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Dignity in end-of-life care: results of a national survey of US physicians

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Abstract

Context—Debates persist about the relevance of "dignity" as an ethical concept in US healthcare, especially in end-of-life care.

Objective—To describe the attitudes and beliefs regarding the usefulness and meaning of the concept of dignity and to examine judgments about a clinical scenario in which dignity might be relevant.

Methods—2000 practicing U.S. physicians, from all specialties, were mailed a survey. Main measures included physician's judgments about an end-of-life clinical scenario (criterion variable), attitudes about the concept of dignity (predictors), and their religious characteristics (predictors).

Results—1032 eligible physicians (54%) responded. Nine out of ten (90%) physicians reported that dignity was relevant to their practice. After controlling for age, gender, region, and specialty, physicians who judged that the case patient had either some dignity or full dignity, and who agreed that dignity is given by a creator, were all positively associated with believing that the patient's life was worth living [OR 10.2 (5.8–17.8), OR 20.5 (11.4–36.8), OR 4.7 (3.1–7.0), respectively]. Respondents who strongly agreed that "all living humans have the same amount of dignity" were also more likely to believe that the patient's life was worth living [OR 1.8 (1.2–2.7)]. Religious characteristics were also associated with believing that the case patient's life was worth living [OR 4.1 (2.4–7.2), OR 3.2 (1.6–6.3), OR 9.2 (4.3–19.5), respectively].

Conclusion—US physicians view the concept of dignity as useful. Those views are associated with their judgments about common end-of-life scenarios in which dignity concepts may be relevant.

Keywords

human dignity; end-of-life care; physician religiosity

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Introduction

The concept of human dignity continues to occupy considerable attention in medical ethics, especially with respect to care at the end-of-life.[1–6] Critics argue that conceptual ambiguity and imprecision make *dignity* a "useless concept" that adds nothing to the principle of respect for autonomy.[7] In 2008, the President's Council on Bioethics published a collection of papers attempting to clarify the concept's origin and meaning, and argued for a prominent place for the concept in the medical ethics lexicon.[8] Critics of the Council's volume asserted that dignity is a "slippery concept",[9] marks an unwarranted intrusion of religion into the secular public square,[10] and should not have been debated by a presidentially-appointed council.[11] Others praised the volume for the "rigorous attempts to elucidate the characteristics of human dignity" from a variety of viewpoints.[12]

The language of 'dignity' is used by opposing sides in debates over end-of-life care. Those who support actively hastening the death of some terminally ill patients argue that such actions promote "death with dignity," while those who oppose such measures argue that hastening death violates respect for the basic dignity that all living humans possess. Such debates illustrate that the term 'dignity' can mean more that one thing.[13]

The word 'dignity' has been used by philosophers in three ways: attributive, intrinsic, and inflorescent dignity.[13] 'Dignity' is used in the attributed sense when it refers to the worth or value we attribute to individuals by virtue of the circumstances in which they find themselves, or who possess various characteristics or abilities, thus bestowing dignity upon them. One can have more or less attributed dignity, depending upon one's characteristics or circumstances. A second and very different notion of dignity is intrinsic dignity, "the value that human beings have simply by virtue of the fact that they are human beings." Intrinsic dignity is not determined by one's social standing, power, or particular abilities. Perhaps the most famous champion of this notion, that dignity precedes individual's achievements or society's judgments, is Immanuel Kant. Finally, inflorescent dignity, a term "used to refer to individuals who are flourishing as human beings," who demonstrate human excellence (p. 473). We often express our admiration for persons of sterling character using phrases such as, "she handled the situation with dignity." Stoic philosophers emphasized the inflorescent sense of dignity in their writings.

In spite of these important theoretical debates, little is known neither about practicing physicians' views regarding the relevance and meaning of dignity nor about the relationship between physicians' views about dignity, their religious characteristics, and their clinical practices. We examined data from a national survey of physicians to ascertain their views about the usefulness and meaning of the concept of dignity and to examine their judgments about a clinical scenario in which dignity might be relevant. We then sought to understand how clinical attitudes regarding the case scenario could be accounted for by physicians' divergent understandings of the concept of dignity, and how both might be related to differences in their religious characteristics.

Methods

This study's methods have been described in detail elsewhere.[14] In 2009, we mailed a survey to a random sample of 2000 practicing U.S. physicians ages 65 and younger from all specialties. These physicians were chosen from the American Medical Association Physician Masterfile. All items, including those reported here, were developed through an iterative process of literature review, question formulation, cognitive interviewing with physicians, and question revision.

Questionnaire

As part of a larger self-administrated survey on moral and ethical beliefs in medical practice, physicians first responded to a case scenario and then to five items measuring their attitudes toward different components of human dignity. As part of the questionnaire development we identified several dimensions of dignity. These dimensions (and their respective survey measures) are: 1) the relevance of the concept ("Dignity is a concept that has no practical relevance for clinical medicine."), 2) dignity as autonomy ("Patients' dignity comes from their ability to make significant choices about their lives."), 3) whether dignity can be lost ("Sometimes humans lose all their dignity."), 4) the origins of dignity ("Dignity is given by a creator."), and 5) the equality of dignity ("All living humans have the same amount of dignity."). Four response categories for each item ranged from *strongly agree* to *strongly disagree*, which we subsequently dichotomized by collapsing *strongly agree* and *moderately agree* into one category and *strongly disagree* and *moderately disagree* into the other.

We also sought to assess respondents' judgments about an end-of-life clinical scenario in which dignity might be relevant. A vignette (shown verbatim in Table 2) described a complicated bed-bound elderly patient with dementia, uncontrolled pain, and little social support. Participants were asked to what extent they agreed or disagreed that "the patient's life was still worth living." They also were asked which of the following best described their view of the patient's dignity: "the patient has lost all her dignity," "the patient has lost some, but retains a minimal level of her dignity," or "the patient has full dignity." In addition, physicians were asked to indicate whether they had no moral objection, a moderate moral objection, or a strong moral objection to "helping a terminally ill patient to actively hasten his/her own death."

The survey also included measures of physicians' religious characteristics that have been used extensively in other physician surveys.[15–18] Physicians indicated their religious affiliation (none, Hindu, Jewish, Muslim, Roman Catholic, Evangelical Protestant, non-evangelical Protestant, Other Christian [including Eastern Orthodox], and Other [including self-reported 'other' religious affiliation and Buddhist]). They also indicated the importance of their religion in their life ("the most important part of my life," "very important in my life," "fairly important in my life," "not very important in my life," and "not applicable, I have no religion") and how frequently they attend religious services (analyzed as never, once a month or less, or twice a month or more).

Statistical Analysis

Survey responses were analyzed using SAS version 9.1 (Cary, NC). We used Pearson chi-square tests to examine univariate associations between physicians' religious characteristics, their conceptions of human dignity, their judgments about the end-of-life case scenario, as well as their degree of moral objection to actively hastening a patient's death. Multivariate logistic regression was also performed to examine whether these associations persisted after adjusting for other covariates including age, sex, region, and specialty. All reported P values are two-sided and have not been adjusted for multiple statistical comparisons.

Results

Of 2000 physicians, 105 could not be contacted; 1032/1895 eligible physicians returned completed surveys (cooperation rate of 54%).[19] Cooperation rates varied somewhat by region (Northeast, 53%; South, 52%; Midwest, 62%; West, 52%; $P = 0.03$) and age category (<50 years, 51%; ≥50 years, 59%; $P<0.001$) but not by sex or specialty. The results we present here are from unweighted analyses. The characteristics of the respondents are listed in Table 1.

Dignity Beliefs

Nine out of ten (90%) physicians reported that the concept of human dignity has practical relevance for clinical medicine. Physicians were evenly divided regarding whether dignity is given by a creator (46% agreed) and whether all humans possess the same amount of dignity (53% agreed). The majority (73%) of respondents believed that dignity comes from the ability to make significant choices about one's life (Table 2).

End-of-life Judgments

In their responses to the end-of-life case scenario, three out of four physicians (75%) believed that the patient's life was no longer worth living. In contrast, when asked about the status of the patient's dignity, only 36% reported the patient had lost all of her dignity; 43% reported she had lost some dignity but a minimal level remained, while 21% reported that she retained full dignity. Similarly, physicians were split on helping a terminally ill patient hasten his/her death, with one-third (33%) expressing no moral objection, one-third (34%) reporting moderate moral objection, and one-third (33%) reporting a strong moral objection (Table 2).

Dignity Beliefs and End-of-life Judgments

In multivariate analyses adjusted for age, gender, region, and specialty, we found significant associations between physicians' ideas about various concepts of human dignity and (a) their judgments about the life of the patient in the case scenario, and (b) whether or not they objected to actively hastening a patient's death. Judging the patient to have either some dignity or full dignity, and agreeing that dignity is given by a creator, were all positively associated with believing that the patient's life was worth living [OR 10.2 (5.8–17.8), OR 20.5 (11.4–36.8), OR 4.7 (3.1–7.0), respectively] and with reporting a moral objection to actively hastening a patient's death [OR 2.2 (1.6–3.0), OR 3.1 (2.1–4.7), OR 5.8 (3.7–9.0), respectively]. Respondents who strongly agreed that all living humans have the same amount of dignity were also more likely to believe that the patient's life was worth living [OR 1.8 (1.2–2.7)]. In contrast, respondents who moderately or strongly agreed that sometimes humans lose their dignity, and who moderately or strongly agreed that dignity comes from the ability to make significant choices about their lives were less likely to believe the case patient's life was worth living and they were less likely to object morally to actively hastening a patient's death (see Table 3).

Religious Characteristics and Dignity Beliefs

Physicians who attended religious services twice a month or more, and physicians who reported that religion was the most important part of their lives, were less likely to agree that humans sometimes lose all their dignity [OR 0.5 (0.3–0.8), OR 0.4 (0.2–0.7), respectively] and less likely to agree that patients' dignity comes from the ability to make choices [OR 0.7 (0.4–1.0), OR 0.4 (0.2–0.7), respectively]. Physicians who reported that religion was the most important part of their lives were more likely to agree that all living humans have the same amount of dignity [OR 2.0 (1.1–3.7)]. Furthermore, most self-reported measures of religious affiliation were predictive of beliefs about human dignity (Table 4).

Religious Characteristics and End-of-life Judgments

Physicians who were more religious (as measured by either attendance at religious services twice a month or more, or who reported religion to be a very important part or the most important part of their life) were more likely to believe that the life of the patient in the vignette was worth living [OR 4.1 (2.4–7.2), OR 3.2 (1.6–6.3), OR 9.2 (4.3–19.5), respectively]. Physicians who reported attending religious services twice a month or more were also more likely to morally object to actively hastening a patient's death [OR 4.6 (2.9–

7.3)]. Also, compared to those for whom religion is not at all important, physicians who rated religion as fairly important, very important, or the most important part of their lives were 3.0, 5.6, and 12.0 times more likely, respectively, to morally object to hastening a patient's death. Finally, most self-reported measures of religious affiliation were predictive of attitudes toward whether the life of the patient in the case scenario was worth living and toward hastening a patient's death (Table 5).

Discussion

In this study we found that the overwhelming majority of US physicians (90%) believe that the concept of human dignity has practical relevance for clinical medicine, although they remain divided on the exact meaning of the concept. Physicians' understandings of the word dignity are significantly associated with their clinical attitudes and moral judgments about controversial practices in care at the end-of-life, and their religious characteristics are associated both with their understandings of the word and their clinical attitudes and moral judgments.

While many debates about dignity remain abstract and theoretical, beliefs about dignity may represent important lenses through which physicians view the care of terminally ill patients. Physicians who endorse concepts of dignity as permanent (human dignity cannot be lost), equal (all humans have the same amount of dignity), and having a transcendent origin (given by a creator) are significantly more likely to believe that the life of the patient in the case scenario is still very much worth living. These conceptions are consistent with the notion of dignity as *intrinsic*. In contrast, physicians who espouse a concept of dignity as more variable (sometimes humans lose all their dignity) or based upon autonomy (dignity comes from their ability to make significant choices about their lives) espouse different beliefs about the meaning and value of caring for patients like the one presented in the case scenario. Understanding dignity as variable or attached to specific abilities would be most consistent with the notion of dignity as *attributed*. As these data illustrate, diverse beliefs of the meaning and origins of human existence, as represented in the concept of human dignity, may figure importantly in physicians' beliefs regarding the ethics of the most controversial aspects of end-of-life care.

Competing notions of human dignity also appear to be closely related to religiosity. Physicians who were more religious tended to espouse a view of dignity that is a permanent, equal, and transcendent feature of humanity. Religious physicians also reported differing attitudes toward the worth of the case patient's life and regarding the morality of actively hastening a patient's death than did their non-religious colleagues. While dignity may sort along religious lines, this does not necessarily make dignity a "religious concept". Rather it is a heterogeneous concept that at key points intertwines with religious concepts.

Limitations

First, it needs to be understood that no amount of empirical data can answer fundamentally normative questions regarding ethical controversies.[20] Moreover, we were unable to assess the influence of physicians' beliefs and judgments about human dignity on their clinical behavior. No single vignette can tease apart all the factors that may influence physicians judgments. Other methodological limitations include sampling physicians from all medical specialties not just physicians who administer end-of-life care. We also forced survey participants to use the word dignity globally in answering each question, when it might have been possible for the same participant to have used the word in two different senses and to have answered the question differently depending on which sense they were using when responding. In this study we explored the relationship between physicians' views about dignity and their religious characteristics. Future work could explore how other

philosophical traditions influence physician's conceptions of dignity. Finally, it is possible that the beliefs and judgments of physicians who did not respond to our survey differ from those who did respond.

Notwithstanding these limitations, these data do at least suggest that for practicing US physicians, religious or non-religious, their beliefs about the meaning and significance of dignity are important and that they find the concept useful. We speculate that varying conceptions of dignity represent important ethical convictions related to diverse and often contested metaphysical commitments such as religious belief that are not easily separated from one's professional sense of responsibility.

While avoiding the use of controversial words may be one strategy for negotiating ethical debates in medicine and public life, a more helpful strategy may be to openly acknowledge the broad diversity of moral beliefs physicians, and to foster a kind of collegial dialogue that takes diverse points of view seriously.[21, 2223] It is important to understand the differences and relationships between the competing conceptions of dignity so that all participants in the debate understand each other's positions and arguments. The fact that moral words are used in certain ways is not a guarantee that such use is logical and morally coherent, and all participants in such a debate should keep their views open to revision. Such an approach would not solve the challenging ethical questions faced in modern medicine, but it might create an open and robust exchange of values that can better acknowledge and deal with the reality of moral diversity faced in modern medicine.

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Table 1

Characteristics of physician respondents.

Characteristic	No./Total No. (%)
Female sex	283/1011 (28)
Age (years)	
Less than 50	471/1011 (47)
50 or older	540/1011 (53)
Race or ethnic group	
White or Caucasian	786/1011 (78)
Asian	146/1011 (14)
Other	50/1011 (5)
Black or African-American	25/1011 (2)
American Indian or Alaska Native	4/1011 (0.4)
Region*	
South	331/1032 (32)
Midwest	251/1032 (24)
Northeast	227/1032 (22)
West[1]	215/1032 (21)
Primary Specialty	
Primary Care	407/1032 (39)
Surgery	212/1032 (21)
Procedural Specialty	206/1032 (20)
Nonprocedural Specialty	175/1032 (17)
Non-Clinical	22/991 (2)
Other	10/991 (1)

* 8 responding physicians were from Puerto Rico

[1] Includes 6 physicians from Hawaii and 3 from Alaska

Table 2

Distribution of responses to items on human dignity and euthanasia.

	N (%)			
BELIEFS ABOUT HUMAN DIGNITY	**Strongly Disagree**	**Moderately Disagree**	**Moderately Agree**	**Strongly Agree**
Dignity is a concept that has no practical relevance for clinical medicine.	642 (64)	261 (26)	68 (7)	36 (4)
Patients' dignity comes from their ability to make significant choices about their lives.	105 (10)	161 (16)	442 (44)	296 (29)
Sometimes humans lose all their dignity.	153 (15)	126 (13)	281 (28)	446 (44)
Dignity is given to humans by a creator.	331 (34)	199 (20)	227 (23)	226 (23)
All living humans have the same amount of dignity.	194 (19)	281 (28)	180 (18)	346 (35)
JUDGMENTS ABOUT CASE STUDY*	**Strongly Disagree**	**Moderately Disagree**	**Moderately Agree**	**Strongly Agree**
This patient's life is no longer worth living	95 (9)	155 (15)	390 (39)	367 (36)
	Lost all	**Lost some, retains minimal**	**Full**	
What is the current state of this patient's dignity?	361 (36)	434 (43)	207 (21)	
JUDGMENTS ABOUT EUTHANASIA	**No Moral Objection**	**Moderate Moral Objection**	**Strong Moral Objection**	
To what degree do you object with helping a terminally ill patient hasten his/her own death?	331 (33)	339 (34)	330 (33)	

*Questions reference the following case study: *Three months ago, an 81-year old woman with a past history of moderate dementia suffered an acute left hemispheric stroke with residual dense right hemiparesis. Her course was complicated by an in-hospital fall resulting in hip fracture that could not be repaired and recurrent aspiration pneumonia leading to PEG tube placement. When awake, she is very uncomfortable. Despite aggressive inpatient rehabilitation, she is unable to participate in or enjoy any activities of daily living and does not remember her family. Her advance directive states she would never want to live in a chronically debilitated condition or in a nursing home.*

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Table 3

Judgments about the worth of the case study patient's life and end-of-life care according to beliefs about human dignity.

	The patient's life is worth living			I morally object to euthanasia		
	No. (%)	**P value**	**Multivariate Odds Ratio (95% CI)**	**No. (%)**	**P value**	**Multivariate Odds Ratio (95% CI)**
BELIEFS ABOUT HUMAN DIGNITY						
State of case study patient's dignity		<0.0001			<0.0001	
Lost all	15 (4)		Referent	194 (54)		Referent
Retains some	134 (31)		10.2 (5.8–17.8)	308 (72)		2.2 (1.6–3.0)
Full	98 (47)		20.5 (11.4–36.8)	161 (78)		3.1 (2.1–4.7)
Sometimes humans lose all their dignity.		<0.0001			<0.0001	
Strongly disagree	76 (50)		Referent	122 (81)		Referent
Moderately disagree	53 (42)		0.7 (0.5–1.2)	91 (74)		0.6 (0.3–1.1)
Moderately agree	64 (23)		0.3 (0.2–0.5)	200 (72)		0.6 (0.4–1.0)
Strongly agree	53 (12)		0.1 (0.09–0.2)	252 (57)		0.3 (0.2–0.5)
Dignity is given to humans by a creator.		<0.0001			<0.0001	
Strongly disagree	52 (16)		Referent	164 (51)		Referent
Moderately disagree	35 (18)		1.2 (0.7–1.9)	134 (68)		2.0 (1.4–2.9)
Moderately agree	47 (21)		1.4 (0.9–2.2)	156 (70)		2.3 (1.6–3.3)
Strongly agree	105 (46)		4.7 (3.1–7.0)	193 (85)		5.8 (3.7–9.0)
All living humans have the same amount of dignity.		<0.0001			0.03	
Strongly disagree	43 (22)		Referent	127 (65)		Referent
Moderately disagree	42 (15)		0.6 (0.4–1.0)	169 (61)		0.8 (0.6–1.2))
Moderately agree	46 (26)		1.3 (0.8–2.1)	132 (75)		1.5 (0.9–2.4)
Strongly agree	116 (34)		1.8 (1.2–2.7)	232 (68)		1.1 (0.7–1.6)
Patients' dignity comes from their ability to make significant choices about their lives.		<0.0001			<0.0001	
Strongly disagree	48 (46)		Referent	85 (82)		Referent
Moderately disagree	63 (39)		0.8 (0.5–1.3)	118 (74)		0.5 (0.3–1.0)
Moderately agree	103 (23)		0.4 (0.2–0.6)	293 (67)		0.4 (0.2–0.7)
Strongly agree	34 (11)		0.2 (0.1–0.3)	167 (57)		0.3 (0.1–0.4)

Table 4

Beliefs about human dignity according to religious characteristics of physicians.

	Sometimes humans lose all their dignity			Dignity is given by a creator			All living humans have the same amount of dignity			Patients' dignity comes from ability to make choices		
RELIGIOUS CHARACTERISTICS	**No. (%)**	**P Value**	**Multivariate Odds Ratio (95% CI)**	**No. (%)**	**P Value**	**Multivariate Odds Ratio (95% CI)**	**No. (%)**	**P Value**	**Multivariate Odds Ratio (95% CI)**	**No. (%)**	**P Value**	**Multivariate Odds Ratio (95% CI)**
Frequency of attendance at religious services		0.001			<0.0001			0.22			0.0003	
Never	101 (78)		Referent	18 (14)		Referent	62 (48)		Referent	97 (75)		Referent
Once a month or less	365 (77)		0.9 (0.6–1.5)	168 (36)		3.4 (2.0–5.9)	241 (51)		1.1 (0.7–1.6)	374 (79)		1.2 (0.8–1.9)
Twice a month or more	245 (66)		0.5 (0.3–0.8)	252 (69)		13.5 (7.7–23.5)	206 (56)		1.3 (0.9–2.0)	246 (66)		0.7 (0.4–1.0)
How important would you say religion is in your own life?		0.0005			<0.0001			0.005			0.0002	
I have no religion	73 (77)		Referent	4 (4)		Referent	48 (51)		Referent	71 (75)		Referent
Not very important	162 (81)		1.3 (0.7–2.4)	37 (19)		5.4 (1.9–15.7)	90 (45)		0.8 (0.5–1.3)	159 (79)		1.1 (0.6–2.1)
Fairly important	201 (73)		0.8 (0.5–1.4)	107 (40)		15.6 (5.5–44.0)	137 (50)		1.0 (0.6–1.5)	213 (78)		1.1 (0.6–2.0)
Very important	219 (71)		0.7 (0.4–1.2)	215 (71)		57.3 (20.2–162.4)	169 (55)		1.2 (0.7–1.9)	219 (72)		0.8 (0.4–1.3)
The most important part of my life	57 (57)		0.4 (0.2–0.7)	76 (78)		87.2 (28–268.2)	66 (67)		2.0 (1.1–3.7)	56 (56)		0.4 (0.2–0.7)
Religious affiliation		0.0002			<0.0001			0.01			0.0005	
None	115 (80)		Referent	10 (7)		Referent	66 (46)		Referent	106 (74)		Referent
Hindu	39 (78)		1.0 (0.4–2.3)	24 (48)		12.9 (5.5–30.6)	34 (68)		2.4 (1.2–4.8)	40 (80)		1.3 (0.6–3.0)
Jewish	110 (82)		1.1 (0.6–2.1)	32 (24)		4.1 (1.9–8.8)	62 (46)		1.1 (0.7–1.7)	105 (78)		1.2 (0.7–2.1)
Muslim	19 (66)		0.5 (0.2–1.2)	13 (46)		12.4 (4.6–33.8)	19 (66)		2.1 (0.9–4.9)	25 (89)		2.9 (0.8–10.4)
Roman Catholic	152 (67)		0.5 (0.3–0.8)	129 (59)		18.9 (9.2–37.7)	124 (55)		1.4 (0.9–2.2)	156 (69)		0.8 (0.5–1.2)
Evangelical Protestant	29 (53)		0.3 (0.1–0.5)	48 (87)		87.3 (31.1–245.1)	37 (67)		2.2 (1.2–4.4)	27 (49)		0.3 (0.2–0.7)
Non-Evangelical Protestant	127 (79)		1.0 (0.6–1.8)	102 (64)		23.3 (11.2–48.3)	79 (49)		1.2 (0.7–1.8)	124 (78)		1.2 (0.7–2.1)
Other Christian	75 (71)		0.6 (0.3–1.1)	58 (57)		17.5 (8.2–37.5)	47 (47)		1.0 (0.6–1.7)	80 (78)		1.2 (0.6–2.2)
Other* (n = 58)	36 (68)		0.5 (0.2–1.1)	12 (23)		4.3 (1.7–10.8)	25 (48)		1.1 (0.5–2.0)	39 (74)		0.9 (0.4–1.9)

*Other includes self-identified 'other' religious affiliation and Buddhist.

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Table 5

Judgments about the worth of the case study patient's life and end-of-life care according to physicians' religious characteristics.

	The patient's life is worth living			I morally object to euthanasia		
RELIGIOUS CHARACTERISTICS	**No. (%)**	**P Value**	**Multivariate Odds Ratio (95% CI)**	**No. (%)**	**P Value**	**Multivariate Odds Ratio (95% CI)**
Frequency of attendance at religious services		<0.0001			<0.0001	
Never	17 (13)		Referent	63 (50)		Referent
Once a month or less	81 (17)		1.3 (0.7–2.3)	281 (59)		1.4 (0.9–2.1)
Twice a month or more	144 (39)		4.1 (2.4–7.2)	307 (83)		4.6 (2.9–7.3)
How important would you say religion is in your own life?		<0.0001			<0.0001	
I have no religion	12 (13)		Referent	35 (38)		Referent
Not very important	27 (13)		1.1 (0.5–2.3)	104 (52)		1.7 (1.0–2.8)
Fairly important	54 (19)		1.8 (0.9–3.6)	183 (66)		3.0 (1.8–5.1)
Very important	94 (31)		3.2 (1.6–6.3)	240 (79)		5.6 (3.3–9.4)
The most important part of my life	56 (55)		9.2 (4.3–19.5)	90 (14)		12.0 (5.6–25.8)
Religious affiliation		<0.0001			<0.0001	
None	16 (7)		Referent	57 (40)		Referent
Hindu	9 (18)		1.8 (0.7–4.5)	44 (88)		10.3 (4.1–26.0)
Jewish	27 (20)		2.1 (1.1–4.2)	69 (51)		1.5 (0.9–2.5)
Muslim	4 (14)		1.3 (0.4–4.4)	21 (72)		3.6 (1.5–8.7)
Roman Catholic	76 (33)		4.3 (2.3–7.9)	171 (75)		4.3 (2.7–6.9)
Evangelical Protestant	27 (50)		8.3 (3.9–18.0)	50 (92)		15.6 (5.3–46.0)
Non-Evangelical Protestant	29 (18)		1.8 (0.9–3.5)	114 (72)		3.8 (2.3–6.3)
Other Christian	36 (35)		4.5 (2.3–8.7)	84 (81)		5.7 (3.1–10.5)
Other*	12 (23)		2.3 (1.0–5.5)	27 (51)		1.6 (0.8–3.0)