

Toward a More Spiritual Approach to Medical Education

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Educators from a number of disciplines within higher education are urging attention to spirituality. The past decade has seen a renewed interest in "spirituality in medicine" on the part of medical educators. Over half of all U.S. medical schools now offer instruction pertaining to spirituality. The implications of including spirituality in medical education relate to curricular issues and medical school culture. The link between spirituality and other issues (e.g., medical professionalism, ethical dilemmas, and physician burnout) is also relevant. If we are to maintain standards of professionalism and meet the needs of students, faculty and patients during this time of upheaval in our health care system, we must consider the ramifications of taking a more spiritual approach to the medical education process itself. This paper explores those ramifications, and concludes that we must seek to humanize medical education and view medical schools as learning communities.

Key words: spirituality; medical education; biomedical ethics.

Introduction

The past decade has seen a renewed interest in "spirituality in medicine" on the part of medical educators. Recent surveys reveal surging attention not only to spirituality, but also to how spirituality relates to medical practice.^{1,2} Over half of all U.S. medical schools now offer some form of instruction about "spirituality in medicine," and residency training programs are also addressing this subject.³

Spirituality has been defined as that which gives ultimate meaning and purpose to one's life.⁴ Do patients want their physicians to be willing to discuss their spiritual values, or at least care for them in a manner that is sensitive to those values? Apparently so, according to a growing body of patient survey literature.⁵ Spirituality is considered by some to be an important and powerful coping skill used by patients; consequently, the scientific study of spirituality and/or religion as a variable that affects health outcomes is receiving increasing attention.⁶ Nevertheless, the current emphasis on studying spirituality as one would study other variables related to health outcomes, and advocating

its inclusion in physician training programs, remains controversial.⁷

Spirituality is a relevant subject for those of us who are educating medical students according to the biopsychosocial model. Some of the issues that are germane to the discussion of spirituality in a medical education context are: what exactly is "spirituality in medicine"? Why is it important? How does one integrate the knowledge of a given discipline or medical specialty with spirituality? What methods should be used to teach about spirituality effectively? And, perhaps most importantly, can one remain true to the science of one's professional discipline and still believe that spirituality is relevant to medical practice? While we cannot address all of these important questions here, perhaps we can at least stimulate further thought about them. In order to do so, we will first briefly consider material from the realm of educational theory.

The Purpose of Education: An Alternative Point of View
Renewed emphasis on spirituality in medical education forces us to think about the purpose of education. Traditionally, when the purpose of education is discussed, emphasis is placed on preparing students to master a given profession so they can obtain a good job, compete in a global economy, and attain a good standard of living. It is this focus on education as a means

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to material gain that is most noticeable in many educational theories.

In contrast, however, many theorists are urging educators to re-focus education on not just the material, but the spiritual as well; that is, teachers should assist their students in achieving a balance between the material and spiritual aspects of life.⁸ As a prime example of this trend, sociologist and educator Parker J. Palmer decries the lack of exploration of the inner life of students and re-defines education as the “pursuit of truth.”⁹ He contrasts this orientation with the prevailing positivistic viewpoint, where the student is pictured as the knower and the world as the known. Positivistic education is thought to mediate the relationship between the two, giving the knower ultimate supremacy and control over the known. In contrast, Parker points out that the root meaning of the word “educate” is “to draw out.” This is a radically different understanding of education, for it focuses not only on what is “out there” but also on what is inside the person, or “in here.”

According to Palmer, the use of the word “truth” in defining education is critically important. The word “truth” comes from a Germanic root that also gives rise to our word “troth,” as in the ancient vow “I pledge thee my troth.” This is a relationship word. By its use, we pledge to enter into “troth,” a relationship or covenant with another. It also means to allow one’s self to be known by another, to be vulnerable to the challenges of a relationship. Educating via a “truth” orientation may not change any of the facts, theories, or concepts. Rather, a truth-oriented approach to education would require us to recognize that education involves cultivating good relationships. If our relationships with our teachers are positive, the facts being taught are often viewed very differently than if those relationships are negative. Education, therefore, becomes a process that involves the pursuit of knowledge, with such knowledge not being merely objective but simultaneously subjective and personal as well. Knowledge is not only “out there,” but is also “in here” and dramatically affected by both the person seeking and the people imparting that knowledge. Education is ultimately based not solely on cold, hard facts but also on more subjective things like imagination, personal value, worth, and beauty. Truth is personal—and this approach to knowing something involves action on both my part and the part of the person from whom I am seeking to learn. According to this view of education, the good educator will not hide from his/her internal, subjective assumptions about knowledge but will state those up front. Far from compromising the educational process, these assumptions will often serve to enrich the process in ways not anticipated by either teachers or students.

The Spiritual Side of Medicine

So what is the relevance of this educational philosophy to

medicine and health care? For medical educators, the emphasis on spirituality in medicine has implications in at least two general areas: curricular issues and the medical school environment. Both of these areas should be explored if we are to determine the role that spirituality is to play within medical education.

In regard to curricular issues, the Association of American Medical Colleges (as part of its Medical School Objectives Project) has recommended that students be trained to “understand the meaning of patients’ stories in the context of the patients’ beliefs, and family and cultural values.”¹⁰ Approaches to this subject differ in medical schools that include spirituality in medicine in their curricula. Some schools offer courses that are organized as separate electives which allow interested students to examine spirituality, religion and related issues in detail as applied to medicine;¹¹ other schools have chosen to integrate selected topical materials across all four years of the medical curriculum. We have taken the latter approach and have focused much effort on training medical students to take “spiritual histories.” We also encourage our students to examine the research literature pertaining to the integration of mind-body-spirit in medicine, and how these connections are related to physical and emotional healing; we want our students to be aware of this emerging research suggesting a connection between spirituality and/or religious practices and health outcomes.

Regarding the environments of medical schools themselves, there has been increasing attention paid in recent years to the “hidden curriculum” within medical schools.¹² The culture of most medical schools is not necessarily conducive to the types of learning experiences called for by proponents of a more spiritually oriented educational approach. We tend to emphasize and reward competition by maintaining extremely competitive grading systems. Training institutions often overwork resident physicians to the point of exhaustion and burnout. An openly adversarial relationship between trainees and faculty often exists.

One reason for this state of affairs is that we are immersed in a largely positivistic approach to the educational process. This approach focuses too infrequently on the personal needs of our students and fails to explore with them the “inner realities” that their educational experiences create. For example, research has shown that the teaching of the principles of bioethics in most medical schools pays little, if any, attention to the ethical dilemmas faced by medical students and resident physicians in their roles as learners¹³. Such dilemmas are fostered by the medical school and teaching hospital environment, and exacerbated by a hierarchical system that expects students to be team players and give unquestioned obedience to those in positions of authority on the wards. Such expectations can have damaging effects on the learn-

ers, resulting in poor health habits, psychological problems, academic dishonesty, and cynical attitudes. Is this not evidence that we have contributed to an educational process that “damages the soul” of many of our students?

Specific Recommendations for Change

We view the formal curriculum, the process of medical education and the culture of the learning environment itself as factors that impact future physician behaviors in important ways. These factors relate at least partially to a basic spiritual concern of our learners: the ultimate purpose to be found in their calling as physicians. To the extent that we can simultaneously emphasize curricular concepts pertaining to spirituality in medicine, as well as re-emphasize the necessity of a more spiritual, humane process of becoming a physician, we anticipate that future physicians will be more willing to discuss the spiritual concerns of their patients. Why? Because they have become sensitized to the importance of those concerns as a result of personal reflection about them during the training process. But how can this be done? We offer suggestions for specific educational activities that will lead our students to reflect on their higher calling as physicians, thereby reflecting on the meaning and purpose of their individual lives, as part of the answer to this question.

We propose that medical schools work toward becoming places where students not only learn the science of medicine, but also where they can relate on a collegial level with each other, their faculty mentors, and their patients. Toward that end, we can provide small group experiences outside the graded curriculum for the purpose of allowing our students to process the ethical dilemmas they encounter during all four years of their training. We can incorporate an end of third year “reflections” ceremony into the curriculum, where students are invited to consider and talk about their most positive and challenging experiences during their clinical clerkship years¹⁴. We can provide students with high quality lectures from nationally recognized speakers who emphasize the role of spirituality and related issues (for students, faculty and patients) in the practice of medicine. We can encourage our students to take care of themselves physically, emotionally and spiritually and provide them with adequate free time needed to maintain their own health during the rigors of medical training. We can invite our students into our homes in order to role model for them what it means to be a humane, spiritually sensitive physician who is concerned about both individual patients and society as a whole. We can talk openly with students about why we chose the healing professions and how our own spiritual values were formed and impact the care of patients. And, we can show our own humanity in appropriate ways so that students will understand that physicians and other faculty members are not afraid to express our own doubts, fears and emotions. We can talk about openly and demonstrate behaviorally our concerns

about spirituality, ethics, professionalism, and upholding the highest standards of the medical profession. When we do these things, we are incorporating a spiritual approach to the educational process, one that addresses both objective and subjective elements of what medical education is really about.

Conclusion

Today’s medical students and resident physicians are leading the renewal of medicine as a profession as they learn about the variety of physiological, epidemiological, psychosocial, and spiritual factors that influence good health. Those of us in medical education should encourage students in this regard by including material on the importance of spirituality in medicine within the formal curriculum. However, in our view we cannot expect future physicians to acknowledge and address the spiritual needs of patients unless we first undertake a more humane approach to the medical education process itself. Such an approach will aid our students in making a connection between the process of becoming a physician and the outcome of a medical education, which we view to be a well-rounded physician who has developed a well-rounded professional identity. This approach will increase the likelihood that our students will not only become more humane physicians, but also discover for themselves the ultimate meaning and purpose in their calling as physicians (i.e., the spiritual meaning they attach to their profession). The re-orientation of medical schools as collegial learning communities as we have described will properly balance the acquisition of factual knowledge and skills (i.e., objective education) with the development of spiritual and professional identity and positive attitudes that reflect honesty, high moral values, empathy, and the selfless commitment to patient care that all medical educators wish to see in our students (i.e., subjective education).

In short, we urge further reform to the process of medical education. We call for deliberate efforts to create a more humane process of training physicians, one that will ultimately equip them not only with objective knowledge and skills but also with a sense of calling as healers. Deliberately establishing a sense of community within the medical education learning environment, where students and faculty agree to be accountable to each other and enter into a collegial relationship, will help us “draw out” (i.e., educate) the best of what is inside our students. This, in turn, will enable them to see the connections between their own purpose as healers and the entire spectrum of patient needs, leading them to practice in a more holistic manner. This is what we mean by a “more spiritual approach to medical education.”

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References

1. Sulmasy DP. Is Medicine A Spiritual Practice? *Acad Med* 1999; 74 (9): 1002-05.
2. Ehman JW, Ott BB, Short TH, Ciampa RC, Hansen-Flaschen J. Do Patients Want Physicians to Inquire About Their Spiritual or Religious Beliefs If They Become Gravely Ill? *Arch Intern Med* 1999; 159: 1803-06.
3. George Washington Institute for Spirituality and Health. URL: <<http://www.gwish.org>>
4. Puchalski CM, Larson DB. Developing Curricula in Spirituality and Medicine. *Acad Med* 1998; 73 (9): 970-4.
5. King DE, Bushwick B. Beliefs and Attitudes of Hospital Inpatients About Faith Healing and Prayer. *J Fam Pract* 1994; 39: 349-52.
6. McBride J.L., Arthur G., Brooks R., and Pilkington L. The Relationship Between a Patient's Spirituality and Health Experiences. *Fam Med* 1998; 30(2):122-126.
7. Sloan RP, Bagiella E, VandeCreek L, Hover M, Casalone C, Jinpu-Hirsch T, et al. Should Physicians Prescribe Religious Activities? *N Engl J Med* 2000; 342 (25): 1913-16.
8. Miller JP. *Education and the Soul: Toward A Spiritual Curriculum*. Buffalo (NY): SUNY Press; 2000.
9. Palmer PJ. *To Know as We Are Known: A Spirituality of Education*. San Francisco: Harper & Row Publishers; 1983.
10. Association of American Medical Colleges (US). *Report One: Learning Objectives for Medical Student Education (Guidelines for Medical Schools)*. Washington, DC: Association of American Medical Colleges; 1998.
11. Barnard D, Dayringer R, Cassel CK. *Toward a Person-Centered Medicine: Religious Studies in the Medical Curriculum*. *Academic Medicine* 1995; 70 (9): 806-13.
12. Hafferty FW and Franks R. *The Hidden Curriculum, Ethics Teaching and the Structure of Medical Education*. *Academic Medicine* 1994; 69 (11): 861-71
13. Musick DW. *Medical Ethics Education Must Include Students' Moral Dilemmas within the Clinical Setting*. *Academic Medicine* 2000; 75 (3): 215.
14. Woods S, Fosson S, Nora LM. The University of Kentucky College of Medicine Professionalism Project: Student Advocacy for a Culture of Professionalism. In Wear, D and Bickel, J. *Educating for Professionalism: Creating a Culture of Humanism in Medical Education*. Iowa City (IA): University of Iowa Press; 2000.