners] will go to a place where they can be sure that any exam [the doctor does] will be 100%." (2) They believed that people in Hartford need these kind of physicians who they can trust, since right now many people mistrust and feel disconnected from the medical community. (2, 7)

Third, informants said CMFHC is needed for the hope it can bring patients. One informant compared his own experiences providing hope to people in the hospital to the work CMFHC will do. He explained that even when praying with people of different faiths, it helps them hope in something bigger. He also said, "The hope [that patients gain from a combined medical and spiritual encounter] is more than I can offer." People in Hartford need this kind of hope especially in difficult health situations. (4)
After affirming that the CMFHC is a good idea and that it is needed in Hartford, the informants used their own expertise to advise CMF on how the CMFHC will be received in the community and what it can do to ensure success (much of which was addressed in the previous section so only new information will be provided here.)

Three informants predicted that the clinic would be successful in the Hartford community. Success was expected for a few reasons. First, the pastors have always been well received in their work within the hospitals were people are sick, and they found that they could minister to people in a way that did not disturb a patient’s own faith. So they expected that a faith-based health center would be equally well received and they did not expect that it would bother people of other faiths or people of no faith.

Second, one informant believed the CMFHC would be “competitive” in the medical field because it would be a medical community that patients’ could trust to truly care about them and serve them well. Third, the CMFHC would be well received because it is free care. Anything free, in a community that has so little in resources, would be appreciated. (4, 7, 8) However, not every informant thought success would come easily to the CMFHC. From the perspective of a well seasoned community service worker, one informant advised that success for the CMFHC would be slow coming. She stated, “It will be slow work, so don’t worry about the numbers at first.” She has seen many ministries start and then crumble, possibly due to decreasing volunteer commitment and disillusionment. Unfortunately, since so many ministries end shortly after they begin, the underserved community expects to be disappointed. It will take time to prove that the CMFHC is a permanent service in the community, so the CMFHC workers will need to be patient. She believed the key to success is
consistency, and then the community will not be disappointed. “It’s more important that you are there, then it is how many people you will see… to be considered trustworthy and available.” (5) Over time she believed the CMFHC will be successful. Finally, other informants recognized the importance of wise marketing. To help with the initial success of the CMFHC, one recommended that “proper dissemination of information and [the] location” of the CMFHC was crucial. A few informants were surprised that they had not yet heard of the CMFHC since they were so involved in the services around the Hartford community. To improve success, they said CMFHC should develop the skill of getting information into the hands of people in need. It can be challenging to disseminate information among a transient underserved population, but it is essential. They provided some suggestions later on in the interviews.

Overall, the informants were pleased to hear about the CMFHC, and they expected that this could be a very effective ministry in the community.

Is the congregation representative of the Hartford community?

When asked to compare their congregation to the Hartford community as a whole, a few informants hesitated to extrapolate what people outside their own congregation might think about faith and health. The first informant declined to answer, saying he really did not know people outside his community well enough to answer accurately. However, others provided interesting commentary on the Hartford community’s state of faith and health.

Six of the informants said that their congregation was predominately dissimilar to people in Hartford, whether ethnically or spiritually or both. One informant was
dismayed that his congregation, while being similar to the Hispanic community as far as medical need, was very different in terms of language and culture; and therefore, services designed for the Hispanic community were not helping them at all. His congregation was predominately new immigrants, and they had different needs (potentially greater needs) than the more well-established Spanish-speaking community. “The Spanish, they are a thousand years… light years ahead of us… we have a hard time… health-wise.” He stated that there were very few social supports for his community in Hartford, while, most people in Hartford connect to services more easily. He did not comment on the spiritual similarities between his congregation and the greater Hartford community. (2) Three other informants agreed that their congregations were different ethnically, because they had predominately Caucasian, middle to upper class congregations. They attend church in Hartford, because they want to interact with underserved people and at least one congregation succeeded in becoming a safety net for many Hartford residents. Two of these informants said that although they differed from Hartford residents ethnically, they thought their views on faith and medicine would be similar. (5, 9) They both had congregations who might be open to the combination of faith and medicine, but had never really given it much thought, and they suspected Hartford residents would be the same way. Generally, “New England people might be skeptical” in regards to combining faith and medicine, but if they experienced it they would appreciate it. (9)

Two informants believed their congregations were dissimilar from the greater Hartford community, not ethnically, but spiritually. They believed that Hartford as a whole might be less religious, or simply different in religion, than their congregations.
One informant stated “Our faith is likely different than most people in Hartford,” but it was hard for him to know for sure what the community around the church believes. (6) The other informant assumed that his congregation’s ideas might be different than most people in Hartford, because many people in Hartford believe in God or prayer, but they do not act on these beliefs. These people have a spiritual history, but they have stopped going to church. He sees that their ethics are quite different than his own and than the people in his church. He describes their ethics as “situation ethics” rather than a true belief in right and wrong. Consequently, since most Hartford residents appear to have different spiritual and ethical beliefs, their ideas about faith and medicine might be different than his and his congregation’s ideas. (8)

Three of the informants believed they and their congregation were quite representative of Hartford as a whole, both ethnically and spiritually, and they asserted that most people in Hartford would also be enthusiastic about the integration of faith and medicine. One informant estimated that “nine out of ten people in Hartford would have similar views” when compared with his own views about faith and medicine. (7) Another said the Hartford community is well aware of the complementary nature of faith and medicine, and apart from a few exceptions, they would agree with the integration of faith and medicine. All three of these informants pastor churches in inner city Hartford, and one emphasized that his church is in the poorest section of the poorest city in the state. But all along his street, there are many churches – “over 25 churches.” It shows him that there are a lot of people of faith in Hartford, and they would connect well with a free faith-based medical clinic. (4, 7, 10)
Overall, a majority of informants who discussed the views of the Hartford community agreed that most people in Hartford would like the integration of faith and medicine in a free faith-based clinic setting. They recognized that their own views might be more favorable towards faith in medicine due to their strong religious beliefs. But they believed that people would be comfortable with faith and medicine together, and they would soon see the benefits of it even if faith integrated with medicine was an unfamiliar concept to them at this time.

Additional comments

At the end of the interview, informants were given an opportunity to provide any additional comments or ask any questions. In an effort to present these comments most accurately, they are simply listed, rather than grouped which might imply some kind of artificial relationship between these ideas. Most of the comments below are paraphrased, but written in first person.

- I recommend that you get out in the community and inform all the churches about the CMFHC. They will put up posters and will put advertisements in their church bulletins. You can advertise on 1360 am (Christian radio) on the show by Brad Davis who is on the air 5:30 to 10 am on Saturday mornings.
- I recommend that you look into the “Gift of Sight” program at Lens Crafters. If people have their eyes checked by a 501.3 non-profit organization, then Lens Crafters will provide free glasses. By coming to the CMFHC for the eye exam, they will not have to wait on the waiting list for the Lens Crafters “Gift of Sight” eye exams.
• I am disappointed that the privacy laws in hospitals prevent me from speaking freely with some people, and this prevents a healing touch on that person sometimes. I am not trying to convert anyone at a hospital. I am only trying to console them. I am glad CMF is thinking about how faith and medicine can complement each other. I am interested in having some Christian medical students come to our youth group to talk about drugs.

• The CMFHC can only be a definite good thing, and it will be well received.

• “Research is what makes books interesting.” I approve of the research you are doing. Also, I am on the board at St. Francis Medical Center.

• “It doesn’t take rocket science to know that the faith community should respond to the need for access to healthcare. I don’t think anyone should be denied access to healthcare.” Illegal immigration burdens our healthcare system. If we control immigration it would impact healthcare costs.

• “I look forward to seeing this develop – more than one day a month.” Are all these doctors volunteers? So, that’s the only day they are open?

At least seven informants requested information on the days and hours that the CMFHC is open with the intent to pass the information on to their congregations, family and friends.
Focus Group

Among the ten people who participated in the focus group, there was uniform consensus that faith and medicine should be integrated and that the CMF Health Center was needed in the city of Hartford. Uniformly, they were excited by the idea of a free faith-based health center nearby, and most people expressed interest in attending the clinic as a patient. Their interest in the CMFHC stemmed from four observations they had about the clinic which were particularly important to them.

First, the clinic would be ideal for undocumented people in Hartford. They described undocumented persons as “shy” when it comes to seeking medical services and stated they are afraid of attending state-operated medical centers due to a perceived risk of the state discovering their illegal status. Unfortunately, most free or affordable medical care comes through the governmental system. A free and private health center would alleviate many fears and would allow them to be more open with their medical providers.

Second, the group approved of faith-based medical care, because they wanted medical providers who could ease fears about spiritual causes of illnesses and educate people properly. In their community, some people do feel spiritual guilt when they are ill, and these people question what they have done to bring an illness upon themselves. They hoped patients would share their spiritual beliefs about illness with a Christian doctor, and they believed that Christian doctors could best educate people and dispel myths about spiritual causes of illnesses.

Third, a free faith-based health center was seen as an ideal opportunity for Christian providers to live out their faith. There were a few foreign doctors in the
group who relished the opportunity to serve their community in such a way, and even
the non-medical participants echoed that this type of service is a natural extension of
their faith. One individual aspired to do this kind of work someday - helping people
both physically and spiritually.

Fourth, the group agreed that the possibility of free blood tests was very
beneficial to the community. Some confessed that they had not had blood tests in over
two years, and they needed tests for diabetes and cholesterol. Sometimes a blood test
can propel people to start seeing a doctor, when otherwise they would continue to put it
off, assuming themselves to be healthy. Some participants in the group hinted that they
liked the convenience of having blood tests at the doctors office, where questions about
the results could be asked right away and additional travel was not required. However,
these comments were not discussed in detail.

In addition to these four positive factors that would draw people to the CMFHC,
the group also had some questions regarding the medical care. First, they asked if
translators would be available at the health center. Lack of translation can be a barrier
for some of them to seek medical care. They do have English skills, but they recognize
that for adequate communication with a doctor to occur, a translator would be
necessary. A few participants did not speak any English during the focus group time,
and they may not be comfortable speaking English at all. Also, having translators
sends a message to the community that they are welcomed. Second, one individual
inquired if the CMFHC had medical specialists, especially gastroenterology. She had
been to some general doctors who were unable to diagnose her medical problems, and
now she needed specialist care. But she did not have access to any medical specialists.
Unfortunately, the focus group did not have any advice for her regarding this problem. Last, there were a number of inquires about the hours the CMFHC would be open. Most people in the group desired to attend the clinic, but they thought it would be difficult to arrive between the hours of 1 and 3pm. Most often they could not attend due to work, but also they had generally hectic lives, and they needed a broader range of hours in which to try to get to the clinic. It seemed that going to the clinic would be another thing on the “To-Do” list, and they were not sure exactly when they would be able to go. The only group recommendations on how to improve the hours of the CMFHC was to be open more often and for longer hours.

Overall, the focus group believed a free faith-based health center would benefit their community. They believed their community had both medical and spiritual needs, and they wanted to support the CMFHC, so they volunteered to help in any way they could.

**Participatory Research**

During the researcher’s time at a soup kitchen in the North End of Hartford, a few individuals offered their opinions on the prospect of a free faith-based health center in Hartford. They believed that people in Hartford do need this kind of care, and they also discussed the various barriers that might affect the provision of care. In general, the volunteers at the soup kitchen were interested, and generally enthusiastic, about the CMFHC.
First, the soup kitchen volunteers agreed that people in Hartford need free medical care, although some groups need it more than others. The elderly, who made up many of the volunteers that day, do have some healthcare through Medicare and generally feel that their basic needs are provided for. However, their healthcare remains a large expense, and free services would reduce the financial strain on them. This group would most likely come to the CMFHC for the free screening services, since they are health conscious, and they want to have their blood pressure and blood sugar checked regularly. There are also many young and middle aged adults in Hartford who do not have regular healthcare. A young man volunteering that day said these adults need to have regular, acute, and preventive healthcare, and often they do not have any health insurance coverage. However, he expects they would only come to the CMFHC for acute care. At this stage of life, this group of adults is focused on meeting immediate needs, and they have not been taught to value long-term needs or goals. So, although they need preventive care, he doubts they would come to the CMFHC until they have an acute problem.

Second, the volunteers saw a great need for spiritual care, especially among the young adults in Hartford. They believed that many people in Hartford have turned away from religion, and instead, focus on immediate pleasures like sex and drugs. It is likely that most of these people would not like the CMFHC’s commitment to spiritual care along with medical care, but they believed that people would continue to come because their medical need is so great. These volunteers thought that the CMFHC would do a great good to provide small exposure to Christianity for patients. They
recognized that Christianity may not be the quick fix these people are looking for, but it might be what they need most.

Third, the volunteers addressed a few barriers that the CMFHC should be aware of. They described location as important, saying that the health center should be convenient and easy to access. True accessibility means that people can walk or take a bus to the health center. Since the CMFHC is directly in front of a bus stop and on a main street near the center of town, the volunteers thought people would travel to it, and its location was not considered a barrier to access. Instead, trustworthiness and reliability were viewed as the largest barriers to healthcare access in Hartford. The volunteers advised the CMFHC to give free care without rules or limitations and to open their doors to anybody who comes. They reported that because of past abuses of certain services, these services have added rules and limits to the care they provide, and unfortunately, this reduces access to healthcare for many people who need it. One man acknowledged that the health center might have to accept some amount of abuse in order to preserve open access to many responsible people who truly need medical care.

In general, there was a feeling of enthusiasm among the volunteers for the prospect of a free faith-based health center. They believed that people need both the medical and spiritual services offered by the CMFHC. They viewed the CMFHC as a great opportunity to minister to the community by meeting immediate needs along with long-term spiritual needs. At least one man offered to volunteer as a patient care assistant for the CMFHC. He was looking for an opportunity to help his peers in a tangible way. Another volunteer eagerly collected fliers so she could spread the news
of the CMFHC to other churches in the North End. Overall, the soup kitchen welcomed advertising the CMFHC to all their clients with fliers and handouts.
DISCUSSION

Fulfillment of the Study Objectives

The results of this qualitative study are rich and diverse. However, concerning the five key objectives of this study, the informants spoke relatively clearly and uniformly. For instance, although each interpreted the relationship between faith and medicine differently, they all agreed that faith and medicine are connected and that connection should be acknowledged during the provision of healthcare. Overall, the study results do define a need for free medical care for the underserved and a need for faith to be incorporated into medical care in some way. Eight providers viewed the CMFHC as a positive step towards meeting the community’s needs, and they offered many useful suggestions for how to succeed in providing free faith-based medical care to the Hartford community.

Perceived Need for a Free Faith-Based Health Center

The informants did describe a “perceived need” for a free faith-based health center in Hartford. The nature and extent of this need is best discussed when the need is separated into its two components: free and faith-based.

Free Health Center

While the majority of the informants acknowledged that their congregation has healthcare, none considered this healthcare adequate to meet the needs of the Hartford community. Some members of their congregation had no healthcare and a small but significant number of entire congregations had no healthcare.
The extent of this need is highlighted by three especially vulnerable populations, identified in this study, who often go without regular medical care: illegal immigrants, those re-entering society, and the working poor and elderly. While this study cannot estimate the number of illegal immigrants in Hartford, these churches represent hundreds of immigrants, and the majority of these immigrants are not receiving healthcare. The main barrier to care is their fear of identification, so although they can receive care from the federally qualified health centers (FQHC) in Hartford, they are hesitant to use them. Also, the FQHCs cost money, and most illegal immigrants prefer to send any extra money they have back to their families in their home countries.

Hartford also has another unique population of people seeking to re-enter society after spending time in prison or any type of recovery program (addiction, abuse, etc…). These people may be staying at one of the city shelters or at Catherine’s Place, which is one of the church ministries in Hartford. They are usually transitioning to the new location, and their health care may be fragmented as a result. If they have state insurance, they may have trouble finding a doctor to accept their insurance, and when they do, access remains difficult for them. They need a doctor’s office that they can go to consistently regardless of current employment or insurance and without long waits for appointments. The third group of vulnerable people is probably the largest group represented in this study, and it is the working poor and elderly. This group of Hartford residents may have access to healthcare, but it is expensive enough for them that they seek financial help from their church or other foundations. They are at risk for skipping medical appointments and not filling needed prescriptions. This group needs some kind of financial relief, and if they can receive some blood tests or
ultrasounds from a free medical center, it would help them financially and potentially improve the quality and consistency of their medical care.

Faith-Based Health Center

There was universal agreement from the informants that faith is a part of health, and that conceptually, faith and medicine belong together. All but one informant said that healthcare would be improved if faith were a part of medical care. However, there was not clear agreement on the exact nature of this perceived need to have faith incorporated into medical care. Do people simply need doctors who will listen to their thoughts on faith and health? Do they need Christian doctors who will understand their perspective, or do they need doctors who will actively encourage them in their faith or even instruct them morally as they make life decisions?

Both the spectrum of opinions on faith and health (Table 3.1) and the range of desires for faith-based medical care (Table 3.3) make it difficult to provide general recommendations to physicians. Although knowing where the patient falls on the faith and health continuum does not help predict what kind of spiritual encounter they want to have with their doctors, (Table 3.4) it is still important for doctors to know their patients’ views on faith and health. For instance, if a patient believes that his sin caused his illness, then he might be less aggressive in treating the illness or taking his medication. He might feel he deserves the illness or he might try to alleviate it spiritually instead of medically. Also, if a patient’s faith affects her medical decisions, the doctor needs to address faith at the time of medical decision making for her to be comfortable and satisfied with the decision. As a third example, if a patient believes God instructs him to take care of his body, this belief can be used to motivate the
patient towards better health practices. In fact, for each point on the faith and health continuum, examples could be given for how that perspective changes the healthcare encounter. In all these examples, the discussion of faith in a healthcare setting would provide an opportunity for doctors to improve the quality of medical care given to the patient.

We can conclude that, at a minimum, faith needs to be an acceptable topic in any medical examination room, because many people will view faith as an integral part of their health and doctors need to know where the patient falls on the faith and health continuum. Independent from the faith and health continuum, the evidence in this study shows that there is a range of desires for faith-based medical care among church communities. With only one exception, informants agreed that patients want some kind of faith-based medical care. Most commonly, they wanted to discuss faith openly and pray with their doctors. This desire represents a need to bring faith into their medical care. The informants concluded that their parishioners need some spiritual touch during medical encounters, with prayer being the most frequent example given. Beyond prayer, many parishioners in local churches feel better cared for when they are spiritually encouraged and given wise counsel from a Christian perspective during their medical care. Informants agreed that patients would be positively impacted if their medical care provider could provide some of the spiritual care as well, instead of patients having to seek out spiritual support elsewhere. This will strengthen the doctor-patient relationship and ensure that the spiritual health of patients, especially during times of illness, is not forgotten. However, this study does not answer the question of when it is appropriate for a doctor to give Christian moral instruction, and many people
in the medical community would say this is never appropriate. This is discussed further in “How should healthcare providers address spiritual needs?”

Overall, we will define the nature of a perceived need to integrate faith and medicine, as a need for discussion of faith and prayer during medical care, with a subset of individuals needing a Christian doctor and spiritual encouragement and/or moral guidance as well.

The extent of this need for discussion of faith and prayer during medical care is difficult to estimate, primarily because the key informants acknowledged that some of their parishioners might not yet recognize this need, though they thought most did. Some people in the Hartford community may need to experience this kind of healthcare before they fully realize the benefits of incorporating faith and medicine. The informants in this study did state that many people, even some outside the church community, would be comfortable discussing faith and praying during medical care for three reasons. First, many ethnicities, especially those represented in Hartford (Hispanic, African American) have a rich faith history. Faith has been an important part of their culture, especially in some of the older generations. Although some individuals may not have a faith of their own, they will be very familiar with Christian concepts and possibly comforted by them during medical illnesses. Second, most people in Hartford already combine faith and medicine in their own ways at home or at church. Universally, church-goers pray when they or a loved one is sick, and beyond prayer, they seek counsel from pastors, read scripture, and believe in the Christian value of keeping their bodies healthy. Many non-religious people still request and benefit from pastoral visits in the hospital. Third, many Hartford residents are
immigrants, and they may have had experiences in other countries where faith and medicine are well integrated. In parts (often rural parts) of some countries, Christian organizations provide the majority of the healthcare. There, it is customary for doctors to pray with patients and advise patients to pray with others as well. Occasionally, faith is prescribed as a way to help people through illnesses. Therefore, although this is not a universal experience of all new immigrants, some of them are well accustomed to the integration of faith and medicine.

Overall, there is a perceived need for free healthcare and for medical care that includes the discussion of faith and prayer. Is it appropriate for these needs to be met in the form of a combined free faith-based health center? The consensus from this study is that a free faith-based health center is not only appropriate, but it is a good way to meet two needs at the same time. As stated above, it is likely that those who need free care will not be turned off by the faith component in their medical care, and many who would choose to attend for the advantage of having a Christian environment would benefit financially as well. The informants represent a significant number of people in Hartford who have both financial and spiritual needs. Therefore, the combination of free care and faith-based care can bring quality and hope to individuals who have many needs.

Are current healthcare providers meeting these needs?

This study indicates that most providers are not meeting the needs of their patients for discussion of faith or prayer during their medical care. Many informants had never or rarely discussed faith during their own medical care. This is especially
striking since each person interviewed worked for a church and most medical doctors would be aware of their patients’ occupations. Most informants believed that doctors as whole were uncomfortable discussing faith in the context of someone’s health, but they would listen politely or generally acknowledge faith if they knew it was important to their patient. Occasionally, especially if they are of similar faith, doctors will pray with patients, but this is quite rare and usually catches patients by surprise. Overall, doctors are becoming more open to faith, according to these informants, but it is rare to find a doctor that truly desires to address their spiritual needs as well as their physical needs. A few of the informants have doctors who pray with them and encourage them, so they recommend these doctors highly. But the majority of people in their congregations, and in Hartford, do not have their spiritual needs addressed during medical visits.

How should healthcare providers address spiritual needs?

Given the range of spiritual needs, from discussion of faith to prayer to moral instruction, how should healthcare providers address these needs? They certainly would not feel comfortable giving moral instruction to every person who comes to the office, nor should they. First, providers should assess where patients are on the faith and health continuum and what desires patients’ have for spiritual care. Tables 3.1b and c, 3.3 b and c, and Table 3.4, were designed to help providers predict the opinions of their patients according to certain characteristics. On the surface, the tables show slight differences between groups and Table 3.4 appears to show that those who believe “God heals” might be more likely to desire prayer in their medical care.
However, the researcher strongly recommends against using any of these apparent relationships in a medical encounter. This data came from qualitative interviews, which means the data is the result of open-ended questions. Although, some informants only mentioned prayer as a desire for faith-based health care, this does not mean if they were asked directly if they wanted discussion of faith as well, that they would not say “yes.” As another example, although only one informant said her faith inspires her to do good to others, it is likely that if the other informants were asked if they agree with this statement, they would say “yes.” The collective responses of the informants give the researchers a complete picture of collective desires for faith-based healthcare, but the individual responses do not give a complete picture of individual desires for faith-based healthcare. To fully detect all the desires that individual informants have, they would need to be asked direct questions, instead of open-ended questions. So, although the data in Tables 3.1-3.4 is interesting, it is not conclusive.

Therefore, each person who visits a healthcare provider should be viewed as having any combination of desires for spiritual care during the medical encounter, regardless of religious denomination or ethnicity or residency status.

Since, physicians cannot predict what patients’ think about faith according to patient characteristics, physicians should ask patients about faith. Then, beyond asking about faith, they should ask if patients would like prayer or any other kind of spiritual support. This can be done in non-threatening and non-coercive language. As recommended in the literature, both HOPE and FICA are good acronyms to use for taking a spiritual history during the medical encounter. The HOPE questions may be more appropriate for a new patient if the physician does not know if he/she has any
kind of faith, because it gives opportunity to talk about meaning in life apart from organized religion. However, the FICA questions better identify how a patient thinks about faith and health compared to the HOPE questions. The “I” questions ask, “What importance does your faith or belief have in your life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?” These questions are very important for determining where a patient is on the faith and health continuum. The FICA questions also offer a simple way of addressing the desires of the patient for spiritual care during the medical encounter. The “A” question is, “How would you like me, your healthcare provider, to address these issues in your healthcare?” This question gives the patient the opportunity to ask for prayer or moral instruction. However, some patients will be hesitant to ask for prayer or a referral to a counselor, even though they desire it and need it. It would be appropriate for the physician to offer prayer or a referral to spiritual counseling, because this study shows many people will be appreciative. Patients may want prayer or counseling, but they may not have the courage to ask for it, likely due to the perception that physicians would not approve. Physicians should provide these opportunities for patients, just as they would offer medical treatment for any physical problem.

Should physicians always offer prayer and counseling to every patient? Not necessarily. Most physicians will feel comfortable offering these services only to those who clearly have some “spiritual distress.” The “E” in HOPE addresses spiritual distress using two questions, “Has being sick (or your current situation) affected your ability to do the things that usually help you spiritually? (Or affected your relationship
with God?)” and “Are you worried about any conflicts between your beliefs and your medical situation/care/decisions?” followed by, “Would it be helpful for you to speak to a clinical chaplain/community spiritual leader?” These questions are particularly appropriate for patients with serious illnesses and chronic disease. If patients affirm some spiritual distress in their life, these may be the best patients to ask if they would like prayer, further discussion or any advice from the physician or the spiritual counselor.

Regarding the need for moral instruction during medical care, which some informants expressed, the researcher advises caution. In certain circumstances, small words of instruction, among a doctor and patient of like faith and who know each other well, might be appropriate and especially meaningful. But, in most circumstances, it would be more appropriate to refer the patient to a Christian counselor or clergy member of like-faith. If the patient desires the physician to be part of that spiritual discussion, the physician could join the meeting, and he/she might learn important information about the patient in that context. This joint meeting might further strengthen the doctor-patient relationship.

Overall, HOPE and FICA can both be effective tools for taking a spiritual history, but FICA may be superior at identifying patients’ views of faith and health and how they would like faith integrated into their health. The CMFHC recognized that neither model is perfect, especially in the area of giving patients’ opportunities to have their spiritual needs met during the medical encounter. Therefore, the CMFHC is in the process of developing a spiritual assessment tool to use with their particular patient population. Dr. Barbara Szajda piloted an initial tool at the CMFHC during the months
of February and March, and the patients attending the clinic received it well. This CMFHC pilot tool differed from HOPE and FICA by asking “Are you interested in praying with someone from the CMFHC?” at the end of the spiritual history. Depending on the patient’s desire, they could pray with the doctor or be directed to a separate spiritual counselor for prayer. Interestingly, some of the patients who did not believe in God, still desired to pray with someone at the CMFHC. The full results of the CMFHC research study assessing the pilot spiritual assessment tool can be acquired from Dr. Peter Schnatz.

Overall, the CMFHC providers should follow generally accepted guidelines when taking a spiritual history or providing spiritual care. As discussed in the literature review for this study, and in keeping with Dr. Puchalski’s recommendations (Table 1.2), doctors should be aware of the sensitive nature of spirituality. Their conversation should remain “patient-centered” and primarily patient-directed. Physicians should provide general care, including compassion, presence, listening and the encouragement of home. They should always show respect for any patient beliefs, and avoid projecting their own beliefs onto the patient in any way.

How can CMFHC be more effective at fulfilling these needs?

Given their depth of experience in the Hartford community, the key informants provided advice on how to make the CMFHC more effective, apart from providing good spiritual care. Their ideas focused on how to attract people to come to the health center and how to provide better than usual care so that patients will return consistently and recommend the clinic to their family and friends. Overall, the recommendations to
the CMFHC were: 1.) be community oriented; 2.) be consistent and trustworthy; 3.) be competent and relational; and, 4.) be available.

First, in keeping with a community-oriented primary care model, the CMFHC should remain community oriented. It should be a visible member of the community, and engage the community to help make the clinic into what the community needs. Practically, this means the clinic should remain located in Hartford; within a neighborhood that it serves. The people who work at the CMFHC should be connected to the community, either by attending some of the local churches or participating in community events. The churches form a large network that can be a resource for the clinic. They can disseminate information rapidly to large numbers of people and can lend credibility to this relatively new idea. The church leaders are already interested; they just need to be utilized. The clinic would also be more attractive to patients if someone from their community volunteered or worked there. The CMFHC should actively recruit community members to be the main volunteer base for the clinic. Many lay people could be trained as receptionists, greeters, prayer partners and counselors. Also, the pastors in the community could be on premise to serve as spiritual counselors. All these actions show the community that the CMFHC is committed to them, and it projects that the CMFHC is the community’s health center, creating a sense of ownership and credibility. The community may need to build a certain level of familiarity and trust with the health center and its members, before they begin to attend it regularly.

Second, the CMFHC needs to be consistent and trustworthy. These characteristics are especially important because the medically underserved are
accustomed to being let down. They often feel let down, because services come and go quickly due to the difficulties of maintaining social programs in a stressful and financially strapped environment. Also, they have become skeptical of free services after being disappointed or treated poorly in the past by other providers. Therefore, to be successful in an underserved community, the CMFHC must be consistent in following through with promises. That means always being open when they are expected to be open, and always having the services advertised available. The CMFHC may have to show itself to the community that it will not disappear after a few slow months or after the volunteers get tired.

Third, the CMFHC needs to be both medically competent and relational. The combination of these two qualities will create superb medical care that people will keep coming back for. Although it has been established that people want more than their medical needs addressed at their doctor’s office, they still value medical competence and they value complete, thorough medical care. The key informants’ excitement about the spiritual component of the CMFHC was contingent on the fact that the medical care would be as complete and competent as any other medical office. Ethically, the medical care should be at the standard of care whether it is free or not. Also, by incorporating faith into medical care, the CMFHC will already be improving the quality of medical care, but it should be done in a relational way – that means through conversation, not simply a form or a pamphlet handed to patients on the way out the door. Patients want to form relationships with their care providers, and they need some kind of continuity with providers. Unfortunately, this is difficult for a clinic that uses rotating volunteer physicians, so the CMFHC may need to change the way
volunteers are used. Some ideas include scheduling providers for certain days of the
weeks, so that patients can easily predict when their provider will be available. Also,
the CMFHC could consider hiring a certain individual to be at every clinic – whether it
is a medical professional or a supporting person. Then patients would see a familiar
face at every visit. The lack of relationship in medical care is what disappoints so
many patients, and the CMFHC will stand out from other clinics if it continues to focus
on people, not just medical problems.

Finally, the CMFHC needs to be available for patients. In casual conversation
about the CMFHC, the most frequently asked question is “When are you going to be
open more than once per month?” It is challenging to staff a clinic with volunteers
very often, but the underserved community is partly underserved, because they have a
hard time getting to the doctors office. Many people in the community work multiple
jobs or unusual hours, or they have very erratic lives in general. So, to ensure that
people have the opportunity to attend the CMFHC, it should eventually expand its
hours or vary its schedule. This, of course, must be balanced with the value of being
consistent and reliable, and it may take some time to determine the best hours for
CMFHC operation.

Overall, the key informants projected a hopeful outlook for the CMFHC. They
believed that the services provided would be attractive to the community and if the
CMFHC incorporates these four values, it will be successful. It will take time for the
CMFHC to build a reputation in the community, and this will require patience. But in
the end, through staying community oriented, consistent, relational and available, the
CMFHC will become a significant member of the Hartford community.
Significance of the Key Informants

The results of this needs assessment were collected from 10 key informants, representing approximately 7000 individuals who were members of their church communities, of which approximately 3500 were Hartford residents. At least two key informants also ministered to groups of poor or homeless individuals outside their church community. Overall, although the key informants were not a representative sample of Hartford residents, they were well connected members of the community and had close relationships with a large number of Hartford residents. The information they provided represents a niche community of church going residents in Hartford. Their opinions should be viewed as “expert” information due to their unique position in the community. They care deeply about the people in Hartford and they sincerely spoke on behalf of the community they minister to daily.

Key Informant Response Rate

The response rates for the recruitment of participants were 11% for cold calls to church leaders, 37.5% for calls to church leaders who may have heard of the Christian Medical Fellowship and 50% to church leaders of small local ethnic churches. These numbers are not unusual for this methodology of recruiting participants, especially since there was no incentive to participate. Even with one church leader who initially said they were very interested and “we believe in this type of project,” it took three calls and approximately four weeks for an interview to be scheduled. The most common reason given for declines was the lack of time for the interview. This is not unexpected given that church leaders do have tight schedules with many meetings per
day. One unusual receptionist said that she did not believe her church members would need any kind of free clinic, and she may have been offended at the suggestion. Another church leader, who originally consented to the interview and later had to cancel, did briefly say that he did not think free medical care was the best way to help people.

For the church leaders who participated in a community breakfast 8 months earlier, one might have expected an even higher response rate, given their initial interest in healthcare issues. However, all of the leaders said they could not recall the breakfast and in at least a few instances, it was discovered that an associate minister or another volunteer had attended the breakfast in the senior minister’s place. Therefore, these individuals were not very different than those in the cold call group, apart from the fact that they might be leaders of larger and more well-known churches.

Concerning the church leaders from small local churches, their response rate was significantly better likely due to the more personal method of recruiting them. One church leader was recruited personally on a chance meeting in front of his church, and the other was recruited through a call and an email that was translated into his primary language. The researcher and this particular informant had a common ethnicity in their families. Overall, the response rate can be interpreted as positive. Since there was no incentive and usually no personal connection with either the researcher or CMF, the topic of the study was interesting and valuable enough for the informants to volunteer their time.
Focus Group Response Rate

The response rate to the fliers given to church leaders was 0%; however, this is not entirely unexpected. Although these informants said they would post the fliers, the researcher cannot be sure that they did post these fliers, and the researcher was not able to choose a strategic location in the church for the fliers. These decisions were left to the discretion of the church leaders. A more active approach should have been taken by the researcher given the improved response rate (22.5%) at the church where the researcher participated in the worship service and then invited the congregation to participate in a group following the service. For a population with little free time and limited resources, they need more than a flier for recruitment even if they are very interested in the topic. The low response rate may be due as much to lack of adequate information as to potential lack of interest. They may have needed to know that the time and place for the focus groups would be convenient for them, or they may have needed more information about the CMFHC clinic to see that their participation would have real effects in the community. Also, given the general distrust of “official” state-run projects that many marginalized members of society have, they may have wanted to see their pastor personally endorse the research project and also see the researcher face-to-face before they decide to participate.

Therefore, the success of the single focus group can be attributed to the addition of face-to-face recruitment, more information provided about the CMFHC and the public endorsement given to the researcher by the pastor. However, it is possible that the researcher had some additional credibility among the people at that church, because the researcher’s husband was of the same ethnicity as the church goers and he was an
immigrant as well. He functioned as a neutral translator, but also facilitated
recruitment by socializing with the church members before and after the service.
Hence, the researcher may have been viewed as part of the community whereas at other
churches she might be viewed as an outsider.

Limitations

There are limitations in this study – some inherent in the research design and
others particular to the content of this study. First, in this study, church leaders were
asked to give their own opinions, but also to estimate the opinions of their parishioners.
However, the ability for church leaders to accurately estimate their parishioners’
opinions is variable among churches and potentially questionable in general. Some
informants felt comfortable speaking for their congregation and other felt less
comfortable. It is logical that those informants who came from small ethnic churches
might be able to accurately describe their congregation’s plight and opinions, since this
community is both smaller and tighter. These congregations often socialize together
outside of church gatherings and they consider their pastor one of their friends and
confidants, not just a formal figure. On the other hand, those informants from larger
churches are most likely speaking from intimate knowledge of some parishioners but
only general knowledge about the majority of parishioners. It would be presumptuous
to assume that a congregation of 1000 to 3000 people would have uniform views.
Therefore, these informants from large churches are truly only representing a subset of
their own congregation. Though the subset of individuals in significantly smaller than
the church membership, it is not an insignificant number overall. Also, pastors are
likely to hear about the struggles and concerns of church members, even those they do not know well, because a pastor is often looked to for prayer support or wise counsel. In large churches, many associate pastors and volunteers in the community will report back to the senior pastor, and therefore, they widen his knowledge beyond his own scope of relationships.

Second, the key informants may have a bias towards incorporating faith and medicine, because they may believe that all people should have faith. In an effort to minimize this bias, the study questions specifically ask about the needs of the church parishioners not the needs of the community at large. These parishioners are presumed to already have faith, and therefore, the informants were instructed to think about the benefits of incorporating faith and medicine for patients who have a faith. Occasionally, remarks were made about the state of spirituality in Hartford in general, or that it would be wonderful for physicians to mention faith to people who do not yet have faith in God. However, overall, the results show that the informants were thinking about their own congregations when they answered any study questions. Despite this, there is the possibility that church leaders might view their parishioners as more enthusiastic about faith in medicine than they truly are. Conversely, some informants might view parishioners as being less spiritual, if they compare their parishioners enthusiasm for faith with their own, even when parishioners view themselves as being very spiritual. Some informants openly said that their own views on faith and medicine might be a step beyond the views of their congregation. This personal bias might lead them to see a “need” for faith in medicine in their parishioners that those individuals might not see in themselves.
Does this invalidate the perceived need? Not necessarily. This perceived need, in the eyes of the informant, is supported by the expressed need that people show when they seek out Christian doctors, or when they ask to pray with doctors, or when they call a pastor to their bedside in the hospital. The key informants gave many examples of parishioners expressing their need for a faith-based medical clinic. Furthermore, key informants are valuable specifically for their ability to see needs in the community that others do not recognize. They see that people need free healthcare despite the fact that those people may not seek out healthcare. We accept that all people need healthcare, even though they do not all express their need by filling up doctor's waiting rooms. Likewise, we can accept the wisdom of key informants who see that people need faith in their medical care, especially those people who already show this in many ways, even though those people may not recognize their own need.

Finally, the response rates discussed under the previous heading could be viewed as a limitation of this study. However, it would be a significant limitation only if it was apparent that the low response rate was due to lack of interest in the study topic or a belief that the study topic was not important to the community. While it cannot be said for certain that these reasons are unlikely, it can be said that there were multiple other reasons for the low response rate overall. It is assumed that if a second attempt was made to gather the focus groups volunteers over many months, and the appropriate changes recommended above were implemented, there would be a much higher response rate.
Questions for Further Study

In the future, the CMFHC may want to pursue further stages in this needs assessment process to create a body of data more representative of the entire Hartford community or to answer some practical questions concerning the operation of the CMFHC. It would be interesting to know if the niche community examined in this study is similar or dissimilar to the Hartford community as a whole. This would further help CMFHC target their advertising to as large a population as possible who might respond favorably to the ads. There may be others outside the church community in Hartford who would like to help CMFHC get started and could lend further credibility to the CMFHC.

Also, the CMFHC should begin to ask their community practical questions about the operation of the health center. For instance, is there a certain medical expertise they should focus on which is needed most in the community – i.e. women’s health or geriatrics? What languages will the CMFHC regularly need interpreters for and how should these interpreters be scheduled – should all languages be available daily or should certain interpreters come on certain days? Is the current CMFHC location appropriate and convenient for the community? How can the CMFHC assist people in getting to the clinic or educate them on how to find easy transportation – i.e. publish the local bus stop schedule or provide shuttles to the CMFHC from the further away homeless shelters? Since this study shows that people want consistent, trustworthy medical care, with “no strings attached,” would transitioning to a sliding scale payment system be viewed as a breach of trust? Does the community view sliding-scale payment as better, or worse, than free healthcare? What types of community
partnerships should the CMFHC seek that will be mutually beneficial and will enhance patient care? Who should be in CMFHC’s referral network and how can CMFHC begin to receive referrals from other medical offices? Finally, should CMFHC expand their focus beyond patient care and begin to train doctors in the skills of taking a spiritual history? This study does display that doctors are mostly uncomfortable discussing faith with patients, and the CMFHC would likely be an ideal training site since their mission includes addressing spiritual needs with patients. How can CMFHC best train these doctors and should this happen after patient care is established or can there be a two-fold mission from the very beginning of operations?

Last, the CMFHC should investigate two issues further, so patients will feel more comfortable using the CMFHC’s services. First, is the CMFHC truly a safe place for undocumented immigrants? Does the government immigration service ever raid health clinics the way they do to some employers known to hire illegal immigrants? What should CMFHC do to maintain their patient’s safety? If there is no documented of legal status or insurance, does this make the CMFHC safe enough? Also, the CMFHC should investigate whether those patients who have private insurance, and choose to use the CMFHC for their primary healthcare, will they have trouble accessing specialists and hospital services with their insurance carrier. Will a referral from CMFHC to a specialist be acceptable? Or will the insurance carrier require a referral from a doctor in its network of providers? The researcher does not anticipate any problems for patients accessing hospital services, however, this should be confirmed before patients begin receiving healthcare at the CMFHC.
Overall, many of these questions can be answered with continued needs assessments in the community and evaluations at the CMFHC. The process itself will enhance community relationships and will maintain the tradition of community-oriented primary care.

Summary

Overall, this study confirms that there is a perceived need for a free faith-based health center in Hartford, CT. There are a large number of people, primarily in church congregations, who have shown an expressed need for free healthcare and for healthcare that incorporates faith. At this time, it can be recommended to the Christian Medical Fellowship Health Center that they continue to offer free care and faith-based care by inquiring about faith and its relationship to patients’ illnesses, and offering prayer during the medical encounter. Many of Hartford’s church leaders are enthusiastic about the CMFHC, and they expect that with time the CMFHC will be a busy, well-liked, community medical practice.
Table 1.1  HOPE model for taking a spiritual history and examples of questions

**TABLE 3**
The HOPE Questions for a Formal Spiritual Assessment in a Medical Interview

| H: Sources of hope, meaning, comfort, strength, peace, love and connection |
| O: Organized religion |
| P: Personal spirituality and practices |
| E: Effects on medical care and end-of-life issues |

### TABLE 4
Examples of Questions for the HOPE Approach to Spiritual Assessment

**H Sources of hope, meaning, comfort, strength, peace, love and connection**
- We have been discussing your support systems. I was wondering, what is there in your life that gives you internal support?
- What are your sources of hope, strength, comfort and peace?
- What do you hold on to during difficult times?
- What sustains you and keeps you going?
- For some people, their religious or spiritual beliefs act as a source of comfort and strength in dealing with life's ups and downs; is this true for you?
- If the answer is "Yes," go on to O and P questions.
- If the answer is "No," consider asking: Was it ever? If the answer is "Yes," ask:
  - What changed?

**O Organized religion**
- Do you consider yourself part of an organized religion?
- How important is this to you?
- What aspects of your religion are helpful and not so helpful to you?
- Are you part of a religious or spiritual community? Does it help you? How?

**P: Personal spirituality/practices**
- Do you have personal spiritual beliefs that are independent of organized religion?
- What are they?
- Do you believe in God? What kind of relationship do you have with God?
- What aspects of your spirituality or spiritual practices do you find most helpful to you personally? (e.g., prayer, meditation, reading scripture, attending religious services, listening to music, hiking, communing with nature)

**E: Effects on medical care and end-of-life issues**
- Has being sick (or your current situation) affected your ability to do the things that usually help you spiritually? (Or affected your relationship with God?)
- As a doctor, is there anything that I can do to help you access the resources that usually help you?
- Are you worried about any conflicts between your beliefs and your medical situation/care/decisions?
- Would it be helpful for you to speak to a clinical chaplain/community spiritual leader?
- Are there any specific practices or restrictions I should know about in providing your medical care? (e.g., dietary restrictions, use of blood products)

*If the patient is dying:* How do your beliefs affect the kind of medical care you would like me to provide over the next few days/weeks/months?

Table 1.2 FICA model for taking a spiritual history with general recommendations

The acronym FICA can help structure questions in taking a spiritual history by Healthcare Professionals.

F--Faith and Belief
"Do you consider yourself spiritual or religious?" or "Do you have spiritual beliefs that help you cope with stress?" IF the patient responds "No," the physician might ask, "What gives your life meaning?" Sometimes patients respond with answers such as family, career, or nature.

I--Importance
"What importance does your faith or belief have in our life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?"

C--Community
"Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?" Communities such as churches, temples, and mosques, or a group of like-minded friends can serve as strong support systems for some patients.

A--Address in Care
"How would you like me, your healthcare provider, to address these issues in your healthcare?"

Adapted with permission from Puchalski CM, Romer AL. Taking a spiritual history allows clinicians to understand patients more fully. J Pall Med 2000;3:129-37. Copyright, Christina M. Puchalski, MD, 1996.

General recommendations when taking a spiritual history:

1. Consider spirituality as a potentiality important component of every patient's physical well being and mental health.

2. Address spirituality at each complete physical examination and continue addressing it at follow-up visits if appropriate. In patient care, spirituality is an ongoing issue.

3. Respect a patient's privacy regarding spiritual beliefs; don't impose your beliefs on others.

4. Make referrals to chaplains, spiritual directors, or community resources as appropriate.

5. Be aware that your own spiritual beliefs will help you personally and will overflow in your encounters with those for whom you care to make the doctor-patient encounter a more humanistic one.

Table 1.3 CMFHC Utilization

<table>
<thead>
<tr>
<th></th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of patients</strong></td>
<td>3</td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td>Shelter</td>
<td>McKinney</td>
<td>South Park</td>
<td>private</td>
<td>private</td>
<td>South Park Inn Mercy House</td>
</tr>
<tr>
<td></td>
<td>Homeless</td>
<td>Shelter</td>
<td>Inn</td>
<td>private</td>
<td>private</td>
<td></td>
</tr>
<tr>
<td></td>
<td>private</td>
<td>private</td>
<td>private</td>
<td>Mercy</td>
<td>House</td>
<td></td>
</tr>
<tr>
<td><strong>Do you have a doctor?</strong></td>
<td>Yes = 1</td>
<td>Yes = 2</td>
<td>Yes = 5</td>
<td>Yes = 1</td>
<td>?</td>
<td>Yes = 2</td>
</tr>
<tr>
<td></td>
<td>No ans = 1</td>
<td>No ans = 2</td>
<td>No ans = 2</td>
<td>No ans = 1</td>
<td>No ans = 1</td>
<td>No = 2</td>
</tr>
<tr>
<td><strong>Language spoken</strong></td>
<td>English</td>
<td>English</td>
<td>English</td>
<td>English</td>
<td>English</td>
<td>English</td>
</tr>
<tr>
<td></td>
<td>Spanish</td>
<td>Spanish</td>
<td>Spanish</td>
<td>Spanish</td>
<td>Spanish</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Portuguese</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 1.4 The IOM's model of community-oriented primary care

Figure 1. Conceptual model of community-oriented primary care.

Figure 1. According to Rhyne et al., experience has shown that the steps of community-oriented primary care may vary in order depending on the community, health problem, or approach taken by the collaborating team.

Strelnick, A. H. Arch Fam Med 1999;8:550-552
Table 1.6
Staging criteria for the development of a community-oriented primary care practice

<table>
<thead>
<tr>
<th>Stage</th>
<th>Defining and characterizing the community</th>
<th>Identifying community health problems</th>
<th>Modifying the health care program</th>
<th>Monitoring the effectiveness of program modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 0</td>
<td>No effort to define or characterize the community</td>
<td>No effort to understand the health status or health needs of the community</td>
<td>No program modifications made in response to community health needs</td>
<td>No effort to determine the impact of modifications in the health care program</td>
</tr>
<tr>
<td>Stage I</td>
<td>Community is characterized from the subjective impressions of the practitioners and/or consumer representatives</td>
<td>Health problems identified through general consensus of the providers and/or consumer groups</td>
<td>Modifications are made more in response to a national or organizationwide initiative</td>
<td>Estimates of program effectiveness are based on subjective impressions of the practitioners and/or consumer groups</td>
</tr>
<tr>
<td>Stage II</td>
<td>Community is characterized by extrapolation from secondary data—census or large area epidemiologic data</td>
<td>Health problems identified by extrapolation from systematic review of secondary data</td>
<td>Modifications are consistent with the particular guidelines of the funding source or agency</td>
<td>Program effectiveness is estimated by extrapolation from secondary data</td>
</tr>
<tr>
<td>Stage III</td>
<td>Individuals within the community can be enumerated and characterized through the use of a data base specific to the community</td>
<td>Health problems examined through the use of data sets specific to the community</td>
<td>Modifications in the health care program are tailored to unique needs of the community</td>
<td>Program effectiveness is determined by systematic examination of a community-specific data set</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Systematic efforts assure a current and complete enumeration of all individuals in the community, including pertinent demographic and socioeconomic data</td>
<td>Formal mechanisms used to identify and set priorities among a broad range of potential health problems in the community</td>
<td>Modifications in the program involve both primary care and community public health components and are targeted to specific high risk individuals within the community</td>
<td>Program effectiveness is determined by techniques that are specific to the program objectives and account for differential impact among risk groups</td>
</tr>
</tbody>
</table>

Figure 2.1 Recruitment of Key Informants

- Google Maps: 41 Church organizations
  - 2 duplicates
  - 5 non-Christian organizations
  - 36 churches (4 asked by name, 32 asked for primary minister or priest)
  - 20 messages
  - 3 called back and consented
  - 1 verbally declined
  - 3 answered

- 6 breakfast churches
  - 6 asked by name
  - 3 messages
  - 1 consent
  - 1 no answer
  - 1 decline
  - 2nd try consent
  - 3 participants

- Small Local Churches
  - 3 called
  - 1 spoke in front of church
  - 1 incorrect number
  - 1 message
  - 1 e-mailed
  - 1 consent
  - 2 participants
## Table 2.2 Key Informant Demographics

<table>
<thead>
<tr>
<th>Miles from CMFHC</th>
<th>Size</th>
<th>Sex</th>
<th>Ethnicity Informant</th>
<th>Ethnicity Congregation</th>
<th>Residency</th>
<th>Denomination</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3.3</td>
<td>M</td>
<td>Afro-Caribbean</td>
<td>A.A. Caribbean</td>
<td>Suburbs</td>
<td>Pentecostal</td>
</tr>
<tr>
<td>2</td>
<td>0.5</td>
<td>M</td>
<td>Brazilian</td>
<td>Brazil Columbia Puerto Rico</td>
<td>Hartford Few in East Hartford</td>
<td>Baptist</td>
</tr>
<tr>
<td>3</td>
<td>0.7</td>
<td>F</td>
<td>Caucasian</td>
<td>Caucasian</td>
<td>Suburbs</td>
<td>Christian Science</td>
</tr>
<tr>
<td>4</td>
<td>0.9</td>
<td>M</td>
<td>Indian</td>
<td>Hispanic French</td>
<td>Hartford v. few in Suburbs</td>
<td>Catholic</td>
</tr>
<tr>
<td>5</td>
<td>1.1</td>
<td>F</td>
<td>Caucasian</td>
<td>Caucasian</td>
<td>Suburbs</td>
<td>Catholic</td>
</tr>
<tr>
<td>6</td>
<td>0.9</td>
<td>M</td>
<td>Nigerian</td>
<td>Nigerian</td>
<td>Suburbs</td>
<td>Celestial Church of Christ</td>
</tr>
<tr>
<td>7</td>
<td>1.0</td>
<td>M</td>
<td>African-American</td>
<td>A.A. Caribbean</td>
<td>½ Hartford ½ Suburbs</td>
<td>Pentecostal</td>
</tr>
<tr>
<td>8</td>
<td>1.6</td>
<td>M</td>
<td>African-American</td>
<td>A.A.</td>
<td>Harford. Suburbs</td>
<td>Baptist</td>
</tr>
<tr>
<td>9</td>
<td>0.2</td>
<td>M</td>
<td>Caucasian</td>
<td>Caucasian + African-American</td>
<td>Suburbs</td>
<td>Congregational</td>
</tr>
<tr>
<td>10</td>
<td>1.5</td>
<td>M</td>
<td>Hispanic</td>
<td>Hispanic</td>
<td>Hartford Suburbs</td>
<td>Pentecostal</td>
</tr>
</tbody>
</table>

* f – families, a – attendees, m - members
### Table 3.1 – Faith and Health Continuum as viewed by key informants

<table>
<thead>
<tr>
<th>Faith...</th>
<th>Indirectly improves people’s health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compels people to do good.</td>
<td><strong>Future State</strong></td>
</tr>
<tr>
<td>Affects people’s medical decision</td>
<td><strong>Future State</strong></td>
</tr>
<tr>
<td>God instructs people to take care of their bodies</td>
<td><strong>Future State</strong></td>
</tr>
<tr>
<td>God gives medical knowledge and directs MDs</td>
<td><strong>Future State</strong></td>
</tr>
<tr>
<td>Good environment for healing – “positivity”</td>
<td><strong>Future State</strong></td>
</tr>
<tr>
<td>In God heals</td>
<td><strong>Future State</strong></td>
</tr>
<tr>
<td>Determines health - sin causes illness</td>
<td><strong>Future State</strong></td>
</tr>
<tr>
<td>And health are inseparable twins</td>
<td><strong>Future State</strong></td>
</tr>
</tbody>
</table>

### Table 3.1b Faith and Health by Christian denomination

<table>
<thead>
<tr>
<th>Baptist</th>
<th>Catholic (R.C.)</th>
<th>Celestial Church C.</th>
<th>Christian Science C.</th>
<th>Congregational</th>
<th>Pentecostal</th>
</tr>
</thead>
<tbody>
<tr>
<td>do good</td>
<td>do good</td>
<td></td>
<td></td>
<td>medical decisions</td>
<td></td>
</tr>
<tr>
<td>care for body</td>
<td></td>
<td></td>
<td></td>
<td>care for body</td>
<td></td>
</tr>
<tr>
<td>directs doctors</td>
<td>directs doctors</td>
<td></td>
<td></td>
<td>directs doctors</td>
<td></td>
</tr>
<tr>
<td>positivity</td>
<td>positivity</td>
<td>positivity</td>
<td></td>
<td>positivity</td>
<td>positivity</td>
</tr>
<tr>
<td>God heals</td>
<td>God heals</td>
<td>God heals</td>
<td></td>
<td>God heals</td>
<td>God heals</td>
</tr>
<tr>
<td>determines health</td>
<td>determines health</td>
<td></td>
<td></td>
<td>twins</td>
<td>twins</td>
</tr>
</tbody>
</table>

132
Table 3.1c Faith and Health according to different communities

<table>
<thead>
<tr>
<th>New Immigrants + city residents</th>
<th>Long term residents + suburban residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>do good</td>
<td>do good</td>
</tr>
<tr>
<td>care for body</td>
<td></td>
</tr>
<tr>
<td>medical decisions</td>
<td></td>
</tr>
<tr>
<td>God directs doctors</td>
<td>God directs doctors</td>
</tr>
<tr>
<td>positivity</td>
<td>positivity</td>
</tr>
<tr>
<td>God heals</td>
<td>God heals</td>
</tr>
<tr>
<td>faith determines health</td>
<td>faith determines health</td>
</tr>
<tr>
<td>inseparable twins</td>
<td></td>
</tr>
</tbody>
</table>

Table 3.2 – Experiences of Healthcare Providers “Faith-Friendly continuum”

- MDs do not talk about faith
- MDs not intimate enough to be natural
- Forms ask religious affiliation
- MDs listen politely but do not “hear”
- MDs affirm patient’s faith
- MDs pray with patient
- MDs share their faith – discuss openly

Unfriendly

Friendly
Table 3.3 – Desires for faith-based medical care (9 of 10 congregations)
In order of frequency requested

1. Prayer during medical care
2. Discussion of faith as it relates to their health
3. Christian doctor
4. Biblical Encouragement + moral instruction

Table 3.3b Desires for faith-based medical care, by Christian denomination

<table>
<thead>
<tr>
<th>Baptist</th>
<th>Catholic (R.C.)</th>
<th>CCC</th>
<th>C.S.</th>
<th>Congregational</th>
<th>Pentecostal</th>
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</thead>
<tbody>
<tr>
<td>prayer</td>
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<td></td>
<td>discussion</td>
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<td>Christian doctor</td>
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<td>Christian doctor</td>
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<td>encouragement / instruction</td>
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Table 3.3c Desires for faith-based medical care, by community

<table>
<thead>
<tr>
<th>New Immigrants + city residents</th>
<th>Long term residents + suburban residents</th>
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</thead>
<tbody>
<tr>
<td>Prayer</td>
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<tr>
<td>Discussion</td>
<td>Discussion</td>
</tr>
<tr>
<td>Christian doctor</td>
<td>Christian doctor</td>
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<tr>
<td>Encouragement / instruction</td>
<td>Encouragement / instruction</td>
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</table>
Table 3.4  Correlation between an informant’s view of faith and health and his/her desire for faith-based medical care

<table>
<thead>
<tr>
<th></th>
<th>do good</th>
<th>medical decisions</th>
<th>care for body</th>
<th>directs doctors</th>
<th>positivity</th>
<th>God heals</th>
<th>determines health</th>
<th>twins</th>
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</table>

Key:
- discussion
- Christian doctrine
- encouragement
- and instruction
Table 4.1 – Advice for CMFHC

1. Be community-oriented
2. Be consistent + trustworthy
3. Be competent + relational
4. Be available
APPENDICES

Appendix A

Key Informant Interview Guide

The purpose of this research study is to determine if there is an identifiable need in the Hartford community for a faith-based medical clinic to serve the urban poor and medically underserved. This interview will be about how you and your community view faith and medicine. Everything you say today will be completely confidential. Your name will not be recorded. I will take notes by hand and will tape record this session so that I do not miss important data. Your participation is completely voluntary and you may end this interview at any time. Your participation and your opinions will not affect the quality of your healthcare if you choose to make myself or my colleagues your healthcare providers in the future. Would you like to begin the interview?

Tell me about your congregation.
   (how large, who are they, how many attend services, how old is the church…)

Are there any health programs in the church, i.e., parish nursing, health screening, health promotion, family life education? Please describe any programs.
How much of a problem is access to health care for your congregation?
Please expand. (What kinds of problems do they have? Are financial concerns a problem for your congregation?)

Do you think there is a relationship between faith and health?

Is this something that gets discussed in your congregation? (describe more fully)
How do members of your congregation incorporate faith into healing and health promotion?

How receptive are most health care providers to discussing faith with patients as it relates to their health? Can you give examples?

How would members of your congregation/community want to have faith or spirituality incorporated in their interactions with health care providers?
Do you think that members of your congregation/community would be interested in attending a faith based health clinic? Why or why not?

Have you heard about the Christian Medical Fellowship Health Center free medical clinic? If so, what thoughts do you have about this new clinic?

Is your congregation similar to the Hartford community? More specifically, is it similar in its views about faith and health?

Would you like to add any other comments/suggestions or ask any questions?
Appendix B

Focus Group Discussion Guide

Thank you all for coming to our focus group today. As you know, today we will be hearing your opinions about faith and health. Everything said today in this room will be confidential. That means that we will not tell anyone that you were here today and we will not tell anyone what you said during this session. We are tape recording your voices only for our own benefit so that we do not miss any comments you have. No one besides our research team will hear these tapes. You are not required to be here. You may leave at any time for any reason. Your participation and your opinions will not affect the quality of your healthcare if you ever choose to make us your health providers.

We will limit our time together to 45 minutes. Please feel free to speak during any time, since we hope to hear from everyone today. No one person should be the focus of this discussion, since each of you has valuable opinions that are important to listen to. There are no right or wrong answers to any topic or question. We ask everyone to be respectful of other people’s opinions. Today we will agree to disagree. We want everyone to have a chance to talk during our discussion.

Before starting, does anyone have any questions? If not, let us start by introducing ourselves to each other by first name. The tape recorder will be turned on after we have finished introductions.

General healthcare topics:
Tell us about healthcare in Hartford.
What do you think about the idea of free medical clinics in Hartford?

Faith
Let’s talk about faith and medicine
Let’s talk about faith and your community

Faith-based medical clinics
What are some of your thoughts about faith-based medical clinics?
What do you think about the possibility of a faith-based medical clinic in downtown Hartford?

Physical healing and spiritual healing
What do you think about physical healing and spiritual healing?
What can we as health care providers do for you?
REFERENCES


Maugans TA. The SPIRITual history. *Arch Fam Med.* 1996;5:11-16.


