Chapter 6
Religion and Spirituality Among Medical Students

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Introduction

The terms religion and spirituality can be hard to pin down. For some, the two terms may be practically synonymous; for others, they may feel mutually exclusive. How we think about religion and spirituality is defined within community, and yet also very personal. In the twentieth century, the tendency in the west had been to see religion and spirituality as occupying a separate set of concerns, as asking different questions, than medicine, and the ancient ties between the two disciplines are often forgotten [22]. In recent decades, however, there has been a growing scientific interest in the influence of religious and spiritual factors on healthcare outcomes, and evidence suggests that effective spiritual religious care results in better patient outcomes, including higher reported quality of life, higher satisfaction with care, and lower costs at the end of life [23]. From movements in patient-centered care, to initiatives in integrative

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D. Zappetti, J. D. Avery (eds.), *Medical Student Well-Being*,
https://doi.org/10.1007/978-3-030-16558-1_6

and holistic health, spirituality in healthcare has become a common topic of discussion and study. Because each clinician will inevitably interact with the spiritual lives of her patients, often at some of the most vulnerable moments in their lives, it is important for clinicians to be comfortable and competent discussing and assessing patients' spiritual needs and resources. It is also important that the clinician be aware of her own convictions and sources of connection and strength, whether or not she considers herself religious or spiritual. In the midst of the stressors of medical education, one's own sense of "what is spiritual," or "what really matters," can be an asset in her work with patients and potentially a bulwark against some of the negative effects associated with medical education, including burnout, moral distress, and compassion fatigue. In this chapter, we will discuss how religion and spirituality are defined in the healthcare context, the positive and problematic ways religion and spirituality intersect with patient care, ways in which medical school administrators can foster positive spiritual/religious coping, and, finally, how medical students can bring their own sense of spirituality and/or religion into their work in appropriate and sensitive ways, as they grow into ever more resilient, compassionate, and culturally competent learners and clinicians.

Defining Religion and Spirituality in Healthcare

There are no consensus definitions for religion or spirituality in medical literature, and it is worth noting at the outset that religion and spirituality are topics that bring with them many associations, past experiences, and strong feelings, for both patients and providers. While we might personally define each term in our own way, the field appears to be moving toward consensus in how the terms are used, and these common themes can serve as a starting point for our discussion.

Religion is often defined as set of beliefs, practices, and/or rituals that is related in some respect to a connection between humanity and the transcendent [8]. Religions vary widely, but they often involve a sense of the mystical or supernatural, and often carry a set of beliefs about what happens after death. They frequently carry codes of conduct for adherents as well as traditions, rituals, practices, beliefs, and behaviors that unify or demarcate a community [10].

The word spirituality is taken from the Latin root *spiritus*, meaning breath of life. The term historically has been associated with religion [8]; contemporary usage, however, may exist within or without—perhaps even in opposition to—a religious framework. Spirituality, as used in the healthcare context, refers most commonly to "that which gives people meaning and purpose in life" [18], and is often spoken of in terms of connection to oneself, others, the natural world, or the transcendent [15].

Medical literature in recent decades has tended to define religion as a subset of spirituality, though some cultures and individuals may make no distinction between the two terms. One's spirituality may or may not be religious, and may or may not be related to a sense of the divine. By this definition, one could have a wholly material spirituality. One might echo Antoine de Saint-Exupery's *The Little Prince* and say what is most important to her cannot be seen with the eyes, which is a spiritual perspective. Another person might very well say that her spirituality lies precisely in what is visible. The natural world, empiricism, and philosophical materialism, these are each capable of inspiring awe, giving purpose, and connecting one to others. Both religion and spirituality are multidimensional and intersectional (Fig. 6.1), and deal "with the ultimate concerns of people and [provide] personal as well as social identity within the context of a cosmic or metaphysical background" [8]. One's spirituality may include many foci that intersect and change over time. When the authors of this chapter in their work as hospital chaplains ask a patient where she finds her sense of the "spiritual," we might hear something

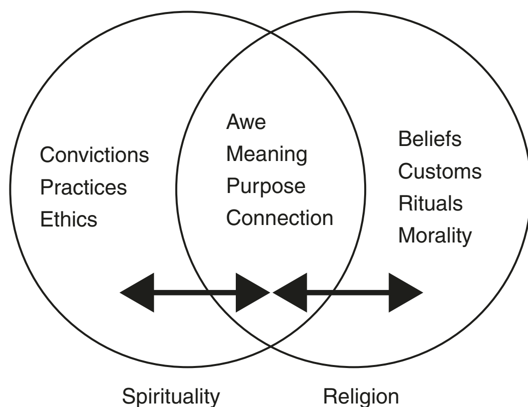

FIGURE 6.1 The intersection of spirituality and religion

like, "My family, my faith community, Wednesday night yoga at the community center, screen printing, activism, and my cat." Ten years later, maybe 10 minutes later, the same person might answer differently.

Spiritual Care Generalists: Culturally Competent Providers

Prayer is the most common alternative therapy in the United States, and patients frequently report wanting their doctors to address their spirituality/religion and its impact on the their medical care [3, 4]. Spiritual/religious care provided by the healthcare team has been shown to improve patient satisfaction ratings [24], create stronger patient-provider relationships [18], lower costs—particularly at the end of life [18]—and increase patient and family satisfaction with end-of-life decisions [25, 26]. Because spirituality as we have defined it is inextricable from one's culture and beliefs about life, illness, and death, spirituality and/or religion are inextricably linked to how a patient thinks, and makes decisions, about illness and health, treatment and

wellness, and death and recovery, in ways that can both help and hinder coping and healing.

Despite patient preference, and despite the positive outcomes associated with spiritual/religious care provided by the healthcare team, physicians rarely report discussing these topics with patients [4], and in one study less than half of the US primary care residents felt that they should engage in spiritual care of their patients [12]. Clinicians list lack of training in spiritual and religious care as the primary barrier to discussing religion and spirituality with patients [18]. This trend may be changing. As of 2009, 85% of medical and osteopathic schools reported offering courses on spiritual care [15].

Much of the medical literature on religion and spirituality has focused on the patient's spirituality, and most commonly instances in which the patient's religious or spiritual perspective was perceived to conflict with medical ethics or the team's plan of care [7, 11, 27]. However, religion and spirituality can also be assets, not just for patients, but also for the clinicians who treat them. In recent years, a growing body of research examines how religion and spirituality influence the care clinicians provide, as well as how they cope with the stressors of their work.

In a 2018 survey of medical students, Callie Ray and Tasha Wyatt et al. point to four overarching themes among respondents: "Religion/spirituality are used as a (a) coping mechanism for the stress of medical school, (b) sense-making tool for processing difficult moments, (c) framework for making clinical/ethical decisions and for processing death, and (d) way to think about practicing patient-centered care" [17]. As chaplains at an academic medical center, we frequently hear similar themes in our conversations with medical students and residents. In an informal survey by the authors of this chapter of medical residents, many respondents endorsed that their own faith and spirituality influence and inform how they relate to patients and family, especially during end-of-life conversations. Many respondents talked about how understanding the spiritual needs of the patients could help provide what one resident called "whole-person care."

A critical tenant of the concept of whole-person care is that *healing* is distinct from *cure*. According to the World Health Organization's definition of "whole health," *cure* is focused on a disease process, whereas *healing* refers to the whole person and to how that person finds peace, a sense of coherence, solace, and/or meaning especially when dealing with loss and illness [15]. Anecdotal evidence suggests that healing is facilitated in the presence of a compassionate clinician, and in the context of that relationship [28].

In 2009, the US National Palliative Care Consensus conference met to discuss guidelines for responsible and compassionate spiritual care in the healthcare setting. The resultant document notes the "critical role" spirituality plays in the patient-provider relationship, in which "professionals and patients enter into a professional relationship whereby each party is potentially changed. Healing, as opposed to cure, is aided by the character of the provider-patient relationship" [16]. To be open to this potential change requires an awareness of the spiritual dimensions of the provider's own life and a reflective process (Ibid). Christina Puchalski et al. continue: "Many physicians and nurses speak of their own spiritual practices and how those practices help them deliver good spiritual care, which, in turn, helps in their ability to deliver good physical and psychosocial care to the seriously ill and dying patients" (Ibid). The conference guidelines name the need for reflective work, stating, "By being attentive to one's own spirituality and especially to one's sense of call to service to others, the health care professional may be able to find more meaning in his or her work and hence cope better with the stresses" (Ibid). This conception of whole-person care is a process of action and reflection in which compassionate care for the patient is linked to the clinician's own sense of meaning and care for herself.

A provider's own religion and/or spirituality can also affect the care they provide in potentially adverse ways. Research has shown that physicians' and medical students' religious beliefs influence their attitudes and decision-

making around topics including death, discontinuation of life support, and abortion [1, 6, 14]. Physicians' personal religiosity has been shown to affect how they inform patients about available medical options, and how much weight they give to patients' expressed wishes in their plan of care [7, 11]. Cultural or ethical differences between providers and patients can result in considerable distress for patients, families, and providers [9]. Finally, due to as the power imbalances between the patient and clinician, there are serious ethical considerations any time a healthcare provider interacts with a patient's religion/spirituality, making it extremely important that the physician maintains personal and professional boundaries and avoids any forms of proselytizing [15].

One increasingly common way of conceiving of the physician's role in the spiritual/religious care of her patients is in terms of spiritual care specialists and generalists. In this model, a "spiritual care generalist" is any member of the healthcare team who has learned to screen for and attend to "spiritual strengths and spiritual distress and incorporate basic spiritual resources into the patient care plan" [18]. The generalist also assesses when to refer to "spiritual care specialists," such as hospital chaplains and community spiritual and religious authorities.

One of the most common and well-researched tools for spiritual assessment is known as FICA, developed by Christina Puchalski, which records a patient's *F*aith/Beliefs, *I*mportance of beliefs, her *C*ommunity, and how the patient wishes these topics to be *A*ddressed in their care [29].

This assessment may be carried out in full by a spiritual care generalist, such as a physician. In other cases, a physician may begin the assessment and then refer to a specialist. The assessment need not move linearly through these questions. It might begin with a question like, "Who are your core people?" or "What is giving you strength right now?" Regardless, the tool can serve as a guide to approaching a patient's story, including spiritual strengths and resources, as well as factors inhibiting coping.

Spirituality and Religion Among Medical Students

Medical education is famously demanding, and a growing body of research has focused on its impact on student well-being, resilience, compassion, and empathy. A 2016 review of the literature by Lauren Wasson et al. found that although matriculating US medical students begin training with significantly lower rates of depression and burnout and report better mental and emotional quality of life than other college-educated young adults, "their reported well-being decreases during the UME years" [21]. Medical students report higher rates of depression and the symptoms of burnout than other graduate students (Ibid). This decline in well-being, according to the study's authors, requires "urgent attention" (Ibid).

Medical education can often lead to students feeling isolated from the communities from which they come. "Well before entering medical school, students learn that their training will involve constant pressure and continuing fatigue. Popular stories prepare them for social isolation, the impossibility of learning everything, long hours, test anxiety, and the fact that medical school will permeate their lives" [20]. These factors "legitimate the special status of the profession the students are entering. They also blunt the students' emotional responses" [20]. In a literature review, Linda Barnes et al. conclude that "distress seems to be a main cause of empathy decline [3]." A variety of factors can lead to distress and comprise what has been referred to as a "hidden curriculum" [2]. These factors include student vulnerability, problems related to lack of social support, high workload, exhaustion, isolation, and difficult clinical realities that may not match the students' idealistic views of medicine before matriculation [2, 13].

If spirituality/religion is about connection, then it can be one tool to combat isolation—from one's family, from one's community, and from one's sense of self before embarking upon medical education—a way to return to one's roots

(Box 6.1). For students who belong to a faith tradition, student organizations such as Christian Fellowships, Muslim Students Organizations, Jewish Student Organizations, Catholic Medical Student Associations, Seventh-Day Adventist Student Organizations, and Orthodox Christian Clubs offer community—a place to celebrate holidays, share meals, and discuss medical ethics through the lens of religion. These clubs provide a wide variety of activities ranging from Bible Study, to Shabbat dinners, to weekly services and medical missions to underserved communities. Students at some schools have founded spirituality groups, open to students from any tradition or perspective, as a place to discuss their experiences and practice mindfulness, yoga, and other activities oriented toward wellness, contemplation, and resilience.

Box 6.1 Maintaining and Cultivating Connections During Medical Training

Hospitalization and illness can cut one off from the habits, activities, and people she is used to. Worse, they can separate one from how she sees herself, and how she sees herself as seen by the people in her life. The people who train and work in healthcare are also at an increased risk of feeling disconnected from their sense of self. Hospital chaplains sometimes think of their role as helping patients connect to who they are "outside" of the hospital or their illness—the activities, people, habits of mind and spirit, and practices that have brought them strength, peace, and connection throughout their lives. This might be a good way to think about your own wellness in the course of medical education. What are the things that connect you to the "You" outside of the hospital, and how can you be intentional about maintaining them throughout the hard work of medical school?

Instructors are integrating practices such as narrative medicine (see Charon et al. [5]) and "existential Fridays" (see Shand [19]) as opportunities in the classroom for students to process the emotional impact of their clinical experiences. Clubs for creative outlets such as drama, music, and art can foster growth and serve as a link to the passions, sources of inspiration, and respite that students have found meaningful in the past. At the hospital where the authors of this chapter work, medical students have the option of rotating in a clerkship program in which students shadow hospital chaplains, in which the students are invited to reflect on their own emotional/spiritual/religious responses to clinical interactions.

Religion and spirituality can function as a cultural asset for medical students and medical schools, both in the students' clinical work and as a coping resource. Respondents in one study named practices such as prayer and meditation as "an additional support system" and "an extra line of defense against the things that have become stressful or induce anxiety" [17]. Evidence suggests the benefits of spiritual care training are twofold: positive patient outcomes and more resilient providers. For instance, spiritual care training has been shown to directly benefit palliative care providers. "In one study, the clinician's spiritual well-being, compassion for oneself, and satisfaction with work increased, and work-related stress decreased following spiritual care training" [18]. Callie Ray and Tasha Wyatt et al. note "an increase in well-being when medical students focus on their spirituality" [17]. They recommend that medical schools provide opportunities for students to employ and recognize religion/spirituality as an asset, including identifying and thinking through "their own coping strategies with death," as a resource in processing the death of their patients (Ibid). Spiritual care training for medical students can be employed as part of an overall curriculum designed to increase cultural competency, and to combat empathy decline during clinical rotations [4, 13]. Melanie Neumann et al. propose the incorporation of "well-researched spiritual modalities, such as mindfulness-based

stress reduction and self-awareness training, allowing students and residents to reflect on issues of vulnerability and responsibility" in healthcare [13]. The aim is to help students to reflect on their own emotional processes and to meet their patients, and themselves, with curiosity, cultural humility, and compassion.

Modalities and Personal Practices

The following are examples of spiritual practices that may be meaningful for medical students as they think about ways to incorporate what is most important to them as an asset in their work with patients and their own coping.

Creativity as Spiritual Practice

Take time to do what you love, to be creative, or quiet, or to spend time in a favorite place, even—maybe especially—when you get busy. Some examples include:

- Spend time in nature
- Take a long walk
- Talk to a friend
- Do something creative
- Cook a nice meal and eat it slowly
- Write in a journal

One exercise is to write whatever comes to your mind for 10 minutes. It might be about school or a clinical experience. It might not. The key is to keep writing without stopping. Let the critical, editing part of your mind take a break. What you write does not have to be "good." If your mind goes blank, that is okay—just write, "something will come" until something new pops into your head. When you are done, read it over and see if anything new or surprising jumps out to you.

Gratitude as Spiritual Practice

Practicing gratitude, intentionally pausing to think about the things you are thankful for, is one of the most well-researched means of combating burnout and compassion fatigue.

An example of a brief gratitude meditation: In a quiet space, allow for silence. Slowly go back over your day, from waking and getting ready until this moment. Think of the things you are grateful for, small or big. It might help to write them down. It might help to say them aloud.

Mindfulness as Spiritual Practice

There are many ways to practice mindfulness. Meditation, prayer, drawing, and physical activity are all potential ways to practice mindfulness. See the chapter on mindfulness for more ideas.

Grieving and Letting Go

Allow yourself to grieve losses fully. Allow yourself, when ready, to move on.

Conclusion

It is an exciting moment in healthcare. Just as scientific advancement opens up new therapies, modalities, and hopes for healing, so too do advancements in how hospitals and providers attend to their patients' humanity in all their diversity and particularity. To become such a provider, it is important to care for oneself. The FICA assessment tool described above can be a good way for the student or provider to check in with herself. One could ask, "What are my beliefs (*F*aith) that this case touches in me? In what way are these beliefs *I*mportant for me in this instance?

What is my *C*ommunity that I can turn to now if I need to? How can I *A*ddress my own needs right now, and who can help?" Attending to these kinds of questions and answers can help us know when to return to our sources of inner strength, as well as when to reach out to trusted friends or family, or professional support.

When we in our work as chaplains ask our patients if they have a spiritual or religious practice, it is a reminder that many spiritualities and/or religions are *practices*, something we do, and are, and something that shapes us, without ever "arriving" or finishing, at least on this side of death. So too is the practice of providing care, as the clinician (or future clinician) works to attend better to the emotional/existential/spiritual/religious dimensions of her patients and herself. Medical students have certainly heard many times what a privilege, and what a challenge, medical education is by the time they begin. Our wish for you is that as you grow in knowledge and clinical acumen, the same things that brought you to this point continue to sustain you, that you discover sources of rest and inspiration throughout your career, and that you attend to your whole self with the same compassion with which you attend to those placed in your care.

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