



Spirituality in Medicine: What Is Its Role, Today and Tomorrow?

KAREN LAWSON

You can soon become so engrossed in study, then [in] professional cares, [then] in getting and spending, you may so lay waste your powers that you find too late with hearts given away that there is no place in your habit-stricken souls for those gentler influences that make life worth living.

—Rudolf Virchow, MD, from an address to medical students
at the Pathological Institute, Berlin

The role of spirituality in health care is often controversial and not universally agreed upon. That is perhaps even truer of spirituality in medical education. However, professional educational organizations, such as the Association of American Medical Colleges (AAMC), and practice organizations, such as the American College of Physicians, have made supportive position statements or have generated tools for use in spirituality assessment of and by medical students and practitioners. According to the AAMC, for example:

Physicians must seek to understand the meaning of their patients' stories in the context of the patients' beliefs and family and cultural values.¹

¹AAMC Medical School Objectives Project, "Report 1: Learning Objectives for Medical School Education: Guidelines for Medical Schools" (January 1998) 4, at <http://www.aamc.org/meded/msop> (accessed 17 November 2009).

The spiritual care of patients is an interdisciplinary responsibility, increasingly requiring both medical caregivers and religious caregivers to work together and understand one another's work. In this article, readers of this journal are given insight into the growing field of spirituality in medicine.

WHAT IS SPIRITUALITY?

In 1988, medical anthropologist and psychiatrist Arthur Kleinman devised eight open-ended questions to uncover a client's explanatory model of illness.² That is, "How does a person understand their illness's causation, treatment, and complications?" These questions allow for the cultural adaptation of medical services by compromising between different conceptions of health and treatment. While at first glance, they may not appear to address spirituality directly, they do enable the physician to begin to understand the patient's story of the illness; their beliefs, fears, and desires; and, perhaps, even the meaning of the illness in the individual's life. These opened the door for medical students to begin intentionally considering the broader construct of spirituality.

1. What do you call your illness? What name does it have?
2. What do you think has caused the illness?
3. Why and when did it start?
4. What do you think the illness does? How does it work?
5. How severe is it? Will it have a short or long course?
6. What kind of treatment do you think you should receive? What are the most important results you hope to receive from this treatment?
7. What are the chief problems the illness has caused?
8. What do you fear most about the illness?

It is important, both in this article and in the educational realm, for us to have a working definition of spirituality, despite its inevitable evanescence. In Elizabeth Lesser's book *The New American Spirituality*,³ she surveyed over two hundred spiritual leaders and received over two hundred different answers to the question, "What is spirituality?" Common themes included:

- Spirituality is a path and a journey.
- It addresses the finding of meaning and purpose.
- It differs from religion, but may be expressed via religious practices.
- Its definition must be inclusive and forgiving enough to hold the fullness of the human condition.

The AAMC has created the following working definition, which is used broadly in medical education:

Spirituality is recognized as a factor that contributes to health in many persons. The concept is found in all cultures and societies. It is expressed in an individu-

²Arthur Kleinman, *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry* (Berkeley, CA: University of California Press, 1981).

³Elizabeth Lesser, *The New American Spirituality* (New York: Random House, 1999).

al's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All of these factors can influence how patients and health care professionals perceive health and illness and how they interact with another.⁴

PHYSICIANS' BELIEFS AND PRACTICES

In a 1992 study by King et al., 93 percent of polled family physicians agreed or strongly agreed that physicians should consider patients' spiritual needs.⁵ In a 1996 survey of three hundred family physicians, 99 percent felt that religious beliefs can heal, and 75 percent believed that prayers of others could promote a patient's recovery. Monroe reported, in a 2003 issue of *Archives of Internal Medicine*, that 85 percent of physicians think they should be aware of a patient's religious and spiritual beliefs, yet only 31 percent (outpatient) and 39 percent (inpatient) believed that they should ask patients about their spiritual beliefs. These findings point out the discrepancy between beliefs and behaviors, which is reinforced by literature reports of actual physician behaviors—fewer than 10 percent of physicians actually ask patients about these issues, even among terminally ill patients.

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Physicians' beliefs and practices around spirituality may also have an effect on the growing challenge of physician stress and burnout. The increasing pressures from the daily rigors of medical practice can lead many professionals to lose perspective and purpose. Physician burnout is a growing issue, impacting not only their own health but the professional practice of medicine. Physician burnout has increased from less than 15 percent in 1973, to between 30 percent and 40 percent in the current decade. Doctors reporting burnout would not choose to enter medicine if they were deciding on a career today. Even more of these physicians would not encourage their children to enter medicine as a career. So, what could help physicians recover from these challenges? Does spirituality play a role?

Rachel Remen, founder and director of the Institute for the Study of Health and Illness (ISHI) at Commonweal in Bolinas, California, and developer of *The Healer's Art* course for medical students (discussed later in this article), is a woman who has been a pioneer in helping physicians recover the meaning and purpose of their work as service, "recapturing the soul of medicine." She helps physicians ex-

⁴AAMC Medical School Objectives Project, "Report III: Contemporary Issues in Medicine: Communication on Medicine" (October 1999) 25, at https://services.aamc.org/publications/showfile.cfm?file=version89.pdf&prd_id=200&prv_id=241&pdf_id=89 (accessed 17 November 2009).

⁵Since this is a report for a nonspecialist audience, full citations for the technical medical literature are not included here.

perience the wonder, surprise, inspiration, and even invigoration available to them through their privileged human interactions. Actively engaging their spirituality, they explore larger questions of meaning—such as where we fit in relation to the society of man, the world ecology, and the universe. Physicians addressing the role of spirituality in their own lives and in their medical practice may find it a way to avoid or recover from burnout and to increase their effectiveness and enjoyment in practice. Maimonides, one of the founders of our Western medical tradition, perhaps stated it best when he said, “[M]edical practice is not knitting, weaving, and labor of the hands, but it must be inspired with soul, filled with understanding, and equipped with the gift of keen observation and compassion.”⁶

WHAT DO PATIENTS WANT AND NEED?

Americans have a strong and vocal faith. In the 1990 and 1999 Gallup Polls, done by the National Opinion Research Center, it was found that:

- 95 percent believe in God
- 72 percent believe that religion is the most important influence in their life
- 57 percent pray at least daily
- 42 percent attend weekly worship services
- 78 percent feel the need in their life to experience spiritual growth (in 1999, compared to only 20 percent five years earlier).

These beliefs form a strong foundation for what individual patients and their families desire within the context of a medical issue. In the *Journal of Family Practice* in 1994, 77 percent of surveyed inpatients wanted their physicians to consider their religious beliefs, but 68 percent reported that their physician had never discussed religious beliefs. In yet another study published in the *Archives of Family Medicine* in 1998, it was reported that two-thirds of patients would like their physicians to pray with them. In 1999, the *Archives of Internal Medicine* published the results of a survey about whether patients wanted physicians to inquire about their spiritual or religious beliefs if they become gravely ill. Two-thirds reported that they would have strengthened trust in physicians who made such inquiries.

The higher the acuity and severity of the situation, the more patients desire physician assessment of their spiritual needs. In the 2003 article, “Patient Preference for Physician Discussion and Practice of Spirituality,” published in the *Journal of General Internal Medicine*, 33 percent of outpatient clinic patients, 40 percent of inpatient hospitalized patients, and 70 percent of hospice patients welcomed physician inquiry into their spiritual beliefs. It seems clear that, in order to respect a patient’s religious beliefs, it is appropriate, at a minimum, for physicians to non-judgmentally address the issue of spirituality or at least ensure that it is addressed by a health care team member.

⁶Cited in Steven R. Simon, “Moses Maimonides: Medieval Physician and Scholar,” *Archives of Internal Medicine* 159/16 (13 September 1999) 1841–1845.

Spirituality impacts morbidity and mortality. Pargament et al. reported in 2001 that unmet spiritual needs are a predictor of increased mortality among medical patients following hospital discharge. The definitive credentialing body for hospitals and clinics, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), has addressed the issue of patients' spiritual needs. In their Standard PC.3.100, they discuss spiritual assessments and require a minimum action of determining the patients' denomination, beliefs, and religious practices. In JCAHO's *Journal on Quality and Safety* in 2003, it was reported that, based on a survey of 1.7 million patients nationwide, patient satisfaction with the emotional and spiritual aspects of care had one of the lowest ratings among all clinical care indicators and was one of the highest areas in need of quality improvement.

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So, given all of the above, what do we know? Americans are generally a spiritual population, whether they are patients or physicians, and everyone agrees that spirituality plays an important role in health care decisions, especially around serious illness. JCAHO requires that facilities address these issues. Despite all of this, physician behavior is not congruent with these beliefs. Actively addressing spirituality in medical training and practice may help avoid the occurrence of burnout and help doctors to find more joy and purpose in their work. Therefore, as AAMC agrees, awareness of spiritual issues and how they should be assessed and valued must be part of the training for today's new physicians.

SPIRITUALITY IN MEDICAL EDUCATION ACROSS THE UNITED STATES

One of the earliest courses in spirituality offered in medical education was begun at George Washington University School of Medicine in 1992, by Christina Puchalski. This course covered topics on research and health, alternative medicine, humor, meditation, and other spiritual practices. This course became required for all medical students at that institution in 1996.⁷ Through grant support by organizations like the John Templeton Foundation and the National Center for Complementary and Alternative Medicine at the National Institutes of Health, other medical schools and residency programs also went on to develop curricula in spirituality and health care.

In 1998 a consensus conference with the AAMC and the George Washington Institute for Spirituality and Health (GWISH) was convened to develop outcome

⁷Christina M. Puchalski, "Spirituality and Medicine: Curricula in Medical Education," *Journal of Cancer Education* 21/1 (2006) 14–18.

goals and learning objectives for teaching courses in spirituality and health.⁸ The following objectives were agreed upon:

- The ability to elicit a spiritual history
- The ability to obtain a cultural history that elicits the patient's cultural identity, experiences and explanations of illness, self-selected health practices, culturally relevant interpretations of social stress factors, and availability of culturally relevant support systems
- An understanding that the spiritual dimension of people's lives gives an avenue for compassionate caregiving
- The ability to apply the understanding of a patient's spiritual and cultural beliefs and behaviors to appropriate clinical contexts (for example, prevention, case formulation, treatment planning, challenging clinical situations)
- Knowledge of the research data on the impact of spirituality on health care outcomes and of the impact of patients' cultural identity, beliefs, and practices on their health, access to, and interactions with health care providers and health outcomes
- An understanding of and respect for the role of clergy and other spiritual leaders and culturally based healers and care providers and how to communicate and/or collaborate with them on behalf of patients' physical and/or spiritual needs
- An understanding of the students' own spirituality and how it can be nurtured as part of their professional growth, promotion of their well-being, and the basis of their calling as a physician.

In the June 2004 issue of the *Student Journal of the American Medical Association*, an article on medical school curricula in spirituality and medicine provided a meta-analysis of recent literature on medical school curricula that focused upon spirituality as well as the prevalence of spiritually based courses currently offered within U.S. medical schools. Fortin and Barnett reported that 84 programs (out of around 125) included discrete courses and/or programmatic components that focused upon spirituality in medicine. This curriculum consistently addresses students' overall preparedness to conduct a patient spiritual history and to respond to spiritual considerations within the context of patient-physician interaction. Then, in many programs, the task of actually taking a spiritual history has been recently introduced into clinical training efforts. By 2006, 70 percent of all medical schools offered some such curriculum.

In 2003, a second consensus conference held by AAMC and GWISH debated the ethical aspects of spirituality in the clinical setting. It was agreed that spirituality is essential to care, not an optional add-on. Spiritual and religious beliefs impact clinical decision making, and related communities may provide important support

⁸AAMC, "Report III," 28.

systems. This group articulated the importance of spiritual discussions being respectful, patient-centered, and careful not to impose upon the health care professionals' belief system, or lack thereof.

Most crucially, especially for the readers of this article, was their emphasis upon the interdisciplinary aspect of spiritual care—all team members provide some aspect of spiritual care. This team should include professionals that are usually thought of as outside the clinical realm, such as clergy, culturally based healers, pastoral counselors, parish nurses, and spiritual directors. On the clinical team, the chaplain is the team member with the most training in this area and should be available for providing the most in-depth spiritual counseling.

METHODS AND MECHANISMS FOR DELIVERING SPIRITUALITY IN MEDICAL EDUCATION

Each medical school and every residency program for graduate-level medical education independently develop their own curriculum and the methods for its delivery, albeit following national guidelines put forth by AAMC, the American College of Graduate Medical Education (ACGME), and the relevant organization within any given specialty. In this broad scope of medical education, teaching in spirituality⁹ often aligns with the outcome goals from the AAMC Medical School Objectives Report. Teaching of spirituality:

- may be a combination of elective and required material
- may be offered in the preclinical classes, clinical clerkships, or both
- may delay more sophisticated or specialty-relevant materials into the residency years
- may involve interdisciplinary courses (with nursing, allied health, or clinical pastoral education students)
- requires strong institutional support if efforts are to be sustainable
- may make use of creative teaching methods including journaling, use of the arts, reflective exercises, meditation, film, small-group discussions, and interdisciplinary panels that include spiritual-care professionals
- may be included in ethics or humanities courses
- may be incorporated into the context of learning compassionate communication skills, especially in the care of seriously ill patients or those suffering from chronic disease
- is ideally integrated into clinical-case conferences and care-plans development
- may make use of standardized patient-case scenarios
- may be included in reflective groups that reflect on patients' spiritual issues

⁹See, for example, the program of the George Washington Institute for Spirituality and Health, at www.gwish.org (accessed 17 November 2009).

as well as students' spiritual issues in the context of their self-care and professional calling to medicine.¹⁰

One excellent example of this last bullet is *The Healer's Art* course that was developed by Dr. Rachel Remen in 1992, and is now offered at over fifty medical schools nationally, including the University of Minnesota.¹¹ This fifteen-hour course, staffed by dedicated and mostly voluntary physician faculty at all of the schools, addresses the hidden crisis in medicine, that is, the loss of meaning and commitment experienced by physicians nationwide under the stresses of today's health care system. This is a process-based curriculum that works through the formation of a community of inquiry, enabling students to explore both the personal and universal meaning in their daily experience of medicine. The major themes addressed are:

- discovering and nurturing your wholeness
- sharing grief and honoring loss
- allowing awe in medicine
- the care of the soul.

The Healer's Art course has been offered at the University of Minnesota Medical School in Duluth since 2004 and in the Twin Cities since 2005. It consistently receives excellent reviews from the students, generating comments like these from participants:

[I chose to participate in this course] for my own well-being. I needed to restore my passion to be a doctor. I would recommend this course to anyone!

I feel a renewed passion for school and will return to the skills I journaled about in this course when my motivation wanes.

Currently, GWISH is in the process of selectively choosing, from over forty applications, six medical schools who are leading the way in this field. These grant recipients will come together nationally to reach agreement on a uniform set of competencies and methods of evaluation in this field. The six selected institutions were invited to a consensus conference in the Washington, DC, area in November 2009 to formulate the competencies and devise a framework for measuring and reporting related outcomes. These selected schools will then pilot these at their home institutions and report results to a central database organized by GWISH. Finally, these six schools will help disseminate results and lead national and international initiatives, continuing to lead national efforts in spirituality and health education. In addition, GWISH has an online educational and clinical resource center with curricula as well as resources for teaching courses on spirituality and health.¹²

¹⁰Compare the objectives and educational strategies of the Association of American Medical Colleges at AAMC, "Report III," 26–28.

¹¹For a description of this course, go to the website for the Institute for the Study of Health and Wellness in the Commonweal, http://www.commonweal.org/ishi/programs/healers_art.html (accessed 22 October 2009).

¹²For more information, please check the GWISH website and click on the SOERCE link: <http://www.gwish.org> (accessed 22 October 2009).

SPIRITUALITY IN MEDICAL EDUCATION AT THE UNIVERSITY OF MINNESOTA

This is an important topic and it is nice to have the opportunity to discuss this. It is a topic that gets over-looked in our training, and more attention should be paid to it. I think that sessions such as this are beneficial. It's difficult as a medical student to come to terms with uncertainty and with beliefs that are different from our own. This gives us an opportunity to reflect on our discomfort and to hear how our classmates are attempting to resolve these issues.¹³

The spirituality curriculum at the University of Minnesota, as is true for much of medical education, is in continual evolution. All medical students receive a required lecture on spirituality in medicine in the first several weeks of year one. The perspectives of *meaning* and *story* in illness are then further incorporated into much of the other preclinical curriculum, especially in small discussion groups led by physician master tutors. Online modules—Spirituality in Healthcare; and Culture, Faith Traditions, and Health—were developed by the Center for Spirituality and Healing under a grant from the National Center for Complementary and Alternative Medicine and are available for the medical students' use throughout their training. These modules are helpful for any health care professionals or those in training, and are available free on the internet.¹⁴

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As of fall 2009, all incoming medical students will be required to do a self-directed, online module: Physician Well-Being. This is designed to help the students recognize, critically assess, and model how to thrive in the medical profession with relation to the demands on health, well-being, and relationships with others. All levels of learning objectives include spirituality as one of the considered aspects of health and well-being.

There are plans in development to pilot a new spirituality project during the medical students' clinical training. This project would offer students the opportunity to develop an interdisciplinary approach to the spiritual care of an actual patient encountered during their in-house clinical training and to receive critical feedback from the Fairview chaplaincy education faculty. Funding to allow this pilot to move forward is pending. Efforts such as these will build interdisciplinary bridges and create opportunities for improving educational outcomes for physicians and chaplains alike.

¹³Evaluation comment from a first-year University of Minnesota medical student after an initial lecture on spirituality in medicine.

¹⁴To see a list of current courses, go to the University of Minnesota, Center for Spirituality and Healing website, www.csh.umn.edu/modules/index.html (accessed 22 October 2009).

Christina Puchalski has perhaps best summarized the medical education efforts in spirituality:

Ultimately, the goal of these courses is improved patient care and a restoration of compassion, service, and commitment to holistic care of patients and their families. Spirituality is an essential aspect of health care rooted in the biopsychosocial spiritual model of care and in the deeply held tradition of medicine as a profession of service and altruistic love and compassion for others.¹⁵ ⊕

KAREN LAWSON, MD, is assistant professor of family medicine and community health and director of health coaching at the Center for Spirituality and Healing, University of Minnesota.

¹⁵Puchalski, "Spirituality and Medicine."