Effects of religious beliefs on the assessment of nurses' work in the perception of patients, nursing students and nurses

Lankau A.[1A-E*], Krajewska-Kułak E.[1A,B,D,E.F], Bejda G.[2D,E], Guzowski A.[1D,E], Baranowska A.[1D,E], Cybulski M.[1D,E]

1. Department of Integrated Medical Care, Medical University of Bialystok, Poland
2. Medical School in Białystok, Poland

A- Conception and study design; **B** - Collection of data; **C** - Data analysis; **D** - Writing the paper; **E**- Review article; **F** - Approval of the final version of the article; **G** - Other (please specify)

ABSTRACT

Introduction: Religious orientation is associated with psychological well-being resulting from treating negative life events as opportunities for personal and spiritual development.
Purpose: To assess the impact of religious beliefs on the evaluation of nurses' work in the perception of patients, nursing students, and nurses.
Materials and methods: the study included 150 patients, 150 nurses, and 150 nursing students, using our questionnaire.
Results: 56.7% of patients, 46.7% of students, and 47.7% of nurses assessed the religious sphere of life as very important. Respondents identified good family life as the most important value in life (82.7% of patients, 76% of students, and 92% of nurses). Emotional needs were the greatest motivation for students (70.7%) and nurses (72.7%) to increase religious activities; for patients, it was an illness in the family (42.7%). Patients (62.4%), students (48.7%), and nurses (61.1%) were of the opinion that religion could affect performing work-related tasks. Blood transfusion was the most likely procedure to be affected by patients' religious beliefs (50% of patients, 44.7% of students, 58% of nurses) or nurses' religious beliefs (29.3% of patients and 18.7% of nurses).
Conclusions: Patients more often reported that religion may have some effects on choice of profession, and most respondents did not consider religious beliefs an obstacle in making new acquaintances or performing work-related tasks. In the case of a conflict between a nurse's therapeutic activities and a patient's or nurse's religious beliefs, the nurse should assign the patient to another nurse.
Keywords: Religion, patients, students, nurses, career

DOI: 10.5604/01.3001.0010.1862

***Corresponding author:**
Department of Integrated Medical Care
Medical University of Białystok
7a M. Skłodowskiej-Curie str, 15-096 Białystok, Poland
Tel.: + 48 85 748 55 28; e-mail: agnieszka_bielemuk@wp.pl

Received: 03.04.2017
Accepted: 10.06.2017
Progress in Health Sciences
Vol. 7(1) 2017 pp 122-130

INTRODUCTION

According to Allport [1,2], humans use religion for the realization of their purposes. He [1,2] believes that internal religious orientation involves practicing religion for its sake as well as integrating it with all areas of life. And it is associated with a lesser tendency to be prejudiced, lower levels of dogmatism and impulsivity, reduced fear of death, as well as increased levels of life satisfaction and more frequent prosocial behaviors. There are two types of religiousness regarding its motives: internal (associated with full commitment and dedication) and external (associated with satisfying other needs) [1,2].

According to Thorson and Powell [3], experiencing diseases, problems and conflicts become an opportunity to become more patient, absorbed in prayer and united with God, and the identification with the will of God brings the feeling of calm, reprieve and safety. According to Flannelly et al. [4] and Kinney et al. [5], people who are more religious show a higher tendency towards healthy behaviors, such as not smoking and alcohol abstinence. Koenig et al. [6] showed in their studies conducted in the elderly that religious behaviors, spiritual attitudes, and experiences were common in this population and were associated with stronger social support and enhanced mental health. Religiousness and focusing on spiritual values had effects not only on mental but also physical health, as evidenced by a positive influence of broadly understood religiousness on conditions such as hypertension, cancer, and longevity [7-10].

According to Pargament [11], religion may be particularly valuable in situations where personal and social coping resources become exhausted, and a man faces his limitations. Barnes [12] believes that suffering is a common ground for spirituality, religiousness, and medicine. Kinney et al. [5] showed in their studies in patients with colon cancer that awareness of religious affiliation was a prognostic factor for longer life expectancy, whereas poor emotional support increased disease progression. Studies by Bjorck and Cohen [13] confirm that religious coping with stress is a specific strategy, different from other task-oriented or emotionally oriented strategies. On the other hand, Feifel [14] found no effects of religion on the fear of death, both conscious and unconscious, in his studies in terminally ill patients and healthy individuals. According to Lazarus [15], Religion is also a factor that reduces depression, and those aware that they fully agree with God's will are less prone to depression when facing unfavorable circumstances.

The aim of the study was to evaluate the effects of religious beliefs on the assessment of nurses' work in the perception of patients, nursing students, and nurses.

MATERIALS AND METHODS

The study was conducted in 2010-2011, after approval No. R-I-002/244/2009 was obtained from the Bioethics Committee of the Medical University of Bialystok. The study included 150 professionally active nurses, 150 nursing students, and 150 patients. A total of 160 questionnaires were distributed among nurses, and 150 were used in the study. A total of 180 questionnaires were distributed among students and patients, and 150 questionnaires from each group were used in the study.

The study used a diagnostic survey method based on a three-part questionnaire:

- I – general part related to age, sex, and place of residence
- II – consisting of self-assessment questions about religiousness
- III - consisting of 14 self-assessment questions about the effects of religion on nurses' professional tasks

RESULTS

The study group included 33.3% of nurses aged 20-30 years, 32.7% aged 31-40, 32% aged 41-50, and 2% aged 51-60 years. Young people under 20 years of an age dominated in the study population of students (47.3%). Respondents aged 21-29 years accounted for 28%, 30-39 years for 7.3%, 40-49 for 14.7%, and 50 and older for 2.7% of respondents. Subjects aged over 50 years (almost 60% of respondents) dominated in the patient population. Respondents under 20 years old accounted for 0.7% of the population, 21-30 years for 11.3%, 31-40 for 9.3%, 41-50 for 16%, 51-60 for 22.7%, 61-70 for 25.3%, and over 70 for 14% of the study population. Only 0.7% of respondents did not state their age. Females dominated among the respondents (94.7%). Males accounted for only 5.3%. The study population of patients included 39.3% of males and 59.3% of females, and 1.3% of respondents did not state their sex. City dwellers accounted for 77.3%, while residents of rural areas for 17.3% of respondents from the group of nurses. 5.3% of respondents did not mention the place of residence. Most of the surveyed students came from urban areas (61%), and 33% from rural areas. Similarly, most of the surveyed patients came from urban areas (63%), 35.3% from rural areas, and 2% did not mention their place of residence.

In a self-assessment of religiousness, 83.5% out of 450 respondents declared themselves as believers and practitioners, 5.3% as non-believers and non-practitioners, and 11% did not declare themselves in this regard. Most non-believers and non-practitioners belonged to the group of students (10%), compared with patients (0.7%) and nurses (5.3%). The observed differences were highly statistically significant and most likely resulted from

age, as opposed to working or health situation (p = 0.0009***). The majority of students undoubtedly belonged to the youngest age group, and their views on religion differed from adult or elderly individuals. A total of 91.3% of patients, 74.7% of students, and 84.7% of nurses considered themselves believers and practitioners, whereas 8% of patients, 15.3% of students and 10% of nurses had difficulty declaring themselves. Most respondents (in each group) assessed their religious commitment at an average level – 'I am rather religious.' Students provided the most diverse responses, some of whom declared themselves as still undecided regarding religious views (Table 1).

Table 1. Self-assessment of religiousness by respondents

Assessment of own religiousness	**Group (*p* = 0.0003***)**			Total
	patients	**students**	**nurses**	
not religious	0 (0.0%↓)	6 (4.0%↓)	1 (0.7%↓)	7 (1.6%)
rather not religious	3 (2.0%↓)	6 (4.0%↓)	8 (5.3%↓)	17 (3.7%)
indifferent	3 (2.0%↓)	3 (2.0%↓)	0 (0.0%↓)	6 (1.3%)
rather religious	**72 (48.0%↓)**	**87 (58.0%↓)**	**98 (65.3%↓)**	257 (57.1%)
very religious	**64 (42.7%↓)**	35 (23.3%↓)	33 (22.0%↓)	132 (29.3%)
not decided	5 (3.3%↓)	10 (6.7%↓)	4 (2.7%↓)	19 (4.2%)
difficult to say	3 (2.0%↓)	3 (2.0%↓)	6 (4.0%↓)	12 (2.7%)
Total	150	150	150	450

There were no statistically significant differences in the approach of the respondents to participation in religious activities. Most of the respondents admitted that they attend religious services once a week. The obtained Kruskal-Wallis result was p = 0.0014**, which indicates differences in the 'intensity' of religious life in the compared groups (Table 2).

Responses related to the importance of religion in their lives were on the border of statistical significance. Most patients (56.7%) assessed this sphere of life as very important compared with students (46.7%) and nurses (47.7%). Almost 40% of students regarded religion as a rather important or very important part of life. The vast majority of nurses (90%) considered religion important in daily living. The additionally used Kruskal-Wallis test did not provide a statistically significant result (p =0.3342), which ultimately indicates that the importance of religion in daily life did not differ between the groups (Table 3).

The respondents were asked to identify the five most important values in their lives. The results in Table IV suggest some differences in the views on the hierarchy of values among young people (students), patients, and professionally active individuals (nurses). Good family life (82.7%) and maintaining good health (70.7%) were most important for patients. Students emphasized the importance of good family life (76%), friends (69.3%), and a good education (64.7%). Good family life (92%) and maintaining good health (80%) were most important for nurses (Table 4).

Table 2. Participation in religious activities

Participation in religious activities	**Group (*p* = 0.1947)**			Total
	patients	**students**	**nurses**	
every day	11 (7.4%↓)	7 (4.7%↓)	6 (4.0%↓)	24 (5.3%)
several times a week	16 (10.7%↓)	10 (6.7%↓)	8 (5.4%↓)	34 (7.6%)
once a week	**78 (52.3%↓)**	**59 (39.3%↓)**	**79 (53.0%↓)**	216 (48%)
several times a month	26 (17.4%↓)	**37 (24.7%↓)**	28 (18.8%↓)	91 (20.2%)
several times a year	9 (6.0%↓)	22 (14.7%↓)	18 (12.1%↓)	49 (10.9%)
do not participate	2 (1.3%↓)	5 (3.3%↓)	3 (2.0%↓)	10 (2.2%)
only for holidays	6 (4.0%↓)	9 (6.0%↓)	6 (4.0%↓)	21 (4.7%)
other	2 (1.3%↓)	1 (0.7%↓)	2 (1.3%↓)	5 (1.1%)
Total	150	150	149	450

Table 3. The meaning of religion in everyday life

Meaning of religion in everyday life	Group (p = 0.0855)			Total
	patients	students	nurses	
not important at all	2 (1.3%↓)	1 (0.7%↓)	1 (0.7%↓)	4 (0.9%)
rather not important	4 (2.7%↓)	3 (2.0%↓)	3 (2.0%↓)	10 (2.2%)
indifferent	8 (5.3%↓)	10 (6.7%↓)	2 (1.3%↓)	20 (4.4%)
rather important	**46 (30.7%↓)**	**58 (38.7%↓)**	**69 (46.3%↓)**	173 (38.4%)
very important	**85 (56.7%↓)**	**70 (46.7%↓)**	**71 (47.7%↓)**	226 (50.2%)
depends on circumstances	3 (2.0%↓)	8 (5.3%↓)	2 (1.3%↓)	13 (2.9%)
difficult to say	2 (1.3%↓)	0 (0.0%↓)	1 (1.3%↓)	3 (0.7%)
Total	150	150	150	450

Table 4. Preferred life values

The most important life values	Group						p
	patients		students		nurses		
	N	%	*N*	%	*N*	%	
good family life	124	**82.7%**	114	**76.0%**	138	**92.0%**	0.0009***
maintaining good health	106	**70.7%**	83	55.3%	120	**80.0%**	0.0000***
other people's respect	73	48.7%	72	48.0%	93	62.0%	0.0234*
group of trusted friends	57	38.0%	104	**69.3%**	71	47.3%	0.0000***
career	61	40.7%	72	48.0%	93	62.0%	0.0009***
good education	59	39.3%	97	**64.7%**	56	37.3%	0.0000***
religious faith	81	54.0%	62	41.3%	61	40.7%	0.0328*
peace and safety	79	52.7%	45	30.0%	62	41.3%	0.0004***
nation's best interest	55	36.7%	22	14.7%	11	7.3%	0.0000***
contact with culture/art	15	10.0%	29	19.3%	15	10.0%	0.0219*
prosperity, wealth	10	6.7%	29	19.3%	12	8.0%	0.0007***
life full of adventure	3	2.0%	18	12.0%	6	4.0%	0.0006***
participation in social and political life	8	5.3%	10	6.7%	3	2.0%	0.1426
success, fame	3	2.0%	4	2.7%	3	2.0%	0.9028

Patients commonly (25.3%) believed that religion might have an effect on the choice of profession, whereas most students (57.3%) were of the opinion that career choice is independent of religion, and every fourth student could not provide a clear answer to this question. Only one in seven nurses (14.7%) admitted that religion has some effects on choice of profession. Other respondents claimed that it is irrelevant (42%), or could not provide a clear answer to this question (43.3%). These correlations were statistically significant (Table 5).

Table 5. Impact of religion on choosing a profession, making new acquaintances and performing work-related tasks

Does religion play a role in …	Group			Total
	patients	students	nurses	
choosing a profession (p = 0.0019)**				
yes	38 (25.3%↓)	26 (17.3%↓)	22 (14.7%↓)	86 (19.1%)
no	**68 (45.3%↓)**	**86 (57.3%↓)**	63 (42.0%↓)	217 (48.2%)
I don't know	44 (29.3%↓)	38 (25.3%↓)	**65 (43.3%↓)**	147 (32.7%)
Total	150	150	150	450
making new acquaintances (p = 0.4910)				
yes	7 (5.0%↓)	8 (5.4%↓)	9 (6.0%↓)	24 (5.3%)
no	**105 (75.0%↓)**	**122 (82.4%↓)**	**117 (78.0%↓)**	344 (76.4%)
I don't know	30 (20.0%↓)	20 (13.3%↓)	24 (16.0%↓)	74 (16.4%)
Total	150	150	150	450
performing certain work-related tasks (p = 0.0002*)**				
yes	16 (10.7%↓)	24 (16.0%↓)	37 (24.8%↓)	77 (17.1%)
no	**93 (62.4%↓)**	**73 (48.7%↓)**	**91 (61.1%↓)**	257 (51.7%)
I don't know	41 (27.3%↓)	53 (35.4%↓)	22 (14.6%↓)	113 (25.1%)
Total	150	150	150	450

The vast majority of respondents claimed that religion does not prevent one from making new acquaintances. According to the respondents, a different religion or no religion did not prevent making acquaintances with anyone. Negative answers in this regard were provided by almost 80% of interviewees from the analyzed occupational group (Table 5). These correlations were statistically significant ($p = 0.491$).

Interestingly, 24.8% of nurses considered religious beliefs to be a factor affecting the performance of work-related tasks (Table 5). The opposite opinion was expressed by 48.7% of students and 62.4% of patients. These correlations were statistically significant ($p = 0.0002$***).

Blood transfusion was the most likely procedure to be affected by patients' religious beliefs (50% of patients, 44.7% of students, 58% of nurses) or nurses' religious beliefs (29.3% of patients and 18.7% of nurses). The results are shown in Table 6.

Table 6. Procedures affected by religious beliefs

Procedures affected by	patients	students	nurses	p
patient's religion				
blood transfusion	**50%**	**44.7%**	**58%**	NS
euthanasia	28%	0.7%	5.3%	p <0.001
transplant	21.3%	19.3%	14%	NS
surgical procedures	0.0%	6.0%	0.7%	p=003
abortion	0.0%	3.3%	8.7%	NS
diet	0.0%	1.3%	4%	NS
in vitro	0.0%	0.7%	4%	NS
sustaining life/ventilator	1.3%			-
gynecological examination			1.3%	-
none	0.0%	2.7%	1.3%	NS
other	3.3%	3.3%	1.3%	NS
difficult to say	38.7%	48.6%	37.3%	NS
nurse's religion				
blood transfusion	**29.3% ***	5.3%	**18.7%**	*p<0.001 vs students
euthanasia	**26.0%**	1.3%	**7.3%**	P<0.001
transplant	13.3%	4.0%*	2.7% **	*p<0.05 vs patients ** p<0.01 vs patients
diet			0.7%	-
in vitro			2.7%	-
abortion	0.0%	5.3%	12.7%	NS
surgical procedures	0.0%	1.3%	0.0%	NS
none	0.0%	8.0%	3.3%	NS
other	5.3% *	3.3%	0.7%	*p=0.04 vs nurses
difficult to say	**52.0%**	**78.7%**	**68%**	

In the case of a conflict between a nurse's therapeutic activities and a patient's religious beliefs, the respondents believed the nurse should assign the patient to another nurse (42% of patients) or discontinue the management of the patient with adequate notification (28.7% of students and 29.3% of nurses). In the case of a conflict between a nurse's therapeutic activities and her religious beliefs, the nurse should assign the patient to another nurse (47.3% of patients, 30% of students, and 38% of nurses). The results are presented in Table 7.

According to respondents, the most likely authorities for nurses included Mother Teresa of Calcutta (14.4% of patients) and Pope John Paul II (35.3% of students and 42% of nurses). Unfortunately, most respondents had difficulty answering this question (65.3% of patients, 46.7% of students, and 38% of nurses) (Table 8).

Table 7. Nurse's course of action in a situation of conflict between therapeutic activities and religious beliefs

Nurse's course of action in a situation of conflict between therapeutic activities and religious beliefs	patient	students	nurses	p
patient				
assign the patient to another nurse	42.0%	12 0%	9.3%	<0.001
perform procedure in conflict with the patient's beliefs	12.0% *	8.0%	2.0%	*p<0.001 vs nurses
treatment discontinuation and inform the patient of this fact	10.0%	28.7%*	29.3%*	*p<0.001 vs patient
take another course of action	7.3%	22.0%	29.3%	P<0.05
difficult to say	28.7%	29.3%	30.0%	NS
nurses				
assign the patient to another nurse	47.3%	30.0%	38.0%	NS
perform procedure in conflict with the nurse's beliefs	14.0%	10.0%	6.7%	NS
treatment discontinuation and inform the patient of this fact	10.0%	14.7%	15.3%	NS
take another course of action	2.7%	8.0%	11.3%	NS
difficult to say	26.0%	37.3%	28.7%	NS

Table 8. Potential authorities for nurses according to students

Potential authorities for nurses	patients	students	nurses	p
Pope John Paul II	12.7%	35.3%	42.0% *	*p<0,001 vs patients
Mother Teresa of Calcutta	14.4%	17.3%	24.0%	NS
Dalai Lama	6.7%	13.3%	16.0%	NS
every pope	8.0%	4.7%	3.3%	NS
every missionary/friar/priest	4.7%	4.7%	3.3%	NS
Prof. Zbigniew Religa	0.7%	3.3%	1.3%	NS
Florence Nightingale	0.7%	3.3%	2.7%	NS
Jesus	3.3%	2.7%	0.0%	NS
Father Pio	1.3%	2.0%	2.0%	NS
Saint Maximilian Maria Kolbe	2.7%	0.0%	0.0%	NS
Buddha	0.7%	0.7%	0.7%	NS
Mahatma Gandhi	0.7%	0.7%	0.7%	NS
Job	0.7%	0.0%	0.0%	-
Muhammad	1.3%	0.0%	0.7%	NS
Irena Sandler	0.0%	0.0%	2.7%	-
others	0.0%	1.3%	3.4%	NS
no suggestions	65.3% *	46.7%	38.0%	*P<0.01 vs nurses

DISCUSSION

Religion and religiousness may modify the interaction between a patient and medical personnel. Therefore, knowledge of a patient's religiousness is a key factor for quality relations between the patient and medical personnel. According to Koenig [16], physicians are often unaware of reasons why they should devote their time and energy to engage in spiritual conversations with their patients.

Furthermore, a large number of physicians reported that they did not consider themselves experts on the subject, that they felt uncomfortable discussing non-medical issues with their patients. They had no time for such conversations, which, in the author's opinion, results from an insufficient level of knowledge about religion and the spiritual aspect of man. They fear that patients would inquire about the physician's religion and religiousness [16].

According to Koenig [6,17] and Hall [18], several areas modified by a patient's and physician's religiousness may be distinguished in the development of the relations mentioned above. These include making important therapeutic decisions by the patient, the risk of conflicts, conflicts between a patient's religious beliefs and scientific knowledge, the likelihood of spiritual dilemmas, and the level of compliance with medical recommendations. According to the above authors [6,17,18], the possibility of a conflict between a

patient's religious beliefs and medical recommendations, which are based on scientific achievements, may be a major problem from the perspective of patient/medical personnel relations.

Hall [18] described the case of a patient with a risk of colon cancer who refused to undergo a regular colonoscopy convinced that the God would listen to his prayers and save him from cancer. He also described the case of a woman who, under the pressure of her religious community, decided to keep her pregnancy and give birth to a child prenatally diagnosed with anencephaly [18]. The study by Koenig [17] shows that increased mortality, regardless of mental or physical health, may be observed in patients with the dilemmas mentioned above. Koenig [17] showed a positive correlation between religiousness and levels of social support, which are associated with the discussed tendency.

High levels of social support, on the other hand, led to stricter compliance with medical recommendations due to the concern of the people around (e.g. reminding patients to take the prescribed medications regularly) and stronger motivation to continue therapy and battle for recovery. The author also found that high levels of religiosity are often accompanied by low levels of depressiveness, and thus increased motivation to act, including active participation in the therapeutic process [17]. Koenig et al. [19] conducted a meta-analysis of forty-two research programs involving nearly 126,000 people. The authors showed that the probability of survival in very religious individuals was higher by 29% compared with those who were less religious. Another study [20], which included 337 patients from internal medicine, cardiology and neurology departments, showed that 90% of respondents used religion as a way of coping with the disease, and 40% claimed that religion was an important factor which gave them hope for recovery. Ellis et al. [21] showed that 96% of family physicians confirmed that patients' spiritual wellness was an important determinant of health.

The present study shows that religion has no effects on making new acquaintances/friends, as confirmed by 75% of patients, 82% of students, and 78% of nurses. Almost two-thirds of patients admitted that their nurse's religion was irrelevant, whereas one in three patients would prefer it if the nurse were also Catholic.

According to Klaassen [22], religious ways of coping with stress is defined as a complex process of confronting stressful situations, which does not merely involve simple behavioral indicators, such as prayer or defense mechanisms in the form of denial. They include active and passive, intrapsychic and interpersonal strategies of coping with stress, which is focused not only on the problem but also on emotions [22]. A study by Koenig [16] showed that 60% of patients from the Center of Lung Diseases at the University of Pennsylvania claimed that religious beliefs would significantly affect their decisions regarding the recommended therapies, while 80% of patients admitted that they would be open to talking about their religious beliefs with medical personnel. A 28-year study conducted by Kark et al. [23], which included 5,286 adults (aged 21-65 years), showed that the probability of death was lower by 23% (risk of error 0.77) in patients who attended religious ceremonies at least once a week. Strawbridge et al. [24] reported similar findings in their 5-year study involving 1,931 individuals (aged 55 years and over); they showed that the probability of death was lower by 24% in those who frequently attended religious services, compared with those who did not participate in religious events. Clerk [25], in his nine-year observation conducted in the USA involving 22,080 adult Americans (aged 20 years and over), found that the risk of death was 1.87 times higher in individuals who did not attend religious services compared with those who practiced their religion.

McCullough et al. [26] analyzed the relationship between religious commitment and the prevalence of cardiac infarction in a population of Jewish origin. The risk of first cardiac infarction was significantly higher in non-believing Jews compared with Orthodox Jews (4.2 in males and 7.3 in females). The evaluated factors included age, ethnicity, education, smoking, physical activity, and BMI [26]. Meraviglia [27] included 60 adult patients, mostly females aged 33-83 years, diagnosed with lung cancer in his studies. The author showed that more frequent prayer had positive effects on the emotional and physical state of patients. A survey carried out by Hall [28], which included 154 hospitalized adults experiencing pain (moderate to severe), revealed that prayer was the second, after analgesics (76-82%), means of coping with suffering.

A total of 23% of nurses reported that a patient's religion might affect the type of therapeutic or nursing procedure, such as blood transfusion. According to 13% f nurses, the kind of therapeutic or nursing procedure may also be affected by a nurse's religion. Examples of such procedures included a blood transfusion. A total of 68% of nurses used the statement 'difficult to say'. According to every fourth student, religion may affect therapeutic procedures. A similar percentage of students expressed the opposite opinion, whereas one in three students had difficulty providing a clear answer to this question. Most students argued that a nurse's religion should not affect their therapeutic decisions.

The new guidelines for nursing care emphasize the need to increase the professional responsibility and autonomy of nurses. In the nursing practice, autonomy is understood as the right to make one's decisions related to patient care and being responsible for one's actions. It may be

therefore concluded that making decisions is a basis for current and future nursing practice. According to Lauri [29], decision-making in nursing practice is defined as *"requiring a choice of specific nursing management from other available solutions."* Narayan and Corcoran-Perry [30] define making clinical decisions as *"a mutual interaction between the decision maker and the object of the decision."* Cioffi [31] describes decision-making as *"insightful thinking used to choose specific, individual and personal solutions."* Clark [32] defines decision-making as *"a process where nurses, using the gathered information on their patients, assess their status and select the best option for nursing care."* According to Case [33], *"nursing assessment of a given situation involves selecting and collecting data, which allow supporting the drawn conclusions."*

The present study showed that religion might hinder performing work-related nursing tasks, as confirmed by 62% of patients, 49% of students, and 61% of nurses. It should be noted. However, that doubts were raised in each group, and the respondents claimed they did not know if there were such effects.

Mill, citing Beauchamp [34], argued that it not be violating others' freedoms, but positive reinforcement of freedom should be an expression of respect for autonomy. This becomes, of course, complicated in the medical practice, with the example of mentally ill, unconscious patients, or patients of different religions [34]. This is confirmed by Komrad, citing Wulff [35], who claims that *"disease is a state of reduced autonomy."*

In the present study, a nurse faced with the necessity to provide therapy or care against a patient's religious beliefs and a lack of alternative therapy should discontinue the therapy and adequately inform the patient (this opinion was supported by 29% of nurses; 30% of nurses had difficulty providing a clear solution). In a situation when a nurse is faced with the necessity to provide therapy or care against their religious beliefs, the nurse should assign the patient to another nurse, as indicated by 38% of respondents.

CONCLUSIONS

1. Patients relatively often claimed that religion might have some effects on choice of profession, and most respondents did not consider religious beliefs an obstacle in making new acquaintances or performing work-related tasks.
2. In the case of a conflict between a nurse's therapeutic activities and a patient's or nurse's religious beliefs, the nurse should assign the patient to another nurse.

Conflicts of interest

The authors declare that they have no conflicts of interest

REFERENCES

1. Allport GW Pattern and growth in personality. New York: Holt, Rinehart and Winston 1961.
2. Allport GW The individual and his religion. A psychological interpretation. Macmillan, New York1950.
3. Thorson JA, Powell FC Meanings of death and intrinsic religiosity. J Clin Psychol. 1990 Jul;46(4):379-91.
4. Flanelly KJ, Ellison CG, Strock AL Methodologic Issues in Research on Religion and Health. South Med J Dec 2004;97 (12):1231-41.
5. Kinney AY, Bloor LE, Dudley WN, Millikan RC, Marshall E, Martin C, Sandler RS. Roles of Religious Involvement and Social Support in the Risk of Colon Cancer among Blacks and Whites. Am J. Epidemiol. 2003 Dec;158(11):1097-107.
6. Koenig HG., George LK, Titus P. Religion, Spirituality and Health in Medically III Hospitalized Older Patients. J Am Geriatr. Soc Apr 2004;52(4):554-62.
7. Koening HG, Idler E, Kasl S, Hays JC, George LK, Musick M, Larson DB, Collins TR, Benson H. Religion, spirituality, and medicine: a rebuttal to skeptics. Int J Psychiatry Med 1999;29(2):123-31.
8. Francis LJ, Robbins M, Lewis CA, Quigley CF, Wheeler C. Religiosity and general health among undergraduate students: a response to O'Connor, Cobb, and O'Connor. Person Indiv Different 2004;37(3):485-94.
9. Levin JS, Markides KS. Religion and health in Mexican Americans. J Relig Health. 1985 Aug; 36(4):9–36.
10. Oman D, Reed D. Religion, and mortality among the community-dwelling elderly. Am. J. Public Health. 1998 Oct;88(10): 1469–75.
11. Pargament KI. Of means and ends: Religion and the search for significance. Int J Psychol Relig. 1992;2(4):201-29.
12. Barnes-Holmes D, Hayes SC, Gregg J. Religion, spirituality, and transcendence. [in] Relational frame theory: A post-Skinnerian account of human language and cognition, Hayes S.C., Bamcs-Hotmes D., Roche B. (ed.), Kluwer/Plenum, New York, 2001, pp 239-51.
13. Bjorck JP, Cohen LH. Coping with threat, losses and challenges. J Soc Clin Psychol. 1993 Nov; 12(1):56-72.
14. Feifel H. Religious convinction and fear of death among the healthy and the terminally ill. J. Study of Religion, 1974;13(3):265-73.
15. Lazarus RS. Psychological Stress and the Coping Process. New York, 1966.

16. Koenig HG. Religion, spirituality, and medicine: research findings and implications for clinical practice. South Med J. 2004 Dec;97(12):1194–200.
17. Koenig HG. Religion and medicine IV: religion, physical health, and clinical implications. Int J Psychiatry Med. 2001;31(3):321-36.
18. Hall DE. When clinical medicine collides with religion. Lancet 2003;326:28–9.
19. Koenig HG, George LK, Peterson BL. Religiosity and remission of depression in medically ill older patients. Am J Psychiatry. 1998 Apr;155(4):536-42.
20. Koening HG, McCullough ME, Larson DB. Handbook of religion and health. Oxford University Press, London, 2001.
21. Ellis M, Vinson DC, Ewigman B. Addressing spiritual concerns of patients. J Fam Pract.1999 Feb;48(2):105-9.
22. Klaassen DW, McDonald MJ, James S. Advance in study of religious and spirituals coping [w:] Handbook of multicultural perspectives on stress and coping. Wong PTP (red.). Springer, New York – London 2006 pp 105-32.
23. Kark JD, Shemi G, Friedlander Y, Martin O, Manor O, Blondheim SH. Does religious observance promote health? Mortality in secular vs religious kibbutzim in Israel. Am J Public Health. 1996 Mar;86(3):957-61.
24. Strawbridge WJ, Cohen RD, Sherma SJ, Kaplan GA. Frequent attendance at religious services and mortality over 28 years. Am J Public Heart. 1997 Jun;87(6):957-96.
25. Clark KM, Friedman HS, Martin LR. A longitudinal study of religiosity and mortality risk. J Health Psychol May 1999 May;4(3):381-91.
26. McCullough ME, Hoyt WT, Larson DB, Koenig HG, Thoresen C. Religious involvement and mortality: a meta-analytic review. Health Psychol May 2000 May;19(3):211-22.
27. Meraviglia MGM. The effect of spirituality on well–being of people with lung cancer. Oncol Nurs Forum. 2004 Jan-Feb;31(1):89–4.
28. Hall BA. Ways of maintaining hope in HTV disease. Res Nurs Health. 1994 Aug; 17(4):283-93.
29. Lauri S, Salanterä S. Decision-making models in different fields of nursing, Res Nurs Health Oct 1998 Oct ;21(5):443–52.
30. Narayan S, Corcoran-Perry S. Line of reasoning as a representation of nurses clinical decision-making. Res Nurs Health. 1997 Aug ;20(4):353–64.
31. Cioffi J, Markhan R. Decision making by emergency nurses in triage assessments Accid. Emerg Nurs Oct 1998 Ocr ;6(4):184 –91.
32. Clark R. Clinical decision-making by beginning nurses, Virginia University, Charlottesville, 1996;25–36.
33. Case B. Walking around the elephant: a critical thinking strategy for decision-making. J Contin Educ Nurs. 1994 May-Jun;25(3):101-9.
34. Beauchamp T, Childress JF. Zasady etyki medycznej. Książka i Wiedza, Warszawa, 1996, pp 131-44 (Polish)
35. Wulff H. R., Pedersen S. A., Rosenberg R. Filozofia medycyny, Wyd. PWN, Warszawa, 1999 pp 237-8. (Polish)