Original Research Article

Patients' spirituality in clinical practice: Physicians' attitude and self-reported behaviour at a tertiary health facility, Southern Nigeria

ABSTRACT

Background: It has been shown that patients would like to discuss their spiritual beliefs with their physicians and that they have spiritual needs which are often under addressed by health care professionals. Whereas, addressing those needs in clinical practice is a component of the holistic care that every patient deserve.

Objectives: To explore physicians' attitude and self-reported behaviour towards patients' spirituality in clinical practice at a tertiary health facility in Southern Nigeria.

Methods: In this cross-sectional survey carried out between August and November 2020, a semi-structured and self-administered questionnaire was distributed to physicians of various ranks, working in the various departments of the hospital. Their attitude towards patients' spirituality in clinical practice and self-reported behaviour were analysed using SPSS version 25.0.

Results: A total of 200 physicians participated in the study, 90% of them were residents of various cadres, two-third (n=122; 61%) had less than 10 years work experience. The majority of respondents (n=163; 81.5%) considered it appropriate to make inquiries about their patients' spirituality and less than half of them (n=98; 49%) were aware that there is a chaplain in the hospital that offers pastoral care. Half of the respondents (n=104; 52%) reported they rarely take spirituality history of patients, 18 (9%) often pray with the patient while 100 (50%) rarely refer patients for pastoral care. Insufficient time was the most frequent barriers to discussing spiritual issues with patients. However, only 5 (2.5%) respondents were able to name 3 common tools a health worker can use to assess patients' spiritual needs.

Conclusion: Physicians enquiry into the R/S of patients was inconsistent, and there were gaps between their attitudes to discussing these issues with their patients and its practice. Incorporating spiritual care courses into physician training is recommended to overcome the barriers to both patient and physician R/S inquiry.

Key words: Patients' spirituality; Clinical practice; Physicians; attitude and behaviour; Southern Nigeria

INTRODUCTION

Religion and spirituality (R/S), which many authorities have used interchangeably, have been associated with many aspects of patients' health and health behaviours, the disease process, medical decisions, provision of social support, and physician-patient relationship [1-3]. Besides, studies have shown that patients would like to discuss their spiritual beliefs with their physicians and that they have spiritual needs which are often under addressed by health care professionals [4-7]. Consequently, the World Health Organization (WHO) and other relevant organisations recommended that spiritual issues be addressed in clinical care and education of health professionals [3]. Thus, most medical schools in US and UK have already included spirituality and health content in their curriculum, teaching students how to take a spiritual history, how to deal with religious conflicts, and when to refer to chaplains, among others [3].

Spirituality is defined as a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose of life, and experience relationship with self, family, others, community, nature and the sacred, and is expressed through beliefs, values, traditions and practices [8]. Whereas spiritual wellbeing, the balance between the physical, psychosocial and spiritual aspects of an individual, is a major element in his/her holistic care [8-10]. Religion/spirituality is an important part of people's lives and provides a sense of connectedness and comfort during times of illness and distress [11].

The experience of illness or hospitalization is an affliction that is both physical, emotional, psychological as well as spiritual. Attending to the spiritual needs of a patient at such time as part of his/her holistic and comprehensive care has been shown to improve stress responses, performance and tolerance of the disease/discomfort and improve his/her interpersonal relationships as well as general well-being [5,7-10]. However, research has shown that there is a significant weakness in the medical model as practiced today, as it lacks in the capacity to fulfil the quest for spirituality [12,13].

For many patients, not only those at the end of their life but also to those confronted with long-term chronic illnesses, S/R is an important resource for coping. Besides, spiritual care is a core component of palliative care, which is a holistic approach to care that focuses on relief and prevention of suffering in order to improve quality of life for those with health related suffering, thereby increasing their satisfaction and improving clinical outcome. [4,14,15].

In Nigeria, there is a dearth of literature on the impact of spiritual care on health outcomes on one side, and on the other, the position of healthcare professionals towards spirituality issues in the delivery of healthcare services. Thus, this study was conducted to explore physicians' attitude and self-reported behaviour towards patients' spirituality in clinical practice at a tertiary health facility.

MATERIALS AND METHODS

This study was conducted at the University of Port Harcourt Teaching Hospital (UPTH), an 800 beds tertiary-care health institution, with a clientele of over 400,000 outpatients and over 10,000 in-patients per annum [16]. It is a major referral centre in Port Harcourt, the capital of Rivers State, which has a 2016 projected population of 7,303,924, serving also the neighbouring states in the southern part of Nigeria [17].

The UPTH has a Palliative Care (PC) unit that was established in 2013 and renders in- and out-patient care and occasionally home care. Its clientele is made of patients referred from the various clinical departments of the hospital as well as those referred from other health facilities in Port Harcourt. The PC unit is run by a multidisciplinary team of healthcare professionals, including physicians, nurses, social workers, a pharmacist and a chaplain.

This was a cross-sectional survey carried out between August and November 2020. Participants of the study were physicians of various ranks, working in the various departments of the hospital. The instrument used to obtain information was a semi-structured, self-administered and anonymous questionnaire, which was distributed during their various departmental activities. Respondents were asked to fill out the questionnaires at the end of their day's work and a 1-week period was established for the questionnaires to be returned.

The questionnaire was adapted from related literature, and a small number of questions, relevant to our environment, were added [2,18,19]. Spirituality was classified into high, moderate and low, depending on the extent to which respondents considered themselves to be a spiritual person. Commonly used tools to assess spiritual needs of patients included FICA, HOPE, Open Invite [20,21]. A pilot study with the questionnaire was first carried out to ensure that the questions were clearly stated and would be easily understood by the respondents.

Information obtained included the participants' demographic data, their attitude and self-reported behaviours regarding spirituality in the clinical encounter, and their knowledge about what can be obtained locally. Provision was made for adding an option in case the ones presented did not reflect the respondent's response.

Approval for the study was obtained from the Ethics Committee of the hospital and consent for participation was sought and obtained from the respondents.

Data were entered into a Microsoft Excel Spread Sheet and analysed using SPSS version 20.0. Chi- square test was used to test for significance. $P < 0.05$ was considered statistically significant. Results are presented using tables and texts.

RESULTS

A total of 200 physicians participated in the study, 102 (51%) males and 98 (49%) females. Residents constituted 90% of respondents, including registrars (n=96; 48%) and senior registrars (n=84; 42%). The majority of them (n=80; 40%) belonged to the 35-39 age bracket, and two-third (n=122; 61%) had less than 10 years work experience. They were mostly of the Christian religion (n=167; 83.5%), while more than half (n=78; 39%) considered themselves of moderate spirituality (Table 1).

Table 1. Demographic distribution of respondents

Variable	Frequency	Percent
Gender		
Male	102	51
Female	98	49
Age group		
25 - 29	8	4
30 - 34	65	32.5
35 - 39	80	40
40 - 44	32	16
45 - 49	5	2.5
50 and above	10	5
Work experience		
<5 years	60	30
5 - 9 years	62	31
10 - 14 years	50	25
>15 years	28	14
Rank		
Consultants	15	7.5
Senior Registrar	84	42
Registrar	96	48
No response	5	2.5
Religious affiliation		
Christianity	167	83.5
Islam	24	12
Traditionalist	4	2
Others	5	2.5
Spirituality		
High	78	39.0
Moderate	106	53
Low	16	8

The majority of respondents (n=163; 81.5%) considered it appropriate to make inquiries about their patients' spirituality, whereas for 72.5% (n=145) of respondents, discussing spiritual issues when the patient initiate it is appropriate (Table 2). About half of respondents

(n=98; 49%) considered it appropriate to talk about their own religious beliefs/experiences only at the patient's request. A lesser proportion (n=59; 29.5%) would do so whenever they sense the need, but 19% (n=38) would never do such. The majority of physicians believed it is appropriate to pray for a patient, more so when the patient asks (n=97; 48.5%) than when the physician senses the need (n=77; 38.5%). Less than half of them (n=98; 49%) were aware that there is a chaplain in the hospital who offers pastoral care, however, only 26% (n=52) of respondents knew a chaplain they can refer a patient to if need be, while the majority (n=148; 74%), including some of those who knew about the chaplain in the hospital, did not know any chaplain they could refer a patient to.

Table 2. Physicians' attitude towards discussing Spiritual matters in clinical consultation

	Frequency	Percent
Is it appropriate to inquire about a patient spirituality?		
Appropriate	163	81.5
Not Appropriate	37	18.5
Is it appropriate to discuss spiritual issues when a patient brings them up?		
Appropriate	145	72.5
Not Appropriate	55	27.5
Is it appropriate for a physician to talk about his/her own religious beliefs/experiences with a patient?		
Never	38	19
Only when patient asks	98	49
Whenever physician senses	59	29.5
Other	5	2.5
Is it appropriate for a physician to pray with a patient?		
Never	21	10.5
Only when patient asks	97	48.5
Whenever physician senses	77	38.5
Other	5	2.5
Is there a chaplain in the UPTH who offers pastoral care?		
Yes	98	49
No	21	10.5
I don't Know	81	40.5
Do you know any chaplain you can refer a patient to if need be?		
Yes	52	26
No	148	74

Half of the respondents (n=104; 52%) reported they rarely take spirituality history of patients, while 23% (n=46) and 20% (n=40) do so sometimes and often, respectively. The large majority of respondents (n=149; 74.5%) share their religious ideas and experiences with their patients. Many of the participating physicians (n=87; 43.5%) agreed that they sometimes pray with the patient, another 40% (n=80) do so rarely while few (n=18; 9%) do so often. Half of the respondents (n=100; 50%) rarely refer patients for pastoral care, while 26% (n=52) do so sometimes and 6.5% (n=13) often (Table 3).

Table 3. Physicians' self-reported behaviours towards spiritual issues in clinical consultation

	Frequency	Percent
How often do you take spirituality history of patients?		
Often	40	20
Sometimes	46	23
Rarely	104	52
Never	10	5
How often do you share your own religious ideas and experiences with the patient?		
Often	12	6
Sometimes	149	74.5
Rarely	39	19.5
Never	0	0
How often do you pray with the patient?		
Often	18	9
Sometimes	87	43.5
Rarely	80	40
Never	15	7.5
How often do you refer patients for pastoral care?		
Often	13	6.5
Sometimes	52	26
Rarely	100	50
Never	35	17.5

Insufficient time was the greatest limitation to discussing religious/spiritual matters for the majority of respondents (n=73; 36.5%), followed by concerns about offending the patient (n=57; 28.5%) whereas insufficient knowledge/ training was a concern for few of them (n=13; 6.5%). Majority of respondents (n=89; 44.5%) claimed self-development as their source of knowledge of taking spiritual history, others attributed it to their undergraduate (n=77; 38.5%) and residency training program (n=29; 14.5%). While many respondents (n=72; 36%) said yes to incorporating spirituality history into the doctors' training, 35% (n=70) had no opinion (Table 4).

Table 4. Barriers to discussing religion/spirituality with patients and source of knowledge of taking spiritual history at a clinical encounter.

	Frequency	Percent
What discourages you from discussing religion/spirituality with patients?		
Insufficient time	73	36.5
Concern about offending patient	57	28.5
Concern that colleagues will disapprove	47	23.5
Insufficient knowledge/training	13	6.5
General discomfort	5	2.5
Others	5	2.5
Source of knowledge of taking a spiritual history during patient clerking		
Self-development	89	44.5
Undergraduate training	77	38.5
Residency	29	14.5
Others	5	2.5
Should taking spiritual history be incorporated into the training of doctors?		
Yes	72	36

No	58	29
I don't Know	70	35

Five (2.5%) respondents were able to name 3 common tools a health worker can use to assess patients' spiritual needs, all 5 were from the Department of Family Medicine; another 2.5% (n=5) could name 2 tools. For 19.5% (n=39) of respondents, answers included among others communication, bible, clerking, personal convictions, but they did not name any of the common tools (Figure 1).

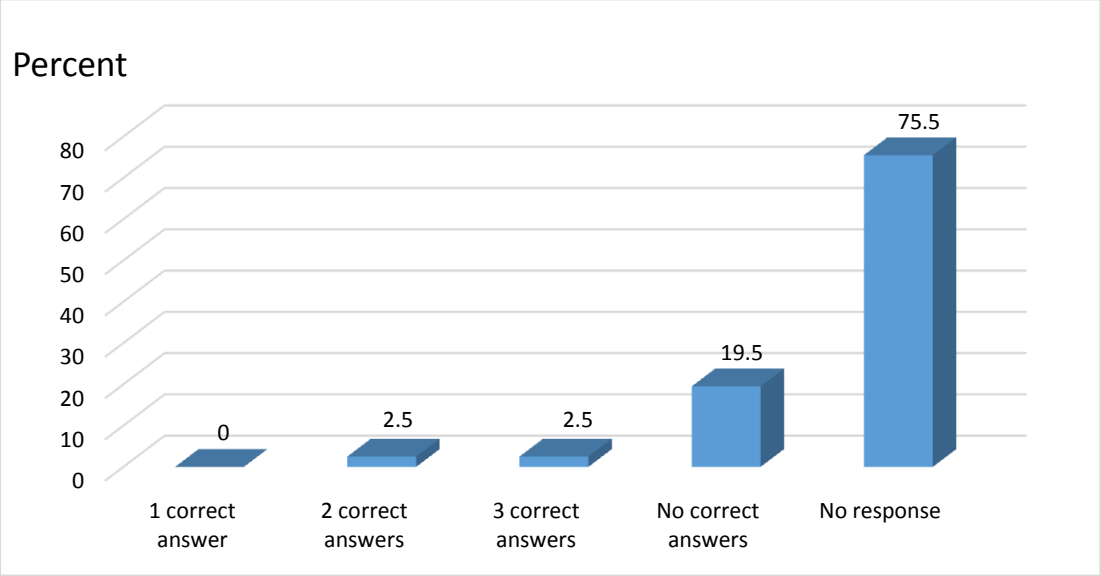

Figure 1. Respondents' knowledge of common tools to assess patients' spiritual needs

DISCUSSION

In this study, most physicians (81.5%) were open to discussions on R/S matters during clinical encounter, which is consistent with previous reports [6,22-24]. This is encouraging as openness towards discussing spiritual matters has been shown to be of great value for patients and strengthens patient–doctor relationships, whereas by integrating the spiritual dimension in patient's care, physicians practice patient-centered compassionate and holistic care, with improved empathy, building trust, and understanding behaviours [24,25]. Yet, for a lesser proportion of respondents (72.5%) in the present study, such discussion is appropriate when initiated by the patient. This is at disparity with several series that reported a higher proportion being open to such discussion when the patient brings them up [18,20]. The reason for this disparity is not clear.

Spiritual needs, which can be defined as trust, hope, love, truth, need for finding out the meaning and purpose of life and relationships among others, are very important concepts for many patients, and can be met by means of relations with humans or God [26]. Besides, research has emphasised the necessity to identify the needs for spiritual care and evaluate spiritual/moral distress, which can be achieve with the conduct of a spiritual assessment or taking a patient' spiritual history [20,21,26].

Spiritual care involves among others, practicing compassionate presence; listening to patients' fears, hopes, pain, and dreams; obtaining a spiritual history; incorporating spiritual practices as appropriate and involving chaplains as members of the interdisciplinary health care team [22]. It is noteworthy that despite most of the respondents of this study being open to discussion on spirituality issues, the majority of them (52%) reported that they rarely take spiritual history, which uncovers coping mechanisms and support systems, provides an opportunity for spiritual care, and helps the physician recognize when cases need referral to the chaplain [27]. This trend has also been previously reported, where doctors did not or infrequently discussed R/S issues, though the frequency increased with terminal illnesses, and such discussions were facilitated by prior training and increased physician religiosity and spirituality [6,19]. This is of great concern as healthcare professionals are expected to provide holistic care to their patients [19,22,23].

Recently, spiritual care has become increasingly recognized as part of a holistic management approach and the responsibility of all health care professionals, and no longer regarded as the sole domain of chaplains [19]. Notwithstanding, physicians should be aware of their limitations in training and expertise in the area of spiritual care. Therefore, while they bring their presence, compassion, understanding and a listening ear to each patient encounter, addressing simple issues of spirituality, more complex matters require referral to trained persons in that field [28]. It is thus worrisome that half of respondents in the present study, were not aware of the availability of a chaplain in our hospital with subsequent poor referral for pastoral care. It is possible that they considered spiritual care as being of low priority or irrelevant to their patients' assessment and care, which portrays a gap in knowledge about the subject. Besides, in an analysis of the pastoral caregiving in the Nigerian hospital context, it was proposed that the Nigerian health care facilities and hospitals will benefit from collaboration or the integration of pastoral care givers into patient care for a holistic quality

hospital care [12]. On the other hand, today, clinical chaplaincy remains an underutilized resource in health care, as patient spirituality continues to be an area that clinicians do not discuss as often as they should [25,29]. This calls for increased awareness for healthcare professional on the benefits of pastoral care, moreover, incorporating spiritual care into patient care has been found to significantly enhance patients' satisfaction with hospital experiences [7].

Several tools exist to help physicians conduct a spiritual history/spiritual assessment, which is often a powerful intervention in itself, and provides the basis for an organized, open and non-biased assessment, while helping physicians recognize when cases need to be referred to chaplains [21,22,30,31]. Commonly used ones include: 1- the FICA Spiritual History Tool which uses an acronym to guide health professionals through a series of questions designed to elicit patient spirituality and its potential effect on health care; 2- the HOPE questions which lead the physician from general concepts to specific applications; 3- the Open Invite, a patient-focused approach to encouraging a spiritual dialogue as it is structured to allow patients who are spiritual to speak further, and to allow those who are not to easily opt out [2,21,22,31]. After spiritual needs have been identified, the physician may incorporate the results of the assessment into patient care.
In the present study however, only 5 respondents were able to name 3 tools that can be used to take a spiritual history, while 95% of could not name any. This identified gap could potentially be addressed at the levels of academia where relatively little attention has been paid to spirituality; medical training where spirituality is not directly considered except in texts on palliative care and in ethics courses/seminars; and practice [30].

The role of prayer in spirituality and particularly, in relation to health cannot be overemphasised, even as research has demonstrated that prayer, which has also been referred to as a potent healing force, has a positive influence on the sick and helps to restore their health [1,26]. In this survey, opinions were however divided about appropriateness of praying with a patient, as many would do so at the patient's request (48.5%), whereas others would when they sense the need (38.5%). In practice however, 43.5% of the respondents pray sometimes with their patients, but 9% of them reported praying often, and these were the ones who identified themselves as highly spiritual.

Previous surveys have revealed several barriers to discussing R/S with patients, commonly reported ones include insufficient time, lack of adequate training to provide competent spiritual care, lack of knowledge to address S/R issues and diverse faith beliefs, concerns about offending the patient and concern that colleagues will disapprove [2,6,7,19,23]. In addition, in a survey at a District General Hospital in UK, 20% of doctors thought it was not their job to ask and 43% felt it was not important for them to prioritize such discussions [19]. These limitations were also found in the present study. But, surprisingly, only 6.5% of respondents mentioned insufficient knowledge/training. These barriers could be overcome by training at both under- and post-graduate levels, which focus on healing illnesses and physical management, producing doctors who are ill-equipped to respond to spiritual issues [2,20]. In a multicenter survey involving 12 medical schools in Brazil, authors found that though medical students (58%) wanted to address spiritual issues, they were not prepared to

do so (48.7%). Whereas, most of them (81%) reported they had never received any training during medical school on "spirituality and health" and that medical faculty had never or only rarely addressed the issue in clinical practice (78.3%), suggesting a gap between students' attitudes/needs in this area and the training they received [2]. Furthermore, in a national survey of family medicine residents in the US, authors found that training in addressing spirituality may make residents more likely to discuss the topic in clinical practice [20]. They postulated that teaching residents the skills, knowledge, and attitudes required to have a thoughtful, supportive, and non-prejudicial discussion of a patient's beliefs and practices was the first step for family medicine educators to enable residents translate willingness to address spirituality into action [20]. In the light of this, it is rather unfortunate that only few respondents (14.5%) in the present study acknowledged residency training as a channel for learning how to take a spiritual history.

There is a complex relationship between S/R, medical practice, and medical education, which when understood, could open new perspectives for a different, more compassionate and more integrated approach to patient care [2]. Moreover, R/S will continue to influence health care on both patient and community levels. It thus becomes imperative for the medical community to appreciate this fact and educate trainees on religion and spirituality's role in health care [29].

Conclusion:

This survey found that physician enquiry into the R/S of patients is inconsistent, and there is a gap between their attitude to discussing these issues with their patients and its practice. Incorporating spiritual care courses into physician training in undergraduate and residency programme is recommended, because of its potential to overcome the barriers to both patient and physician R/S inquiry, and improve patients' satisfaction with hospital experiences.

Limitations to the study

The sample size was small. The study was conducted in a single center and results may reflect local rather than national practice. But all the same strong point of the study is that the spiritual assessment of patients' needs remain unsatisfactory.

REFERENCES

1. Igboin BO. Spirituality and medical practice: a Christian perspective. Indian J Med Ethics. 2015; 12(4): 199–206
2. Lucchetti G, de Oliveira LR, Koenig HG, Leite GR, Lucchetti ALG, for the SBRAME Collaborators. Medical students, spirituality and religiosity-results from the multicenter study SBRAME. BMC Medical Education 2013, 13:162
3. Lucchetti G, Lucchetti ALG, Espinha DCM, de Oliveira LR, Leite JR, Koenig HG. Spirituality and health in the curricula of medical schools in Brazil. BMC Medical Education 2012, 12:78. http://www.biomedcentral.com/1472-6920/12/78
4. Selman L, Young T, Vermandere M, Stirling I, Leget C, on behalf of the Research
5. Subgroup of the European Association for Palliative Care Spiritual Care Taskforce. Research Priorities in Spiritual Care: An International Survey of Palliative Care Researchers and Clinicians. J Pain Symptom Manage 2014; 48(4): 518-531
6. McCord G, Gilchrist VJ, Grossman SD, King BD, McCormick KF, Oprandi AM *et al*. Discussing Spirituality With Patients: A Rational and Ethical Approach. Ann Fam Med 2004;2: 356-361. DOI: 10.1370/afm.71.
7. Best M, Butow P, Olver I. Doctors discussing religion and spirituality: A systematic literature review. Palliative Medicine 2016; 30(4): 327-337. doi.org/10.1177/0269216315600912
8. Keith AE. Pastoral Care in Public Settings: A Theoretical and Theological Premise with Effective Outcomes of Chaplaincy. Testamentum Imperium 2018; 5: 1-18
9. Spiritual Care and Physicians: Understanding Spirituality in Medical Practice Making Spiritual Care a Priority [Internet]. [cited 2021 Jan 5]. Available from: www.healthcarechaplaincy.org
10. Zehtab S, Adib-Hajbaghery M. The Importance of Spiritual Care in Nursing. Nurs Midwifery Stud. 2014;3(3).
11. Heabert RS, Jenckes MW, Ford DE, O'Connor DR, Cooper LA. Patient perspectives on spirituality and the patient-physician relationship. J Gen Intern Med 2001; 16(10): 685–692
12. African Palliative Care Association. Standards for providing quality palliative care across Africa. Kampala: African Palliative Care Association, 2010.
13. Agbiji EO. Pastoral caregivers in the Nigerian hospital context: A pastoral theological approach. Dissertation presented for the Degree of Doctor Philosophy in the Faculty of Theology at Stellenbosch University 2013.
14. Sulmasy DP, Kilbreath E. The Healer's Calling: A Spirituality for Physicians and Other Health Care Professionals. The Linacre Quarterly 2003; 70. Available from: http://epublications.marquette.edu/lnqAvailableat:http://epublications .marquette. edu/ lnq/vol70/iss2/11
15. Worldwide Hospice Palliative care Alliance, World Health organization. Global Atlas of Palliative Care 2nd Edition. London, UK 2020: 12-16

16. Rodriguez KL, Barnato AE, Arnold RM. Perceptions and utilization of palliative care services in acute care hospitals. J Palliat Med 2007;10:99- 110.
17. Nte AR, Eke GK. Celebrating the World Breastfeeding Week in the Era of COVID-19 Pandemic in Southern Nigeria: Lessons Learned. Journal of Scientific Research & Reports 2020; 26(9): 46-57
18. National Bureau of Statistics. 2017 Demographic statistics bulletin. May 2018
19. Curlin FA, Chin MH, Sellergren SA, Roach CJ, Lantos JD. The association of physicians' religious characteristics with their attitudes and self-reported behaviors regarding religion and spirituality in the clinical encounter. Medical Care. 2006; 44(5):446–453.
20. Abdulla A, Hossain M, Barla C. Toward Comprehensive Medicine: Listening to Spiritual and Religious Needs of Patients. Gerontol Geriatr Med 2019; 5: 1-6
21. Saguil A, Fitzpatrick AL, Clark G. Are residents willing to discuss spirituality with patients? Journal of religion and health. 2011; 50(2):279–288
22. Dameron CM. Spiritual assessment made easy. . . with acronyms!. JCN 2005; 22(1): 14-16
23. Puchalski CM. The Role of Spirituality in Health Care. Baylor Univ Med Cent Proc 2001; 14(4): 352–357. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305900/
24. Vasconcelos APSL, Lucchetti ALG, Cavalcanti APR, da Silva Conde SRS, Gonçalves LM, do Nascimento FR, *et al*. Religiosity and Spirituality of Resident Physicians and Implications for Clinical Practice - the SBRAMER Multicenter Study. J Gen Intern Med. 2020; 35(12): 3613-3619. doi: 10.1007/s11606-020-06145-x.
25. Rassoulian A, Seidman C, Loffler-Stastk H. Transcendence, religion and spirituality in medicine: Medical students' point of view. Medicine 2016; 95:38(e4953)
26. Zaidi D. Influences of Religion and Spirituality in Medicine. AMA Journal of Ethics 2018; 20 (7): E609-612
27. Demirsoy N. Holistic Care Philosophy for Patient- Centered Approaches and Spirituality. Patient Centered Medicine: 119-138. http://dx.doi.org/10.5772/66165
28. Büssing A, Koenig HG. Spiritual Needs of Patients with Chronic Diseases. Religions 2010; 1: 18-27. doi:10.3390/rel1010018
29. Anadarajah G. Doing a culturally sensitive spiritual assessment: Recognizing spiritual themes and using the hope questions. Virtual Mentor. 2005; 7(5): 371–374
30. Best M, Butow P, Olver I. Do patients want doctors to talk about spirituality? A systematic literature review. Patient Educ Couns. 2015;98(11):1320-1328.
31. D'Souza R. The importance of spirituality in medicine and its application to clinical practice. The Medical Journal of Australia. 2007; 186(10): S57
32. Saguil A, Phelps K. The spiritual assessment. American Family Physician. 2012; 86(6):546–550. [PubMed: 23062046]