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How spirituality is understood and taught in New Zealand medical schools

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ABSTRACT

Objectives: The objective of this research was to explore how spirituality is currently understood and taught in New Zealand Medical Schools.

Methods: A mixed methods study was carried out involving interviews (n = 14) and a survey (n = 73). The first stage of the study involved recorded semi-structured interviews of people involved in curriculum development from the Dunedin School of Medicine (n = 14); which then informed a cross-sectional self-reported electronic survey (n = 73).

Results: The results indicate that spirituality is regarded by many involved in medical education in New Zealand as an important part of healthcare that may be taught in medical schools, but also that there is little consensus among this group as to what the topic is about.

Significance of results: These findings provide a basis for further discussion about including spirituality in medical curricula, and in particular indicate a need to develop a shared understanding of what 'spirituality' means and how it can be taught appropriately. As a highly secular country, these New Zealand findings are significant for medical education in other secular Western countries. Addressing spirituality with patients has been shown to positively impact a range of health outcomes, but how spirituality is taught in medical schools is still developing across the globe.

KEYWORDS: spirituality, health, medical education, whole person care

INTRODUCTION

Addressing spirituality with patients has been shown to positively impact a range of health outcomes including improved quality of life, increased ability to cope, increased self-esteem, a greater sense of hope and a greater ability to find meaning in their situations (Calman, 2008; Egan, 2010; Egan et al., 2011; Swinton et al., 2011). Olson et al.'s (2006) qualitative study assessed the beliefs, attitudes and practices of family physicians towards the integration of patient spirituality into clinical care and revealed that these physicians believed that an "openness to discussing spirituality" would "contribute to better health and physician–patient relationships" (Olson et al., 2006; Olson et al., 2006, p. 234). Further studies in the US, UK, Australia and New Zealand suggest that patients want their spirituality addressed in medical contexts (Egan, 2010; Murray et al., 2004; Puchalski, 2006a). Spirituality is increasingly seen nationally and internationally in healthcare policy, guidelines and practice (McSherry et al., 2008; Ministry of Health, 2000; 2010; Puchalski, 2006a). In New Zealand, due to commitments to the Treaty of Waitangi[1], the ubiquitous

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[1]The Treaty of Waitangi was signed in 1840 establishing a constitutional and political relationship between Maori chiefs and the British Crown. Its principles have been incorporated into legislation providing a mechanism for taking Maori history, rights

Māori model of health Te Whare Tapa Wha (Durie, 1998) and our increasingly multi-cultural population, understanding spirituality is critical to comprehensive and culturally competent healthcare.

Pre-service and in-service education in spirituality for healthcare professionals has already been introduced in a number of countries (Lucchetti et al., 2011; Puchalski, 2006a) and globally the number of medical schools where spirituality is taught is increasing (Culliford, 2009). The first formal spirituality course for medical students in the United States was started by Puchalski in 1991 at George Washington University Medical School (Puchalski, 2006b, p. 23). Since then more that 80% of US medical schools have begun to offer spirituality courses (Booth, 2008). As a result, the Association of American Medical Colleges has developed comprehensive, "guidelines and learning objectives for the courses" (Puchalski, 2006b, pp. 23–24). Neely and Minford surveyed medical schools in the UK, and found that 59% (n = 10) of the schools who participated in their study provided some form of teaching on spirituality in medicine (Neely & Minford, 2008). The purposes of the study reported here were firstly to investigate whether and how spirituality is taught in New Zealand medical schools, and secondly to ask those currently involved in curriculum design and delivery what they understand spirituality to be and what obstacles they perceive in teaching it.

It was recognized in developing this study that the term spirituality can be conceived in a variety of ways and is often given a very broad scope. When presenting our questions to participants we adopted the following provisional definition recently developed by Egan et al: "spirituality means different things to different people. It may include (a search for) one's ultimate beliefs and values; a sense of meaning and a purpose in life; a sense of connectedness; identity and awareness; and for some people, religion. It may be understood at an individual or population level" (Egan et al., 2011).

New Zealand is the largest of the South Pacific islands in the Oceania group located some 1,200 miles southeast of Australia. It has a relatively small population of 4.2 million people with only two medical schools at the University of Otago and the University of Auckland. The University of Otago has three distinct clinical schools in Dunedin, Christchurch and Wellington.

METHODS

This study employed mixed methods. The qualitative conversations provide the depth required by the topic, while the survey data provides complementary breadth (Ivankova et al., 2006). The first stage of the study involved recorded semi-structured interviews with people involved in curriculum development and delivery from the Dunedin School of Medicine. Recruitment was done through use of a 'snowball' recruitment method (Patton, 2002). Participants were asked the following questions, developed from current literature and discussion within the research team:

1. What does the term spirituality mean to you?
2. Is teaching about spirituality an important part of medical training? If yes, why?
3. Where in the medical curriculum is spirituality currently taught, and how?
4. Where in the medical curriculum should spirituality be taught, and how?
5. If teaching about spirituality is an important part of medical training, do you perceive any challenges to this being done in your medical school? If yes, please explain.

The interviews were recorded on an audio recording device and the recordings were analyzed and coded for thematic analysis (Patton, 2002). For rigour three members of the team (DL, RE, SW) discussed the transcripts, coding scheme and themes at length, with consensus found when different interpretations ensued. From this generic qualitative analysis, a cross-sectional self-reported electronic survey was developed. The second stage of the project was analysed using basic descriptive statistics. The survey was distributed via SurveyMonkey (http://www.surveymonkey.com) to key Otago and Auckland Medical School Curriculum Coordinators (including Dunedin, Christchurch, Wellington and Auckland sites).

RESULTS

Interviews

17 curriculum coordinators[2] from the Dunedin School of Medicine were approached to be interviewed, 15 agreed to participate and 2 declined (both citing work commitments and one also a current lack of student contact). 9 participants were male and 6 were female. Interviews lasted between 20–60 minutes.

There was considerable variability in responses to the question 'What does the term spirituality mean to

and interests into account and addressing the injustices of the colonial period.

[2]Curriculum coordinators are individuals involved in the design and/or implementation of the medical school curriculum.

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you?' 9 interviewees advanced a positive definition using one of more of the following terms: '*meaning', 'values', 'belief'*, '*world view'* and '*purpose.'* The other 6 interviewees did not offer a positive definition, but rather expressed difficulty in answering this question, using words such as '*vague'* or '*intangible'*. One of this six simply replied '*I don't know*' and another said '*spirituality is indefinable'*. One said that '*spirituality means something different to everyone'* while another asserted that '*spirituality is a misleading term*.'

When asked 'Is teaching about spirituality an important part of medical training?' all interviewees replied in the affirmative, though several replied in a qualified manner, e.g. by also saying that whilst spirituality is important it is not the 'main focus' of medical care. When asked to explain why spirituality was an important part of medical training some said in various ways that healthcare deals with *'whole persons'* The other and that people are *'more than just physical bodies'*. One interviewee stated that, *'...we need to treat the whole person, not just the medical problem and spirituality is a part of that.'*

Only four interviewees gave a definite response to the question 'Where in the medical curriculum is spirituality currently taught, and how?' with 2 saying that it was taught and that they knew where and 2 saying that it was not taught. 2 said that it was taught but they did not know where, while the remaining 9 said that they were unsure whether and where it was taught. Of this group of nine, one said it "*probably comes up occasionally"* and another that it is "*touched on"* alongside a number of different subjects.

When asked 'where in the medical curriculum spirituality should be taught and how', 12 said it should be taught somewhere while 3 said that it should not be taught. Of the first group one said "*we need to take the spiritual values of patients into account"*, another that *"we need to see healthcare problems in the context of a patient's life and spirituality is a part of that"*, and another that *"spirituality needs to be addressed, but only in its broadest sense."* There was no agreement on how spirituality should be taught, though a number did say that it should be revisited at various points over the course of training. Specific methods for teaching about spirituality that were mentioned included 'small group tutorials', 'opportunistic teaching' (e.g. as relevant issues emerge in the care of particular patients), 'teaching by example', 'mentoring' and 'role modeling'. One participant commented, "*role models can have a profound impact on us."* One maintained that students need to be receptive to this kind of teaching before it can be effective, and that the students' interest needs to *"provoked"*. A number of participants suggested that the concept of spirituality could be introduced along one or more of the following topics: empathy, self-reflection and cultural sensitivity.

The participants raised a number of issues in response to the question about the challenges they perceive in teaching about spirituality in their medical school. Several indicated that they did not think spirituality should be taught in a 'generic' way, with one saying that *"the teaching of spirituality should not become another box to tick."* Some said that understanding the spiritual aspects of a patient's health required years of clinical experience, and implied that this was a barrier to teaching spirituality to medical students. Several stressed the need for sensitivity in addressing spiritual issues with patients. One said *"spirituality is very individual for medical professionals and patients"*, another that *"patients are in a vulnerable position...they should not be lectured."*, and another that *"clinicians would not want to see patients being harassed by misguided attempts of students to address these highly sensitive and personal issues."* This concern about sensitivity was also raised in relation to students being taught, as one participant said that *"it* [the teaching of spirituality] *would be logistically difficult as students bring such a wide array of cultural, personal and experiential backgrounds to their learning."* Another participant commented: *"...anything that hints at religion would alienate a substantial number of students."*

Survey

The survey was sent out electronically to 59 people from the Auckland School of Medicine and 128 from the Dunedin School of Medicine. 23 from Auckland responded (rr = 39%) and 50 from Dunedin (rr = 39%). 56% (n = 40) of respondents were male, 44% (n = 32) were female. 91% identified their ethnicity as NZ European or New Zealander, 5% as Maori, 3% as Tongan and 1% as Chinese. 71% identified themselves as an academic and 57% as a medical doctor.

Survey respondents were asked to identify from a list words they would include in a definition of spirituality. The four words most commonly identified were 'meaning' (n = 45, 63%), 'beliefs' (n = 45, 63%), 'faith' (n = 42, 59%) and 'purpose' (n = 36, 51%). 'Connectedness' was selected by 33 respondents (47%), as was 'religion' and 'values'. 'God' was selected by 32 participants (45%), 'sense of awareness' by 29 (41%), 'transcendent' by 27 (38%), and 'life giving force' by 25 (35%). 5 respondents (7%) chose the option 'it is meaningless' (other words were that were selected less frequently were 'sense of awareness', 'essence', 'inner core, 'balance', 'identity', 'relationships' and 'mystery').

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In response to the question 'is spirituality an important aspect of health?' 38 selected 'Yes' (52%). 13 selected 'it is important in some situations' (18%), 16 'it is important to some patients' (22%), 17 selected 'it is important to some patients in some situations' (24%), and 2 selected 'No' (3%). None of the participants selected 'not sure'.

When asked whether they thought it important that doctors understand their own spirituality, 48 respondents selected 'Yes' (71%); 7 selected 'it is important for doctors working in certain areas of medicine' (10%); 10 selected 'it is important for doctors who have personal spiritual or religious views' (15%). 8 stated that it is not important for doctors to understand their own spirituality (12%). 2 selected 'not sure' (3%).

In answering the question 'Where is spirituality currently taught in your medical school', 14 said small group tutorials (21%), 6 said independent learning (9%), and 4 said lectures (6%). 12 respondents stated that spirituality is not currently taught (18%) and 39 respondents indicated that they were not sure if spirituality was currently taught (58%).

Respondents were also asked to select from a list the best way to teach about spirituality. 50 selected 'small group tutorials' (79%), 26 'independent learning' (41%), 25 'opportunistic teaching' (40%), 12 'lectures' (19%), and 8 'it should not be taught' (13%).

When asked about potential obstacles to teaching spirituality in medical school 56 respondents selected 'lack of consensus regarding the nature of the topic' (81%), 41 selected 'lack of expertise among teaching staff' (59%), 31 selected 'teaching staff do not regard it as sufficiently important' (45%), 30 selected 'the curriculum is already overcrowded' (44%), and 22 selected 'students would not perceive its relevance' (32%). 10 selected 'it is not sufficiently important' (15%).

DISCUSSION

Studies of this nature have not previously been conducted in New Zealand, however the level of response achieved is similar to studies of a like nature done elsewhere.[3] While the low survey response rate inhibits generalization, the key findings fit broadly with the themes that emerged from the in-depth interviews of key curriculum coordinators, and also with the growing literature. Taken in this way, the study results provide an important indication of how medical educators in New Zealand view the relationship between spirituality and medical education, and the kinds of issues that should be addressed if or when spirituality is to be taught in these schools.

The results of this study suggest that those involved in medical education in New Zealand currently regard spirituality as an important aspect of healthcare and yet understand it in a variety of ways. All of those interviewed said that teaching about spirituality is an important part of medical training and 97% of survey respondents indicated that they thought spirituality was an important aspect of health at least 'to some people in some situations'. Only 3% of survey respondents indicated that they thought spirituality was not an important aspect of health, while only 7% indicated that they thought the concept was meaningless (presumably the 3 who thought it was meaningless *and* an important aspect of health were allowing for the fact that other people regard it as meaningful and important). 71% of survey respondents indicated that they think it is important that doctors have an understanding of their own spirituality, and the majority of interviewees thought that teaching about spirituality could be included in medical training. This broad agreement about the relevance of spirituality to medical education seems consistent with trends elsewhere in the world, as reflected in the widespread formal integration of teaching about spirituality in medical schools, which we noted earlier.

The major challenge that seems to emerge from these results is an apparent lack of consensus amongst participants as to what spirituality means. There was no clear agreement on this point amongst those interviewed, and more than a third expressed skepticism about whether a precise definition could be formulated. Participants in the survey identified a wide range of concepts as related to the meaning of spirituality, and 81% identified 'lack of consensus regarding the nature of the topic' as a potential obstacle to teaching about spirituality in medical school. This lack of consensus appears to be demonstrated by the conflicting views as to whether spirituality is currently being taught, with some saying that it was taught, others saying that it was not, and others being unsure. Thus, while the participants in both arms of the study identify spirituality as in some ways important to healthcare there is little agreement in either group as to what the concept means.

There are a number of ways one might explain how people could agree that spirituality is important while disagreeing about its meaning. One possibility is that in discussing this term people are confusing different things that are each important in different ways to different people. However, if the explanation were this simple it would be reasonable to expect that the confusion would be resolved as discussion proceeded, but evidently this has not happened. Another

[3]See for example, 'Spirituality and health in the curricula of medical schools in Brazil' where 47.7% of people responded (Lucchetti et al., 2012).

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possibility is that the term refers (or perhaps invokes) a set of issues or questions that people share, e.g. questions about the value of our lives and manner in which we respond to suffering (issues that are relevant to healthcare), and that these shared questions can be and are addressed by people in a variety of ways. This might explain how spirituality can be both important and 'indefinable', as many people could recognize the relevance of such questions and yet not be able to articulate a definite response to them.

The idea that the term spirituality refers to something that is both important to people and open to multiple interpretations fits with the concerns raised by participants about the potential sensitivities in teaching about it. Several of those interviewed spoke in cautionary terms about the potential harm of discussing spirituality with patients in an insensitive or inexpert way. Some extended this caution to discussing the topic with students, and mentioned the diversity of perspectives on spirituality among the current student population. While it is no doubt important to be aware of these potential difficulties, they should not be regarded as insurmountable. In a study undertaken in New Zealand into early clinical exposure to people who are dying, early clinical students were quite open about exploring their own and the patient's understandings of spirituality (MacLeod et al., 2003). More broadly, there has already been considerable discussion within healthcare about the importance of understanding and respecting how people of different cultures view illness, as in, for example, Arthur Kleinman's "explanatory models approach" (Kleinman, 1988). One might also argue that the latent sensitivities of the topic are a reason to include teaching about spirituality in the curriculum, especially as there is evidence that suggests that increasing numbers of patients want spirituality to be addressed as part of their healthcare. If spirituality is a sensitive topic that needs to be addressed, then it would be better that doctors do so in an informed way.

Given the apparent uncertainty regarding the meaning of the term, it is not surprising that there was no clear consensus as to how spirituality should be taught. It does seem however that using only a didactic, lecture format is not the most appropriate, and that a more personal approach is favored by participants, either through small group tutorials, role modeling, or opportunistic teaching.

Medicine in New Zealand is largely informed by and follows overseas trends, and to this extent these findings may be significant for and generalized to medical education in other secular countries. According to recent surveys, 90% of US medical schools and 59% of British medical schools have courses on the subject of spirituality (Lucchetti et al., 2012). However, there is still little research on the teaching of spirituality in medical schools in regions such as Latin America, Asia, Australia and Africa (Lucchetti et al., 2012). The New Zealand Ministry of Health produced a National Palliative Care Strategy in 2001, and was one of the first countries so. Included in this was the intention 'to develop the palliative care workforce and training requirements' (Ministry of Health, 2001). Despite this national initiative New Zealand medical schools have been slow to embrace aspects of palliative care training for undergraduates (MacLeod, 2001). This suggests that while there is on an international level a growing interest in the role of spirituality in health (Cobb et al., 2012) this has not yet – in some countries at least – been fully reflected in medical education.

In summary, the results of this study suggest that spirituality does not yet have a well-defined place in New Zealand medical schools and that the concept is not clearly understood by those involved with curriculum development and delivery. At the same time, the results also suggest that many in this group regard spirituality as an important aspect of health that should be addressed in medical training. The example of medical schools elsewhere in the world appears to be that this is achievable, though it seems on the basis of this study that there is a need for further discussion and research directed at developing a shared understanding of what the term refers to and how it is best taught in New Zealand.

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