Spirituality and Health: The Development of a Field

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Abstract

Spirituality has played a role in health care for centuries, but by the early 20th century, technological advances in diagnosis and treatment overshadowed the more human element of medicine. In response, a core group of medical academics and practitioners launched a movement to reclaim medicine's spiritual roots, conceiving of spirituality as more than religion and ethics and defining it as each person's search for meaning and purpose. This commentary describes the history of the field of spirituality and health—its origins, its furtherance through the Medical School Objectives Project, and its ultimate incorporation into the curricula of over 75% of U.S. medical schools. The diverse efforts in developing this field within medical education and in national and international organizations created a need for a cohesive framework. The National Competencies in Spirituality and Health—created at a consensus conference of faculty from seven medical schools and reported here for the first time—answered that need.

Also reported are some of the first applications of these competencies— competency-linked curricular projects.

This issue of *Academic Medicine* features articles from three of the participating medical schools as well as one from an additional medical school. This commentary also describes another competency application: the George Washington Institute of Spirituality and Health–Templeton Reflection Rounds initiative, which has provided clerkship students with the opportunity, through reflection on their patient encounters, to develop their own inner resources to address the suffering of others. This commentary concludes with the authors' proposals for future directions for the field.

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Spirituality is an essential element of humanity. It encompasses individuals' search for meaning and purpose; it includes connections to others, self, nature, and the significant or sacred; and it embraces secular and philosophical, as well as religious and cultural, beliefs.[1] Spirituality has been foundational in health care for centuries but became overshadowed by early 20th-century technological advances in diagnosis and treatment. Though these advances were dramatic and resulted in countless lives saved, the scientific focus moved the culture of medicine away from a holistic, service-oriented model to a technological, reductionist model. In response, a core group of medical academics and practitioners launched a movement to reclaim medicine's spiritual roots, helping to define spirituality as more than religion and

ethics and to build acceptance for its essential relevance to patient care. Over the last 25 years, spirituality and health has emerged as a significant field in medical education as evidenced by the 2012 Oxford publication of the first textbook on spirituality and health.[2] Drawing from this textbook and other seminal work, we review the history of the field—from its origins, through its advance via the Medical School Objectives Project (MSOP), to the recent creation of competencies in spirituality and health, published here for the first time. We also describe the efforts of others to use these new competencies to advance the evidence base for the field. We end the commentary by proposing future directions, emphasizing spirituality and health's expanding role in global education and interdisciplinary models of care as well as its potential for transforming medical education.

From Courses to Clinical Guidelines to Competencies

The alignment between spirituality and health is centuries old, as evidenced both by the healing roles of shamans and priests and by the history of hospitals, whose genesis was through religious organizations that emphasized health,

healing, and the whole person. In 1910, the Flexner Report,[3] which set the stage for much of 20th-century medical education, gave medical education a much-needed grounding in science. A regrettable consequence of this scientific grounding was that it altered the alignment between spirituality and health, resulting in the downplaying of the humanistic and spiritual elements of patient care. By the late 20th century, a resurgence of research in spirituality and health supported spirituality's potential effect on health.[4] This research, along with the public's outcry against the lack of holistic approaches to care, inspired one of us (C.P.) to launch in 1992 a spirituality and health elective at the George Washington University (GW), the first university to offer such a course.[5] This course defined spirituality in broad terms of personal meaning and covered a spectrum of clinical applications. In 1996, on the basis of the positive reactions of students and faculty, the GW School of Medicine set a precedent by vertically integrating spirituality and health into the required curriculum.

In the same year, the Association of American Medical Colleges (AAMC) launched the MSOP initiative in an

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effort to build consensus on the learning objectives in medical education.[6,7]

One of us (C.P.), working at the time with National Institutes for Healthcare Research, partnered with the AAMC's then-education director to convene experts in medical education to produce the MSOP III.[7] This report provided a definition of spirituality and proposed how it might be integrated into patient care and medical education. The report defined spirituality as an individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. The definition was generated from evidence that all of these factors can influence how patients and health care professionals perceive health, illness, and their interactions.[7] The report identified seven learning objectives and three outcome goals for courses in spirituality and health, reflecting the group's recommendation that spirituality be recognized as significant across the life span of patients, as part of students' professional development, and as part of whole-person care.[7]

In response to the MSOP III report and a number of other factors—the growing evidence of spirituality's role in patient care outcomes, attention from the lay press, patients' desire for the inclusion of spirituality in their care (as reported in patient surveys), and theoretical and ethical frameworks that support spirituality as central to person-centered care[8–10]—increasing numbers of medical schools began to address the role of spirituality in medicine in their curricula. Critical to this expansion of interest were the Spirituality and Health Curricular Awards, funded by the John Templeton Foundation (see Supplemental Digital Lists 1 and 2 at http://links.lww.com/ACADMED/A168). Originally, they were awarded to the National Institute for Healthcare Research. Later, they provided the foundation for the creation of the GW Institute for Spirituality and Health (GWish), which is led by one of us (C.P.). When the program launched in 1995, three medical schools offered courses in spirituality and health.[5,11] Although only the schools with the most comprehensive proposals for integrating spirituality into their curricula received the awards, the application process led many others to integrate spirituality

into their curricula. By 2011, more than 75% of medical schools had integrated spirituality-related topics into their training programs. These courses, along with a developing body of evidence, triggered similar initiatives internationally.

Linking to Broader Initiatives

The increasing number of spirituality and health courses, along with research in the field, influenced international and national medical professional organizations to recognize the role of spirituality in patient-centered care. The American Medical Association developed a Code of Medical Ethics stating that physicians should provide competent care based on respect and compassion—values many would consider core to spirituality. The American College of Physicians noted that physicians should extend their care for those with serious medical illness by attending not only to their physical pain but also to their psychosocial, existential, or spiritual suffering.[12] In 2004, the field of palliative care cited spiritual, religious, and existential issues as a required domain of care.[13] The Joint Commission on Accreditation of Healthcare Organizations recognized the importance of spirituality to patients[14] and eventually required that patients' spiritual issues be addressed.[15] These standards and guidelines for attending to patient suffering and for recognizing spirituality as part of holistic health, healing, and wellness provided the impetus to train physicians who could implement them.

Additional efforts further supported the national and international momentum. In 2009, members of a National Consensus Conference (NCC)[1]—convened by City of Hope (which is a national comprehensive cancer center) and GWish—developed models of interprofessional spiritual care, assessment, and treatment. NCC attendees cited the need for a taxonomy for spiritual distress and recognized spirituality as essential to the provision of dignity- and person-centered care. The NCC noted that spirituality is a means to activate the transformational clinician–patient relationship through which healing can occur and that, within this professional relationship, patients and clinicians

can find meaning and connection. Also in 2009, GWish began a Summer Institute in Spirituality and Health for interprofessional health care providers and educators. The curriculum-changing efforts of GWish and of broader, interprofessional initiatives— both nationally and internationally— influenced one another and resulted in widespread recognition that spirituality is essential to health care education. Together, GWish and other initiatives reinforced the ideal of clinicians educated to provide relationship-centered care and to be open to the transformational potential of the clinician–patient encounter.

The National Competencies in Spirituality for Medical Education

As the field of spirituality and health continued to grow, its leaders recognized the need for a framework to establish common grounds for communication, curriculum analysis, and scholarship in order to bring cohesiveness to the field. The development of the National Competencies in Spirituality and Health, previously presented at national meetings but reported in the literature for the first time in this commentary, addressed that need. In 2011, GWish proposed the creation of a common framework in the form of competency domains with which to understand and assess spirituality in the medical school curriculum.

GWish's National Initiative to Develop Competencies in Spirituality for Medical Education (NIDCSME), funded by the FISH (Funding Individual Spiritual Health) Foundation, convened representatives from seven medical schools in the United States that already had well-developed curricula in spirituality and health (see Supplemental Digital List 3 at http://links.lww.com/ACADMED/A168). Participants reached consensus on the domains of a competency framework and populated each domain with measurable behavioral objectives that learners would be expected to demonstrate in performance assessments. To be easily useable by educators, the group modeled their framework (presented as Appendix 1) after the familiar Accreditation Council for Graduate Medical Education competencies. The group decided on an

additional competency—Compassionate Presence, a domain unique to spirituality and health—deeming it critical to effective patient care. Participating schools also developed yearlong research or curricular projects and assessed their effectiveness in improving student performance in one or more competency domains. This issue of *Academic Medicine* highlights three of these projects from these schools, all of which both won a GWish-Templeton Award in Spirituality and Health Curriculum Development and participated in GWish's National Competency Initiative.

McEvoy and her colleagues[16] at Albert Einstein College of Medicine explored the patient care and communication competencies. They assessed students' ability to address patients' spiritual distress with a specially designed standardized patient case in a clinical skills examination. They found that although 64% of the students recognized spiritual distress, resulting in chaplain referrals, only 2% actually addressed the issues with the patient. This study highlights the need to better train students to communicate about patients' spiritual distress—especially in a time-constrained setting in which their biomedical issues also need to be addressed.

Kucsewski and colleagues[17] at the Loyola University Stritch School of Medicine centered their work around the communication, compassionate presence, patient care, and personal and professional development competencies in a qualitative study of students' reflective essays on their experiences caring for dying patients. In their analysis of these essays, the investigators found that students focused on their own desensitization, struggling to find a balance between professional distance and emotional presence. They also struggled with being true to their aspirations of addressing patient and family issues and overcoming the systematic fragmentation of patient care, which sometimes resulted in no one taking responsibility for patients' human needs. Their work uncovers avenues for supporting students in their professional formation as well as for system reform.

Talley and Magie,[18] from Kansas City University School of Osteopathic

Medicine, describe the development of their evolving required curriculum in spirituality and health, which is designed to address all of the competencies and is moving toward more vertical integration. It showcases their efforts in developing educational means to teach and evaluate spirituality and health, which should prove useful to others who have parallel aspirations for their schools. Especially noteworthy is how they use chaplains in medical education and their strategies for sustainability, bolstered by the newly crafted competency domains in spirituality of the National Board of Osteopathic Medicine Examiners.

The final paper in this series by Ledford and colleagues[19] is not one of the competency initiative schools. Their highly innovative educational project incorporates an objective structured clinical exam featuring a patient who raises spiritual issues as a sensitizer for a series of three reflection exercises: a written personal reflection, a guided personal reflection with a mentor, and a group discussion. Their purpose is to prompt learners to engage in mindful practice with patients who identify religion or spiritual issues as part of their biopsychosocial contexts. Equally innovative is their evaluation strategy. Using Prochaska's transtheoretical stages of change model, these authors assess progress by comparing their learners' willingness to address spiritual issues after written personal reflection versus after the mentor-guided reflection which followed. Analyzing the written reflections and mentor reflection transcripts to determine stage of change, they found significant progress ($P = .001$); all learners reached at least the preparation stage by the end of guided reflection. Finally, in the group reflection, learners worked with experienced faculty to devise strategies for action in managing spirituality-related conversations with patients. The authors present a reflective pathway that could be useful to others who strive to motivate learners to address spirituality and other emotionally difficult topics with patients.

The National Competencies in Spirituality and Health have also informed a new curriculum initiative funded by the Templeton Foundation: the GWish-Templeton Reflection

Rounds (G-TRR). As evidenced by several of the reports in this issue, reflection is a powerful way to teach competencies in spirituality and health. Over the past year, reflection rounds, which create a space for students to reflect on their encounters with patients in mentored small groups, were piloted in eight medical schools (see Supplemental Digital List 3 at http://links.lww.com/ACADMED/A168). The clerkship directors at these schools integrated the reflection rounds into the student clerkships' traditional rounding schedule. Through the process of reflection on patient encounters, G-TRR aimed to give students the opportunity to become aware of spirituality in their own lives, to develop ways of expressing spirituality, and to mobilize their inner resources for addressing the suffering of others. A second reflection rounds program has just been funded. And a request for proposals was announced in January of this year.

Both the NIDCSME and G-TRR have collected student and program evaluation data. Short-term process outcomes include assessments of trainees' knowledge, skills, and attitudes related to the National Competencies in Spirituality and Health as well as assessments of burnout, depression, and spiritual well-being. Assessment of long-term outcomes of spirituality-focused medical education curricula will be more challenging, but the NIDCSME should prove useful to researchers and educators as a framework around which to organize these endeavors. The National Competencies in Spirituality and Health framework has other important potential applications integral to the future development of the field, including informing curriculum development and guiding licensure exams and program accreditation.

Future Directions

Pioneering U.S. efforts on spirituality and health have galvanized both international and interprofessional interests in the field. In the years ahead, we anticipate greater global dialogue focused on developing spirituality and health curricula. We also anticipate action to implement spirituality and health innovations in interprofessional education. For example, the reflection rounds initiative,

piloted at GW, lends itself easily to fostering collaborative professional development among medical, nursing, social work, and chaplaincy students, as well as educational research across professions. It also lends itself to collaboration among educators from many professions, including board-certified chaplains.

Another future direction for spirituality and health is its full integration from year one of medical school into residency and continuing professional development, thus making it an integral part of the entire spectrum of professional formation.[20] Daniel Sulmasy[21] has described the ideal result of formation as the spiritual–scientific clinician: the physician who can navigate the scientific, as well as the spiritual or humanistic, part of medicine. We believe that the professional formation process must occur along two pathways to result in complete maturation of students into spiritual–scientific clinicians. The first leads to competence in basic and clinical science; the second, to the heightened awareness of self and others, resulting in competence in compassion. When scientific and personal growth occur symbiotically, they result in a physician who can address spiritual and emotional, as well as physical suffering, and who can recognize the full dimension of health and healing. Through its part in allowing students to identify spiritual distress and spiritual well-being in patients and in themselves, in broadening the concept of healing and recognizing that authenticity is rooted in one's inner life or spirituality, "spirituality and health" becomes an essential element in the professional formation process. Future challenges include seamlessly integrating the two pathways into professional maturation. The work, based on the National Competencies in Spirituality and Health, presented in the articles that follow as well as G-TRR, are steps in that direction. Steps in that direction are the work in the articles that follow as well as G-TRR--both are based on the National Competencies in Spirituality and Health. Nevertheless, many opportunities for innovation and research remain.

Conclusion

In this commentary we have described a movement, culminating in a field called spirituality and health, which aims to restore the balance between the scientific and humanistic sides of health care. Grounded in core principles of service, compassion, dignity, and the interconnectedness of all people, the field is a commitment to making patients' search for meaning and relationship an essential focus of medical education, patient care, and the health care system. We have described its history, which has culminated with an initiative to give the field coherence through the establishment of the National Competencies in Spirituality and Health. These competencies provide a framework with which to understand the medical education innovation and research in the articles that follow. The work described in these articles contributes to the effort of complementing scientific advances with educational and humanistic advances that will renew and reinvigorate medicine's tradition of compassion and holistic care for the 21st century.

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Appendix 1
National Competencies in Spirituality and Health for Medical Education, 2011*

Competency: Application to spirituality and health	Behaviors (competency no.)	Pedagogical methods (see below)	Performance assessments (see below)
Health care systems: Apply knowledge of health care systems to advocate spirituality in patient care	• Describe the importance of incorporating spiritual care into a health care system (HCS1) • Describe and evaluate spiritual resources in a health care system and in a community (HCS2) • Compare and contrast spiritual resources in different health care systems (HCS3) • Discuss the ways in which health care systems may complicate spiritual care (HCS4) • Describe methods of reimbursement for spiritual care, including funding for other disciplines such as nursing, chaplains, and counseling (HCS5) • Discuss how the legal, political, and economic factors of health care influence spiritual care (HCS6) • Explain how effective spiritual care impacts the overall quality of and improvements to patient care (HCS7) • Describe how spiritual care is provided by interdisciplinary team members and community resources (HCS8) • Apply advocacy skills to spiritual care within health care systems, including the local, regional, and national systems (HCS9)	8, 10, 15, 18, 19, 22, 24, 31, 32, 33, 34, 35, 36, 41, 44, 49	1, 2, 3, 4, 8, 13, 14, 15, 16, 20
Knowledge: Acquire the foundational knowledge necessary to integrate spirituality in patient care	• Compare and contrast spirituality (broadly defined) and religion (K1) • Discuss the relationships between spirituality, religious beliefs, and cultural traditions (K2) • Describe how spirituality interrelates with complementary and alternative medicine (K3) • Discuss major religious traditions as they relate to patient care (K4) • Differentiate between a spiritual history, spiritual screening, and spiritual assessment (K5) • Describe common religious/spiritual problems that arise in clinical care (K6) • Compare and contrast sources of spiritual strength and spiritual distress (K7) • Differentiate between spirituality and psychological factors such as grief, hope, and meaning (K8) • Describe boundary issues in providing spiritual care (K9) • Outline key findings of spirituality–health research (K10) • Locate and evaluate spiritual/religious information resources both online and in print (K11) • Describe how a patient's spirituality may affect his or her context-specific clinical care (K12)	8, 18, 20, 22, 24, 34, 36, 41, 43, 44, 46, 48, 49	2, 4, 7, 8, 9, 11, 12, 13, 15, 20, 23

(Appendix continues)

Appendix 1 (Continued)

Competency: Application to spirituality and health	Behaviors (competency no.)	Pedagogical methods (see below)	Performance assessments (see below)
Patient care: Integrate spirituality into routine clinical practice	• Appropriately use and incorporate patients' spiritual network and supports (PC1) • Perform a detailed spiritual history at appropriate times—for example, completing a medical history when giving bad news (PC2) • Perform spiritual screening at appropriate times (PC3) • Perform ongoing assessments of patients' spiritual distress (PC4) • Integrate patients' spiritual issues and resources into ongoing treatment and discharge plans (PC5) • Collaborate with staff, family, pastoral care, and other members of health care team to address each patient's spiritual care (PC6) • Invite patients to identify and explore their own spirituality or inner life (PC7) • Respond appropriately to verbal and nonverbal signs of spiritual distress (PC8) • Make timely referral to a chaplain or spiritual counselor (PC9) • Respect patients' spiritual/religious belief systems (PC10)	1, 2, 4, 5, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 20, 22, 23, 24, 25, 26, 27, 28, 29, 32, 34, 45, 36, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49	2, 4, 5, 7, 8, 10, 12, 13, 18, 20, 23
Compassionate presence: Establish compassionate presence and action with patients, families, colleagues	• Discuss why serving the patient is a privilege (CP1) • Describe personal and external factors that limit your ability to be fully "present" with a given patient (CP2) • Discuss why the illness experience of the patient is an essential element of the physician–patient relationship (CP3) • Discuss how you as a provider may be changed by your relationship with the patient (CP4) • Demonstrate the ability to be engaged and fully "present" with a patient (CP5) • Describe strategies to be more present with patients (CP6)	1, 5, 8, 11, 12, 16, 18, 20, 21, 22, 26, 27, 31, 32, 34, 35, 36, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47	1, 2, 3, 4, 7, 13, 14, 16, 19, 20
Personal and professional development: Incorporate spirituality in professional and personal development	• Explain the reasons and motives that drew you to the medical profession (PPD1) • Explore the role that spirituality plays in your professional life (PPD2) • Reflect on signs of a personal spiritual crisis and methods of intervening (PPD3) • Identify your sources of spiritual strengths (PPD4) • Describe how spirituality functions as a way of connecting with the health care team, family, and patients (PPD5) • Identify your personal and professional support communities (PPD6)	1, 2, 3, 4, 5, 6, 8, 13, 17, 18, 20, 21, 24, 30, 37, 38, 39, 40, 41, 43, 44, 36, 47	2, 4, 7, 8, 10, 14, 15, 20, 21
Communications: Communicate with patients, families, and health care team about spiritual issues	• Practice deep listening—hearing what is being communicated through and between the words, the body language, and the emotions (C1) • Practice curious inquiry—a nonjudgmental practice of exploration without goals or expectations (C2) • Practice perceptive reflections—mirroring for the client what you hear or perceive, but always checking the "truth" of your reflection with the client (C3) • Communicate professionally with spiritual care providers and other team members about the patient's spiritual distress or resources of strength (C4) • Use appropriate nonverbal behaviors to signal interest in the patient (C5) • Demonstrate the use of silence in patient communication (C6)	1, 4, 7, 8, 14, 15, 18, 20, 23, 25, 26, 27, 35, 36, 42, 43, 45, 47, 48, 49	2, 3, 4, 5, 7, 8, 10, 12, 13, 14, 18, 20

(Appendix continues)

Appendix 1 (Continued)

Teaching (pedagogical) methods

1. Arts (music, visual/theatre)
2. Bioethics course
3. Careers in medicine (understanding yourself) program
4. Case studies
5. Case-based learning
6. Centering ritual
7. Communication Skills Course/Doctoring/Intro to Clinical Skills
8. Electives/selectives with spirituality curriculum/content
9. Exercises in listening and being present
10. Experiential/local politicians
11. Experiential/mentors and pastoral care
12. Experiential (e.g., practicing being in a wheelchair)
13. Feedback/patient
14. Feedback/trained faculty observers giving feedback with SPs
15. Feedback/trained faculty observers giving feedback without SPs
16. Guided observation
17. Interdisciplinary team training with chaplain participation
18. Lecture/interactive and didactic
19. Living will/do your own
20. Mentoring with clinician and/or chaplain
21. Mindfulness training
22. Observe preceptors/mentors
23. OSCEs (objective structured clinical examinations) / developmental/with checklists and guidelines
24. Panel discussions
25. Parallel charting/case studies with spiritual issues
26. Motivational interviewing
27. Patient interviewing/practice
28. Patient logbooks/student documentation
29. Patient speakers/teachers
30. Portfolio
31. Student presentations
32. Problem-based learning sessions/theme oriented (e.g., advance directives)
33. Quality improvement projects
34. Reading/directed
35. Role modeling
36. Role-playing
37. Personal well-being log
38. Self-awareness/self-care/spiritual experiences
39. Self-reflective writing
40. Narrative writing
41. Service learning
42. Shadow chaplain/other "expert" at addressing spiritual needs
43. Simulations
44. Small-group discussion/debates
45. Small groups/dyads with facilitators
46. Standardized patients
47. Video interviews with review
48. Videos/films
49. Web searches/Webcasts

Performance assessments

1. Assessment of narratives/journal entries
2. Assessment of student present/writeups
3. Assessment/pastoral care
4. Case-based learning/problem-based learning
5. Chart review
6. Checklist evaluation live/recorded performance
7. Feedback or evaluation/faculty/mentor/precept/expert
8. Exam/multiple-choice questions/written
9. Exam/short answer
10. Feedback or evaluation/360-degree
11. Exam/essay
12. Feedback or evaluation/Mini-CEX (clinical evaluation exam)
13. Feedback or evaluation/patients
14. Feedback or evaluation/peer
15. Feedback or evaluation/self
16. Feedback or evaluation/tutor
17. Global ratings of live/recorded performance
18. Objective structured clinical exams
19. Observation of performance/various settings
20. Portfolios
21. Pre/post testing (written/video)
22. Simulation/virtual patient
23. Standardized oral exams

*The final competency framework, including behaviors and teaching and evaluation methods, identified six domains: (1) Health care systems, (2) Knowledge, (3) Patient care, (4) Compassionate presence, (5) Personal and professional development, and (6) Communications. These competency domains align with those of the Accreditation Council for Graduate Medical Education, with one exception; Compassionate presence is a unique domain.