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ORIGINAL PAPER

Religion and Spirituality as a Cultural Asset in Medical Students

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Abstract We explored the ways that religion and spirituality (R/S) work as a cultural asset in the lives of medical students and how students anticipate using this asset as physicians. A group of sixteen religiously diverse medical students were interviewed, and data were analyzed using grounded theory. The results indicate that regardless of faith, students repurposed their R/S to help them cope with the stress of medical school, make clinical decisions, resolve inexplicable events, and practice patient-centered care. Medical educators should leverage this asset to help students understand how to practice in ways that are consistent with patient-centered care.

Keywords Medical students · Cultural assets · Patient-centered care · Diversity · Qualitative research

Introduction

In response to the need for more diversity in health care, medical schools across the USA have been developing new policies and procedures that focus on the recruitment and selection of diverse students, with a specific focus on those considered underrepresented in medicine. As a result of this national effort, our institution now has a student population that is the most culturally and ethnically diverse it has been since the institution was established in 1828. In an effort to get to know our diverse student body, we have been studying cross sections of our medical students from various cultural, ethnic, and geographical backgrounds seeking to understand their cultural assets (i.e., perspectives, skills, experiences, and knowledge that students bring with them to an educational setting). Identifying cultural assets in students can be helpful to administrators and educators who

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are looking to leverage students' strengths in designing educational programs (Benson et al. 1998; Borrero 2009; Moll et al. 1992; Nieto 2002).

As an extension of our work on cultural assets, this study examines the role of religion and spirituality in medical students. We decided to pursue this line of inquiry because our previous work indicated students positioned religion and spirituality as a cultural asset and planned to integrate it into their practice of medicine. Precedence for this study is found in prior research, which indicates practicing physicians use their religious and spiritual beliefs in clinical practice (Lawrence and Curlin 2009). Therefore, this study focuses on the ways in which students use religion and spirituality, while in medical school and how they anticipate using it when they become physicians. To guide our investigation, we used the following research questions to guide our study: (a) *What role does religion and spirituality play in the lives of medical students?* and (b) *How do students anticipate using religion and spirituality in the practice of medicine?*

Theoretical Framework

This study used a cultural assets paradigm (Delgado 2007) to investigate the intersection and use of religion/spirituality by students in medical education and future clinical practice. Cultural assets are a broad term that encompasses the practices, skills, perceptions, and experiences of an individual, family, or community that develop as a result of their unique cultural background. While there are different terms to describe these assets, such as *funds of knowledge* (Moll et al. 1992) and *cultural resources* (Cooper 2011), in essence they are the accumulated wealth of knowledge that develops out of everyday lived experiences of students and their families (Au and Kawakami 1994).

People develop cultural assets from a variety of contexts, including families, peers, schools, neighborhoods, cultural groups, institutions, and the political climate through their active engagement within and across these settings (Bronfenbrenner 1979). By engaging with others and these contexts, individuals develop cognitive structures in the form of beliefs, mental operations, and understandings that guide individual's thinking and acting. Cultural assets are considered the cognitive and behavioral consequences of cultural opportunity because they develop out of the cultural milieu that surrounds an individual (Nerlove and Snipper 1981). Not all individuals are consciously aware of the cognitive structures they use, or how they are guided by them, yet these structures—found in such areas as religion and spirituality—serve as powerful tools to shape one's thinking and behavior (Tharp and Gallimore 1998). We positioned religion and spirituality as cultural assets because students indicated they use their religious and spiritual lenses as tools for understanding aspects of their professional life.

Religion, Spirituality, and Medicine

Landmark research on the presence of religion/spirituality within medicine is often portrayed as a hindrance to decision making and generally problematic (e.g., Curlin et al. 2005, 2007; Lawrence and Curlin 2009). However, when religion/spirituality are positioned as assets, perspectives that physicians can draw upon in their clinical practice, the focus moves to the way in which religion/spirituality assist physicians in their framing and practicing of medicine.

By and large, religion/spirituality and medicine are separated even though they have a long and tangled history. Their relationship can be traced back to when hospitals formed out of churches as a way to help the sick and poor (Mollat 1986). The majority of these early hospitals did not provide clinical care. However, as they expanded across Europe and North America in the eighteenth and nineteenth centuries, they included more clinical care services. The promise of biomedicine's success split the two professions, such that physicians and clergy began to separate into two distinct fields (Porter 1993). This split was eventually considered a turning point in the history of medicine because for the first time, clergy who had not received formal medical training were prohibited from practicing medicine (Numbers and Sawyer 1982).

The relationship between religion/spirituality and medicine remains inextricably intertwined, with several indicators pointing to an increased interest in these areas within the medical community (Bull 1990; Lucchetti et al. 2012). For example, the number of courses on religion and spirituality in medical schools has increased exponentially in recent years (Barnard et al. 1995; Guck and Kavan 2006) as a way to help students reduce stress and promote professional and personal well-being (Schonfeld et al. 2016). Other examples come from research, which has found that physicians' religious beliefs and practice influence their decision making around such issues as physicians' willingness to remove patients' life support (Christakis and Asch 1995) and when patients should have abortions (Aiyer et al. 1999).

To understand the relationship between religion/spirituality and medicine, in the last two decades researchers have launched several studies to answer the question: What differences do physicians' religious traditions and commitments make with respect to their clinical practices? This question is being investigated because research indicates religion and spirituality substantially influence physicians' decision making with regard to patient care. What is known thus far is that religious physicians feel less obligated to provide patients with information about medical interventions they find objectionable (Curlin et al. 2007). They also give less weight to patients' expressed wishes for care (Lawrence and Curlin 2009).

Most research in this area focuses on physicians, rather than medical students, because they are thought "to have a unique and privileged vantage point" that allows them to observe the ways in which religion or spirituality influences a patient's experience of illness (Curlin et al. 2005, p. 762). What little has been studied in medical students shows that religion and spirituality act as a hidden curriculum running alongside the legitimized one as students become socialized into medicine (Balboni et al. 2015). Therefore, to extend the work on physicians' relationship to religion/spirituality and medicine, this study seeks to understand the role of religion/spirituality and medicine in the lives of medical students and how they anticipate using it in their clinical practice. By understanding this relationship, medical education has an opportunity to develop educational programs that help students leverage this asset.

Materials and Methods

Context of the Study

The context for this study is a large US medical school located in an urban area in the southeastern region of the USA. The school's medical student population is approximately

1000 students, with roughly 230 new students entering in each year. Published reports indicate the student body is highly diverse in ethnicity and educational background. Participants were recruited through the purposeful sampling of 16 medical students in their first or second year of medical school, using the snowball method (Strauss and Corbin 1998). The snowball method entails requesting that existing subjects recruit future participants based on their network. This method was used to ensure a broad representation of faiths in our sample and recruit participants that we may not have access to otherwise. The majority of the participants were in their first year of medical school. Table 1 lists participants by pseudonym, year in medical school, and religious denomination.

Role as Researchers

This research project is a collaborative effort between a senior medical education researcher and a rising second-year medical student interested in learning how to conduct educational research. In a mentoring role, the authors worked collaboratively to develop a research question, frame the research design, and make decisions for data collection and analysis. The senior researcher specializes in studying the intersection of culture and education and has extensive experience examining the intersection of culture and education. The junior researcher brings a wealth of personal experience examining the relationship between religion/spirituality and medicine.

Data Collection and Analysis

After consenting participants, we used semi-structured interviews to understand students' perspectives on how they use their religion and spirituality in their lives as medical students, and how they plan to use it in the practice of medicine. Interview questions asked students to discuss the extent to which they considered themselves religious/spiritual, the

Table 1 Participants' demographics

Name	Religious affiliation	Gender	Year
James	Agnosticism	Male	1st
Sam	Buddhism	Male	1st
Ellen	Christianity—Catholicism	Female	1st
Kathy	Christianity—Catholicism	Female	1st
Sallie	Christianity—Catholicism	Female	1st
Benson	Christianity—non-denominational	Male	1st
Kent	Christianity—non-denominational	Male	1st
Meg	Christianity—non-denominational	Female	1st
Kelly	Seventh Day Adventist	Female	1st
Savita	Hinduism	Female	1st
Sai	Hinduism	Male	1st
Nureen	Islam	Female	2nd
Shreya	Islam	Female	1st
Elaine	Judaism	Female	1st
Adam	Judaism	Male	1st
Allen	Non-religious	Male	1st

ways in which they practiced their faith, and where students viewed religion/spirituality intersecting in medicine. Interviews were recorded using a digital voice recorder, transcribed, and analyzed using Dedoose™, a cloud-based qualitative software program that allows multiple researchers to work with the data simultaneously.

Interview data were then coded using a multi-step process beginning with the creation of open codes. Specifically, we identified the ways in which students talked about how they use religion and spirituality in their lives and how they anticipate using it when they became physicians. Following this, we met to discuss our codes and reconcile differences. This resulted in a code book that defined each code and provided exemplar statements. A second level of analysis identified relationships between the codes using a constant comparative method (Glaser and Strauss 2009). We used memos as a way to track our thinking about the relationship between codes and to refine our initial assumptions. This process resulted in the development of four themes. We conducted member checks with study participants, which involved sharing preliminary results with participants for feedback and providing a final paper for their review. IRB approved this study, and researchers have no conflict of interest.

Results

The results of our qualitative analysis indicated that regardless of students' specific faith or denomination, religion and spirituality were instrumental in students' path to medical school, important to students' well-being, and prominent in their perceptions of future practice of medicine. Specifically, we found four overarching themes: 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. Below, the results are organized by our research questions: How students described using religion and spirituality in medical school, and how they planned to use these assets as physicians.

Religion as a Coping Mechanism

Students indicated medical school can be more overwhelming if they had not had religious and spiritual practices to help them cope. Although many indicated they were religious or spiritual before medical school, their educational experiences reinforced the need for practices that bring religion and spirituality to the forefront. Many students also discussed daily practices such as prayer and meditation, which they felt contributed to their well-being. For example, Sai shared that the frequency of his prayers has increased since starting medical school and others, such as Kathy, who had always integrated prayer into her life, found that being in medical school influenced the content of their prayers. Kathy explained, "In terms of what I pray about, I feel medical school has changed that dramatically… I am really stressed, and so I am asking God for things." For her and others who used prayer and meditation, such practices provide "an additional support system" and "an extra line of defense against the things that have become stressful or induce anxiety." In this way, students used their spirituality as a way of creating internal peace as they navigated medical school.

Approximately, half the students planned to continue these practices once they began seeing patients. Specifically, they intended to set aside time for self-reflection and use this

time as a way to understand the experiences they went through in a particular day. Further, they planned to contemplate the meaning and impact of these experiences on themselves as physicians and their patients. In this way, religion and spirituality can be thought of as valuable cultural assets because they help students cope in a highly demanding profession.

Religion Provides a Sense-Making Tool

In addition to protecting students from professional stress, religion and spirituality were also used as a way to make sense of events. In essence, students saw religion and spirituality as a way to frame challenges in order to emotionally and cognitively process them. Students who used religion and spirituality as a sense-making tool often discussed needing a framework to cope with the fragility of life. For example, Meg shared that since studying medicine, she could see how disease and illness randomly affected patients and how she uses her religion to make sense of these events.

> It's hard to know why a disease is here, why disease affects people. I know that I am not immune to [getting the same disease], so it makes you cling to faith. No matter what happens, you know God is going to be here.

Meg, who used her religion as a framework to understand the randomness of poor health, positioned God as both healer and savior. By doing so, she believed that if her patients developed disease, they would have access to God's healing. If they died, they would have access to God's salvation. From this perspective, religion gave her a sense of peace that no matter what happened, a higher power was available and in control. In other words, it grounded her in ways similar to other students and afforded a way to understand the inexplicable. Even those who were not religious, such as the student who was agnostic shared that importance of a sense-making tool. He described it this way:

> Obviously, we will be faced with a lot of tough times in our career. To be grounded with religious or faith roots somewhere I think will be extremely helpful because I am sure
> … we won't understand why something happened to [our patients]. [Religion] gives you a source to refer to for guidance and influence, and that will be extremely helpful.

Students expressed that while they are in medical school, they planned on rooting themselves further in their beliefs. From their perspective, the more work they can do now, the better prepared they will be as physicians. Allie described the process in this way: "I am trying to root myself a lot more in the religious beliefs that I stand by, so I will not be as shaken as much as when I face adversities and challenges that in a lot of ways can wipe you out entirely." For these students, they position religion and spirituality as an asset that will be valuable throughout medical school and into their practice.

A Framework for Clinical/Ethical Decision Making

In addition to issues related to students' well-being, students indicated they planned to use their religion and spirituality to make clinical decisions. Given that physicians are often faced with difficult decisions, students expressed that their religion/spirituality will help them rationalize and justify courses of action when there may not be clear answers. In this way, religion and spirituality function as cultural assets because they help students navigate an environment that is new to them (Cooper 2011). In this case, students will eventually

have to make health decisions on behalf of someone else, a responsibility students are aware of even though they have had very little clinical experience at this point in their training. However, they seem to recognize that there will be ethical decisions that will need to be made that may be difficult, such as abortion, physician-assisted suicide, and end-of-life care, all of which are highly contentious and have been shown to provoke physicians' religious backgrounds and beliefs (Curlin et al. 2007).

These kinds of issues became ethically charged for many students once they were exposed to "the physician side of things." Medical school helped students see that they had to be "able to step back and see [an issue] from two different views," as Kelly described it, which creates tension for students who have historically turned to their religion and/or spirituality for answers on the best way to think about ethical issues. Some students described trying to get ahead of their anticipated discomfort by investigating their religion's beliefs while in training. For example, Allie attended both pro-life and pro-choice meetings to get a better sense of the issues raised on both sides. As a Catholic, she disagreed with the treatment options of abortion and birth control, but because abortion was positioned as a "women's rights issue" in medicine, she was uncertain how she should respond as a physician. On the one hand, she supported women's rights, but on the other, she opposed abortion. She explained that she felt challenged in trying to find "the intersectionality between how we fight for women's rights and how abortion plays a role" in that process. She, like other students who see religion/spirituality as an asset recognize the ways in which their religious or spiritual beliefs may create tension.

Another student, Shreya, who is struggling with similar ethical issues, consulted religious leaders in her Islamic community to better understand her religion's core values on the issue of physician-assisted suicide. Given that she was uncomfortable with this issue, she decided that the best thing she could do was provide a referral for someone, but would not be able to participate in the process. Other students are trying to navigate these ethical challenges by reading their religion's text. Meg recognized that not knowing how to make this decision was potentially problematic for her in the role of physician.

> I need to read the Bible more to have a fully formed opinion on what the text says. I believe suicide in general is wrong, but people can argue that people who commit suicide are sick. And then physician-assisted suicide… If someone is dying and terminally ill, and it is their request, I don't know where I stand, and that could be a problem.

Even though religion/spirituality can be seen as assets, they also plunge students into ethical quandaries where they need to discern and balance what is right for them and the health of the patient. Allen's comments described this tension in terms of balancing "what you believe" with "your responsibilities for other people." The tension comes from whether to use one's own religious beliefs or what the patient desires. Many students expressed a lack of certainty for how much weight to give each of these considerations, though most of the students seemed to use their religious beliefs as a way to think through these considerations. Given that there are no right answers with regard to issues that evoke ethical concerns, three students indicated that they had decided not to go into certain specialties because they didn't want to be forced to contemplate how to navigate these issues. None of the students indicated they had resolved this tension, but they planned to continually monitor their own feelings and how the medical field deals with these tensions as they grow into their profession.

Religion as a Framework to Accept Death

All of the students in this study talked about the importance of religion in processing the experience of a patient's death. Students seemed to be imagining what this experience could do to a physician if they did not have some way of processing it. Sai explained how this might influence a physician: "If you see death a lot of time, it could bog you down, but if you keep faith, it helps you cope with the fact that you see death a lot."

For many, a strong religious faith or spiritual practice helped to process and accept death as a part of life. As an example, Adam shared that in his religion, Judaism, there is a practice that when someone dies, they must be buried as soon as is feasible. This short time frame had helped him process death more quickly, which he felt would be an asset when he began to practice medicine. He explained,

> When people die in Judaism, they are buried as soon as possible…. People don't have that much time to mourn or they might not be able to get to the funeral. I think Judaism deals with death in a way that helps me deal with death in every form.

Other students explained that religion helped relieve some of the burden and responsibility they speculated many physicians feel when patients die. Nureen explained that because patients entrust them with their lives, it would be easy to feel an inappropriate level of responsibility. However, having religion/spirituality relieves this burden because it reframes death in a way that can be processed. For example, Shreya shared her experience in the school's anatomy laboratory, which for many is of the first time students encounter death. This experience can be overwhelming, but Shreya, who is Muslim, expressed that she felt both nervous and faint the first time she saw a cadaver on the table. To help her process what she was seeing, she used her religious text as a way to calm herself. As she explained,

> Especially for me, anatomy was very exhausting, but it was incredibly spiritual… I was very nervous… As we were about to open up the bodies, I remembered this verse from the Quran that honestly set the tone for not only the entire anatomy course, but the entire year. It essentially says, "To remember God, sitting, standing, laying down, and reflect on his creations in heavens and on the earth. You have not created anything in vain or without a purpose. Glory be to You." It went from me being like oh, I'm looking at a dead person to this idea of how many people get to study God's creation at this level? How many people get to open up and see our nerves and our vasculature and how perfectly he created everything inside to have worked as it does?

Shreya's story illustrates how intertwined religion and medicine can be for those who must frequently interact with and process death. In her case, religion provided a way for her to think about death, and the body that is left behind, in a way that facilitated greater connection with her religion. It also helped her reposition death as a powerful learning opportunity, thus further strengthening the relationship between religion/spirituality and clinical practice.

Religion as a Framework for Patient-Centered Care

Students shared that religion provided a useful framework for thinking about patient-centered care and the role of the physician to primarily be of service to others. Students expressed that this was one of the top reasons they decided to go to medical school. For

example, Shreya took direction from the Quran, citing a specific verse that describes the relationship an individual should have with others. She recited it in her conversation on how she came to medical school: "Someone who has saved one life, it's as if they save all of humanity." She indicated that this verse was powerful and influential in her thinking because she felt that if she could heal her patients, she could also fulfill her religious duties. Additionally, Savita pointed to a specific concept in Hinduism, Dharma, which encourages duty to others and one's community. From her perspective, by practicing medicine, she could integrate her religious duty with her day-to-day work as a physician.

Some students clearly expressed the integration of medicine and service. Meg explained that '[God] is the great physician, and [in going to medical school] we get to follow His path." Others, such as Kathy, simply described practicing medicine as "doing the work of God." Several students, such as Sallie, argued that all religions have this in common, and this aspect of religion could be leveraged in the training of medical students. As Sallie explained,

> All of the religions really put a stress on being kind and treating your neighbor like you would want to be treated. And that's really what medicine is about is providing the care to whoever you see, regardless of the whatever differences in background you might have.

In positioning religion/spirituality as cultural assets, several students suggested that medical school should make this connection explicit to ideas fostered in patient-centered care. They emphasized using religion and spirituality as a method for framing and treating patients in a whole-person manner, underscoring the idea that medicine should not just teach students to look at the physical characteristics of a patient, but also the emotional and psychological aspects that may not be seen on the surface. Allie asserted, "There is a spiritual component that we are not at all addressing," and then offered a better way for thinking about the role of religion in medicine and how it could be utilized:

> [Religion] hasn't necessarily been a part of medicine, but I think it can very much be beneficial as every physician is aiming to ultimately care for the human being in front of them in a way that will help them feel better… Using religion and spirituality and caring for an individual or patient [in this way] is a really important way to do that, yet we don't necessarily do [it] in medicine.

Regardless of the faith practiced by students in this study, they viewed it as a cultural asset that they could rely on as they thought about how to practice patient-centered care. It helped them make sense of various aspects such as putting the patient's needs and concerns in the center of the decision-making process, demonstrating empathy, and being of service to those in need.

Discussion

This study examined the role of religion and spirituality as a cultural asset in religiously diverse sample of medical students, an area that has been understudied in medicine (VanderWeele et al. 2017). It identifies how medical students who identified as religious or spiritual used religion and spirituality in their lives as medical students, and how they anticipated using it in their practice as physicians. Earlier work in this area indicates that practicing physicians use their religious and spiritual beliefs in clinical practice (Lawrence

and Curlin 2009), yet very little research has examined the role that religion and spirituality have in the lives of medical students, especially those who are non-Christian (VanderWeele et al. 2017). The results of this study indicate that even though students have varying religious and spiritual backgrounds, they use these assets in similar ways: as a coping mechanism for the stress of medical school, a sense-making tool for processing difficult moments, a framework for making clinical/ethical decisions and for processing death, and a way to think about practicing patient-centered care. Taken together, these results indicate that religion and spirituality serve as powerful cultural assets that help students navigate their educational experiences and the challenges they anticipate as physicians.

The implications of this study suggest that medical schools should provide opportunities for students to refer to and recognize religion and spirituality as an asset, and in doing so, they may be able to positively influence clinician well-being. This idea has been reinforced in earlier studies on the intersection of religion/spirituality and medicine that shows an increase in well-being when medical students focus on their spirituality (Ivtzan et al. 2013; Saleem and Saleem 2017). Earlier studies also show that when students use prayer and meditation, they are able to mitigate strong emotional reactions to challenging events (Balboni et al. 2015), and when students are given structured opportunities to identify and think through their own coping strategies with death, they are better equipped to process the death of patients (Williams et al. 2005).

However, the major contribution of this study is that it extends previous work on physicians' use of religion and spirituality in clinical decision making (Curlin et al. 2007; Lawrence and Curlin 2009), demonstrating that the process of integrating religion and medicine begins, or is at least underway, while physicians are in medical school. This finding is important because it provides an opportunity for administrators and educators to recognize and leverage this asset to help students integrate their faith into the practice of medicine in ways that are useful for them and their patients. Administrators should take note that when individuals are confronted with new and challenging experiences, they rely on their cultural assets to guide and navigate them through the process (Cooper 2011). In the case of this study, students used religion and spirituality to make sense of their experiences in medical school and those they anticipate in clinical practice.

What is important to understand is that adults have coherent frames of reference that they rely on to help define their world (Mezirow 1997). Most individuals are not aware of these frames of reference, but they become visible when people undergo major life events or crises, such as when individuals experience cognitive dissonance (Festinger 1962). In these situations, these frames become visible and individuals are able to see them more clearly. This notion is important because it offers medical educators an opportunity to think about ways to help students integrate the new medical knowledge into their preexisting knowledge structures, such as those that have been developed out of religion and spiritual beliefs. By exploring the ways in which students' religion/spirituality underscore duty, service, compassion, and respect for others, students can deepen their understanding of what it means to practice in ways that are consistent with the values upheld in patient-centered care.

Medical educators can also begin to have conversations on important topics, such as how religion helps physicians take care of their own health (VanderWeele et al. 2017), including maintaining physician well-being (Saleem and Saleem 2017), and improving to their inner life (Vicini et al. 2017). In other words, religion and spirituality comprise a powerful asset that can be leveraged to address many of the issues that our healthcare workers are struggling with in a physically and emotionally demanding profession.

Limitations

Although this study demonstrates some interesting findings that provide a modicum of evidence for the efficacy of religion and spirituality as protective factors for medical students across various religious groups, the students in this study were recruited from an institution in a geographical area known to value the role of religion in health and well-being in everyday life. The southern part of the USA is well known for its emphasis on Christian religions and religious communities. Therefore, future research should examine the role of religion and spirituality in medical students from a variety of cultural and social contexts to ensure that the findings cut across other medical student populations. Further, this study was conducted on preclinical medical students who have yet to engage in clinical care that will require them to take ownership of their patients (Wyatt et al. 2016). Therefore, it can be argued that students only shared how they anticipated using religion and spirituality in clinical practice without having the opportunity to demonstrate this. In other words, students who have clinical experiences may have very different views on the way religion and spirituality assists them in the practice of medicine, which may be a fruitful next step for research as researchers seek to understand the role of religion and spirituality across the learner continuum.

And, finally, this study examined one cultural asset, that of religion and spiritual beliefs in its role in medical education. There are other cultural assets that our diverse medical students will be bringing that could be leveraged in their education. Future research should examine these cultural assets in an effort to achieve our goal of educating physicians that provide high-quality, compassionate care.

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