Incorporating and Teaching Spirituality into Medical Education: An Overview of the Field and Possible Educational Strategies

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Abstract Resulting from the increasing scientific evidence on the correlations between spirituality and health (S/H), important institutions such as the World Health Organization, American College of Physicians and Association of American Medical Colleges have already formally recommended the approach of spirituality in clinical practice. In addition, most US and UK medical schools have already included S/H contents in their curriculum, students and medical teachers believe this issue is important to clinical practice and there are several studies showing promising results on the incorporation of S/H courses or strategies to medical students. This chapter will provide a brief panorama on the S/H field, aiming to bring an update overview of the development of the field, the current scientific evidence, the most common educational strategies and initiatives used, the S/H curriculum goals, objectives and general competences. Future challenges of this field are to create an international consensus including the minimum required competences that a

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medical student should learn concerning S/H, to increase the number of S/H content worldwide and to provide high-quality and continuing training for teachers and students.

Keywords Spirituality · Medical education · Religion and health · Educational models · Medical students

1 First Things Coming First: Why to Teach About Spirituality in Medical Schools?

It is probably the case that many chapters in the book have already covered some of the reasons to insert spirituality into the curriculum of medical schools worldwide. However, it seems opportune to reflect deeper on those reasons before going any further once they lead straight to the main topics that we will argue as the most important ones to be covered in medical curriculum.

Spiritual and religious (S/R) topics gained some notoriety in health debates in the 1960s–1980s, when epidemiologists published some data revealing that people with high-attendance to religious services presented lower mortality rates and better health outcomes (Koenig 2012). Since then, the field of S/R and health is constantly growing and consolidating in the scientific community (Lucchetti and Lucchetti 2014). A recent search (performed in June 06, 2019 by this chapter's authors) for the terms (spiritual∗ OR religio∗) in *Pubmed* revealed 72,830 articles and most of the studies show positive associations between different health outcomes and S/R, empathizing how important this topic is in clinical practice.

Probably, the most important reason to approach spirituality in clinical scenarios is that S/R beliefs can influence quality of life and both physical and mental health. Concerning physical health, different studies have correlated S/R beliefs with lower levels of blood pressure, less postoperative complications (Lucchetti et al. 2011b), lower levels of C-reactive protein (King et al. 2001), and lower cognitive decline rates (Kaufman et al. 2007). Interestingly, some meta-analyses suggest that people with higher S/R beliefs have a reduction of about 18–25% in mortality rates. This impact is similar to that of fruit and vegetable consumption on cardiovascular events and the use of statins for dyslipidemias (Lucchetti et al. 2011a). Evidence related to the impact of S/R on mental health is even more robust. Higher S/R beliefs are associated with lower levels of anxiety, depression, substance use and abuse, suicide attempts and higher quality of life (Moreira-Almeida et al. 2014).

Concerning the impact of S/R in clinical practice, many patients would like to have their S/R beliefs addressed by their physicians. When analyzing several studies related to this topic, a systematic review showed that 70% of patients want doctors to address these issues (Best et al. 2015). Nevertheless, other systematic review found that only 16%–32% of physicians address such issues in clinical practice (Best et al. 2016). The most common barriers that prevent physicians from talking to their patients about this topic, are the lack of time, lack of training, fear of imposing religious beliefs to patients, fear of offending patients and difficulty to identify patients who want such approach. We emphasize that the last three barriers are

strongly related to the lack of training (Curlin et al. 2007; Lucchetti et al. 2013; Mccauley et al. 2005; Tomasso et al. 2011). Nevertheless, the first two barriers could also be related to the way students may use their own coping strategies (Balboni et al. 2015) as it will be discussed further in this chapter.

Another reason for giving some space to S/R content in medical education is that religious beliefs and practices often influence medical decisions. Patients may (or may not) accept blood transfusion, vaccines, prenatal care and interventional measures at the end of life depending on their beliefs. An study with 177 patients from an outpatient clinic revealed that almost half (45%) of them considered that their religious beliefs would influence medical decisions if they became seriously ill (Ehman et al. 1999).

Many patients also make use of their faith, spirituality or religion to deal with stress and negative life challenges, such as illness. Such use has been named "spiritual/religious coping" (Panzini and Bandeira 2007). Thus, patients may make use of positive S/R coping strategies such as seeking comfort in religious literature or negative coping strategies such as seeing disease as God's punishment. A study with 337 outpatients from Duke University Hospital found that 90% of them used their religion to cope with their illness. Furthermore, about 40% of them indicated that it was the most important factor contributing in their coping process. (Koenig 1998)

From the data presented here and throughout this book, it seems reasonable to argue that physicians should be prepared to identify S/R beliefs and needs, as well as patients' spiritual coping strategies. In order to do so medical students should be prepared during their undergraduate training.

1.1 Introducing S/R Content in Medical Schools

Resulting from the increasing scientific evidence on the correlations between spirituality and health, important institutions such as the World Health Organization, American College of Physicians and Association of American Medical Colleges have already formally recommended the approach of spirituality in clinical practice (AAMC 1999; Group 2006; Moreira-Almeida et al. 2014). Following such recommendation, important education institutions began to introduce content on S/R in their regular curricula.

In the US panorama, there was an impressive growth of initiatives recently (Puchalski et al. 2014a). In the 1990s, only three medical schools had courses approaching spirituality; nowadays, around 90% of them approach S/R topics. (Koenig et al. 2010) In this scenario, the "GWish Spirituality and Medical Education Program" has been the most important responsible for the support and increase of spirituality in the US medical schools. Initiatives at the University of Missouri, Kansas City (USA); Brown Medical School, Rhode Island (USA) and Duke University, North Carolina (USA) are also worthy of note.

In the United Kingdom, Neely and Minford found that 59% of the British medical schools already include topics on spirituality and health (S/H) in their curricula, either electively (80%) or compulsory (50%) (Neely and Minford 2008). On the same line, emerging countries have increasingly demonstrated their potential for

including spirituality in medical education. In India, a country with a strong cultural and spiritual background, this discussion has gained ground in medical centers as the Adibhat Foundation for Integrating Medicine and Spirituality in New Delhi (Ramakrishnan et al. 2014). In Brazil, approximately 40% of medical schools have content related to H/S, although only 10% of them had a specific course dedicated to this subject (Lucchetti et al. 2012b).

In a paper published in 2012, a broad panorama of teaching Spirituality in Medical Schools, based on publications of all parts of the world was gave and demonstrated a predominance of studies in US and Canadian medical schools in detriment of other parts of the world such as developing countries (Lucchetti et al. 2012a).

1.2 Brief Summary of S/H Studies in Medical Education

In the last decades, several initiatives have been published in this area of research. Although this part of the chapter will discuss some of the studies dealing with S/H in medical education, our objective is just to provide some of this evidence, including studies describing educational strategies or courses, as well as, S/H opinions and attitudes of teachers and students.

Concerning S/H courses, Table 1 provides 15 studies, which incorporated spirituality in medical schools. We can note that most studies have shown positive results, despite the fact that few of them had a control group and only one study was a randomized controlled trial. More studies are needed in order to understand how and when spirituality should be incorporated in the medical curriculum.

1.3 Medical Students and Teachers' Opinions Towards S/H

There is also some evidence showing that medical students', medical teachers/staff and even medical director believe spirituality is important in clinical practice and in education. A study carried out at the medical university of Vienna with 1400 students (Rassoulian et al. 2016) found that 75.6% of the students agreed that religiousness/spirituality might have an effect on how cancer patients cope, 85.9% would consider talking with their patients about religious/spiritual beliefs if patients wish to do so and 86.3% would involve chaplains if they feel it is necessary.

Another study including 1300 students and 106 Faculty at Queen's University Belfast Medical School (UK) (Harbinson and Bell 2015) found that most students supported availability of spiritual interventions for patients, 90% felt that faith/spirituality was important to some patients and 60% agreed that this influenced health. However 80% felt that doctors should never/rarely share their own spiritual beliefs with patients and 67% felt they should only do so when specifically invited.

Table 1 Evidence of spirituality and health courses

Author, year	Country	Participants	Strategy	Results
Anandarajah et al. (2007); Anandarajah et al. (2007)	USA	10 fourth-year medical students	17-h elective on spirituality and patient care	Medical students rated the elective positively and increased their knowledge of spirituality and medicine
Gonçalves et al. (2016)	Brazil	50 first and second-year healthcare students	8-month theoretical and practical training	Students felt more comfortable and tended to believe the patient liked the approach, felt better and more motivated
Frazier et al. (2015)	US	166 first-year medical students	3 h of chaplain rounds	Most students (63%) wrote that spiritual care needed and had positive opinions concerning S/H
Schonfeld et al. (2016)	US	70 four-year medical students	S/H month-long rotation	Student feedback for the course was uniformly positive
Perechocky et al. (2014)	US	21 medical students	Shadowing a trauma chaplain during an on-call shift	90% of respondents agreed or strongly agreed they learned about the chaplain's role in the hospital and that the experience was useful
Talley and Magie (2014)	US	250 medical students	Lectures, panel discussions, role-playing, and training in the use of a spirituality assessment tool	Students were sensitive to patients' spiritual needs, assessed patients' and their own spiritual needs and appropriately used chaplain services
Lennon-Dearing et al. (2012)	US	53 healthcare students	1 day S/H workshop	Students were able to take a spiritual history, understand the role of clergy and chaplains and rated well the workshop
Ellman et al. (2012)	US	217 healthcare students	An online interactive, case-based learning module, and a simulation workshop	Students perceived that the program met its learning objectives and highly rated the program
Barnett and Fortin (2006)	US	137 medical students and residents	2-h workshops with lecture, discussion, and role-play	Increases in agreement regarding the appropriateness of inquiring about spiritual beliefs, competence in taking a spiritual history, and knowledge of available pastoral care resources

(continued)

Table 1 (continued)

Author, year	Country	Participants	Strategy	Results
King et al. (2004)	US	146 first-year medical students	Spiritual history-taking curriculum with theory, practice history taking, and standardized patient scenarios	65% of students were able to recognize the patient's spiritual concern, the attitude survey has increased and 94% answered correct the test
Musick et al. (2003)	US	192 medical clerkship students	Two groups with identical theoretical classes. Group 1 worked on a S/H problem-based learning case and group 2 not	Students' from group 1 rated higher their knowledge of taking a spiritual history. However, the spiritual history taking was similar
Culliford (2009)	UK	27 third-year medical students	8-week theoretical course	High satisfaction (78%) between students
Sandor et al. (2006)	US	316 nursing and medical students	Course designed to provide scientific evidence in the field and on how to take a spiritual history	There was an increase in perceived importance of spirituality in practice and reduced dogmatic perception on the theme
Ferreira et al. (2016); de Carvalho Ferreira et al. (2016)	Brazil	305 first to forth years medical students	"Transversal "module on spirituality and health based on 8 encounters with theoretical contents	80% of students rated the module as 'good' or 'very good' and 96.30% reported that participation in the module will influence their future medical practice
Osorio et al. (2017)	Brazil	49 first and second year healthcare students	Randomized trial with an intervention Group (a theoretical-practical course in S/H) and a control group (waiting list)	Intervention group had higher scores of knowledge, better attitude and demonstrated more ability in obtaining a patient's spiritual history when compared to the control group

A Brazilian multicenter study including 3630 medical students from 12 medical schools (Lucchetti et al. 2013) found that students believed spirituality has an impact on patients' health (71.2%) and that this impact was positive (68.2%). The majority also wanted to address S/R in their clinical practice (58.0%) and considered it relevant (75.3%), although nearly one-half (48.7%) felt unprepared to do so.

In the USA results were similar, 254 medical students at the Creighton University School of Medicine (Guck and Kavan 2006), indicated that religiousness and spirituality were considered important, spiritual practices were seen helpful for acute and mental health conditions as compared to chronic or terminal conditions and students believed that patients could benefit from spiritual practices more than they could for their own health conditions.

Medical teachers have also positive views towards S/H. A Brazilian study evaluated 53 teachers (Mariotti et al. 2011) and found that most of them (72%) believed that faith or spirituality can positively influence the treatment of their patients, 62.3% wanted to address spirituality with patients and 50% believed that it is important for a medical school to prepare students for this issue. However, only 43.4% reported they feel prepared to address this issue, 27.8% have ever mentioned this issue in their classes and 92.3% felt that the Brazilian medical schools are not giving all required information in this field. Same results were identified in another Brazilian study which evaluated 44 teachers (Banin et al. 2013) and found that 61.4% believed that spirituality influence positively in health, 59.1% frequently address this issue and 58.1% believe medical students should be prepared to discuss spiritual beliefs with patients. However, 95.5% believed Brazilian medical school were not providing the required information in this field.

Finally, two studies addressed how medical school directors valued S/H in Brazil and the USA. Most Brazilian directors believe that S/H is "very important" to be taught in medical schools, followed by 35.6% who found "somewhat important" and 10.5% who found "of little importance" (Lucchetti et al. 2012b). Concerning the US directors, 43% indicated that their institution needed more S&H curricular content and only 25% would open additional curricular time (Koenig et al. 2010).

All these studies underscore that S/H is considered an important issue to medical students, teachers and directors. However, there is a concern on how to appropriately incorporate this theme in a time-restricted curriculum.

2 Methodological Considerations on How to Teach S/R in Medical Schools

Possibilities involving the process of inserting S/H content in medical schools need to be discussed. The inclusion of specific, compulsory or elective courses, as well as study groups or tutorial modules should be performed using a systematic approach, identifying the core competences which should be acquired, defining the teaching strategies and endowing with a logical sequence.

One of the easiest ways to start a S/H discussion in a medical school is to offer single courses, symposiums, workshops, journal clubs or specific discussions. Although this is a limited approach, It can have important impact in demystifying some stereotypes that this issue could bring to the academic community. However, many of these strategies are located in the elective areas of medical curricula and, perhaps because of this, they face some difficulties to strength themselves when faced with traditional curricula contents.

Another way of including S/H in the curriculum is through an elective or compulsory course. Compulsory courses allow a wide-ranging approach and information access to all students, independent of cultural backgrounds and/or prejudices. In this perspective, compulsory curricular proposals seem to be the most effective

strategy to disseminate knowledge on S/R and expanding the possible interest of students that at first would not be willing to participate in an elective course due to misconceptions on the topic. However, as it is common for new paradigms that come to the curricular discussion scenario, it seems reasonable to also invest time and effort to stimulate elective initiatives (as the ones we will present in this chapter) or introducing the topic inside existing courses in the medical curricula, as a first step, in order to allow the theme to gain visibility between teachers and staff.

In this scenario, two considerations may be valuable. First, it is important to avoid the clash between traditional curricular topics, such as the anatomy, pharmacology and physiology chairs, against an innovative educational content such as S/H. But, it might be a good strategy to insert topics related to S/R in existing courses, such as Ethics course, Integrative medicine, Palliative Care and the Clinical skills course. Table 2 presents a proposal that could be developed in such course: three theoretical meetings, followed by practical training performed alongside with the already existing practical clinical skills activities, such as bedside teaching encounters. The second point related to the teaching-learning methodologies adopted. It is necessary to expand pedagogical practices and overcome models that do not contemplate students' autonomy. Active methodological strategies represent a feasible option, since they are directed to the production, sharing and use of tools that are close to the needs of those who learn and teach.

In the words of Calman (2008): "most doctors (professors/tutors) do not have the background to facilitate learning on the theoretical aspects of the subject, but they do have extensive clinical experience of how such topics impact on the care of patients. Linking this experience with those of people with wider backgrounds in ethics or spirituality may provide a useful model for teaching." (Calman 2008) Also, one option to overcome the lack of knowledge that many professors present could be to offer training courses at national medical education congresses or continuing S/H training to medical schools' staff.

Other possibility is the use of an elective "transversal" model of teaching (same topics are offered to students from different levels of training) (de Carvalho Ferreira et al. 2016). This strategy may allow memorization of contents and a deeper discussion between students. An example of topics included in this strategy can be found in Table 3.

Table 2 Propose content to introduce S/H in existing medical courses

	Topics
Session 1 (2 h)	Defining: What is spirituality and religiosity? Why is it important to address spirituality with patients?
Session 2 (2 h)	When is it appropriate to address spirituality in clinical practice Tools to approach spirituality in clinical practice
Session 3 (2 h)	Limits and barriers: When can religion be harmful? Religious and spiritual coping

Table 3 Possible topics that can be included in an elective "transversal" model of teaching

	Topics	Teaching method
Session 1 40"	Health care models: Magical-religious, biomedical, integral – biopsychosocial	Team-based learning (TBL)
Session 2 40"	Conceptualization: Spirituality, religiosity, religion, faith and belief;	Team-based learning (TBL)
Session 3 40"	Spirituality in the therapeutic process – part I: Psychoneuroimmunology and epigenetics	Lecture and debate
Session 4 40"	Spirituality in the therapeutic process – part II: Physical and mental health	Lecture and debate
Session 5 40"	Spirituality, humanization and medical humanities	Lecture and debate
Session 6 40"	Spirituality and finitude	Lecture and debate
Session 7 40"	Spirituality in clinical practice – part I: Spiritual anamnesis	Team-based learning (TBL)
Session 8 40"	Spirituality in clinical practice – part II: FICA Questionnaire (1)	Lecture and debate

3 Teaching S/R Topics Using Active Learning Strategies

Historically, the training offered in health related courses has been based on the use of traditional methodologies, which usually has a more passive learning. In the last decades, active learning has emerged as a very promising strategy (Prober and Heath 2012; Tosteson 1990). Considering that graduation process lasts only a few years and professional activity remains for decades, it becomes essential to reflect on methods that empower students and give them co-responsibility during the learning process. The active teaching and learning methodologies emerge in this scenario pointing out that the act of learning must be a constructive and, above all, a significant process (Prober and Heath 2012).

In dealing with H/S, some medical schools have focused on fostering the thematic using active methodologies and strategies. Problem-Based Learning (PBL) is a teaching tool that focuses on developing students' autonomy and valuing their prior knowledge. In PBL students are divided in small groups and are presented with different problems that aim to generate doubts or imbalances and evoke necessary reflections to lead to the search for creative solutions (Onyon 2012). This strategy has already been used by some institutions teaching S/H (Musick et al. 2003; Puchalski and Larson 1998).

Team-Based Learning (TBL) is another active learning strategy. It was developed by Larry Michaelsen in the 1970s. Its theoretical foundation is based on constructivism and it values collaborative work as a mean to find solutions for realistic and contextualized problems. It differs from PBL in its simpler execution dynamic: TBL dispenses individual spaces or tutors for small group. Three principles are fundamental to TBL: (1) Building and managing teams appropriately; (2) Student's responsibility for pre-activity studying and teamwork performance; (3) Execution, in teams, of tasks that promote learning, interaction and development of learning objectives (Michaelsen and Sweet 2011). This could be a promising strategy to teach S/H in larger groups of students.

In an attempt to contemplate different domains of learning, such as attitudes and practical performance, the "Role Play" tool emerges. On such technique an actor plays a patient with needs and issues often encountered in clinical scenarios. Role play allows students to experience different practical situations leading to learning and possible evaluations of systems and actions proposed as objectives. This strategy has already been used by different institutions to teach S/H (Anandarajah et al. 2007; Barnett and Fortin 2006; Bell et al. 2010; Pettus 2002).

Another important educational strategy is the chaplain shadowing. Shadowing a chaplain can help the medical student to understand the role of a chaplain, which is considered a broader role than performing rituals and supporting patients and families dealing with death (Frazier et al. 2015). There are some successful strategies using chaplain shadowing to teach S/H (Anandarajah et al. 2016; Frazier et al. 2015; Graves et al. 2002; Perechocky et al. 2014).

Other possible active learning strategies can be used, such as blended learning (distance learning and on-site classes), flipped classroom (inverted classrooms), case-based learning, mindfulness training, portfolio, student presentations, self-reflective writing, and video interviews, among others (Puchalski et al. 2014a).

Interdisciplinary approaches (religious studies scholars, sociologists, anthropologists and religious leaders) are also welcome in the teaching strategies in an attempt of broaden the discussion of this topic, fostering different views and different cultural perceptions.

Finally, there are some methods that could be used to evaluate clinical competences in S/H, such as OSCE (Objective Structured Practical Examination) and the use of SP (standardized patients). OSCE method seeks to evaluate, in a role-simulation environment and clinical competence in a planned, structured and objective way. It directly observes students' performance when performing different practical skills. In the process, students were challenged to recognize spiritual needs, to experience physician-patient communication and to reflect on strategies to approach S/H in clinical settings. The OSCE has already been used to assess skills in S/H (Ledford et al. 2014; McEvoy et al. 2014) and SP encounters are also used to train and assess skills acquisitions in S/H (King et al. 2004; Osorio et al. 2017).

All these methods should take into account the "hidden curriculum" as presented in a previous work carried out by Balboni et al. (Balboni et al. 2015). According to the authors, medical students R/S beliefs could result in positive and negative outcomes. S/R beliefs could potentially protect against some challenges in medical

training (i.e. less emotional stress, compassion, work-life balance, relationship strife) but also could intensify other challenges (i.e. stress for knowledge acquisition, self-doubt and disillusionment). Likewise, these students may use different coping strategies during training, in a sense that non-S/R students are more likely to mention a repressive coping style, compartmentalization and a higher self-protection, whereas S/R students tend to use prayer and faith as a central coping mechanism.

4 Teaching S/R Topics Through "Health and Spirituality Academic Leagues": A Brazilian Initiative

In the last section of this chapter, we presented some learning strategies to teach S/H. In this section, we will present a Brazilian initiative that may be interesting to get known by other countries. In a scenario of increasing emphasis of S/R content in medical schools, it is evident the difficulty that some professors have to be open to content outside the mainstream medical curriculum. Thus, students who desire to study S/H may find prejudice and misunderstanding in some of their professors and tutors' opinions. Aiming to change this scenario, many students in Brazil have pioneered initiatives to study the subject through the "Health and Spirituality Academic Leagues" (HSALs).

An academic league is a project designed and executed by students who are seeking to learn more about a topic usually not covered in regular curricula. It consists of theoretical and practical activities, as well as research and extension initiatives. Students voluntarily sign to participate and are followed by a teacher who helps them to manage the activities. The HSALs gained great prominence in Brazilian medical schools. In Brazil, academic interest on the topic is increasing, but it has not been followed by curricular transformations. That is probably the reason for the country to count with around 40 Academic Leagues studying the interface between S/H. Such academic leagues develop its theory training using active and/or traditional teaching-learning methodologies. Many topics are covered such as myths and truths involving science and spirituality, definitions involving spirituality, reasons to address spirituality with patients, empathy and compassion in patients' care, students' own spirituality, bioethics of early and late life, mind and brain interface, near death experiences- NDEs, among other (Gonçalves et al. 2016) (Table 4).

Other than theory, students may also perform practical training, such as practical role-play training on how to conduct a spiritual history as well as visits to the hospital in order to take a spiritual history with hospitalized patients. A study revealed that most HSAL students felt comfortable taking the spiritual history after this training (Puchalski and Romer 2000). Another study showed even better results in a HSAL initiative. Students were randomized and evaluated before and after receiving theoretical and practical training. Students in the intervention group (participating in HSAL activities) presented higher scores on theoretical knowledge about

Table 4 HSAC course outline

	Topics	Teaching method
Session 1 (2 h)	Myths and truths involving science and religion	Lecture
Session 2 (2 h)	What is spirituality?	Lecture, group discussion
Session 3 (2 h)	Why is it important to address spirituality with patients?	Lecture
Session 4 (2 h)	How can we approach spirituality in clinical practice?	Group reading of scientific papers, lecture
Session 5 (2 h)	When is it appropriate to address spirituality in clinical practice?	Lecture
Session 6 (2 h)	What may result from the spiritual approach in clinical practice?	Lecture
Session 7 (2 h)	Limits and barriers approaching spirituality: When can religion be harmful?	Lecture, discussion
Session 8 (2 h)	Religious and spiritual coping	Guest speaker, discussion
Session 9 (2 h)	FICA spiritual assessment tool	Lecture, group discussion
Session 10 (2 h)	Palliate care: Dealing with conflicts	Guest speaker
Session 11 (2 h)	Bioethics and early life: Abortion and research on embryonic stem cells	Lecture
Session 12 (2 h)	Bioethics and end of life: Euthanasia and organ transplantation	Lecture
Session 13 (2 h)	Interface mind and brain	Guest speaker
Session 14 (2 h)	Near death experiences- NDEs	Guest speaker

Retrieved from Gonçalves, L. M et al. 2016

H/S, had better attitudes towards S/H and scored higher in the SP encounter taking a spiritual history than a control group (waiting list) (Osorio et al. 2017) It seems that offering theory follow by practice activities is one of the most prominent and feasible strategies to teach spiritual related-topics during medical education.

5 S/H Curriculum Goals, Objectives and General Competences

There are several competences that should be met in a S/H curriculum. In a recent article, Puchalski et al. (Puchalski et al. 2014a) have included the minimum required competences to be acquired by medical students, the possible teaching methods and the performance assessments. There are 6 core groups of competences, described below:

- **Health care systems:** Apply knowledge of health care systems to advocate spirituality in patient care (9 competences such as "Compare and contrast spiritual resources in different health care systems "and "Discuss how the legal, political, and economic factors of health care influence spiritual care ").
- **Knowledge:** Acquire the foundational knowledge necessary to integrate spirituality in patient care (12 competences such as "Differentiate between a spiritual history, spiritual screening, and spiritual assessment "and "Locate and evaluate spiritual/religious information resources both online and in print").
- **Patient care:** Integrate spirituality into routine clinical practice (10 competences such as "Perform spiritual screening at appropriate times" and "Make timely referral to a chaplain or spiritual counselor").
- **Compassionate presence:** Establish compassionate presence and action with patients, families, colleagues (6 competences such as "Discuss why serving the patient is a privilege " and "Discuss how you as a provider may be changed by your relationship with the patient".
- **Personal and professional development**: Incorporate spirituality in professional and personal development (6 competences such as "Explore the role that spirituality plays in your professional life" and "Identify your sources of spiritual strengths").
- **Communications:** Communicate with patients, families, and health care team about spiritual beliefs (6 competences such as "Communicate professionally with spiritual care providers and other team members about the patient's spiritual distress or resources of strength" and "Practice deep listening—hearing what is being communicated through and between the words, the body language, and the emotions").

6 A Call for the Development of International Curricular Guidelines

Medical education in S/H is a relative new field. The first initiative (an elective course) was launched in 1992 (Puchalski et al. 2014a). In 1996, the Association of American Medical Colleges (AAMC) launched the MSOP initiative providing a definition of spirituality and proposing how it might be integrated into patient care and medical education (Puchalski et al. 2014a; Puchalski and Larson 1998). Other initiatives of a consensus in the field were followed (Puchalski et al. 2009, 2014b) and, in 2011, the George Washington Institute for Spirituality and Health 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, entitled "GWish's National Initiative to Develop Competencies in Spirituality for Medical Education".

The field is consolidating and we believe it would be appropriate to create an international consensus including the minimum required competences that a medical student should learn concerning S/H worldwide. Although this consensus could

help standardizing the field, we believe that each institution could add topics that are relevant to their context, including cultural and social backgrounds. This may be an important further step in the field and can help to booster the teaching of S/H in medical education.

7 Conclusions

This chapter provides an overview of "Spirituality and Health" in medical education. Although spirituality is a new field, it stands out as an important topic to be incorporated into medical undergraduate and graduate training. Several studies, initiatives and different educational strategies have been published in the last decades proving further evidence for this training. Future challenges of this field are to create an international consensus including the minimum required competences that a medical student should learn concerning S/H, to increase the number of S/H content worldwide and to provide high-quality training for teachers and students.

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