Methods
The questionnaire, derived from that used by Ehman et al in 1999, included questions on whether participants have spiritual or religious beliefs that would affect their medical decision making and to what extent they would want their physician to inquire about those beliefs. The survey was targeted to those who attend Neo-Pagan religious services or visit Neo-Pagan-themed Web sites. Clergy members contacted through Neo-Pagan interfaith groups distributed surveys to their congregations. To find Neo-Pagans not affiliated with such organizations, the survey was also available on the Web; a request for participation in the survey was made through the site www.witchvox.com. The questionnaire was available from March 3 through April 15, 2004.

Results
Using this dual distribution convenience sample, 68% of 673 surveys were completed. Eighty-nine percent of those who entered their religion listed some form of Neo-Paganism. The largest single religion specified was Wicca, with 188 respondents; 162 participants described themselves as Pagan or Neo-Pagan. Responses were received from 42 US states and five Canadian provinces.

Seventy-three percent of respondents stated that they have religious/spiritual beliefs that would influence their medical decisions; 84% agreed that it would be important to have their physician ask about religious beliefs, even if the physician might not agree with those beliefs; and 81% reported that it would strengthen their trust in their doctor if she/he asked about beliefs that would influence medical decisions.

Eighty percent of those surveyed reported seeing a physician within the past 12 months.

Discussion
Surveyed Neo-Pagans, who might be expected to be reticent to discuss issues of spirituality and religion with their (presumably non-Neo-Pagan) physicians, looked for physician discussion of these topics at rates comparable to those reported by the general population in earlier studies. Because this study dealt specifically with Neo-Pagans, the results of this survey cannot be generalized to members of all minority religions. Further, readers of the Witchvox Web site and members of targeted congregations may not be representative of Neo-Pagans overall. Despite these limitations, the findings of this study may reassure physicians who are hesitant to discuss matters of religion and spirituality because of concerns that their inquiries will be unwelcome.

Jennifer L. Hamilton, MD, PhD
Jeffrey P. Levine, MD, MPH
Department of Family Medicine
UMDNJ-Robert Wood Johnson Medical School

Corresponding Author: Address correspondence to Dr Hamilton, Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School, 1 World’s Fair Drive, Somerset, NJ 08873. 732-743-3326. jennifer.hamilton@umdnj.edu.

REFERENCES
lins, 1999:60.

Education for All in Clinical Prevention and Population Health: An Opportunity for Family Medicine Educators

To the Editor:
The specialty of family medicine was created to fill a need in the US health care system. Since its inception nearly 4 decades ago, not only have members of the specialty been providing needed access to primary care, but family medicine educators have been taking a leadership role in ensuring that medical education includes instruction in prevention and health promotion. Now, with the recent publication of a comprehensive framework that identifies core elements for clinical prevention and population health instruction,1 family medicine educators have an organized set of content areas for reference when teaching medical students. Within the four sections of the framework—Evidence Base for Practice, Clinical Preventive Services-Health Promotion, Health Systems and Health Policy, and Community Aspects of Care—a total of 19 domains provides additional specificity while encouraging educators to determine the degree of detail and emphasis to place on each.

A multiprofessional task force consisting of two representatives from each of seven clinical health professional disciplines (advanced practice nursing, allopathic medicine, dentistry, nursing, osteopathic medicine, pharmacy, and physician assistants) developed the framework as a way to achieve Healthy People 2010’s objective to “Increase the proportion of schools of medicine, schools of nursing, and health professional training schools whose basic curriculum for health care providers includes the core competencies in health promotion and disease prevention.”2 Three particular aims the group sought to achieve were to promulgate a common language as well as to
Letters to the Editor
demonstrate the relevance of health promotion and disease prevention for all clinical health professions. Recently, each of the seven health professions’ national organizations has either ratified or affirmed the framework. Thus, as we in family medicine use the framework to expand on and take a lead in ensuring that elements of prevention and population health are included in our curricula, we can know that curricula for other health professions students will be guided by this same framework. This wide use of the framework should help us achieve one of the goals articulated by the Institute of Medicine for health professions education,4 i.e., to promulgate a common language as well as to demonstrate the relevance of health promotion and disease prevention for all clinical health professionals.

Given the growing emphasis on prevention and population health, the framework is both timely and germane. Moreover, as medical students are requesting additional opportunities to learn about our health care system (Personal communication from Kao-Ping Chua, American Medical Student Association’s Jack Rutledge Fellow, August, 2005), the Healthy Systems and Health Policy component provides an opportunity to examine medical schools’ curricula to determine where elements of this component can be inserted. Family medicine educators—with our history of promulgating clinical and public health services, as well as understanding the rudiments of health care financing, health workforce issues, and health policy—can make a significant contribution to medical education by ensuring that the framework’s Health Systems and Health Policy domain is included in medical students’ education.

As we slowly shift from a medical care-focused to a health care-focused delivery system, the next generation of clinical health professionals will need to be trained in the multifaceted elements of prevention and population health. The clinical prevention and population health curriculum framework provides a common core curriculum for the clinical professions that offers opportunities for broadening students’ understanding of health and health care systems. We in family medicine can take the lead by ensuring that our schools’ curricula not only incorporate the elements of this framework but also provide opportunities for interprofessional team training. Family medicine faculty members have a unique opportunity to teach as well as to serve as role models for how clinical prevention and population health can be integrated into health professions education and thus into the health care delivery system of the future. The clinical prevention and population health curriculum framework can serve as a useful resource to support this mission.

Suzanne B. Cashman, ScD
Department of Family Medicine and Community Health, University of Massachusetts

David Garr, MD
South Carolina Area Health Education, Charleston, SC

Corresponding Author: Address correspondence to Dr Cashman, University of Massachusetts Medical School, Department of Family Medicine and Community Health, 55 Lake Avenue North, Worcester, MA 01655. 508-856-2930. Fax: 508-856-1212. suzanne.cashman@umassmed.edu.

REFERENCES