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Integrating Spirituality and Medical Education: What Students and Teachers Have to Say - A Qualitative Study

Sharon N. Hatcher, *The University of Western Ontario*

Supervisor: Moira Stewart, *The University of Western Ontario*

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INTEGRATING SPIRITUALITY AND MEDICAL EDUCATION:
WHAT STUDENTS AND TEACHERS HAVE TO SAY –
A QUALITATIVE STUDY

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By: Sharon Nur <u>Hatcher</u>, MD, FCFP

School of Graduate and Post-Doctoral Studies in Family Medicine

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Abstract

Aims

This thesis explored the perceptions of medical students and teachers with regards to spirituality, its role in health care, and its integration into medical education.

Methods

Two studies were conducted using qualitative descriptive thematic analysis: the first using focus groups with students, and the second depth interviews with teachers. Both studies were carried out in Francophone Canada.

Findings

Teachers spoke of a concept of spirituality evolving as a *journey*, while students reported sudden *turning-points.* Both regarded spirituality as important to *patient care*. Students were struggling with their *future physician role* and their *commitment to rationality*, whereas teachers emphasized the *central role of the patient-doctor relationship* in healing. Spirituality was perceived as a *taboo topic* in medical circles. *Barriers* and *facilitators* for integrating spirituality in medical curricula were identified.

Conclusion

Both groups made recommendations for *earlier exposure to patients* and *increased physician mentorship.* A holistic and integrated approach to medical education is required.

Keywords

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Co-Authorship Statement

The research for this thesis was conceived, planned and conducted by the author.

The following contributions were made:

Dr. Moira Stewart provided input and advice regarding the research protocol and ethics submission.

Dr. Moira Stewart contributed as well to the thematic analysis of both qualitative studies.

Dedication

This thesis is dedicated to my father, the late William S. Hatcher, mathematician, logician, Bahá'í scholar and Platonic philosopher, whose love of truth drove him to dedicate his life to the pursuit of harmony between Science and Religion. I am eternally indebted to him for his encouragement, guidance and love.

The following is an extract from one of his favourite prayers:

«O Lord, help Thou Thy loved ones to acquire knowledge and the sciences and arts, and to unravel the secrets that are treasured up in the inmost reality of all created beings. Make them to hear the hidden truths that are written and embedded in the heart of all that is…» 'Abdu'l-Bahá

It is my hope that in carrying out this research project, I have contributed in some small way to fulfilling the aspirations of these beautiful words.

Acknowledgements

Working on this thesis has been a labor of love, as well as a profound personal and professional growth experience. I would like to express my deepest gratitude and appreciation to the following people:

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Chapter 1

1   Introduction

1.1   Thesis Overview

This research project explored the perceptions of medical students and teachers with regards to integrating spirituality and medical education. Two qualitative studies were conducted between 2010 and 2012 in Francophone Canada. They are both included in this thesis in article form.

This thesis is comprised of four chapters. **Chapter 1**, the Introduction, provides an overview of the literature related to the topic, highlighting the relevance of the research project. The reader will also find an outline of qualitative methodology as well as a discussion of the trustworthiness and credibility of the methods used in these studies. **Chapter 2** presents the study carried out with medical students using focus groups. **Chapter 3** presents the study of teachers using individual depth interviews. Lastly, **Chapter 4** integrates the findings from the two studies, comparing and contrasting them. This chapter also includes recommendations for medical education and for future research.

1.2   Literature

Since the late 1990's, a steadily growing body of new literature has emerged reflecting a groundswell of interest in the topic of spirituality and health. Initially more a topic of the social science literature, the number of articles in the medical literature has grown significantly in the past fifteen years. A literature search performed by the author in data bases PubMed and Scopus, using keywords such as Spirituality and Health revealed over 4000 articles since the year 2000, while using Spirituality and Medical Education gave access to over 400 articles.

1.2.1   Definition of Spirituality

In many studies about spirituality and medicine, spirituality has not been easy to define. Often, very little distinction has been made between spirituality and religion. McKee and Chappel noted that spirituality deals with "the search for a sense of meaning and purpose in life" and is "that part of the psyche that strives for transcendental values, meaning, and experience."[1] Speck et al. echoed this definition stating that spirituality relates to "the search for existential or ultimate meaning within a life experience", whereas religion is "an expression of spiritual belief through a framework of rituals, codes and practices."[2] Calman emphasized that spirituality "is neither a doctrine nor a set of practices, but relates to the integration or wholeness of people and the connection between the individual and the whole of humanity."[3]

In an Australian study, Hilbers et al. asked 228 patients in a public teaching hospital in Sydney to define religion and spirituality. They reported that themes like "a sense of purpose or meaning", "a guiding framework", "a higher power", "a sense of belonging or connection" were included in the definition of both. However, spirituality seemed generally more positive and inclusive, "fluid and personal" whereas religion appeared "more formal" and was sometimes seen as divisive.[4]

King and Koenig have also made the point that spirituality is sometimes used to refer to the "good" part of religion in Western culture where religion has been more highly criticized. In their paper *Conceptualising spirituality for medical research and health service provision,*[5] they questioned the usefulness of definitions of spirituality that are so broad that they encompass all aspects of human experience. They also arrived at a working definition of spirituality that was comprised of four components: belief (in a domain "that goes beyond the material world"), practice ("without conscious awareness"), awareness (of being moved "intellectually and/or emotionally"), and experience (may be discrete or ecstatic).[5]

One of the caveats of trying to define spirituality for medical research purposes is the problem of including a sense of well-being or other positive feelings in the definition, thus confounding a possible association with positive outcomes.[5,6,7]

Perceptions of spirituality in the medical arena need to be further explored and elucidated. Monod et al. have stated: "At present, no definition of spirituality is universally endorsed and no consensus exists on the dimensions of spirituality within health research. As a result, numerous conceptualizations of spirituality have emerged."[8]

1.2.2 **Physicians and Spirituality in Patient Care**

Several clinical studies have explored the relationship between spirituality and health outcomes. Many have found positive associations, mostly related to religiosity such as church attendance and prayer,[9-14] but their methodology has also been criticized.[6,15,16] Other studies have demonstrated that a majority of patients (60-70%) wish their physicians would address their spiritual needs and religious beliefs.[17-20] McCord et al. surveyed a sample of 921 patients in family practice residency training sites in Ohio, and found that 83% wanted to be asked about their beliefs in at least some circumstances such as with life-threatening illnesses, serious medical conditions, and loss of loved ones – the most important reason being a desire for physician understanding.[19]

Despite the growing importance of spirituality in patient care, several studies carried out surveys that disclosed a significant gap between physician attitudes and practice patterns with regards to spirituality.[21-24] Ellis et al. found that 96% of Missouri family physicians surveyed "considered spiritual well-being an important health component" but only 58% believed physicians "should address patients' spiritual concerns."[21] Monroe et al. surveyed 476 U.S. Family Physicians and General Internists and found that 84.5% agreed that "they should be aware of a patient's religious and spiritual beliefs", but few felt that they should ask about them (30% in the office, 39% in the hospital), except with the dying patient (74%).[23] Curlin et al., in a survey of 1144 practicing U.S. physicians, reported that 91% felt it was appropriate to discuss religious or spiritual issues if patients brought them up, but only 55% would inquire about them on their own.[24] In a peer-reviewed presentation (Canadian Family Medicine Forum 2012), Micheal Lee-Poy

presented results from his 2009 survey of 139 family physicians in Ontario, Canada, finding that, although 81.8% held religious or spiritual beliefs, 65% felt that it is "sometimes important to know patients' religious or spiritual beliefs", and 51.5% responded that religion and spirituality are not relevant to health care. Only 4.4% asked patients about these aspects of their lives "most of the time" (51.8% asked "sometimes").[25]

Few studies have looked at possible explanations for this gap between physician attitude and practice. Some have cited lack of time, lack of training and physicians' fear of projecting their own beliefs onto patients.[21,23,26]

Several studies have also found that physicians were generally less religious than the general population.[27-30] Curlin et al., in the same survey mentioned previously, found that when compared with the general population, U.S. physicians were less religious (58% vs 73%), did not believe as much in life after death (59% vs 74%), and were "twice as likely to cope with major problems in life without relying on God" (61% vs 29%). Moreover, physicians were more likely to self-identify as "spiritual, not religious" than the general population (20% vs 9%).[28]

Three studies focused specifically on the profiles of academic physicians.[29,30,31] Catlin et al. surveyed 116 pediatricians from 13 U.S. academic centers and found that, compared to the American public, 67.8% vs 84.8% had current religious affiliation, 13% vs 40% believed in God. Moreover, these academic pediatricians were found to be notably less religious than other physicians. Of interest, 88% of respondents were raised in a religious tradition that was subsequently rejected, causing the authors to suggest that "the educated may be more open to eclectic forms of spirituality" or that "an academic career socializes physicians in these ways."[30] These are hypotheses that call for more research concerning the beliefs and attitudes of academic physicians about spirituality in patient care.

1.2.3   **Spirituality and Medical Education**

Of all the articles selected about spirituality and medical education (approximately 60), most were from U.S. schools. A few were from the U.K.,[32,33,75] South Africa,[34] and

Brazil.[35,36] Four were Canadian: one from a nursing program,[37] one from a psychiatry residency program,[38] and two from an undergraduate program.[39,40] None were found in French or from Francophone Canada.

In a 2010 review of 38 articles, of which three were from Canada, Lucchetti, Lucchetti and Puchalski found that the majority of studies related to health, medicine and spirituality were from U.S. schools,[41] where teaching on these issues has risen dramatically since 1993 when only three medical schools had incorporated them into the curriculum, compared to over 84% (of 115) in 2008.[42]

Several articles on spirituality in medical education gave a glimpse of the wide variety of educational activities and approaches that have been used in this area, however few were very detailed or offered a conceptual approach to teaching and learning about spirituality in medicine.[41] Anandarajah offered a template for medical curricula that included knowledge of scientific research and beliefs of world religions; importance of "spiritual self-understanding" and "seeing the patient as a whole person"; learning about "spiritual assessment" and "spiritual care"; as well as practical experiences with hospice chaplains and/or community resources.[43] Indeed, tools for spiritual assessment have multiplied,[44-50] as well as reference texts for teaching and learning about spiritual care.[51-55]

Puchalski emphasized the following components for a "successful" introduction of spirituality into a medical curriculum: that it be required content, integrated stepwise throughout the program, and involve interdisciplinary courses and creative teaching methods.[58]

In a 2012 review article from the University of Toronto, Hartung et al. looked particularly at recommendations for undergraduate medicine curricula.[40] Besides the above components outlined by authors such as Anandarajah,[43,72,73] Puchalski,[57,58] and Fortin and Barnett,[59,70] they noted that four educational approaches appeared to be most effective for teaching about spirituality: "academic study with literature review, experiential learning, reflective exercises, and small-group discussion with other students, faculty, and spiritual experts."[40]

One study asked teachers if they thought it would be appropriate to teach about spirituality or religion in medical school. McEvoy et al. surveyed 633 clinician educators in a New York medical school and found that those who self-identified as "both spiritual and religious" (32.5% vs 30.6% "spiritual-not religious" and 32.5% neither), had statistically significant higher correlation scores with positive attitudes towards teaching medical students about this topic.[60] King and Crisp surveyed 101 Family Medicine program directors in the U.S. and found that the presence of faculty members with "specific interest, expertise, or training in spirituality and health education" was a significant factor related to successfully introducing spirituality into the curriculum.[61] Surveys of teachers were limited in number and difficult to compare because they did not always use validated questionnaires with similar measures and/or were limited to certain types of teachers.

Most studies about spirituality that included medical students were evaluations of course satisfaction and retention, as well as a subjective sense of increased interest and competence with respect to integrating spirituality in their future practice.[62-75] Some studies explored medical student attitudes towards the topic. Williams et al. did a qualitative study using narrative analysis of first year medical student papers on death and dying at the Uniformed Services University of the Health Sciences in Maryland. A majority of the participants (76%) described themselves as religious or spiritual and 43% wrote about the role of religion, specifically that "belief in an afterlife" helped them cope with dying and death.[76]

Guck and Kavan found that 82.5% of students in a Catholic medical school in the U.S. believed spirituality should be included in the curriculum.[77] Moreover, authors such as Chibnall and Duckro,[62] Hull et al.,[63] and King et al.,[68] found that the more students were exposed to spiritual and religious issues in medical school, the more positive were their attitudes on the subject and the greater their willingness to integrate it in their future practice.[56,62,63,67,68,78]

One issue in medical education is the role of evidence that associates spirituality with positive health outcomes. Some authors have felt that this would be an important issue

for students.[43,58,79] However, Saguil et al. found in a survey of family medicine residents that only 39% strongly agreed that "they would be more likely to initiate discussions of spirituality with patients" given such evidence; whereas almost twice that number would talk about a new medication given similar evidence.[56]

There were also conflicting findings in the literature regarding optimal timing for introducing the topic of spirituality to learners. Luckhaupt et al. found that residents who were older were more likely to talk to patients about spirituality.[78] In the Guck and Kavan study, medical students stated that they felt this issue should be addressed early in the curriculum, even in preclinical years.[77] The conflicting results in studies regarding medical students may stem from several flaws, such as small sample sizes and/or because they were limited to certain types of students.

1.2.4   Summary

While the literature on spirituality and health has expanded substantially in recent years, several gaps have seemed apparent with respect to the integration of spirituality and medical education, thereby leading to the purpose of this thesis. These have included: 1) the confusion about the definition of spirituality; 2) the lack of studies from Canadian medical schools; 3) the limited amount of reliable data about the beliefs and attitudes of academic physicians who teach in these institutions; 4) the conflicting findings concerning the perceptions of medical students about spirituality in health care and education; and 5) the lack of clarity regarding the integration of spirituality in medical curricula. The aims of this research have been to fill some of these gaps, to elicit medical students' and teachers' perceptions of the topic of spirituality, and to question them about what they think would be appropriate educational activities in this domain.

1.3   Qualitative Methodology

Qualitative methodology has been ideally suited to inquiries that seek to understand perceptions of a topic,[80-84] especially one such as spirituality whose definition is still being developed. The research method chosen for the two studies presented in this thesis

was qualitative descriptive thematic analysis. The goal of these studies was not to have generalizable conclusions, but to offer a comprehensive summary capturing all the elements of the subject as explored with the study participants, as well as the *meanings* participants gave to their experience.[83]

Within qualitative methodology, different methods of analysis were reviewed and considered. These could be partly differentiated according to the level and method of interpretation of the data.[80,81,82] Grounded theory was an example of a method that sought to construct theoretical models of the topic from the data, with or without reference to a theoretical framework existent in the literature. Putting it simply, the question typically asked was: *How* does this process come about? Phenomenological analysis, on the other hand, sought to understand *why* participants lived or spoke of certain experiences. The purpose of this research project was not to relate the data to an existing or newly constructed theory about spirituality in medicine, nor to interpret the underlying motivation of participants, but to describe *what* was said about the research topic.

In this research project, descriptive thematic analysis was a useful method for at least four reasons. First, the purpose was to do justice to the complexity of participants' perceptions as revealed in the data. This was certainly the case for the topic of spirituality which was deeply personal and related to the complexity of human experience.

Second, the analysis included a process of repeated cycles of "immersion/crystallization",[85] whereby the researchers were able to reflect on the participants' experiences as expressed in the data and develop thematic insights.

Third, this simpler (but not simplistic) form of qualitative methodology offered a more accessible form of analysis, better suited "for those early in a qualitative research career".[84]

Fourth, descriptive thematic analysis has been known to be particularly useful "when you are investigating an under-researched area, or you are working with participants whose views on the topic are not known."[84]

1.4   **Trustworthiness and Credibility**

The trustworthiness and credibility of the study findings in this thesis resulted from several aspects of methodological rigour, the first being that of methodological congruence,[86] i.e. the research method of qualitative descriptive analysis fit with the research questions and the topic. Second, participant recruitment and sampling were conducted in order to ensure maximum variation with respect to selected variables over which the principal researcher had control. Third, well-defined qualitative data gathering techniques were used (semi-structured interviewing using focus groups as well as individual depth interviews). Moreover, the transferability of the findings was enhanced by the care and time taken to ensure saturation of themes across the data set. The analytic process was done with rigour, and coding reliability was increased by repeated cycles of team review and discussion. Flexibility was necessary in reworking of themes, thus increasing the validity of the analysis. The process of team decision-making was well documented and dated. Field-notes were made both during and after the interviews. These contributed to the reflexivity of the principal researcher, increasing her own awareness of her personal beliefs and feelings, thereby decreasing the risk of bias. Finally, the accuracy of the translation of data from French to English was enhanced by having randomly selected extracts back-translated. Member-checking was not done for feasibility reasons.[81,82]

The two studies (one of students and one of teachers) were conducted in a parallel time frame, with both contributing equally to the overall research findings. The team analysis of the teacher data was carried out first, followed by the analysis of the student data. Care was taken, to the extent possible, not to have the findings from one study influence the analysis of the other.

1.5   **Analytic Preconceptions**

In "*Doing Qualitative Research*",[81] Stephen Bogdewic pointed out that "every attempt should be made to explore one's preconceptions prior to entering the field."[87] He was referring to the necessity of researcher self-reflection and self-awareness in participant observation studies. Although the main data gathering technique used in the two studies of this research project was interviewing, there were inevitably elements of participant observation for the principal researcher, who is herself a medical teacher and administrator in the same medical school where these studies were carried out.

Thus, in order to decrease researcher bias within the data gathering and analytic process, the principal researcher made prior note of her preconceptions with respect to the topic of integrating spirituality into medical education:

- ❖ The principal researcher had already come up with her own working definition of spirituality, based on the literature review and other reading.

- ❖ The principal researcher had personal beliefs and practices of her own. For her, spirituality was positive and could not be negative.

- ❖ To the principal researcher, there was an obvious difference between spirituality and religion as currently practiced.

- ❖ The principal researcher as a clinician had cumulated several spiritual experiences with patients that she had never shared with colleagues.

- ❖ The principal researcher perceived a lack of content and openness with respect to spirituality in medical curricula in general.

- ❖ To the principal researcher, medical students appeared on the surface to have little personal experience or interest in spirituality.

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Chapter 2

2   What Students Have to Say

2.1   **Introduction**

Medical education has been in a process of transformation since the end of the last century, widening its scope and focus to include the humanities, communication skills, ethics, and other aspects deemed necessary for competent, professional patient care. Some might say it has gone back to its roots after an overemphasis on the more technical aspect of scientific medicine, and in response to patient demand.[1-4] In recent years, a new dimension has been added to the curriculum by some medical schools, that of spirituality. In the U.S., this phenomenon has grown rapidly to include over 84% of medical schools in 2008.[5,6]

For the most part, spirituality has not been distinguished easily from religion. Some medical studies have referred to Religion/Spirituality (R/S) as a research topic,[7,8,9] although many authors have contrasted the two by pointing out that religion refers more to some type of formal practice, whereas spirituality has a wider, holistic connotation.[10-13]

The literature has reported descriptions of educational activities in medicine related to spirituality and religion that have included lectures, readings, discussion groups, personal reflection, practice of spiritual history-taking and assessment, rotations with hospital chaplains, and courses on cross-cultural and religious diversity.[6,14-21] However, many of these activities have been offered in elective courses with low attendance.[6] Most published studies about spirituality that have included medical students were reports of evaluations of these courses with regard to student satisfaction and retention, as well as a subjective sense of increased competence.[6,7,16,17,19,20,24,25,35]

We found that few studies examined what medical students felt or thought about integrating spirituality into the medical curriculum. Some authors have suggested that students were more likely to be interested in the topic if shown evidence that spirituality had positive effects on health outcomes.[15,18] Others showed that such correlations

influenced only a minority.[23] Several studies revealed that the more students were exposed to the subject, the more its significance and relevance increased in their eyes.[7,17,24,25]

Some authors wondered if educational efforts would be better directed towards residents rather than medical students, since the former have demonstrated a greater interest and willingness to incorporate such issues in practice.[17,26] However, one qualitative study found that students felt this issue should be addressed early in their program.[22]

Overall, these studies have not created a clear picture of students' perceptions of spirituality in health care or in medical education, demonstrating several gaps in the literature. Some of these may stem from the fact that 1) most studies were surveys; 2) many of these were course evaluations; 3) several studies showed conflicting results which may possibly be due to small sample sizes or that findings were limited to certain types of students; 4) few have questioned student definitions of spirituality itself. Our guiding premise in this study was that a better understanding of medical students' world view, as well as attitudes and beliefs with regard to spirituality and health, were thought to be essential to answering the many questions that remained about what might be relevant and effective in their education.

2.2   **Study Questions**

In light of the gaps in the literature noted previously, the following research questions were chosen for this study:

1. How do students perceive spirituality?

2. How do students perceive the role of spirituality in health care?

3. What educational activities can assist students to integrate and apply spirituality to their future professional practice?

2.3   **Methods**

2.3.1   **Context of Study**

This research project was conducted as part of the Masters in Clinical Science program of the principal author, assisted by two co-researchers, one of whom was the author's thesis supervisor. The study was carried out in Francophone Canada, namely in the two provinces of Quebec and New Brunswick. The students involved in the research project were all from the same medical school comprised of one main campus and two regional sites.

The curriculum of this medical school consisted of four years of training including two problem-based preclinical years followed by an integration session and eighteen months of clerkship.

2.3.2   **Methodology**

We used qualitative descriptive thematic analysis with data from six focus groups in order to capture the richness and depth of "multiple stories and diverse experiences."[27] Student focus groups were conducted in the three sites, grouping first and second year students together in some groups, and third and fourth year students in others. This was decided in order to increase a feeling of safety for participants at different stages of training and to ensure sufficient homogeneity to favour a rich discussion.[28]

2.3.3   **Participant Recruitment**

Sampling was done via repeated emails to all students in the three sites, after approval by the Program Director (see Appendix A for original invitation). The principal researcher was also able to directly invite students in all sites at the beginning of some of their regular courses via videoconference. Most students who volunteered (via email) came to their scheduled focus group. A few students showed up unannounced which offset those who did not come. Focus groups were held during an optimal time in the student schedule, in their own study site. Thus, the sampling strategies that were used for this

study were purposeful (those students who volunteered were selected as participants), and at times opportunistic (students replacing others at the last minute), with certain criterion being applied for maximum variation between academic sites and year of study. Some homogeneity was inherent and inevitable in the sampling given the similar cultural context of the participants (who were mostly Caucasian, Francophone, originally from Canada). This reflected the current demographic reality of the study sites. Also, students were recruited from only one university simply for reasons of feasibility. Thus, there was also a level of convenience sampling relied upon in this study.

The size of the focus groups varied. Of the six focus groups eventually formed, the largest had 7 participants, followed by one with 6 and another with 4 participants. The other three had 3 participants. The goal was to recruit six participants per focus group but this was not always possible for a variety of reasons (see 2.6 Strengths and Limitations).

2.3.4   **Data Collection**

A total of six focus groups were held lasting two hours each. The discussion was in French, moderated by the principal researcher for all groups except for two held in the site where the principal researcher had an administrative role in the Undergraduate Medical Training Program. For these latter groups, one of the co-researchers acted as moderator in order to avoid any conflict of interest. All focus groups were audio-recorded and then transcribed verbatim in an anonymous fashion by an assistant. The accuracy of the transcriptions was verified by the principal researcher listening to the audiotapes. The principal researcher also took notes during and after the groups.

Prior to the focus group, each participant read and signed a consent form (see Appendix B) that had been sent previously by email. Participants also filled out a demographic data form just prior to the start of the interview.

The interview guide was developed in French (see Appendix C for original French and translated English versions). Four open-ended questions were devised for each of the

three research questions in order to elicit discussion between participants. An earlier version of the interview guide was piloted a year before the current study, with a focus group of medical students from one site, in the context of a postgraduate course of the principal researcher. This permitted the interview guide to be refined and adapted. The more specific questions and prompts used by the moderator varied according to the dynamics of each group and the synergy and spontaneity of the participants, as is usually the case with focus groups.[27] After the first two focus groups, three questions were added to the interview guide concerning the discomfort of students in participating in the study: Why did you come here today? Why do you think others did not come? To what extent do you talk about spirituality with your colleagues?

2.3.5 **Data Analysis**

Thematic analysis was carried out as an iterative process with constant interaction between the data, the principal researcher and the two co-researchers. The transcribed focus groups were read through by each researcher independently in order to become familiar with the data set as a whole, while noting initial ideas. There were no predefined codes that were used from the literature. During this "immersion" phase of the analysis, initial codes were generated by highlighting interesting features of the data such as within-group and across-group areas of similarity, areas of difference, as well as striking aspects. Notes about each focus group were re-read and expanded. The principal researcher then suggested codes and potential themes related to each of the three research questions that were discussed with the two co-researchers in order to arrive at a coding template. The focus group transcripts were then re-read, collating data relevant to each code comprehensively across the entire data set as well as gathering all data relevant to each potential theme.

The analytic process permitting "crystallization" of themes was iterative, reflexive, and creative. Using multiple copies of computer text, coded data were grouped under each related theme. Some extracts could be collated to more than one theme. Further discussion between the principal researcher and the two co-researchers focussed on identifying important elements that were missed, discrepancies and alternative interpretations. After five focus groups were conducted, it appeared that saturation of

themes had been achieved in the data set. However, given that some of the focus groups had fewer than the ideal number of participants, it was decided to conduct a sixth focus group in order to validate that saturation of themes had effectively been reached.

Final verbatim extracts were then selected that best reflected each theme and translated into English by an independent assistant. In order to verify the accuracy of the presented data, randomly selected extracts were then back-translated into French by another person.

2.3.6 **Ethics Approval**

This study was submitted and received full ethics approval from the appropriate ethics committee responsible for evaluating research projects in medical education at the university (see Appendix D). A follow-up report was sent annually and at the end of the project as requested. The standard criteria for preserving participant and data confidentiality and anonymity were followed. Students did not receive any reward for their participation but light refreshments were provided.

2.3.7 **Sample Demographics**

Of the six focus groups, three (50%) were held on the main campus, and the three others (50%) in the regional sites. Four focus groups involved 19 participants (73.1%) from the first two years of the medical program and two focus groups involved 7 participants (26.9%) from the last two years, making a total of 26 student participants.

The age of the participants ranged from 19 to 38 with an average of 23 which was the same for both types of focus groups. Seventeen participants were female (65.4%) and nine were male (34.6%) which corresponds approximately to the ratio of female to male students at the medical school. All students were Caucasian, with 24 (92.3%) of Francophone background and 2 (7.7%) of Anglophone background.

A minority of participants (8 = 30.8%) had some level of previous university studies including History, Communications, Public Administration, Biochemistry, Occupational Therapy and Nursing.

Half of the participants (13 = 50%) stated in the demographic survey that their religious belief was Roman Catholic although five of these added qualifiers such as "Christian", "non-practicing", "agnostic", and "non-believer." The remaining half did not present any beliefs although one student stated: "spiritual but not religious." Four (15.4%) stated they were atheists, three (11.5%) stated they were agnostics, and the five others used words like "none", "lay", "don't know", "more or less". This represented a total of sixteen (61.5%) with no clear beliefs.

Thus, there was maximum variation of participants according to age, gender, year of study, academic site, and prior studies before entering medical school. With respect to religious beliefs and spiritual practices, although there was no other religion represented except for the Christian faith, there was diversity in that few participants shared the same expressed beliefs, and there was maximum variation between those who had some beliefs and those who had none.

2.4   Findings

The findings from this study can be divided into three major themes (see List of Themes and Codes in Appendix E). The first theme, **Understanding Spirituality**, includes as subthemes the **Concept of Spirituality** and its **Expression in Daily Life**. The second theme, **Student Dilemmas**, relates to three subthemes brought forward by the students: **Personal Change in Direction**, concerns about their **Future Physician Role with Patients,** as well as their **Struggle with Rationality in Medicine**. The third theme, **Perceptions of the Medical Curriculum**, relates to the barriers and facilitators of integrating spirituality into medicine.

2.4.1 **Understanding Spirituality**

Focus groups struggled with trying to define spirituality, as indicated by the following statement: *«It's hard to define because it's not something that is tangible.»*

Several came forward with some philosophical and abstract concepts as summarized in 2.4.1.1, but most found it easier to describe practical applications of spirituality in daily life as found in 2.4.1.2.

2.4.1.1 **The Concept of Spirituality**

Participants in many groups found it difficult to find the right words to express something they felt was very **personal,** almost too intimate to talk about. Some stated that they had never thought much about the topic before, much less talked about it: *«It's so personal... to expose it, it's not a given.»*

Students agreed that spirituality related to an **intangible** aspect of human existence, summed up in words like *«thoughts», «energy», «spirit», «soul», «unconscious».* As one student put it : *«It's what's left when your body is not there anymore. For me, that's the soul.»* However for many groups, this non-physical aspect of spirituality did not equate necessarily in a belief in life after death: *«I don't bring it down to a life before or after.»*

Participants also evoked a sense of the **transcendent**, of *«superior», «supernatural»* forces, which was a broader concept than a belief in God: *«It's not necessarily God, because I don't know if I am a believer or not, but I do believe that there is something superior to me and to us.»* Several groups had a prolonged discussion about whether someone who was an atheist could still be spiritual. One participant pointed out that atheists still believed in other transcendent things such as love: *«You are atheist, except that love is not religious, but at the same time, it's something that is superior to you.»* Participants also mentioned other uplifting aspects of the transcendent, such as the

«harmony of the physical world», «a beautiful river», «a walk in the forest» and *«listening to music».*

Groups shared many thoughts about the **difference between spirituality and religion**. For many, they appeared to be interchangeable. *«For me it's difficult to disentangle spirituality and religion, for me it has always gone together.»* Most referred at length to experiences with religion when asked about spirituality. There emerged however the generalized concept that spirituality as a personal experience was different and somewhat broader than religion, which was referred to as an *«organized system of values», «a mass movement»*, necessary for *«social cohesion»* and *«civil order».*

«I think that for me spirituality is searching outside of oneself for answers that we don't have. To find them elsewhere without necessarily practicing a specific organized religion.»

2.4.1.2   Expression of Spirituality in Daily Life

Groups referred repeatedly to the effect of spirituality on daily life: *«I have the impression that spirituality is part of my everyday life. I have the impression that it's there all the time. For me.»*

Participants described spirituality as related to guiding principles, a **framework for beliefs and values** that represented an anchor, *«something you can hang on to when you are somewhat at a loss or you don't really know which way to go.»* Participants described this framework as giving a sense of direction in life, of *«guiding choices»* and **helping to make decisions**: *«I see spirituality as deep beliefs that kind of guide our way of acting.»*

Some students spoke of trying to be *«better people»*, of humanistic values that led to *«less individualism»* and to **helping others**. As one student put it: *«I think it's really about looking outside of ourselves. To try and get a sense of the world that surrounds us and the people we have relationships with.»*

Several groups stated that spirituality helped **deal with life's difficulties** by providing a way of *«making sense of it all»* on a daily basis: *«But it's a bit every day, it's really the way you approach life and what sense you make of it and of your decisions. Yes, it is seen even more in difficult moments, but I think that it's every day.»*

Positive Effects

Participants emphasized that spirituality helped themselves and those who were facing difficulties, including illness and even death, by increasing **resilience, optimism** and **serenity.**

Resilience was described as having the inner strength and resources to face a difficult situation, as well as the courage and confidence to get through it.

«There's like an aspect of a patient's spirituality that relates a lot to, I wouldn't say inner strength, but the capacity to face the situation, manage it,... a bit how will I be able, with my personal spiritual baggage, my energy, my self-confidence, the confidence I have in the situation to get through the fact of receiving bad diagnoses or good diagnoses, my prognosis...»

Participants spoke of how spirituality increased a sense of optimism, giving hope to many, and helped keep a positive outlook on life's challenges and events.

«Sometimes..., in the same situation, you can have one person who is extremely pessimistic and who is really not doing well and another person who still remains optimistic and who is doing well, like spiritually. It's just the way the situation is seen that changes the thing and often, spirituality plays a big role in that.»

Students gave many examples of meeting people where spirituality was conducive to serenity, a sense of *«calm»*, an acceptance of their situation or of what was to come. Some wondered if this serenity could contribute to passivity in the face of difficulties, but others felt that it contributed rather to resilience and the capacity to confront them.

«You give yourself a certain serenity that is more solid, to have more confidence in yourself and in where you are going. I think it's something that is important because it brings a balance that shows.»

Negative Effects

Participants reported that negative effects usually occurred in the context of certain rigid religious practices. Groups raised several concerns about the effect of spirituality in people's lives, including increasing **passivity** as previously mentioned, as well as **guilt** and **anger** at God leading to a crisis of faith. One student told the following story :

«I didn't go to church, but I went to catechism. Then, they would always talk about that, about how we had to pray every evening and I didn't pray. How to be a good Christian. I remember, in the news there was like a girl who had disappeared and we prayed every day and we were told that if we prayed enough, we would find the girl and finally they found the girl: only her skeleton. I told myself it was because we hadn't prayed enough.»

Participants also spoke of the negative effects of **religious extremism** leading to divisiveness, hatred, fanaticism, and a *«loss of autonomy»* and *«critical thinking»*.

«At the level of the masses, fanatics or whatever, there are all the disadvantages that we see today,... there's too much of putting oneself in the hands of someone else. Someone who would need to believe to the point where he has the impression that his life belongs to God - it becomes dangerous. First there's like a loss in autonomy, a loss of the person proper and self-determination. I think it can be one of the disadvantages, if it's pushed to the extreme.»

2.4.2 **Student Dilemmas**

Students recounted three main areas in their lives where they appeared to be facing significant dilemmas with regards to their past personal lives, to their future physician role with patients, and to their current role as students of scientific medicine.

2.4.2.1 **Personal Change in Direction**

Focus groups pointed out that no matter what background participants came from - very *«hard line»* religious, somewhat spiritual, or nothing at all - they were all originally influenced by their parents' beliefs and attitudes: *«When you're young, your parents often are your model; the more you grow up, the more you look for other models.»*

Many participants recounted growing up in families with strongly determined religious beliefs and practices that influenced them greatly. Participants referred to these **childhood beliefs** as a reference point for their current perceptions of spirituality.

«When I think of spiritual people or believers, the first reflex I have, it's the generations who've been there before us... When I think spiritual I see my grandparents, I see my grandmother who's going to mass, saying her rosary, saying her prayers; it's really the image I have in mind of spirituality as a first reflex.»

Several participants spoke of their current values being influenced positively by the early religious framework, even if they were not practicing anymore: *«For most people, it's things that were positive and it's still things that were imbued by their parents. Often when it's less radical, those are the values that will stay after.»*

For others, their childhood experiences were not so positive; they felt that they were caught in a situation where belief was imposed and could not be questioned.

«I never had the opportunity to ask those questions, the answers were given to me before even understanding the questions... I grew up in a very religious family... you believe what your parents say because they are adults and they are the ones that know...»

Turning-Point

Several participants spoke of arriving at a moment of change, **a turning-point**, where their desire for autonomy and the freedom to shape their own spirituality took precedence.

«It's because the child who is baptized, who since he was very small has been imbued with a religion, for sure at one point he will more easily adhere to that religion until the day when you decide (I call that 'think by yourself') to say: 'OK certain things were instilled in me, but now, does this satisfy me still? Does it make sense in my life?'; and you can very profoundly change your beliefs.»

«My kind of break; which is not really one. It's kind of a snowball effect. It's more like when I entered my first year of high school.»

Some participants recounted their personal struggle, often with emotion, between rejecting parental beliefs but not wanting to break family ties or *«create tension»*.

«It took a while for me to come out of that idea, to find my own spirituality instead of following what I had learned since my early years and do like my family, do like my church. It took me a long time to really decide for myself what was best for me and what I felt like I wanted.»

«You feel guilty of thinking on your own, so necessarily when you decide to throw it all in the garbage, you experience a great void and it's hard, it's the part that's not easy.»

Even those students who did not reject their childhood beliefs described a process of seeking spiritual **autonomy** : *«The beliefs I had, I did not want them only because that is what I was taught when I was young.»*

Groups emphasized the importance of **questioning** and of **critical thinking** leading up to the moment of potential change in direction.

«When you are a child, when you're young, you may not necessarily have the capacity for abstraction, to be critical and all that, and then, as you get older, through your experiences, you become emancipated and it becomes a more active spirituality.»

«Therefore, I looked to find my own answer to what life is... in the third grade, I was 8-9 years old.»

For some groups, spirituality itself seemed more about asking questions than receiving answers: *«For me, I think spirituality is to look outside of oneself for answers that we don't have.»*

For others, personal experiences of suffering, like illness, triggered certain questioning: *«Sometimes I ask myself the question... I say: If God is infinitely good, why is there so much suffering. This troubles me...»*

Death, of family members, of patients, was mentioned frequently as a subject of questioning about life and spirituality: *«I try to find the answer to what life is, why are we here? What will happen in the end? We die, after we die? Is there a part of us that stays here or will we just cease to live?»*

Several participants also spoke about continued **reflection** and **introspection** as part of their spirituality: *«It's a lot of adjustments, self-evaluation, where I'm at, how do I realign myself. It's really a moment when I stop myself, when I think about how I act, what I want, the mistakes I've made, that I would like to correct, it's really a realignment.»*

All in all, students stated that from then on their spirituality would probably keep changing, through life's experiences and difficulties and with *«personal maturity»*: *«It's a constant self-questioning.»*

2.4.2.2 Future Physician Role with Patients

With regards to the role of spirituality in patient care, students seemed torn between two concepts in their anticipated physician role: the importance of engagement with patients and the need for proper distance from them.

Engagement

Groups felt that **taking into account a patient's spirituality or religious beliefs** could be important to patient care. Students expressed that asking about these issues was part of taking into account the whole person, particularly with regards to decision-making about interventions and treatment.

«You have to see the person as a whole. There's the person, his physical environment, his social environment, his spirituality, there's all that - the person is not just an arm, for example. There's something that gravitates around that, that's important to take into account because the approach will be totally different according to the person's beliefs. You will not opt for the same treatment depending on the person, because it will vary.»

«Whether you want it or not, the patient's spirituality is part of the patient. It's still one of the great parts of his life. Whether you believe in it or not, it doesn't change the fact that the person believes in it, that's what's important. It's not whether it's true or not, the person believes in it and it's an aspect of the patient that can change what the patient wants for treatment and it can change his hope.»

Several participants went further, stating that patients who are suffering and facing bad news also need someone who *«cares»*, *«comforts»*, and is *«supportive»*. Many mentioned the singular importance of **listening**.

«The number of patients who told me: 'In any case, when you become a doctor, listen to us, we feel so unheard.' It's happened to us, it's happened to a lot of people. I have at least four faces of patients in mind, especially elderly, but, even one girl who was quite young and who looks you in the eye and she looks so unwell. She looks at you and says: 'I do not feel listened to.' All you can answer is like yes, yes... It's crazy. I was so upset.»

Students spoke of the importance of **welcoming** patients, even if they have differing beliefs and values.

«It would be welcoming distress and... by welcoming distress, [I mean] what's important to look for: what is the distress and try to define it... I have the impression that whether you want to or not it would come naturally if it was what the person wanted with regards to his spirituality.»

«Without needing to talk about spirituality. Just the fact of having someone in front of you, who's interested in you, who wishes you well, who is there to encourage and support you, to give you hope. We don't need to talk about supernatural things.»

As the previous extracts indicate, many students questioned the need to talk explicitly about spirituality with patients. The point was made that a physician can get to know a patient and infer his or her beliefs and values, *«picking up on cues»,* without actually discussing the topic.

«I think there's a way to go get all that but it's not necessarily our first objective when we have a patient or sick person in hospital. You have to take it into account, you have to go in the same direction, but I'm not sure that's it's relevant to get into that, those big discussions.»

<u>Distance</u>

Participants questioned their role as physicians with patients wondering about the **proper boundaries** with regards to such an intimate, personal topic.

«I think that it is a personal belief that doesn't necessarily need to enter into the patient-doctor relationship. I don't think it's our role to talk about spirituality with our patients. They have family members for that... Our role is to talk about the physical, talk about medicine.»

Some participants were concerned about **ethical dilemmas**, anticipating situations where their own beliefs would be different from their patients.

«We talk about informed consent, but at the same time we are always told how to do positive counselling, how to convince patients. As much as they teach us to respect their choices, at the same time, they teach us to contradict them and to try and change their mind to explain to them how we think. It's pretty contradictory when you see it that way.»

«The doctor should not always put aside his personal values; he should just not impede on those of the patient... Sometimes we come to make very difficult decisions on the ethical side, if the doctor does something that is completely opposed to his values, it will be very, very difficult to live with his entire life. I think we can hardly change our values. Managing both is complicated. It's easier when the person has the same values as us, that's for sure.»

Groups also mentioned **lack of time** as an issue, based on observations of physicians around them, but some suggested ways to overcome this obstacle.

«I think the doctor has only, like what? Twelve minutes for each patient and seven minutes to fill out charts and write notes, therefore not enough time to establish a strong relationship with the patient.»

«Despite this, even if you don't spend a lot of time with the patient, as a doctor, with the two minutes that you can spend, attitude can change a lot of things for his or her progression afterwards.»

Participants stated that **using referral sources**, such as a priest, spiritual counselor, or support group, represented one solution to their dilemma. As one student summed up the discussion :

«How do we really want to address spirituality in medicine: ... there are really two camps: one is 'OK... the doctor takes care of everything, the physical, the biological and the spiritual'; and you have the other camp that says: 'OK, we are not guys who are necessarily religious, we don't have any training, we don't want to harm a patient like discussing spiritual things and it doesn't work with the patient.' So they say: 'No, that's not our job, but it would be a good thing to have... like having another member in the team'...»

It is interesting to note that despite many concerns about proper boundaries between doctors and patients, several students (particularly those who were already in their clerkship years) told stories of personal engagement with patients on an emotional level.

The following are two of these stories :

«First day of my rotation, there's a patient I was talking to who started crying in front of me and I stayed really like 15 minutes talking to her because she was so stressed, she was so stuck in her stuff. She did not have the impression that she was listened to and had the impression that she was a disturbance if she talked to them. I just arrived like that and I had nothing else to do but just be there.»

«He was a patient who... during the history-taking, there was something that wasn't right and finally while questioning him he started crying a bit, it wasn't going well. Finally, it's as if that patient, I didn't see him as a patient with a lung problem. Right away I saw him more as a patient who had a psychological problem. Each time I went to see him I would ask him more on a psychological level how he was doing. At one point, he asked me many times (no one would come to see him, he was always alone at the hospital) if there was a priest, if I knew a priest. If I could find a priest. It was my first rotation and I didn't know there were priests at the hospital, and he told me: 'Yes I saw one walking around earlier, can you ask for him.' Finally, I made a request for him; I was kind of told how it worked. In the end, I think that he only needed an ear, it was not in a context of imminent death.»

2.4.2.3 **The Struggle with Rationality in Medicine**

In all of the focus groups, students struggled with how something as *«subjective»* as spirituality could fit with their commitment to scientific truth and **evidence-based medicine**.

«You know, we always talk of 'evidence-based medicine', we don't talk of 'evidence-based spirituality.'»

«To believe something that is not scientific, what's the use of science?»

Students expressed that part of what led them into medicine was their love of science and the importance of **rationality**. The reassurance of *«proofs»*, backed by *«studies»* was contrasted with the discomfort of the unknown and possibly the unknowable. The following extract reflects similar statements made in all focus groups: *«I'm not uneasy, but I don't understand and I have difficulty with what I don't understand.»*

Groups did speak of studies that had shown positive health outcomes of spirituality. Participants pointed out that **emotions** and **stress** were factors in the evolution and the cure of disease and that spiritual practices such as *«prayer»*, *«meditation»*, *«reflection»*, *«relaxation»*, as well as *«alternative therapies»* could have a positive impact. They also referred to the beneficial effects of spirituality on attitudes necessary for healing, such as resilience, optimism, and serenity as stated earlier.

«I think that there's a part that's real, you know, when you say that you are stressed or that you don't feel good about yourself or on the contrary that you feel good, that it really has an influence on your health, like we don't know the link there is between our abstract thoughts and our concrete body, but there is one. We are not separate. It's just that we don't know what it is.»

Some participants felt that the effect of the spiritual on illness was through the placebo effect, **strong belief** causing some kind of physiological change: *«All of the placebo effect; we talked about it, the effect of mind on body. I am convinced that it influences a lot, a lot. If for certain people, it helps them, well so much the better.»*

All groups had met with patients suffering from severe arthritis, as part of the curriculum, who impressed upon them the **power of the mind** and of alternative therapies (massage, acupuncture, tai chi, etc) in keeping themselves symptom-free. Many had also watched a film of cardiac patients expressing their belief that stress and emotions had played a role in their illness.

Some students expressed an understanding that even scientific truth as applied to human beings contains elements of *«belief»*. As one participant pointed out : *«You believe something that you don't see. It's like saying that I give someone a pill and I kill bacteria. I have never seen the bacteria, I have never seen the pill kill the bacteria... it's a form of belief...»*

Despite their concerns about being rational and scientific, students told stories of **unexplained events**, either in their family, or with patients, which demonstrated for them the effect of spirituality:

«It's just funny, like my mother with her cyst it's kind of funny a bit. It's just that, it's a fact that it was really, really big and she was on the operating table (laparoscopy) and when they opened, they realized that there wasn't any anymore, it had disappeared. She is really certain, certain that it's because she worked on herself, that she resolved internal conflicts, that it disappeared like that. Even the doctors don't know how it disappeared.»

«A friend's uncle received a diagnosis of terminal cancer, three weeks left and him, he decided to take this on the positive side. I don't know about his spirituality, he's the uncle of a distant friend; he's not someone who's very close. He takes it on the positive side, he went out and rented all the funny movies from the video club and watched them non-stop. Him, he wanted to laugh. His three weeks became six months. He did die, but in the sense that... now medicine makes mistakes too, we can say that the diagnosis was not good,

blah, blah, blah, but ... you know, I think that it influences a lot. He laughed and his goal was to have fun, laugh, and relax. He really went through all the Mr. Bean movies!»

In an attempt *«to explain the unexplainable»*, two participants resolved the perceived dialectic of scientific rationality versus spirituality in medicine in the following way:

«I want to believe that it... helps. It's something that, whether there are studies or not, I don't care... (laughing). Whether there are studies or not, I believe enough... it's maybe the only part of my life where I'm not rational.»

«I think it's not exclusive, like one does not exclude the other. I can be fascinated by the human machine and think that spirituality really has a role anyway. It doesn't exclude the other.»

2.4.3   Perceptions of the Medical Curriculum

Focus groups were asked to discuss integrating spirituality in the medical curriculum. In response, participants expressed many concerns about medical education according to their own experiences. These concerns were coherently related to the three subthemes regarding student dilemmas previously described: preoccupation with **Opportunities for Student Self-Determination** in the face of the oft times inflexibility of a medical program (congruent with the dilemma of rejecting authority and seeking increased autonomy); an expressed desire for **Early Clinical Exposure** with real patients (congruent with the dilemma regarding their future role as physicians); concern about the **Priorities of the Curriculum** which over-emphasizes scientific learning at the expense of the human experience (congruent with the struggle with rationality in medicine).

2.4.3.1   **Creating Opportunities for Student Self-Determination**

Many groups brought forward a sense of struggle for student self-determination that was confronted with several barriers, in particular the **lack of flexibility** of the curriculum. They felt that the curriculum was *«loaded»*, highly structured, leaving little room for innovation.   They doubted there would be any **time** to integrate something like spirituality: *«Just at the functional level, the program is so loaded, anyone who adds any material will get rapped on the knuckles.»*

Some participants voiced their frustration at having to all fit in the same mold: *«I will have my own way of interviewing my patients. I want to be unique in speaking with my patients.»*   As one student expressed with regards to her session on interviewing techniques, where she was attempting to follow a highly-structured interview guide: *«It was written between this box and this box to do empathy. I am someone who is very empathetic; I don't have any difficulty, but having to teach us that like that, it's not natural at all. When I see a patient, for sure the first two times, it will be really bizarre.»*

Participants recognized that many students felt enormous **performance pressures** and were obsessed with grades, reducing their openness to *«ethical, moral, or spiritual questioning»*. They noted that even if a subject might be important to future practice, if it was not graded, students remained indifferent: *« When I told people that I was coming here, they were like, 'Well, why?' It's secondary for them. 'Well I'm going to study!' 'OK, but this is also going to be useful.' 'Yeah, but there aren't questions on the exam!'»*

Many groups felt that integrating something new like spirituality into the curriculum would more likely be successful if **student self-determination** and **self-expression** were encouraged, such as involving the students in curriculum planning and not necessarily making such educational sessions compulsory, but finding creative ways to reach all students. Groups felt that some students might feel initially uncomfortable with the topic of spirituality but would appreciate unstructured **small group discussion** and sharing.

«The word [spirituality] is scary, but if you take groups of eight people and you say: 'We are going to try something, we are going to do something, we're just going to chat'; everyone will be open and will talk.»

«If it's going to be personal, for sure there has to be the possibility of interaction for the student. If it was to really be integrated into the curriculum, in my opinion, it would absolutely have to be done in small groups.»

2.4.3.2 Enhancing Early Clinical Exposure

As previously stated, most groups, in particular those with first and second year medical students, voiced the fact that they had not benefitted from sufficient clinical exposure at their stage of training in order to feel comfortable with engaging patients at the spiritual level: *«I think we haven't been exposed to patients. All we see is in textbooks, we always have our faces in books, we don't see patients and the patients we do see are standardized.»*

Consequently, some students suggested that it would be ideal to defer discussion of spirituality until students had more clinical experience in their clerkship years, or even in residency.

«The phase we are in is really pure science, it's reading, it's 'hard sciences' and it's as if spirituality has nothing to do with it, with what I study and it has nothing to do with the exams I'm going to take in a month and a half. I don't have time to think about it, but when, ohhh, in three weeks we will be in the hospital, we will start our clerkship, we will see plenty of patients; then, maybe we'll see the relevance.»

However, many students expressed a yearning for **meeting and talking with real patients** as early as possible in their program, of hearing first-hand of their illness experiences and their suffering. One student expressed very poetically how early exposure can have later benefits: *«You learn now, the little seed that was planted behind will develop over time. When we get to clerkship it will be a lovely pretty flower.»*

Participants indicated that they needed greater assistance in learning how to engage with patients at a deeper level, especially with the seriously ill and dying patients. They felt that **clinical role models** were very inspiring and helpful. One third year student spoke of certain teachers in the following way:

«*I had preceptors who had crazy schedules, but we finished at 7 o'clock because each patient we saw, they would ask where their kids were, what they did for a living. The preceptor systematically asked all his patients: 'Do they come and see you? Who comes and sees you during the day? How much time do you spend? How do you live with that?' It was moving how these preceptors took the time to do that. Yes he did not have the time to do it, but I think that for him, in his entire scale of things to do in his day, the complete management or the spiritual aspect and deeper relationship was a priority versus finishing at a specific hour, versus getting through my thirty patients in the day before 5 o'clock..*»

Another student gained insight by observing a colleague, who had previously been a nurse:

«*There are people in our year who have a bit more experience, who were nurses for many years, those people who have worked with seniors in palliative care, etc. who have pretty good experience; not just two years, seven years experience... Often the nurses are much closer to patients than doctors. I saw one of my colleagues do an interview and... it was marvellous to watch. All along I was telling myself: 'Oh my God, I want to be like him, I want to be as good as him, I want to know what to say'. And his words were so sincere... it was just the way he approached someone, he really had the knack and me, I promised myself that I would be like that when I approached a patient. It was my model.*»

Groups indicated that they were aware that integrating real patients early in the curriculum could create problems of feasibility. Many groups made alternate suggestions such as making DVDs and vignettes of real patients. Many participants also recounted the profound effect of hearing **patient stories** from teachers such as problem-based learning (PBL) tutors or clinical skills preceptors.

«*I think one of the things that is not an integral part of the program officially-speaking, but that is much more profitable is the contact that we have with our tutors. We have tutors who have 30-35-40 years experience and when they tell us an anecdote, let's say, or when they talk to us about a patient that they've had, it's worth gold. It's contact we*

have with the experience that they have had with their patients, their experience, it's really rich.»

«We want to hear stories, we want to hear about stuff.»

Groups also suggested that spirituality could be integrated *«more naturally»* into existing educational activities, such as **ethics** or **clinical skills sessions**. Many groups had prolonged discussions about ethics sessions, with some students stating that discussion of ethics led to exploration of spirituality: *«Ethics, it appears to me kind of like spirituality that is a bit rationalized, thus it will probably pass over better in the context of medical students. Also because it's academic, it's easier to evaluate.»* Others expressed concern that the sometimes *«rational»* and *«legalistic»* approach of ethical problem-solving could be too limiting.

With regards to clinical skills sessions, students expressed that learning how to be engaged with the patient as a real person as well as his or her spirituality and belief system should be more explicitly addressed: *«You'll do a good history, you'll do a good exam, if you are not able to console your patient, you have completely trashed what you just did.»*

2.4.3.3   Questioning the Priorities of the Curriculum

Groups expressed that medical students were ultimately driven to over-value **scientific rationality** and **evidence-based medicine** at the expense of other dimensions of the human illness experience, in part because the medical curriculum itself regarded topics like spirituality as a low priority, either explicitly or implicitly: *«In general, in the program, it's always about psychological problems and spirituality is kind of slipped into it like... we hide it in that, we don't name it because it's spirituality and us, we do science and that's not science.»*

Some participants mentioned the medical school **admissions process** as contributing to the over-emphasis on academics: *«The first line of selection remains still and forever the*

academic. Thus, before all, it's academic machines that we have here, well before anything else... It's a selection of people who are very rational, very scientific.»

Students stated that certain teachers unwittingly promoted this slanted perspective because of **disinterest** or possible **discomfort** with subjects like spirituality.

«In matters of spirituality, I have the impression that if I take the faculty, spirituality for them, is probably the last of their worries. Not their last worry, I'm exaggerating, but it won't be in their priorities. I have the impression that they will minimize the importance of this.»

«It's really not all the tutors who have the same experience, it's not all tutors who are comfortable talking about it in the same way, it's not all the tutors who will reach people as much.»

However, groups did point out that medical curricula were changing and that for some universities, integrating spirituality in the curriculum might be embraced as innovative and patient-centered. *«The image of the university..., among others, in medicine, they are very proud of that; like that we are patient-centered, like we are super humanistic. For that image, it would fit.»*

2.5 Discussion

This study contributed to further understanding of medical students' perspectives with regards to spirituality and medicine. Although at first glance, articulation by student focus groups of concepts regarding spirituality seemed tentative and not well-defined, participants coherently expressed across all groups their perceptions of real-life dilemmas they faced with regards to themselves and their families, their future role with patients and their current challenges as medical students.

2.5.1 **Turning Point in Young Adulthood**

This study pointed to the critical life-stage that most medical students were crossing as they began their program. The group participants were young adults still strongly influenced and affected by childhood experiences and the belief systems of their families. They were in the process of questioning and defining what they themselves believed and valued. They cherished their growing autonomy but still wanted anchoring support in order to face their many challenges and make life decisions. When speaking of spirituality in their own lives, group participants were forthright and open about their doubts and current struggles. These themes were consistent with the literature on identity formation in adolescence and emerging adulthood, based on Erickson.[29] Several authors have referred to this period as a time for doubt, questioning, and exploration in all developing spheres including spirituality.[30,42] Although adolescents have been known for diminishing outward religious behavior such as church attendance,[31] they appear however to be more likely to engage in private "spiritual exploration".[32] The findings of this study are relevant for medical institutions and educators who may realize that their bright, hard-working elite students are also experiencing concomitant life changes.

Particularly striking was the dramatic personal change of direction voiced by study groups with respect to childhood religious beliefs and practices. This finding probably stemmed, at least in part, from the reality of Francophone Canada with generational attitude changes towards religion. Although 83% of the Quebec population defined themselves as Roman Catholic in 2000, only 20% attended church on a weekly basis[33] (versus 40% in the US[34]). The majority of these were older than 55 years of age. Only 5% of young Quebecers between the ages of 18 and 34 attended religious services regularly versus 12% in the Canadian population.[33] These demographic and contextual realities need to be taken into account when any medical school is planning to introduce spirituality into its curriculum.

2.5.2 **The Challenge of Engaging with Patients**

This study brought into focus the struggle and ethical dilemmas that medical students faced as they learned how to engage real human beings as their patients. Groups referred to the importance of accompanying patients, expressing an awareness that spirituality in medical practice implied a caring approach to the whole person. These findings were similar to those of some authors.[35,36] Anandarajah and Stumpff found that 80% of clerkship students surveyed agreed that the spiritual well-being of patients should be considered, but that number increased to 98% of students who favored a compassionate and patient-centered approach, including empathy and listening.[36] However, group participants in our study mentioned they were also becoming aware of the ethics of patient care and the need to respect certain boundaries, including the importance of not imposing their beliefs. In the Anandarajah and Stumpff study, 83% of students were concerned with various ethical issues related to talking about spiritual matters with patients.[36]

Student groups suggested three major ways to resolve this dilemma of engagement versus keeping a proper distance: 1) meeting and talking with real patients much earlier in their training; 2) listening to their teacher's stories; 3) witnessing clinical role models of the patient-doctor relationship. In a Canadian four-year longitudinal case study of medical students at McGill University, Boudreau et al. identified such activities as important for apprenticeship that *"promoted and sustained medical professionalization."*[37]

To a great extent, students were also intuitively stating what scholars in the field of narrative medicine have been exploring: narrative as a powerful healing and teaching tool.[35,38,39,40] As Rita Charon has pointed out: *"To know what patients endure at the hands of illness and therefore to be of clinical help requires that doctors enter the worlds of their patients, if only imaginatively, and to see and interpret these worlds from the patients' point of view."*[40]

Underlying many students' experiences with patients and with teachers was the issue of time. Could students take the time to reflect and discuss issues that were important to their future practice but were not on the exam? Could medical curricula be less rigidly packed and give students and teachers more time? Could teachers take the time to talk to students about their patients? And ultimately, could physicians make time to ask patients about their spiritual lives or even just listen to what they have to say? In this regard, it is interesting to note that students in this study emphasized the importance of attentive listening as a skill necessary for future practice. Referring to the importance of listening in medicine, Eric Cassell has made the following statement: *"Physicians are sure that attentive listening takes up a lot of time and they are very aware that the clock is always ticking. They do not have the time, they think, to really listen attentively. The evidence is that attentive listening is the most time efficient way."*[41]

2.5.3   **Science and Medicine**

Group participants spoke of experiencing a struggle stemming from their commitment to scientific rationality, for which they felt they were admitted to medical school in the first place. Their growing awareness of the role of thoughts and feelings on illness in patients appeared in conflict with the emphasis of the curriculum on the primacy of scientific evidence and proofs. This study cast light on the effect on medical students of the long-standing mind/body schism, derived from Cartesian dualism, that categorized as empirical science only those intellectual endeavours that related to the observable bodily functions of a human being, thereby discounting the other dimensions of the whole person as irrelevant, and their exploration as unscientific. Or as Scott Peck put it: *"In regard to methodology, science has tended to say, 'What is very difficult to study doesn't merit study.' And in regard to natural law, science tends to say, 'What is very difficult to understand doesn't exist.'"*[42]

With respect to science and medicine, Eric Cassell has also stated: *"The problem is not that so many aspects of clinical medicine cannot be dealt with scientifically. Rather, the romantic but impossible idea that science was going to create a clinical medicine from which subjectivity, opinion, and the greater inherent authority of some rather than others would be banished is not now and never was helpful."*[43]

When asked about spirituality and medicine, students in this study demonstrated that they were struggling with several challenges to their previously held values and beliefs about science and medicine, trying to learn how to be *"good doctors"*. As Boynes and Chandler have stated: *"With the onset of formal operational thought, however, young people begin to realize that knowledge is an interpretive achievement rather than an automatic by-product of experience with objective reality."*[44] In other words, our study participants were precisely at the age of transition described by these authors when they typically began to discover that scientific knowledge does not always lead to objective black and white answers, and that, as future clinicians, they would have to interpret, reflect on, and apply what they had learned to many different situations and contexts.

Concordantly, student groups expressed a desire for greater freedom and opportunities within their curriculum to explore and discuss a wider breadth of issues related to human illness and suffering. At the same time, they wondered if they were part of a silent minority that would be marginalized by other students. They recognized that they would need the support of faculty to bring about such changes, requiring a major shift in the priorities of the curriculum, which would not be easy to modify. Indeed, Koenig et al. underlined, in a survey of medical school deans in the U.S., that although the vast majority (90%) indicated that spirituality was important to patients and 43% felt that their institution needed more curricular content on this topic, only 25% *"would open additional curricular time."* The authors concluded that spirituality *"remains a relatively low priority for U.S. medical school deans and their faculty."*[5]

2.6   **Strengths and Limitations**

2.6.1   **Strengths**

One of the strengths of this study stemmed from the fact that few qualitative studies have been done on the integration of spirituality in medicine from the perspective of medical students, and certainly none in the Canadian and Francophone contexts, as far as we were able to ascertain.

Also, the methodological rigour of the team analysis was a strength of this study. Team analysis enabled the principal researcher to discuss iteratively with co-researchers coding, themes and sub-themes, increasing the validity of the findings.

2.6.2   **Limitations**

One limitation of this study was that participating focus groups were all from the same medical school and that most students were of Caucasian Roman Catholic background. This homogeneity may have been mitigated by recruiting participants from three different learning sites and with different levels of training. There was still maximum variation in terms of the scope of current personal beliefs of the participants.

The challenge of interpreting in one language (English) what was expressed in another language (French) could possibly have introduced an element of bias; this may have been offset by analysis by a team of three researchers, two of them bilingual (living and working in French), and the third fluent in reading French.

The findings may not be transferable but only reflect the perspectives of students who chose to participate in the focus groups, and may not be representative of the entire student population. As previously mentioned, three of the focus groups had only three participants, thus possibly limiting the richness of the discussion. The factors affecting student participation appeared not to be related to how participant recruitment was conducted, but to the reported discomfort of some students with the topic itself, as well as

concern about prioritizing their studies. These reasons were coherent with the actual findings of the study.

Nonetheless, student participants in all focus groups provided rich descriptive comments and reflections offering a window by which to better understand student perception and experience of spirituality.

2.7　**Conclusions**

Medical students, despite their relatively young age and inexperience, had rich inner lives and past histories. Moreover, they were precisely in the age group that was categorized by certain cognitive changes, questioning, doubts and exploration of new realities and possibilities. [30,31,32,44] These changes were necessary in order to achieve healthy identity formation, autonomy and decision-making capacity, characteristics essential for physician competence.

Some students were realizing that personal and subjective issues like spirituality were important to high standards of patient care. They were yearning for earlier clinical exposure and engagement with patients as human beings, with their stories, their lives, and their suffering. They were also looking for mentors and role models in this regard amongst their teachers and in their medical school. As such, they were pointing the way for integrating spirituality into medical curricula.

2.8　**References**

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Chapter 3

3   What Teachers Have to Say

3.1   Introduction

In the past fifteen years, there has been an explosion of interest in the literature on the topic of spirituality and health.

There have been many possible reasons for this, one being the finding in some studies that a majority of patients (60-70%) wished their physicians addressed their spiritual needs and religious beliefs.[1-4]   Another major source of interest have been the somewhat controversial studies making a link between religiosity and positive health outcomes.[5-13,58]

In many studies about spirituality and medicine, little distinction has been made between spirituality and religion. However, several authors have pointed out that they are not the same. Religion is often referred to as an organized system of rituals and practices,[14,15,16] whereas spirituality has been generally related to a search for meaning and purpose in life, a sense of harmony within individuals, and a capacity to connect with others.[14,17,18] However, no consensus has existed on the definition of spirituality within health research.[16,19]

Some studies looked at the beliefs and attitudes of physicians about spirituality, pointing out that physicians were generally less religious than the general population.[20-23] The majority of physicians recognized that spirituality and religion might be important to their patients but a minority felt that they should ask about them and very few actually ever did ask.[24-27]   Other studies looked at possible explanations for the gap between physicians and patients citing lack of time, lack of training and physicians' fear of projecting their own beliefs onto patients.[24,26,28,45]

Few studies explored specifically the perceptions of clinical teachers and/or academic physicians about spirituality,[22,23,25,29] despite the fact that a majority of US schools (84%-90%) have incorporated this topic in some form or another into their curriculum.[30,31] Educational approaches described in several articles were varied and included lectures on world religions and the positive health effects associated with religiosity, "spiritual self-understanding" workshops, clinical skills sessions using patient spiritual assessment tools, as well as rotations with hospice chaplains.[32-38] However, educational objectives have remained unclear and the effectiveness of these approaches has not been well documented.[31] We did not find any studies asking teachers what they thought would be most effective with regards to integrating spirituality into medical education. It would be helpful to know their perceptions prior to implementing any major curricular change or new direction.

In summary, there was an increasing amount of literature on spirituality and health but a lack of consensus on the definition of spirituality, or sufficient explanations why physicians showed a low level of inclusion of spirituality in their practice. Available data about academic physicians' beliefs and attitudes about spirituality may not have provided consistent messages given the use of survey instruments that were difficult to compare, not necessarily validated, and limited to certain types of teachers. It would be a contribution to the literature to elicit academic physicians' perceptions of spirituality and their ideas of educational approaches and activities relevant to this domain.

3.2   **Study Questions**

The goals of this study were to fill some of the gaps in the literature on spirituality with respect to medical teachers. Thus, three research questions were chosen:

1. How do teachers perceive spirituality?

2. How do teachers perceive the role of spirituality in health care?

3. What educational activities can assist students to integrate and apply spirituality to their future professional practice?

3.3   **Methods**

3.3.1   **Context of Study**

This research project was conducted as part of the Masters in Clinical Science program of the principal author, assisted by two co-researchers, one of whom was the author's thesis supervisor. The study was carried out in Francophone Canada, namely in the two provinces of Quebec and New Brunswick. The teachers involved in the research project were all faculty members of the same medical school, comprised of one main campus and two regional sites.

3.3.2   **Methodology**

The research method chosen for this study was qualitative descriptive thematic analysis.[39,40] A quantitative approach via survey was considered, but of the validated questionnaires available in this field, most had been used for clinical research on religious/spiritual beliefs and well-being[19,41,42,43] or were surveys of physicians' beliefs and attitudes toward spirituality in patient care.[24-27] Neither was it the purpose of this study to construct and validate such a tool for medical education.

3.3.3   **Participant Recruitment**

Data from teachers were collected via depth interviews. The main reason for this was feasibility of scheduling, compared to focus groups, given the workload and busy schedules of academic physicians.

Sampling was done via email, telephone or personal contact by the principal researcher. Participants were recruited in order to maximize variation according to the following pre-selected variables: age, gender, academic site in the medical program, practice specialty

and expertise, academic title, status and responsibilities. Consideration was also given to the potential richness of the interview based on previous professional contact between the principal researcher and her colleagues in various academic contexts (conferences, committees, retreats, and workshops). Religious affiliation and/or beliefs were unknown to the researcher prior to the interview. Thus, the sampling strategies that were used for this study were essentially purposeful, with certain criterion being applied for maximum variation.

A certain homogeneity was inherent and inevitable in the sampling given the similar cultural context of the participants (who were mostly Caucasian, Francophone, originally from Canada). This homogeneous sampling reflected the current demographic reality of the study sites. Also, teachers were recruited from only one university simply for reasons of feasibility. Thus, there was also a level of convenience sampling relied upon in this study.

A list of nineteen potential participants was drawn up by the principal researcher. Of the eleven who were first selected based on the criterion described previously,, all accepted to be interviewed, except one who declined on the day of the interview for lack of availability. The principal researcher was then referred to a twentieth person who accepted to do the interview on short notice, illustrating a case of chain sampling.

3.3.4 Data Collection

Eleven teachers participated in a semi-structured depth interview lasting from one to one and a half hours. The interviews were conducted in French by the principal researcher (who is fluently bilingual), audio-recorded and then transcribed verbatim in an anonymous fashion by an assistant. The accuracy of the transcriptions was verified by the principal researcher listening to the audiotapes. The principal researcher also took notes during and after the interview.

Prior to the interview, each participant read and signed a consent form (see Appendix F) that had been sent previously by email. Participants also filled out a demographic data form prior to the start of the interview.

The interview guide was developed in French (see Appendix G for original French and translated English versions). Four open-ended questions were devised for each of the three research questions in order to elicit "narratives detailing the informant's conception of the identified domains".[44] The more specific questions and prompts used in the interviews varied according to the unfolding dialogue between researcher and participant, as is usually the case in qualitative research. One question was added to the interview guide concerning talking about spirituality with colleagues, after this emerged as a constant theme in the first few interviews. The additional question was the following: "To what extent do you talk about spirituality with your colleagues?"

3.3.5   **Data Analysis**

Thematic analysis was carried out as an iterative process with constant interaction between the data, the principal researcher and the two co-researchers. The transcribed interviews were read through by each researcher independently in order to become familiar with the data set as a whole, while noting down initial ideas. There were no predefined codes that were used from the literature. During this "immersion" phase of the analysis, initial codes were generated and notes about each interview were re-read and expanded. The principal researcher then suggested codes and potential themes related to each of the three research questions that were discussed with the two co-researchers in order to arrive at a coding template. The interviews were then re-read, collating data relevant to each code comprehensively across the entire data set as well as gathering all data relevant to each potential theme.

In order to completely answer the third research question about the educational activities that could be included in the curriculum, content analysis was also carried out where an inventory of all suggestions by participants was made.

The analytic process permitting "crystallization" of themes was iterative, reflexive, and creative. Further re-reading and analysis of the data set permitted reviewing, refining and naming of themes. Using multiple copies of computer text, coded data were grouped

under each related theme. Some extracts could be collated to more than one theme. Further discussion between the principal researcher and the two co-researchers focussed on identifying important elements that were missed, discrepancies and alternative interpretations. At this stage it was felt that saturation of themes had been achieved in the data set and no further interviews were needed. Final verbatim extracts were then selected that best reflected each theme and translated into English by an independent assistant. In order to verify the accuracy of the presented data, randomly selected extracts were then back-translated into French by another person.

3.3.6   **Ethics Approval**

This study was submitted and received full ethics approval from the appropriate ethics committee responsible for evaluating research projects in medical education at the university (see Appendix D). A follow-up report was sent annually and at the end of the project as requested. Standard criteria for preserving participant and data confidentiality and anonymity were followed and teachers did not receive any reward for their participation.

3.3.7   **Sample Demographics**

The eleven participants in the study were divided equally among the three teaching sites (4,4, and 3). The age of the teachers ranged from 39 to 62 years, with an average of 52. Six were female (54.5%) and five were male (45.5%). They were all Caucasian of Francophone background except for one whose first language was English.

Participants were asked to state their religious affiliation: eight were Roman Catholic (72.7%) of which one added the term "non-practicing" and another "Christian culture." The remaining three stated: Atheist, Bahá'í Faith, and belief in "higher powers but not religious dogma." This corresponded to a total of three (27.3%) who appeared to hold no beliefs. Thus, although there was little diversity in terms of religious background among participants, there was maximum variation in the scope of their current personal and spiritual beliefs.

All participants had received their MD degree from a Quebec University. The majority had specialty training in Family Medicine (9 = 81.8%). A majority (6 = 54.5%) had further postgraduate training in Health Education.

There was also balance in the study sample between participants who were Clinical Teachers (5 – 45.5%) and those who held full-time Faculty positions (6 = 54.5%). Of the latter, participants had academic responsibilities and experience at all levels of the undergraduate medical program.

3.4   **Findings**

Analysis of the data resulted in themes that were initially grouped in three sections: The **Participants as Persons**, the **Participants as Physicians**, and the **Participants as Teachers** (see List of Themes and Codes 1 in Appendix H). Further analysis revealed that perceptions of the topic of spirituality were reflected in themes where the **Participants as both Persons and Physicians** were intertwined (see List of Themes and Codes 2 in Appendix I). Participants described several dimensions of spirituality consisting of the **Inward**, the **Outward**, and the **Upward** dimensions. These were not fixed in time, but evolved in a process of change summarized by the theme of a **Journey** nurtured by certain **Spiritual Practices**. The thematic map in Figure 3.1 depicts these themes and their inter-relationship as will be discussed in the following sections.

<u>Figure 3.1 Thematic Map: Dimensions of Spirituality</u>
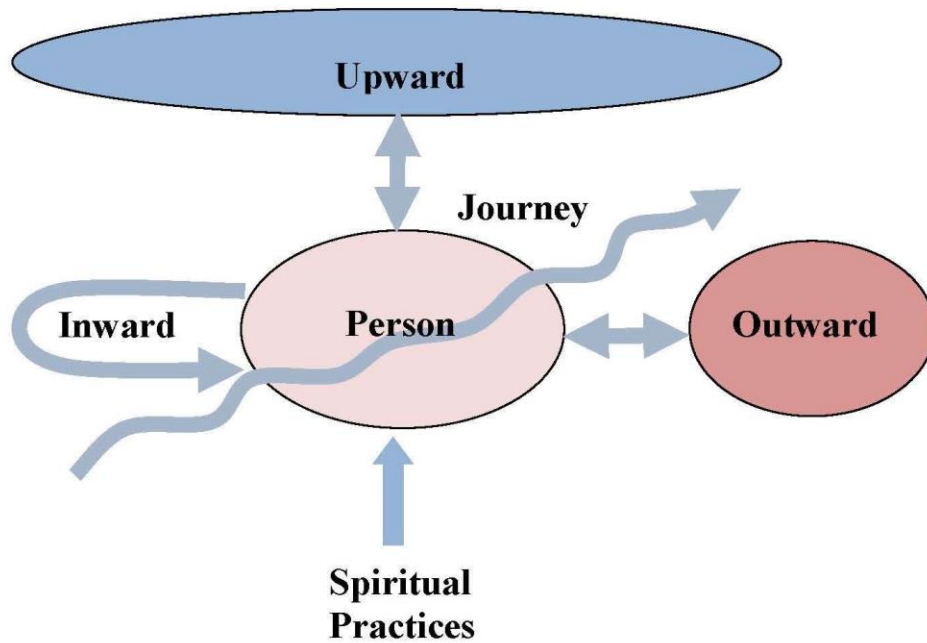
These themes will be presented in the following two sections: Section 3.4.1 **Participants as both Persons and Physicians** also includes the theme of the challenge of **Talking about Spirituality**; Section 3.4.2 **Participants as Teachers** describes the **Barriers** and **Facilitators** to integrating spirituality into the medical curriculum.

3.4.1   **Participants as both Persons and Physicians**

3.4.1.1   **The Inward Dimension of Spirituality**

Participants described the subject of spirituality as deeply **personal** and intimate within a person's own self: *«Spirituality must be experienced from the inside and be personal. It cannot be imposed, it is above all a personal choice.»*

Some participants expressed a sense of aloneness with respect to life's great questions and experiences, even leading to a sense of isolation: *«I understood that we live the great moments of our existence alone, alone with ourselves and our beliefs.»*

Participants relayed a sense of relationship with a person's own self, fostered by introspection and related to emotions and life experiences: *«There is a part that will be conscious, but there's also a part of spirituality for me that is unconscious. That colours our actions, our reactions. And it's often in periods of joy or sorrow that we will turn inward and analyze that.»*

The process of bringing the unconscious to the level of the conscious via **introspection** and **reflection** was a recurring theme. As one participant put it : *«In fact, for me spirituality is reflecting, looking, coming to a halt. I don't see how that can be detrimental.»*

Exploring one's inner self appeared to help define for many their **values** and **beliefs.** Indeed, participants found the concept of spirituality difficult to put in words, but related it somehow to their values and/or beliefs: *«For me, it means the whole system of beliefs, values, meanings,... on which are based my reflections, in day to day life.»*

It is interesting to note that many participants felt that spirituality was a normal part of being human, *«a natural yearning»*, common to all: *«Does it really exist, someone with zero spirituality? I don't think so... I'm thinking at the same time as we talk. Can we have zero...? That would be bizarre.»*

However, a distinction was made between **spirituality and religion**. For some, spirituality was apart from religion and for others it included religion but was not the same, usually in reference to something larger, more universal.

«It's difficult for me to put it in words, to describe it. For sure religion is still part of it, in my mind, but I can see that people can live their spirituality without necessarily having that more religious aspect to it.»

«I can't associate spirituality with religious beliefs only, I find that it is more global than that, but it still is one of the elements that patients bring up to me.»

3.4.1.2 The Outward Dimension of Spirituality

The process of turning inward, of relating to one's self was often felt to be linked with the relationship a person develops with others, as influenced by one's **behavior** and one's **actions**. Spirituality as an inner process was perceived as *«overflowing onto others».* Participants navigated between themselves as persons and as physicians, describing the need *«to care for others»,* be they family, friends or patients.

Spirituality was perceived as having an influence on creating **deeper relationships** than would have existed otherwise. The concept expressed repeatedly by many participants was that of creating a special **connection** between two human beings.

«If we live our spirituality, we bring it into what we are as a physician and we offer it like an entire package to the patient. For me, when I care for a patient, when I care for my patients, somehow, one of the things I try to do is to connect with them on a spiritual level.»

Such a relationship was described by some as having a **reciprocal effect**, as influencing the caregiver as much as the patient, much like unto a *«mirror»*. For some, experiences with patients had a transformative effect and helped shape their own spirituality: *«I've experienced things during all that time with my patients, personally, that make it... that I am not the same person.»*

Others spoke of a deep connection that helped *«disentangle»* difficult patient-doctor relationships. Several told moving stories like of the following patient on a geriatric floor:

«He was a guy who could be vulgar; he was a guy who could be opposing, etc. Everyone had a difficult time with this person and, initially, viscerally, again coming into contact with him, I had a bit of the same thing. But I told myself: 'I absolutely have to find a way to connect with this person'... And I remember,... we were able to sit down one afternoon. I told myself: 'You have to be able to connect with him on a spiritual level, not by talking about spirituality per se, but by using spiritual principles to get to the essence of what this person really is.' We spent a half hour where we were able to... he was not vulgar, he was not aggressive, he wasn't mean. It's as if he had let all that go and we were able to connect just heart to heart, soul to soul.»

Negative Effects with Others

Spirituality as lived with others was not always perceived as having a positive effect on relationships. One example of this was the **conflict** that could occur within families, especially when a patient's inner process was not synchronized with his or her family's.

«Let's say that people were not religious anymore, they start to look for God again, to ask themselves questions on what purpose has my life served, where do I go after death. Because for them, it's a reality... it should be a reality for everyone, but it is more blatant for them. Sometimes it can estrange them from their families or people will not understand them.»

Another example was **intolerance** that could come from rigid points of view, as with religious extremism.

«I find there are drawbacks to having a too restricted definition because if it's limited to religious beliefs, even to religious systems created by humans, but very dogmatic, in that case it creates a confrontation zone between human beings. It's a zone of stubbornness, a zone of differences,... I see it as a drawback on the human side of it, on the relationship level.»

Positive Effects with Others

However, many participants spoke of spirituality in society as leading to **openness** and *«respect of the beliefs of others»*.

«We can't really do otherwise but respect differences and listen to someone talk about their spirituality in a given context - it generates respect. You don't have to be the same, we know that we don't experience it all in the same way, and at that level, there is no judgement to make, you can only try and understand the meaning of things for the other person.»

3.4.1.3   The Upward Dimension of Spirituality

Participants spoke of a concept of **transcendence,** referring to something greater than themselves, especially in times of difficulty. Again, the sense of a reciprocal relationship was evoked where the turning upward provided some kind of assistance.

«It has happened to me occasionally to talk with patients who are dead and ask them to help me. To tell them: 'I helped you with that, I accompanied you in that. Now, I need you to be there.' (crying) Then, I drew upon there a strength that helped me to help other people.»

This process of seeking **powerful forces** in order to alleviate a sense of helplessness was perceived positively as giving strength to many, but also as possibly negative, as a crutch or a cop-out reinforcing passivity.

«The discourse on spirituality is sometimes used as a way of offloading one's responsibilities. If you assign non-decisions or behaviours to another force, it's like an easy way of not taking responsibility, I believe.»

The upward dimension of spirituality did or did not necessarily include a **belief in God**. Some participants spoke of *«forces»* in the universe or of a sense of *«destiny»*, of a reason for life events.

«Feeling part of a bigger whole. It is as if we are a beach; one grain of sand on the beach, but it takes that grain of sand for the whole beach to exist and it's because there's a beach that we're there. I would say, that's spirituality. It's believing in something that is greater than us, that can guide us, help us.»

3.4.1.4   Spiritual Practices

Participants evoked the concept that spirituality in all its dimensions could be cultivated, that strategies should be used to develop *«spiritual wealth»*. Even when not stating this explicitly, most referred to some kind of spiritual practice. Some were very **personal** like prayer, meditation, reading, or writing.

«In moments when I was the most undecided, in my childhood also when I had very difficult moments, I always found a lot of reassurance in prayer. My grand-parents were that way, they prayed a lot and that brought me closer to them too. I always felt that; my parents also prayed a lot too. I've always quickly resorted to that, to prayer, when things were not going well in my life. I still do.»

Other participants expressed the need to **discuss** and **share with others**, some informally and others in more structured groups, which could take many forms such as prayer groups, Balint or other support groups, retreats, and conferences. Some participants spoke of themselves or patients who were helped by some sort of spiritual counsellor, such as a priest, healer or a therapist: *«I don't think that we build it [spirituality] all alone, but if you never take care of it,... if it's never discussed with anyone, it is going to be poor that little corner, at one point.»*

The issue of religious or ceremonial rituals seemed to be associated with some ambivalence, as many of these, participants pointed out, have been put aside, especially in the hospital setting. But for some, rituals still had their relevance to spirituality.

«Often families like him a lot [the priest], so he comes and administers the last rights and all that. Often people will ask him to preside, to take care of the religious ceremony and all that... In fact, I think we want to evacuate religious rituals too much, no matter which ones, whether it makes sense or not. McDonald's deaths you know, it's settled, done, bye, that's not good. What I'm seeing, I find it's not good at all.»

Figure 3.2 illustrates how different spiritual practices related to the dimensions of spirituality evoked by participants.

Figure 3.2 Dimensions of Spiritual Practices
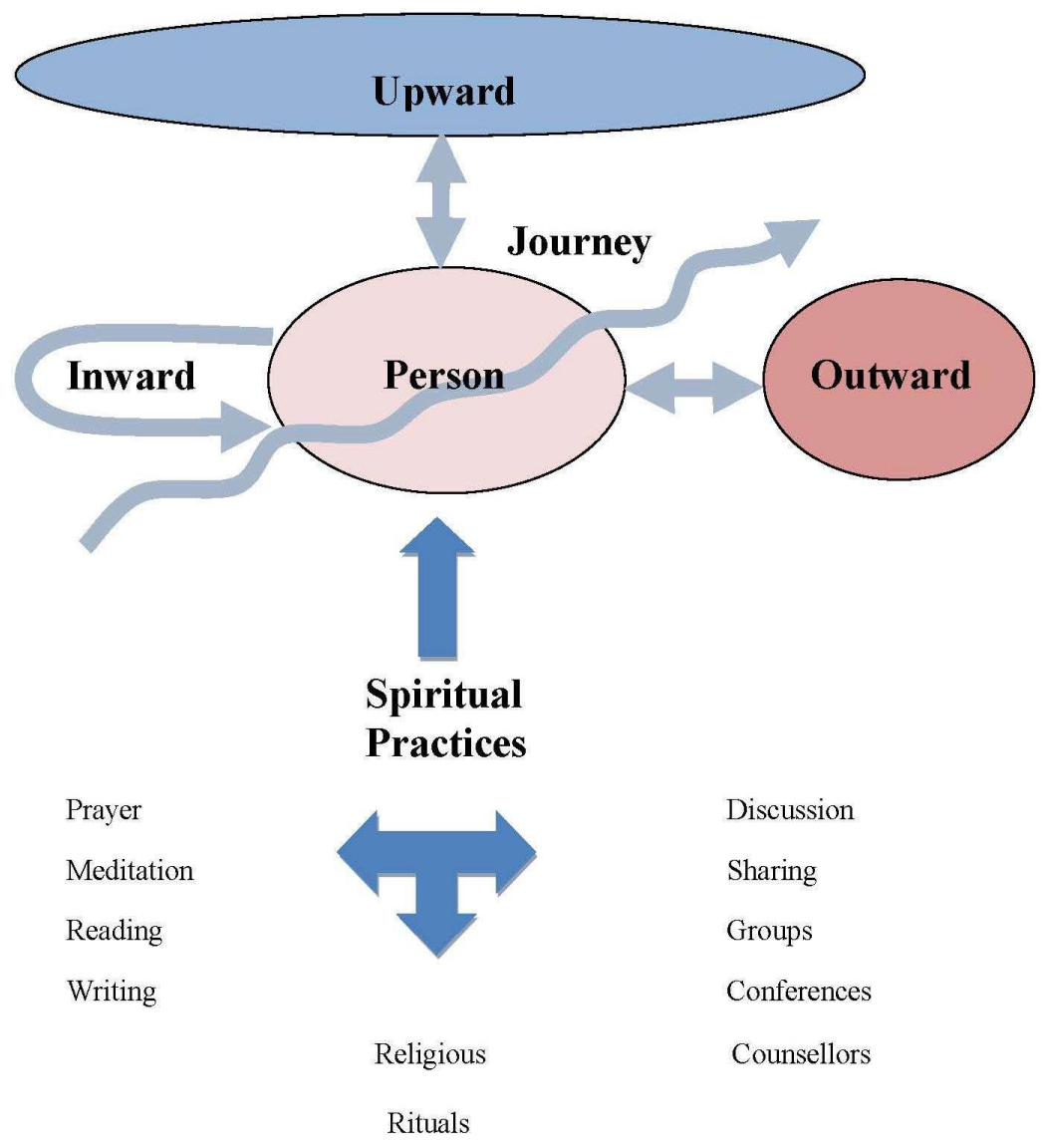
3.4.1.5 **The Journey**

Participants referred to the passage of time as affecting a person's spirituality, his or her *«inner journey»*. A growth and maturation process was evoked (*«cheminement»* in French), both **personal** and **professional**, marked by different life events and critical incidents in participants' lives and in those of their patients.

«Is there one outstanding event? No, not really. I'd say it's a continuation, a journey – I'd say a bit more like a journey.»

The Personal Journey

To begin with, participants referred to **childhood beliefs and practices** that continued to influence them. Some felt the need to break away from them, whereas wanted to return more closely to them: *«But now I tell myself: 'Oh no, no, all beliefs have not disappeared, even if I question many of them.'»*

Participants went on to describe periods of **questioning** in their lives, of doubt within themselves and/or within their patients. For some this questioning led even to a *«crisis of faith»*, whereas for others it led to redefining their outlook on life.

«It can torment, it can preoccupy, it can in fact make you question things and tell yourself: look here, what I thought was good, is it still so much?... I think it's one of the secrets, to be able to question oneself and to reflect, and to say: 'What I believed was good or the right thing to do before, well maybe there's better than that.'»

This questioning was closely linked with a **search for meaning**, making sense of life events. Participants spoke of helping others, including patients, find meaning in their own lives.

«I learned to trust that, despite limitations, difficulties, anxieties, a human being always finds… the energy to live with what is presented to him or her and give meaning to it. For me this led me to tell myself: spirituality is the ultimate zone where we will make sense of

things. So there is no limit to what we can tolerate or endure. You cannot look at someone and say: 'It makes no sense what he is going through.' If it's connected to this zone, there will be a meaning that will be given.»

For most participants, life's existential questioning and search for meaning were often triggered by **crisis and difficulties**, including illness. Participants perceived that these difficulties shaped one's spirituality.

«I think that illness will automatically awaken your spirituality, it's my point of view. I think that even the least spiritual person, in sickness, will have to go through this repositioning towards people, towards... well, why we are there. I think illness awakens that.»

Participants also felt that spirituality, with its varied and imprecise definitions, somehow reciprocally helped people cope with difficulties and illness, based on experiences in their own lives and in the lives of others including their patients.

«There are all kinds of things, all kinds of experiences that show me that it has positive effects, in any case... For sure if the person is at peace with him or herself, if it does not improve healing, it will help the person get through difficult periods more easily than if that person is not at peace; or if his or her spiritual quest is still only a small grain of sand, compared to a person who has reflected a lot about it, thought a lot, has personally evolved a lot on that path.»

Some participants mentioned also reading or hearing of studies in the literature about the positive effect of spirituality on health outcomes. However, there was a wide diversity of opinion expressed as to how this effect occurred, whether via *«lifestyle choices», «a stronger immune system»,* a greater *«resistance to stress»*, a more *«positive»* and *«hopeful»* outlook in dealing with adversity, or simply a greater acceptance, *«inner peace»* in face of the inevitable.

Finally, **confronting death** was mentioned as a critical stage of life's *«spiritual journey»*. Participants spoke of the vast array of human reactions to approaching death and generally linked greater acceptance and serenity to a person's spirituality.

«It's tough, you go from I am well to I will die. The first reaction is: I will die, I am afraid of dying. So when they manage to say: everyone dies, I know that it will happen earlier to me than to others, but I have a certain time. Now you are in peoples' values, in what is important at this point. Then I tell myself we are going towards an evolution towards death but it will be filled with beautiful things, filled with suffering mind you, filled with grief, but filled with beautiful things also. But when people don't go down that road, when they stay with the injustice, it does not allow for... it's very difficult sometimes to bring them to pass on, to see.»

Belief in the afterlife was not perceived as a sine qua non of spiritual development. Death was represented as being the ultimate test of a person's capacity to deal with the unknown, with unanswerable questions: *«Even if it's unclear to them what will happen after, they are more at peace, less tormented, they are struggling less. I have seen so many struggle, struggle till the end.»*

Participants also spoke of the need of physicians to help patients in the process of confronting death. Several stories were told illustrating this theme, including this one of an elderly patient:

«There are elderly patients that have no serenity with regards to growing old, with regards to illness and death. I was seeing, last week, a 90 year old man, long life, multiple illnesses, death has arrived. His wife tells me: 'Listen, it can't be true, he was very, very well even 6 months ago.' I said: 'Well thank God ma'am.' (laughter) I said: 'He is a 90 year old man exhausted from 6 months of illness. It's extraordinary that he was able to stay well until 89 years and a half. But it's not a guarantee of his future.' As much for the patient as for his wife, it was unacceptable.»

Figure 3.3 summarizes the subthemes comprised in the Personal Journey.

Figure 3.3 Spiritual Dimensions of the Personal Journey
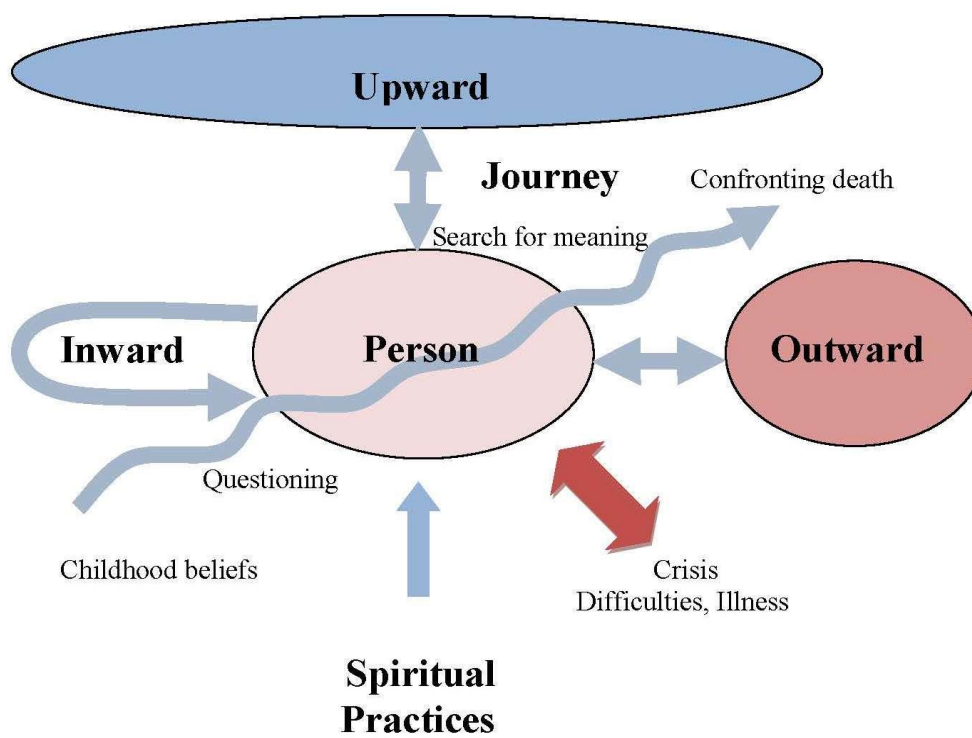
The Professional Journey

Participants as physicians described an evolution in their understanding of their own profession as they experienced **unexpected situations in patient care** on the frontier of science in medicine, where spirituality appeared to play a greater role. Examples given were situations where treatment was limited and physicians felt most helpless.

«In all our classes in medicine, in all my time as a resident, me here, I cured everyone. You had pneumonia, you would take antibiotics, you get better; then you see the patient at home, cured, there. It's just when I arrived in practice, sometimes they did not get better...»

«Life dies, medicine proposes things, but it has yet to keep anyone from dying from terminal cancer for which no treatment works.»

In such situations, participants expressed that offering of themselves and their presence seemed to have more of an effect than the medicine prescribed: *«Even though I had prescribed morphine, I had the impression at that moment, that time, that visit, that maybe I had helped him more than all the pills that I had given him.»*

Other examples given were patients with suspected psychosomatic symptoms:

« Of course I'm thinking of people who come see us with a bunch of physical complaints, that we've investigated but we can't put a finger on one disease to explain it. These are people that are going through difficult things in their life, whether current or past,... and they have swept it all under the carpet, people to whom sometimes we say: 'Well now, I think your body is speaking to you'...»

Many participants told compelling stories of **events unexplained by science**: miracle cures, dreams, premonitions and strange coincidences. Again, the importance of a connection between the persons involved was highlighted. Eight of these narratives can be found in their integral form in Appendix J, covering such themes as patients dying at the same hour as their physician dreamed of them; healing via intercessory prayer; a "chance" encounter that changed the course of an illness for an elderly patient; premonition of her fatal car accident by a woman who had earlier confided in a physician friend responsible for her current attempt at resuscitation; unlikely cancer cures and remissions.

3.4.1.6   **Talking about Spirituality**

In marked contrast to the stated importance that spirituality had come to mean in their personal and professional journey, participants expressed that talking about spirituality was *«not easy»* and *«not very frequent»* generally, either with patients or with colleagues. To begin with, participants stated that very little mention of the topic was made in their own training and early professional development.

«There wasn't a lot of room for that in my medical training... My memory is that of a training focussed exclusively on science, on the great progress of science and how to act in all circumstances with regard to the medical guidelines from the advances in science. I liked that, I am a medical specialist and I like to apply the basics of science..., but on the spiritual side, it's a total void, sincerely, they taught us absolutely none of that.»

<u>Facilitators</u>

Talking about spirituality seemed facilitated in **serious and chronic illness** including **mental illness**, **care of the elderly**, **end of life care and decision-making**, as well as settings such as **hospital and home care**. In these situations, physicians practiced with a more structured allied health care team where participants mentioned discussing spiritual issues. The following example concerned a palliative care team :

«When patients die, certain patients who we know, they touched us a lot, they stirred us a lot; the death was horrible by its intensity..., we always take time, the following week, in fact the following meeting to stop and say: 'OK, how did you experience that, like you, how did you feel? What are you left with?' So I think that we touch on a level which is a bit different and yes it's important.»

Apart from **interdisciplinary team meetings**, participants recounted discussing spiritual needs of patients sometimes directly during **case transfers and discussions** with physician colleagues or with nursing personnel. For instance:

«It has happened to me with nurses when we do joint follow-up and compliance is not there, to talk, to tell the nurse who that patient is, what his or her story is, how I approach him or her, what are my expectations, what her expectations should be and how she should talk to the patient. That, that can happen.»

In the practice settings mentioned above, participants spoke of the more frequent need to inquire about *«patient beliefs»* in order to take them into account in **ethical decision-making.** Moreover, some participants told stories of talking to patients more directly about spirituality in a context that even stretched the usual boundaries of patient care. The following extract is from a participant who spoke about spirituality with a suicidal patient:

«I found it slippery a bit, at the time that I did it because I was telling myself: 'I have to take a risk.' If she's not spiritual,... if she sees me as someone who is religious: 'Well then if you want to haul out God and make me feel guilty'; that will probably not work. The way I approached her, it worked well and after, I told myself: 'No, deep down there was no risk, all she could have told me is no',... I would have respected that, I would have taken another path, I think.»

Barriers

Participants evoked several reasons for having difficulty in talking about spirituality. With regards to patients, **time** was cited as being a major barrier. Taking extra time in order to address spiritual issues with patients caused them to run even later on tight schedules:

«I think that we often neglect it [spirituality] because we lack the time to talk about it. There are so many other additional things for a family physician. There is always something new, that must be done, that must be discussed; lifestyle, blah, bah, blah. For sure, one should take the time to fit in spirituality as well.»

«To date, throughout my career, it has been very much somewhat of a dissatisfaction to say: 'Well OK, I have to see people, I have to roll.' Then to always be late, because when I tried to talk to people, well, it made me run late.»

Some participants felt that the **level of physician discomfort** in talking with patients could be offset if they had addressed somewhat their own spirituality: *«I think that to be at ease with them expressing that, first, I think one has to be at ease with the principle.»*

Another reported barrier was **medical culture** that made spirituality a taboo topic of discussion with patients and in medical circles, particularly if associated with religion.

«Oh yes, it's more intimate, I think, spirituality than psychology. There are already a thousand taboos with regard to psychotherapy and psychology; I think there are even more, there must be at least ten thousand with regard to spirituality. Oh yes, I think that it's more difficult, oh yes, yes. And if within spirituality, one refers to religion, then it's really difficult to address…»

«No, never. I think it [spirituality] is a bit taboo. I think it has been so associated with the religious aspect, and you know, religion is not talked about or hardly talked about. It's rare that I have had such discussions. I don't even remember having discussions like this with colleagues.»

«I don't think that it's in the culture of the medical community to have such exchanges about everyone's values. I don't think so.»

Fear of ridicule or anticipation of a negative reaction was often inhibiting: *«I was too afraid people would think I was crazy or that I imagined things.»*

In this context, participants expressed that talking about spirituality with colleagues was easier on a one to one basis, *«depending on the type of relationship that had been established».*

«I wouldn't say the whole team; it's more like one to one. There are certain colleagues with whom I won't be able to talk about it one on one or sometimes there will be three of us and we will talk about what we find difficult or easy or beautiful.»

However, participants did recount situations where they had received a positive reaction from colleagues, as when this participant told a story about creating an *«oasis of love»* during a team meeting marked by longstanding conflict:

«So I see it as a spiritual principle, so I tried bringing that up: that we try to conceptualize what an oasis of love would look like in our department, how we can help each other, value each other, always see each other through a positive eye, try and avoid bringing negative things one towards the other, and try and note what is positive. So I was able to expose that concept a bit in our team and surprisingly, two people came up to me after to hug me and tell me how they were like, touched.»

3.4.2 **Participants as Teachers**

When asked about the integration of spirituality in medical education, participants expressed that little was being done specifically at that time in their setting. In contrast with their stated opinions about the role of spirituality in patient care, participants expressed some concern about making spirituality a *« should »* in the medical curriculum, particularly at the undergraduate level.

Some teachers suggested a cautious and progressive introduction into the curriculum, making it non-compulsory and without exams: *«I think we should, we could raise awareness on that. Justify its usefulness. Integrate it where it is easy to integrate. Already people are starting to talk about it. It doesn't force anything and all that. We are starting to hear about it. That for me would be facilitating.»*

Others stated that spirituality could be introduced by integrating the topic with current academic activities, much like how ethics or public health was introduced successfully into medical curricula in the past.

«Yes, I would make the parallel with ethics, like we say: hey, we have to talk about it,... spirituality, I think we have to talk about it.»

«It had to be named... Now, we talk about ethics quite easily, but it wasn't natural in the beginning.»

3.4.2.1 Barriers

A number of prohibitive factors were expressed to justify the cautious approach to integrating spirituality into medical education.

One difficulty raised was using the word spirituality itself, even more if associated with religion which was perceived as a **taboo topic** in medical education.

«The main barrier is the fact of having difficulty with, first, saying the word. When we speak with our students, we will say the word spirituality and they will look at us... I think it is being able to say the word and say: 'Look, this is spirituality and we are going to discuss spirituality, and have an open mind.' People will want to discuss it, listen.»

«And the other thing is that we have another workshop like this, so that it is no longer taboo. We take away the fact that it is taboo to talk about spirituality that is often linked to religion.»

Participants pointed out that spirituality may already be included to a certain degree in teaching, about the patient-doctor relationship for instance, without it being named specifically: *«We addressed it, but we do not pronounce the word spirituality necessarily. I think that the word 'value' is more easily accepted than the word 'spirituality'.»*

Another major barrier for participants was the **loaded curriculum**, leaving little leeway time to add something new. Participants spoke of students being *«under pressure»*, *«stressed»* and pushed to excel, *«be the best»*.

«The first barrier is the amount of medical science that one has to acquire. We have much, much, much precise knowledge to update constantly to be able to practice medicine and that is an important barrier... Medical training is very short, everything is condensed, under pressure, optimized so that you retain as much of it as possible in as little time as possible.»

Participants questioned the **receptivity of students** to the topic of spirituality for other reasons besides performance pressures, such as a lack of *«interest»*, *«maturity»* or *«experience»*: *«Young people do not talk about this, it does not interest them.»* Some participants wondered whether a more appropriate moment to introduce the topic would be during residency training: *«In my opinion, actually I think that it's something that is easier to open up to when you're a resident.»*

Finally, participants raised the issue of possible **discomfort of teachers**, themselves included, thus presenting a challenge for faculty development. As one participant put it : *«Could I? I would like to. Could I? I don't know.»* And another : *«I'll put my faculty development hat on, I don't know how I could train a professor, you understand?»*

3.4.2.2 **Facilitators**

Despite many perceived barriers for medical education, certain approaches did emerge that echoed the dimensions of spirituality expressed in participants' personal lives and in their relationships with patients: helping students to turn **inward**; helping them to turn **outward**; accompanying students in their **personal journey** as young adults beginning their **professional journey**; and the importance of group discussion and sharing, which can be aligned with examples of **spiritual practices** as seen earlier.

The Inward

Participants perceived that current efforts to integrate elements of **reflective practice** in medical curricula would be conducive to integrating spirituality, and vice-versa: *«I think there should be, all through the curriculum, reflective moments on what it is to be a doctor, what am I learning, where am I on this, can I recognize my values?»*

Participants felt that a good place to start would be getting students in touch with their own spirituality, their *«inner»* lives.
«It's the exercise that you made me do in the first part [of the interview]; make me think about it for myself. I tell myself: they should all do it.»

«What would be facilitating is to be able to address, in my opinion, that we are all spiritual beings and how, by taking away all that confusion with religion when talking about spirituality,..., how we can use it in practice, our practice. I think that it would be a way of facilitating... student awareness of their own spirituality (a lot of them know it), but that it's OK, that we can talk about it and that it can be useful in our professional practice.»

The Outward

Participants stressed the importance of getting students in touch with the **reality of patients' lives** as persons, their *«sufferings»,* and their *«stories».*

«I think there are certain patients who are passionate about it and who are open to discussing their experience. I think that using patients to do certain kinds of workshops or meeting with students,... to talk about their situation, their experience - I see it happening that way. I think that us telling students about how spirituality works with our patients, it's not the same thing as having patients come and tell their story.»

Participants also suggested increasing student awareness and acceptance of the diversity of patient beliefs and values and how these could affect patient care and decision-making.

«I think that having them meet patients or people who have beliefs and allow them to listen to these people so that they see that a little later, it's human beings they'll be caring for and it speaks to what I was saying: the reality of life, suffering, aging then death, those values are the most fundamental.»

Participants felt that teachers should show personal initiative in **sharing their own experiences** with patients:

«It is encouraged to bring examples from our practice. When I bring an example, I have an order in my head: I bring my example, I talk about my experience, I see if it resonates with them and then I try to decontextualize a little bit to bring to the fore the underlying principle; that is teaching in my sense.»

The Personal and Professional Journey

Participants expressed an awareness of their role as **mentors** in the initial stages of professional development of their students, in helping them to understand their own future role as physicians. Intertwined with this role, it was suggested that mentors often accompanied students in their *«personal growth»* as well: *«I think that we have to help students make sense of their life and their role as a doctor.»*

The following extract compared this process to a gardener nurturing young plants: *«I don't know to what extent we can open doors. I think we have to open some, we have to try, we have to at least plant some seeds while telling ourselves: 'If the ground is fertile, it may grow well and if not, at least they will have heard about it' [spirituality].»*

Participants voiced the need for teachers to be more forthright about their own journey, including their own difficulties: *«And I would tell them: you know you are 20 years old, you have known a grand-mother; when you are 30, you will all have known someone who has died; and probably at 35, someone your own age or younger. That is the meaning of life.»*

Beyond the elements of mentorship described above where teachers accompany students in their development, participants insisted on the importance of **role models** in order to succeed in integrating spirituality in medical education: *«I would first start with the mentors, make them aware and bring to their consciousness [spirituality], it's something that can be transmitted as a role model.»*

Making use of teachable moments during clinical experiences was viewed as an essential component of this integration.

«When we review cases with our students, during their clerkship or residency, to be able to discuss with our students in the sense: on the spiritual side, is there anything we can explore with our patients? Is there anything that the patient said that you think would have been an opening for you to explore those aspects?»

Group Discussion and Sharing

Participants felt that favoring opportunities for students to share their experiences and points of view about spirituality would be a useful approach: *«I think that there could be workshops to discuss each person's spirituality, so that everyone could share their personal baggage and experience.»*

Discussion groups were viewed as meaningful by teachers in their own personal and professional maturation and therefore could contribute to student competence overall: *«Maybe discussions and sharing on the subject can help someone grow and facilitate his or her progression as a student; that could happen.»*

Figure 3.4 summarizes the facilitators for introducing spirituality into medical curricula:

Figure 3.4 Dimensions of Spirituality in Medical Curricula
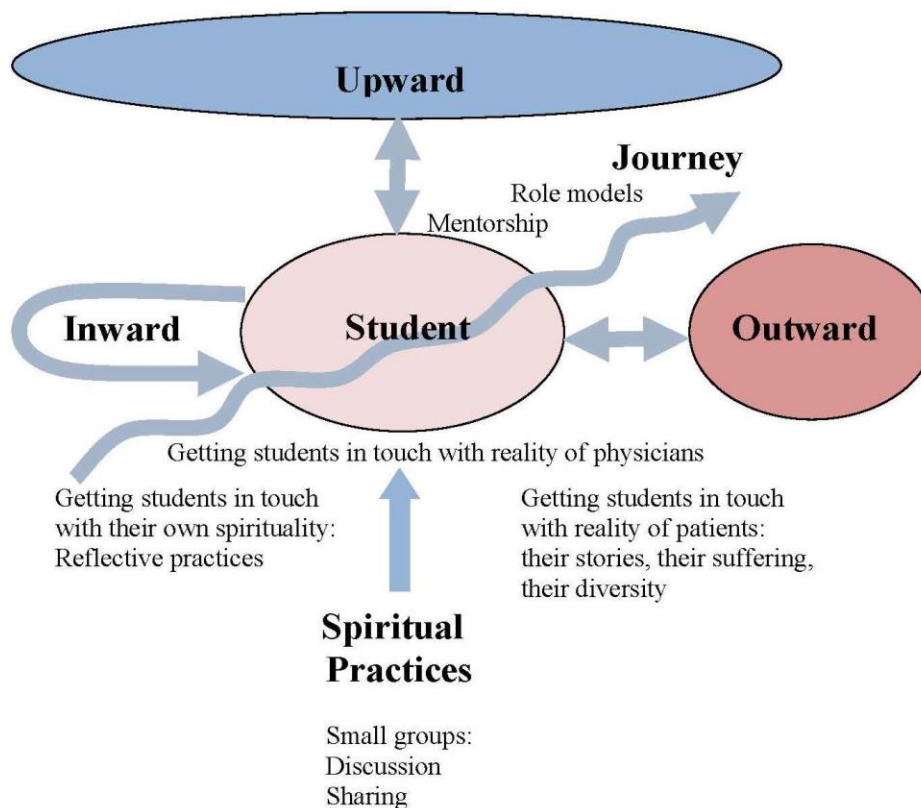
Participants as teachers made a number of specific suggestions for educational activities with regards to the integration of spirituality in an undergraduate curriculum. These can be found listed in Appendix K.

3.5   **Discussion**

The themes that emerged from this study contributed to further understanding the following aspects of physician teachers' perspectives with regards to the integration of spirituality in medical education: 1) The Perception of Spirituality; 2) The Central Role of the Patient-Doctor Relationship; 3) The Gaps between Belief and Practice; 4) The Personal and Professional Journey.

3.5.1   **The Perception of Spirituality**

This study contributed insights as to how physicians, specifically medical educators, viewed and defined spirituality. Findings were at first glance extremely diverse but in-depth analysis revealed the following dimensions as summarized previously in Figure 3.1. An individual human being experiences a personal journey, continuously redefining his or her values and beliefs via relationships with the self (turning inward); with others be they family, friends or patients (turning outward); with a self-defined transcendence (turning upward); and nurtured by diverse spiritual practices. These dimensions of spirituality captured elements of definitions found in the literature such as the search for meaning and purpose of life, connectedness with others, as well as transcendental experiences.[14-18] In a 2011 systematic review of instruments measuring spirituality, Monod et al. presented a working definition of spirituality that also referred to a *"vertical dimension"* (relation to God or a higher power), and a *"horizontal dimension"* (sense of life purpose and life satisfaction).[19] These dimensions were congruent with the findings of this study which offered added understanding of physicians' perceptions of these dimensions and their inter-relationship.

3.5.2   **The Central Role of the Patient-Doctor Relationship**

Strikingly, participants felt that integrating spirituality in patient care was linked to the central importance of the patient-doctor relationship in healing. The capacity of those physicians to establish deep connections with their patients as human beings, as an outward manifestation of their own spirituality, contributed to helping patients cope with illness and find meaning in difficulties. This central role of the patient-doctor relationship as an important component of spirituality in health care has received insufficient attention in the literature so far. In a qualitative study of spiritual care-givers identified by their dying patients (of which the majority of participants were physicians), Daaleman et al. found that *"being present"* was a dominant theme, which *"incorporates an intention to openness, to connection with others."*[45] In another qualitative study by Olson et al. with Family Practice residents, participants felt that integrating spirituality in medicine was a *"medium for improving doctor-patient relationships."*[46] These studies were consistent with our findings.

The physicians in our study learned from accompanying their patients, thereby enriching their own inner lives. As Eric Cassell pointed out: *"The extraordinary power of sickness to make patients susceptible to change at all levels of the human condition is matched by the equal power of this benevolent relationship with its unseen but powerful connection to induce physicians to extend themselves at all levels of the human condition."*[47] The participants in this study illustrated eloquently the reciprocal relationship between their own spirituality and that of their patients. Interestingly, in a qualitative study of palliative care physicians, Seccareccia and Brown's overarching finding was also that *"the impact of a physician's personal spirituality on practice and practice on spirituality were inextricably woven together."*[48]

The finding that the participants of this study felt that spirituality of patients contributed to health was consistent with the literature.[25,49] However, perceptions of how this might occur were multiple, varied and appeared secondary. Indeed, as Curlin et al. noted, *"the level of empirical evidence for a 'faith-health connection' may have little influence"* or even importance on physicians' approaches with patients, but rather their focus is on how

patients *"cope and make decisions related to their illnesses."*[49] This observation was consistent with our study.

3.5.3 **Gaps between Belief and Practice**

Although there was coherence between participants' perceptions of spirituality as it applied to their personal lives, to their care of patients, and to their role as teachers, there were gaps between beliefs and actual practice with patients and students.

Firstly, this study confirmed the gap noted in previous literature between physician beliefs and attitudes about spirituality, and their capacity and willingness to talk about it with patients.[24,25,26,28] End of life care and decision-making were already noted as facilitators.[24,25,26] In addition to these, this study highlighted other facilitators such as chronic illness, mental illness, and care of the elderly in the practice settings of the hospital as well as home care. The importance of the interdisciplinary team with respect to this area was not found in the literature (except in palliative care[45,50]) and therefore merits further exploration. Time was found to be a major barrier with patients as had been noted by Ellis et al.[24,28] and Daaleman[45], as well as the varying level of physician comfort with spirituality.[24,28,46] Our study elaborated on the ethical boundaries involved, participants wanting to take into account patient beliefs in decision-making, but also feeling that talking about spirituality with patients involved taking risks outside of usual boundaries. This issue deserves further exploration.

Secondly, with regards to medical education, this study highlighted a marked contrast between physician teachers' perceptions of the importance of spirituality in patient care and their comfort and willingness to integrate spirituality into medical curricula. One possible explanation is that this represented a relatively new and less explored area in medical education in Canada, where our study was carried out, as compared to the United States, where a majority of medical schools have implemented spirituality into their curriculum in some way, as previously mentioned.[30,31] Neely and Minford, in a study of teaching on spirituality in U.K. medical schools, have made the point that "it is

recognized that cultural differences exist between the American and U.K. populations and these need to be taken into account."[51] The same could be said for the participants of our study. Teachers expressed the concern that spirituality would be confused with religion which they felt was a source of discomfort in their settings. It has already been suggested that Academic physicians are less religious than other physicians as well as the general population.[21,22,23] Also, the Canadian general population is less officially religious than its counterparts in the U.S., 20% versus 40% attending religious services on a weekly basis.[21,52] More specifically, French Canadians, the original demographic group of the majority of physicians in this study, although mostly still officially Roman Catholic,[52] have undergone a widely acknowledged social transition in attitudes and practices toward religion,[53] which could potentially contribute to the cautious approach to the integration of spirituality in medical education, as indicated by our findings.

A further explanation lies in the barrier of medical culture itself referred to repeatedly by study participants, where spirituality is hardly talked about among colleagues. Several participants suggested that spirituality was a taboo topic in medical circles. This also deserves further exploration in future studies.

Despite the barriers outlined above, teachers suggested approaches compatible with current trends in undergraduate medical education: integrated, reflective, experiential, longitudinal learning experiences.[54,55] It can be argued that these trends are also facilitators for the integration of spirituality as they are consistent with the dimensions of spirituality as evoked by teachers (see Figure 3.4).

3.5.4   **The Personal and Professional Journey**

This study evoked the concept of a journey as a dimension of spirituality, a notion not detailed or spelled out per se in the medical literature. As illustrated in Figure 3.3, spirituality was perceived as evolving in the lifetime of the person, from childhood beliefs and practices until death. Crisis and difficulties, including illness affected a person's spirituality by triggering questioning and existential search for meaning. The

role of spirituality in helping to cope with illness has been mentioned in the literature.[56,57,58] In this study participants went further, observing in themselves and in their patients an inverse reciprocal effect where illness caused spiritual growth (by triggering crisis and a search for meaning), which in turn made coping with illness easier.

The findings of this study pointed to a fascinating parallel between the physician's personal journey and his or her professional one. Participants described a process by which their assumptions and understanding of their professional roles and practice, based on their initial training, were challenged by unexpected situations with patients, causing them to face and question the limitations of current technological medicine and treatment. Of particular interest were the many stories of unexplained events that challenged the fundamental view of scientific materialism on what it means to be human and what it means to be sick. Two quotes illustrate this phenomenon:

Scott Peck has recounted: *"Fifteen years ago, when I graduated from medical school, I was certain that there were no miracles. Today I am certain that miracles abound. This change in my consciousness has been the result of two factors working hand in hand. One factor is a whole variety of experiences I have had as a psychiatrist… These experiences…led me to question my previous assumption that miraculous occurrences were impossible. Once I questioned this assumption, I became open to the possible existence of the miraculous. This openness was the second factor causing my change in consciousness."*[59]

Eric Schumacher has stated: *"It is claimed that only such knowledge can be termed 'scientific' and 'objective' as is open to the public verification or falsification by anybody who takes the necessary trouble; all the rest is dismissed as 'unscientific' and 'subjective'. The use of these terms in this manner is a grave abuse, for all knowledge is 'subjective' inasmuch as it cannot exist otherwise than in the mind of a human subject, and the distinction between 'scientific' and 'unscientific' knowledge is question-begging, the only valid question about knowledge being that of its truth."*[60]

For the participants in this study, these experiences with patients caused them to reconsider the theoretical basis of their professional truths and to search for new models to explain them. Kuhn has explained that this process is the basis for what is called a *"paradigm shift"* in the evolution of scientific knowledge.[61] We suggest that this points to the effect that the different dimensions of spirituality (the inward, the outward, the upward, and the journey nourished by spiritual practices) might have on the professional development of physicians as illustrated in Figure 3.5. Organized as a conceptual framework, these dimensions deserve further exploration.

Figure 3.5 Spiritual Dimensions of the Professional Journey of Physicians
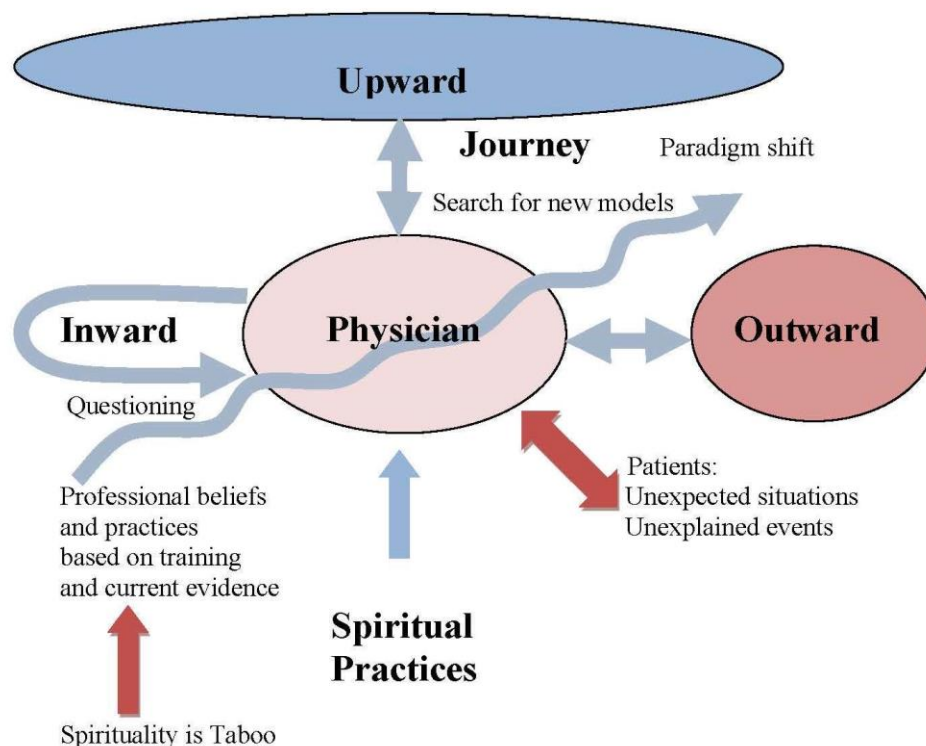
3.6   **Strengths and Limitations**

3.6.1   **Strengths**

The strengths of this study stemmed from the fact that few studies have been done on the integration of spirituality in medicine from the perspective of academic physicians, and certainly none in the Canadian and Francophone contexts, as far as we know. Exploring how to introduce spirituality into medical curricula, from the perspective of teachers, is a necessary contribution to this new field.

Another strength of this study was its methodological rigour. Care was taken to ensure a diversity of age, gender, academic roles, responsibilities and experience during participant recruitment. Team analysis enabled the principal researcher to discuss iteratively with co-researchers the coding, themes and sub-themes, leading to the emergence of a coherent interpretative thematic mapping.

3.6.2   **Limitations**

One limitation of this study was that participants all came from the same medical school. This was offset somewhat by recruiting participants from three different learning sites and with a diversity of roles as mentioned above. Participants were mostly of Caucasian Roman Catholic background, which reflected the current demographic reality of much of Francophone Canada in outlying regions. Despite a lack of diversity in terms of religious background, there was maximum variation in terms of current personal beliefs and practices among participants. Finally, a certain degree of homogeneity can be acceptable and even desirable when conducting depth interviews.[44]

The challenge of interpreting in one language (English) text that was expressed in another language (French) could possibly have introduced an element of bias; this challenge could be weighed in the balance by team analysis of the three researchers, two of them bilingual (living and working in French), and the third fluent in reading French.

A selection bias may have been inherent in this study because some participants were recruited on the basis of expressed interest in the study topic. The findings may not be transferable which is true of qualitative studies in any case. Nevertheless, the richness and depth of the expressed reflections by the participant teachers, as well as the emotional intensity of many of their stories, some shared for the first time, constituted new contributions to the literature.

3.7 Conclusions

This study explored the perceptions of physician teachers with regards to the integration of spirituality in patient care and medical education. The conceptual framework that emerged regarding the various dimensions of spirituality may be useful for practice, teaching and future research.

The importance that participants gave to the healing relationship offers further insight into how physicians enact patient-centered care. Indeed, one could argue that including spirituality in patient care is a natural and necessary extension of the patient-centered clinical method.[62]

Sulmasy stated in answer to the question 'Is medicine a spiritual practice?': *"To heal means to make whole. If we are committed to healing patients as whole persons, we must understand not only what disease and injury do to their bodies but what disease and injury do to them as embodied spiritual persons grappling with transcendent questions."*[63]

Physician participants in our study were struggling with integrated and holistic concepts of the human condition as well as new paradigms for their professional role. This transformation of practice needs to occur accordingly in medical education where significant barriers to the integration of spirituality exist. Hopefully, this study has provided some useful direction for medical curricula that can be developed further. As

Eric Cassell stated: *"The bond between doctor and patient shares aspects of the bond between teacher and student (in its best sense) and is a facilitator of learning and*

changing…all learning requires personal change."[64] We submit, on the basis of the literature reviewed and the findings of this study, that change, personal transformation, is fundamentally a spiritual process.

3.8   **References**

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Chapter 4

4 General Discussion and Integration of Findings

The medical students and teachers who participated in these studies were all asked basically the same questions about the integration of spirituality in medical practice and education. There were understandable differences between the two groups with respect to life and professional experiences, depth of understanding and of expression. Nonetheless, some striking commonalities in certain themes were noted involving spirituality as part of a maturation process, as well as the importance of the patient-doctor relationship and the role of narrative within it. In this chapter, the predominant findings from the student and teacher studies will be compared and contrasted. Lastly, a comparative look at what students and teachers had to say about integrating spirituality into medical curricula will be made with final reflections and concluding recommendations for medical education.

4.1 Becoming a Physician: Spirituality as Part of a Personal and Professional Maturation Process

Both students and teachers touched on similar concepts when defining spirituality in terms of personal values and beliefs affecting decisions and subsequent behaviour. However, students seemed to be more concrete in their thinking, trying to figure out how to approach daily life and face its difficulties; whereas teachers conveyed a more abstract definition of spirituality involving several dimensions of meaningful and reciprocal relationship (the **inward**, the **outward**, and the **upward**).

Both students and teachers made a distinction between spirituality and religion, but for teachers, the distinction was clearer and the definitions more nuanced. Some students did not distinguish spirituality from religion, which they viewed, more than teachers did, as having negative effects, generating discomfort and mistrust about spirituality itself.

A common theme between the two groups was the discourse on the personal and professional maturation process toward becoming a physician. This theme has been a subject of inquiry in the medical education literature, as most medical schools have now developed some form of physicianship course in view of enabling the progression of their learners from students to health professionals. Two recent studies from Canadian medical schools have looked at the factors that have affected this transition in their students, commenting on the importance of reflection and mentorship.[1,2] Boudreau et al. made the point that in this process, personal and professional maturation became *"enmeshed"*, which was congruent with our findings.[2]

Both teachers and students used a similar analogy: that of a seed that is planted, grows, and flowers. Both groups referred to crisis and difficulties, including illness, as part of their own personal maturation process, interlinked with an ever-evolving and changing spirituality. Whereas teachers emphasized the process of a spiritual **journey** (*"cheminement"* in French – related to 'chemin', following a path) in their own and patients' lives, where questioning led to finding new meaning in life events, many students had experienced more sudden change, **turning-points**, where questioning of family and personal beliefs had led to dramatic shifts in outlook.

In *"The Road Less Traveled"*, Scott Peck has written the following insight about questioning, which is evocative of the metaphor of the journey: *"To develop a broader vision we must be willing to forsake, to kill, our narrower vision. In the short run it is more comfortable not to do this – to stay where we are, to keep using the same microscopic map, to avoid suffering the death of cherished notions. The road of spiritual growth, however, lies in the opposite direction. We begin by distrusting what we already believe, by actively seeking the threatening and unfamiliar, by deliberately challenging the validity of what we have previously been taught and hold dear. The path to holiness lies through questioning <u>everything</u>."*[3]

With regard to growth and maturation during the transition from adolescence to early adulthood, several authors have expanded on the related changes in thinking and attitudes

as described by Erickson, which were congruent with our findings.[4-7] The dilemmas that student participants were facing should help to remind teachers that their students are at a sensitive age of transition, and that some are going through much personal angst as a backdrop to their medical education.

Regarding their professional maturation, teachers naturally had more years of clinical experience to draw upon. However, both groups discussed the **role of science in medicine**. Teachers had progressively modified, over the years, their traditional paradigms of disease and illness, based on experiences with patients and unexplained events. Students, having been exposed to certain events or stories, some told by their teachers extemporaneously, were struggling with their **commitment to rationality** and their understanding of evidence-based medicine. Both groups gave a sense that they were aware that there was something more going on with patients than meets the eye, and both groups appeared to relate these phenomena to the power of feelings, of the mind, of the invisible, or of the transcendent in the lives of human beings.

Referring to the relationship between rationality and spirituality, William Hatcher has stated the following: *"It is gratuitous and arbitrary to declare what lies beyond objectivity and/or reason to be irrational. Undoubtedly there are indeed irrational and subrational elements to human subjectivity, but why can there not also be ... aspects of our inner experience which go beyond the rational without contradicting the rational? Why is it necessary to see such things as intuition or mystic experience as against rationality instead of adjuncts to rationality which can indeed illumine reason? ... Reason alone is like a perfect mirror in a dark room – a mirror which can serve its purpose only when illumined by the light of inner experience."*[8]

4.2   Engaging with Patients and the Role of Narrative

Most noteworthy was the emphasis placed by both students and teachers on the importance of the patient-doctor relationship in healing and the successful practice of

medicine. Students manifested a willingness to engage with patients and felt that part of the physician role was to listen and accompany while taking care of patients. However, this desire for **engagement** was tempered with concern for respecting certain ethical boundaries and keeping also a proper **distance**, particularly with regard to spirituality in patient care. Some students mentioned that they would prefer to use referral to specifically-trained spiritual care resource persons. Several authors have published studies and commentaries with respect to the ethical implications of addressing spiritual and religious issues with patients.[9-12] There appears to be a consensus that physicians should not impose their beliefs on patients, but that it might be appropriate to inquire about and support whatever belief system or framework that was meaningful to patients. One of the greater challenges that students referred to was mediating conflict in the decision-making process of medical care. In this regard, Curlin et al. have made the following comment: *"Science tells patients what they <u>can</u> do, but physicians also tell patients what they <u>should</u> do, and the latter is always a moral exercise…Rather than striving for illusory neutrality, physicians should practice an ethic of candid, respectful dialogue in which they negotiate accommodations that allow them to respectfully work together with patients, despite their different ways of understanding the world."*[12]

In contrast, the teachers interviewed had few reservations about the central importance of **connecting** with their patients as human beings, some going so far as to take ethical risks to go beyond traditional boundaries of the patient-doctor relationship, in order to be truly present. McWhinney and Freeman have made the following statement about the spiritual aspect of healing, noting that it often involves some risk: *"Does a physician who brings this quality to a relationship enhance it? One result is likely to be that patients feel able to be open about expressing their own spiritual experiences… Perhaps also the sense of presence engendered by this quality plays some part in mobilizing the patient's own power of healing."*[13]

Stories by teachers unfolded that revealed deep, meaningful relationships, some of which were being told for the first time. Students told stories about connections with patients as well. Most fascinating of all, both teachers and students illustrated the important role of narrative in teaching and learning about engaging patients as a physician. Greenhalgh

and Hurwitz have pointed out: *"The narrative provides meaning, context, and perspective for the patient's predicament. It defines how, why, and in what way he or she is ill. It offers, in short, a possibility of <u>understanding</u> which cannot be arrived at by any other means."*[14]

Both groups indicated that there should be more opportunities in the curriculum for sharing stories by patients, by teachers and by students about their own experiences. Rita Charon has written: *"Narrative medicine can open doors, as sickness does, toward the search for meaning in routine clinical practice… If we can fortify our clinical training with narrative training, we will find ourselves transforming our practice, enabling those who suffer to be heard and making our care of them more effective."*[15]

4.3   Medical Education: What Needs to Happen?

4.3.1   Barriers

In Table 4.1, the reader will find a comparison of teachers and students with regard to the expressed barriers of integrating spirituality in medical education.

Most striking was the **discomfort** that both teachers and students expressed in talking about spirituality in their own milieu, despite the evident richness of thought, feeling and experience with the topic in both groups. Teachers expressed that spirituality was a **taboo topic** in medical culture, and both groups perceived that it would be less well received in their settings if **associated with religion**. Issues with **time**, the **loaded curriculum** and **performance pressures** were also enunciated by both teachers and students. It would be interesting and relevant to explore further the relative importance that teachers and students give to these barriers in a future study, possibly via a quantitative survey.

It is possible that the decreasing religiosity of the Francophone culture in Canada may have had an impact on perceptions of barriers by both students and teachers.[16] Indeed, the participants of our studies lived and worked in a social context where a widely

acknowledged transition in attitudes and practices toward religion has occurred, which could potentially have contributed to our findings.[17]   All of these factors require further study.

Table 4.1 Barriers to Integrating Spirituality in Medical Education

BARRIERS	Teachers only	Students only	Both
Discomfort of teachers			✓
Discomfort of students			✓
Taboo topic in medical culture	✓		
Spirituality associated with religion			✓
Lack of time			✓
Loaded curriculum			✓
Performance pressures			✓
Challenges of faculty development	✓		
Admissions process		✓	
Inflexibility of the curriculum		✓	

4.3.2 **Facilitators**

Table 4.2 is a comparison of teachers and students with regards to the expressed facilitators for integrating spirituality in medical education.

Students and teachers felt that integrating spirituality into medical education was desirable and possible, both groups suggesting a similar approach favoring a **mentorship** by teachers to help with the professional maturation of students over the course of their studies. This would include a more intimate sharing, via **stories**, of the challenges of teachers as physicians, especially with regards to balancing the art and the science of medicine. Both groups suggested getting students in touch with the reality of patients, and expressed the need for enhanced teacher **role modeling** of engagement with patients. Both also pointed to the need for enhanced **reflection** and **small group discussion**. Students and teachers recognized that these suggested approaches would require openness and flexibility on the part of their medical schools in order to make room for a certain degree of **student and teacher initiative**. Both groups also favored integrating the topic of spirituality into **existing learning activities**, particularly those related to **patient-centered competencies**.

Boudreau et al. noted that students in their study of professional maturation *"became frustrated with the paucity of clinical experiences"* in the first years of their program, wanting to know how to approach patients and establish a relationship.[2] This finding was congruent with our study where students expressed a desire for **early clinical exposure** in their program. Regarding the role of mentorship, the same authors also found that the student–teacher relationship involved was *"more intense than might be evoked by the term 'mentoring relationship.' The metaphor of family or kinship may be appropriate."*[2] This was concordant with the intimate bond that was depicted and hoped for by both students and teachers of our studies.

Table 4.2 Facilitators for Integrating Spirituality in Medical Education

FACILITATORS	Teachers only	Students only	Both
Mentorship			✓
Students hearing patient stories			✓
Students hearing teacher stories			✓
Clinical role modeling			✓
Reflective component			✓
Small group discussion			✓
Room for student initiative			✓
Room for teacher initiative			✓
Integrate into existing learning activities			✓
Integrate into patient-centered competencies			✓
Early clinical exposure		✓	
Link to University reputation		✓	
Progressive introduction into curriculum	✓		
Getting students in touch with their own spirituality	✓		

4.3.3 **Recommendations for Medical Education**

These findings point the way to recommendations for a renewed educational approach to teaching and learning the practice of medicine from a holistic and integrated point of view. Students and teachers appeared to agree on what they did not want in the medical curriculum with regards to spirituality: activities that are compulsory, imposed, graded, lecture-driven, top-down or add-ons. Rather, both groups favored a stepwise approach to integrating a broad based definition of spirituality, as part of learning about whole-person patient-centered care, throughout the medical program. Consultation and involvement of students and teachers in co-creating curricular activities that would allow for intimate sharing of personal and professional experiences through small-group discussion and reflection would be essential. This would need to go hand-in-hand with early student engagement with patients and their stories, accompanied by learner-centered mentors and role-models. These recommendations have support in the literature concerning what approaches appeared to have been most successful in integrating spirituality into medical curricula thus far.[18,19,20] Strong institutional support in order to overcome stated barriers would be crucial for their implementation.[19]

These findings were also congruent with current recommendations for curricular change and reform being considered in medical schools in Canada, the United States and the world over. The Association of Faculties of Medicine of Canada (AFMC), in their 2010 report recommending major changes in undergraduate medical education, called upon medical schools to better address individual and community needs by incorporating *"a competency-based and flexible approach"* into medical curricula. While *"building on the scientific basis of medicine"*, medical schools should *"value generalism"* and comprehensive care, as well as *"address the hidden curriculum"*, defined as *"a set of influences that function at the level of organizational structure and culture affecting the nature of learning, professional interactions, and clinical practice."*[21]

The Lancet Commission for the Education of Health Professionals for the 21st Century wrote in its landmark report about the unique linkages between education and health systems and practices.[22] Although its recommendations went beyond the specific subject of spirituality in medicine, the focus of its work could not be more relevant, as illustrated by this statement:

"Health is all about people. Beyond the glittering surface of modern technology, the core space of every health system is occupied by the unique encounter between one set of people who need services and another who have been entrusted to deliver them."[22]

4.3.4   Final Reflections

In Chapter 1 of this thesis, the principal researcher described the analytic preconceptions that were noted prior to conducting the research project, in order to maximize the trustworthiness and credibility of the findings. It has been a validating process, therefore, for the principal researcher to observe that the very personal perceptions, thoughts, and feelings of the participant students and teachers mirrored her own, concordant with but elaborating significantly on what has been generated in the literature to date about the concept of spirituality and its importance in patient care, and therefore in medical education.

Moreover, it has been a personally enriching process to behold the capacity for deep reflection and introspection of medical students, and very moving to witness some of their very real struggles in their personal and professional development. Most astonishing has been the discovery that colleagues have also had spiritual experiences with patients that have similarly led them to question the assumptions of their profession, experiences that were not talked about or shared. It would appear that the time to begin a more open dialogue about spirituality and medicine is overdue.

As demonstrated by the study findings, and suspected by this author, the challenges of implementing curricular change at the level suggested in the previous section could be

daunting. However, it has been encouraging to note the consensus that emerged from this study to not reinvent the wheel, so to speak, but to build on a more complete and deeper implementation of the teaching and learning about patient-centered care that already exists in medical curricula.

In its most simple expression, integrating spirituality in medicine is more about who we are as physicians and teachers than what we do, and enabling our students to realize the same. Considering the level of distress that physicians and patients can experience with the current practice of medicine, despite acknowledged advances, these research findings have reaffirmed the commitment of this author to pursue the topic of the integration of spirituality in medical education as a worthwhile field in academic medicine.

4.4　Conclusions

In his book of memoirs "A Call to Heal, Reflections on a Life in Family Medicine", the late Ian R. McWhinney wrote in a chapter called "Final Thoughts on My Career", that as he was becoming older, he was *"much more aware of the healing role of medicine as contrasted with the more technical aspects."* He wrote that changes that occurred in him throughout his life did not *"signify an intellectual shift but, rather, a maturing process… not just a change in thinking but a change in the whole self."*[23] Furthermore, McWhinney stated: *"The greatest task for doctors is reconnecting medicine with its spiritual roots. This is difficult because, I think, people often misunderstand what we mean by spirituality… I do feel that this is sort of a groundswell, something that is growing…"*[23]

It is validating that the founder of Family Medicine as a discipline in Canada should conclude such a remarkable life with reflections and observations that coincide with several of the findings of these two studies and the conclusions drawn therefrom. It is hoped that this research will have made a contribution to the emerging literature on the integration of spirituality into medical practice and education, and will encourage dialogue on the subject in medical circles, as well as between students and teachers. Both groups can and should learn more from each other. When reading this thesis, teachers

might be surprised by what students are expressing, and students might be struck by the richness of their teachers' experience.

But further exploration is needed. Richards and Morse have pointed out regarding qualitative studies: *"Some investigators do not consider a study finished until any changes indicated to be necessary by the results are implemented, evaluated, and moved firmly into practice."*[24] Concordant with this thought, it is the sincere hope of this author that a paradigm shift in medical education with regards to spirituality can not only be suggested but actually, realized.

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Appendices

Appendix A: Invitation to Students

Une invitation

La spiritualité peut être perçue comme un concept vague, subjectif, non-scientifique. Et pourtant, on parle et on écrit de plus en plus sur le lien entre la spiritualité et la santé des patients. Qu'en est-il de la formation médicale? Y a-t-il une place pour la spiritualité dans l'approche centrée sur le patient? Comment aborder ces questions dans la formation médicale?

Nous voudrions vous inviter à un groupe de discussion sur le thème de la spiritualité dans le cadre d'une recherche intitulée 'Spiritualité et formation médicale : Qu'en disent les étudiants? Qu'en disent les enseignants?'. Cette recherche est effectuée dans le cadre du programme de maîtrise de Dre Sharon Hatcher, chercheuse principale, professeure agrégée du département de médecine de famille de la Faculté de Médecine et des Sciences de la Santé de l'Université de Sherbrooke. Dr Hassan Soubhi (Université de Sherbrooke) et Dre Moira Stewart (University of Western Ontario) agissent également comme co-chercheurs.

Si vous acceptez, vous participerez à un groupe de discussion une fois pour une durée maximale de 2 heures. Une collation sera servie. La discussion sera enregistrée en audio et retranscrite de façon anonyme. Les données brutes de la recherche seront conservées de façon strictement confidentielle.

Pour signifier votre acceptation ou pour de plus amples informations, veuillez nous contacter par courriel à l'adresse suivante :

Appendix B : Student Consent Form

Spiritualité et formation médicale : Qu'en disent les étudiants? Qu'en disent les enseignants?

Chercheuse principale : Dre Sharon Nur Hatcher, Professeure agrégée, Département de médecine de famille, Faculté de Médecine et des Sciences de la Santé de l'Université de Sherbrooke

Programme d'étude : Maîtrise en Sciences Cliniques, Department of Family Medicine of the University of Western Ontario, London, Ontario

Co-chercheurs: Dre Moira Stewart, University of Western Ontario, Dr Hassan Soubhi, Université de Sherbrooke

Madame,
Monsieur,

Nous vous invitons à participer à la recherche en titre. Les objectifs de ce projet de recherche sont les suivants :

- Explorer comment les étudiants et les enseignants en médecine perçoivent la spiritualité ainsi que son rôle dans le soin des patients.
- Regarder quelles activités pédagogiques pourraient aider les étudiants en médecine à intégrer et utiliser la spiritualité dans leur pratique professionnelle future.

En quoi consiste la participation au projet?

Votre participation à l'étude implique que vous participiez, sur une période maximale de 2 heures, à un groupe de discussion (focus group). Ces groupes seront animés pour le site de Saguenay par le Dr Soubhi, et pour les sites de Moncton et de Sherbrooke par la chercheuse principale Dre Hatcher, afin de mieux documenter et connaître vos perceptions par rapport à votre vécu et apprentissage de la spiritualité en médecine. Vous serez guidés dans ces groupes par une série de questions avec lesquelles l'animateur va animer la discussion et vous serez appelé à donner votre opinion sur ces questions. Ces séances feront l'objet d'un enregistrement audio qui sera par la suite retranscrit.

Les seuls inconvénients liés à votre participation sont le temps consacré à la recherche, soit au maximum 2 heures, et le déplacement nécessaire. Il est possible que vous ressentiez un malaise par rapport à certaines questions qui vous seront posées. Si c'est le cas, vous êtes libres de refuser de répondre à toute question et au besoin, nous pourrons vous référer à des ressources appropriées (les services aux étudiants de votre site déjà en place pour le programme de médecine, incluant psychologues et adjoints à la vie étudiante).

Votre participation implique également que vous complétiez une fiche signalétique, c'est-à-dire un court questionnaire contenant des renseignements démographiques mais sans que votre nom n'y figure.

Qu'est-ce que la chercheuse fera avec les données recueillies?

Pour protéger votre identité et votre vie privée, vous ne serez pas identifié par votre nom. Les enregistrements audio des groupes de discussion seront retranscrits et ne seront pas identifiés par les noms des participants. Toutes les données recueillies dans ce projet seront strictement protégées et seuls les chercheurs impliqués dans ce projet y auront accès. Les chercheurs impliqués dans ce projet sont Dre Sharon Hatcher, étudiante à la maitrise en sciences cliniques à l'University of Western Ontario, Dre Moira Stewart, directrice de recherche de Dre Sharon Hatcher et co-chercheure dans ce projet, et Dr Hassan Soubhi, co-chercheur dans ce projet. Les co-chercheurs participent à la conception de l'étude, à la collecte des données, aux analyses, et à la rédaction des publications issues de cette recherche. Tous les renseignements personnels qui vous concernent seront codés et conservés sous clé. Les informations découlant de l'étude seront confinées dans un rapport de recherche et un certain nombre de publications pourra en découler. Les résultats de cette étude feront également l'objet de présentations dans des congrès scientifiques. En aucun cas, des renseignements personnels permettant votre identification ne seront inclus dans un rapport ou une publication. Les données seront conservées sous clé pendant une durée de cinq ans soit jusqu'en 2015 et seront ensuite détruites en préservant la confidentialité.

Vous-mêmes et les autres personnes qui participerez au *focus group/groupe de discussion* connaîtrez l'identité des personnes participantes et des renseignements et opinions partagés lors de la discussion. Nous comptons sur votre collaboration afin de préserver la confidentialité de ces informations.

Est-il obligatoire de participer?

Non. La participation à cette étude se fait sur une base volontaire. Vous êtes entièrement **libre de participer ou non**, et de vous retirer en tout temps sans avoir à motiver votre décision ni à subir de préjudice de quelque nature que ce soit. La décision de participer ou non à cette étude n'affectera en rien le déroulement de vos études médicales.

Y a-t-il des risques, inconvénients ou bénéfices?

Au-delà des risques et inconvénients mentionnés jusqu'ici [risque d'identification, malaise par rapport à certaines thématiques abordées, inconvénient de temps ou de déplacement], les chercheuses et le chercheur considèrent que les risques possibles sont minimaux. La contribution à l'avancement des connaissances au sujet de la spiritualité en médecine sont les bénéfices indirects prévus. Aucune compensation d'ordre monétaire ne sera accordée cependant pour vous remercier une collation sera servie après (ou pendant) le groupe de discussion. Tout sera fait pour faciliter votre participation en organisant la rencontre selon votre horaire étudiant et dans un endroit accessible. La durée du groupe de discussion sera limitée à un temps maximal de 2 heures en une seule séance.

Que faire si j'ai des questions concernant le projet?

Si vous avez des questions concernant ce projet de recherche, n'hésitez pas à communiquer avec moi aux coordonnées indiquées ci-dessous.

Signature :   *Date :*

Dre Sharon Nur Hatcher
Chercheuse responsable du projet de recherche

J'ai lu et compris le document d'information au sujet du projet **«** Spiritualité et formation médicale : Qu'en disent les étudiants? Qu'en disent les enseignants**? »** *J'ai compris les conditions, les risques et les bienfaits de ma participation. J'ai obtenu des réponses aux questions que je me posais au sujet de ce projet. J'accepte librement de participer à ce projet de recherche..*

☐   *J'accepte de participer aux entrevues de groupe.*

☐ *Je m'engage à respecter la confidentialité des renseignements partagés lors du focus group/ de l'entrevue de groupe (noms des autres participants et informations dévoilées).*

Signature :

Nom :

Date :

S.V.P. Signez les deux copies.
Conservez une copie et remettez l'autre à la chercheuse.

Ce projet a été revu et approuvé par le comité d'éthique de la recherche Éducation et sciences sociales, de l'Université de Sherbrooke. Cette démarche vise à assurer la protection des participantes et participants. Si vous avez des questions sur les aspects éthiques de ce projet (consentement à participer, confidentialité, etc.), n'hésitez pas à communiquer avec M. André Balleux, président de ce comité.

Appendix C : Student Interview Guide

1. **Comment les étudiants en médecine perçoivent-ils la spiritualité?**

   Que signifie le terme 'spiritualité' pour vous?

   Avez-vous eu des expériences en lien avec la spiritualité (dans votre propre vie ou chez d'autres autour de vous)?

   Y a-t-il, selon vous, des bénéfices à la spiritualité? Si oui, lesquels?

   Y a-t-il des inconvénients? Si oui, lesquels?

2. **Comment les étudiants en médecine perçoivent-ils le rôle de la spiritualité dans le soin des patients?**

   Que pensez-vous est le rôle de la spiritualité dans le vécu des patients? Dans le soin des patients? Dans la relation médecin-patient?

   Pensez-vous que la spiritualité affecte le développement de certaines maladies? La guérison de certaines maladies?

   Avez-vous souvenir d'une expérience clinique où la spiritualité a été importante?
   Indiquez en quoi elle a été importante?

3. **Quelles activités pédagogiques peuvent aider les étudiants à intégrer et utiliser la spiritualité dans leur pratique professionnelle future?**

   Quels souvenirs reliés à la spiritualité gardez-vous de votre formation médicale?

   Dans votre formation, avez-vous souvenir d'une expérience clinique ou d'un événement que vous pensez avoir été un point tournant dans votre perception de la spiritualité?

   Selon vous, quelles sont les barrières à l'intégration de la spiritualité dans la formation médicale? Quels sont les facilitateurs?

   À votre avis, quelles activités pédagogiques pourraient aider à intégrer la spiritualité dans la formation médicale préclinique? Dans la formation médicale clinique?

   Quelles autres recommandations feriez-vous pour l'intégration de la spiritualité dans la formation médicale?

Questions ajoutées :

   Pourquoi êtes-vous venu aujourd'hui? Pourquoi pensez-vous que d'autres ne sont pas venus?
   Dans quelle mesure parlez-vous de spiritualité avec vos collègues?

Student Interview Guide (English Version)

1. **How do medical students perceive spirituality?**

   What does the term 'spirituality' mean to you?

   Have you had experiences related to spirituality (in your own life or in others' around you)?

   According to you, are there benefits to spirituality? If yes, what are they?

   Are there drawbacks? If yes, what are they?

2. **How do medical students perceive the role of spirituality in patient care?**

   What do you think is the role of spirituality in what patients experience? In patient care? In the doctor-patient relationship?

   Do you think that spirituality affects the development of certain diseases? The healing of certain diseases?

   Do you remember a clinical experience where spirituality was important? In what way was it important?

3. **What educational activities can assist students to integrate and apply spirituality to their future professional practice?**

   What memories related to spirituality do you have of your medical training?

   In your training, do you remember a clinical experience or event that you feel was a turning point in your perception of spirituality?

   According to you, what are the barriers to integrating spirituality in medical education? What are the facilitators?

   In your opinion, what educational activities would help integrate spirituality in preclinical medical training? In clinical medical training?

   What additional recommendations would you make for the integration of spirituality in medical education?

 Added questions:

   Why did you come here today? Why do you think others did not come?

   To what extent do you talk about spirituality with your colleagues?

Appendix D : Ethics Approval Certificate

Université de Sherbrooke
Comité d'éthique de la recherche
Éducation et sciences sociales

Attestation de conformité

Le comité d'éthique de la recherche Éducation et sciences sociales de l'Université de Sherbrooke certifie avoir examiné la proposition de recherche suivante :

Spiritualité et formation médicale : Qu'en disent les étudiants? Qu'en disent les enseignants?

Sharon Hatcher

Professeure, Département de Médecine de famille, Faculté de médecine et des sciences de la santé

Dans le cadre d'une Maîtrise en sciences cliniques en médecine familiale (M.Cl.Sc.), University of Western Ontario, London, Ontario

Le comité estime que la recherche proposée est conforme aux principes éthiques énoncés dans la

Politique institutionnelle en matière d'éthique de la recherche avec les êtres humains.

Membres du comité

André Balleux, président du comité, professeur à la Faculté d'éducation, département de pédagogie.

France Jutras, professeure à la Faculté d'éducation, département de pédagogie

Jean-Pascal Lemelin, professeur à la Faculté d'éducation, Département de psychoéducation

Julie Myre-Bisaillon, professeure à la Faculté d'éducation, Département d'adaptation scolaire et sociale

Carlo Spallanzani, professeur à la Faculté d'éducation physique et sportive

Serge Striganuk, professeur à la Faculté d'éducation, Département de gestion de l'éducation et de la formation

Eric Yergeau, professeur à la Faculté d'éducation, Département d'orientation professionnelle

Micheline Loignon, membre représentante du public

Le présent certificat est valide pour la durée de la recherche, à condition que la personne responsable du projet fournisse au comité un rapport de suivi annuel, faute de quoi le certificat peut être révoqué.

Le président du comité,

André Balleux, 1er décembre 2009

Appendix E : List of Themes – Student Focus Groups

Understanding Spirituality

Concept of Spirituality

- ➢ Personal
- ➢ Intangible
- ➢ Transcendent
- ➢ Spirituality vs Religion

Expression of Spirituality in daily life

- ➢ Anchor: guidelines, framework for beliefs and values
- ➢ Decisions, actions, behavior towards others
- ➢ Making sense of difficulties, of life
- ➢ Positive effects : resilience, optimism, serenity
- ➢ Negative effects: guilt, anger, passivity, rigidity, extremism

Student Dilemmas

Personal Change in Direction

- ➢ Relying on childhood beliefs and practices
- ➢ Turning-point : Autonomy, rejecting authority
- ➢ Questioning, Reflecting
- ➢ Changing Spirituality

Future Physician Role with Patients

- ➢ Engagement: listening, caring, accompanying; taking into account patient's spirituality
- ➢ Distance: respecting certain boundaries (not imposing one's beliefs, challenge of differing beliefs, best to use referral sources); limited time

The Struggle with Rationality in Medicine

- ➢ *Strengths* : evidence, proofs, rationality
- ➢ *Limitations*: effect of feelings, of the spiritual; the placebo effect
- ➢ Unexplained events

Perceptions of the Medical Curriculum

Creating Opportunities for Student Self-Determination

- ➢ Inflexibility of curriculum
- ➢ Loaded curriculum/lack of time
- ➢ Performance pressures/emphasis on grades
- ➢ Discomfort of students
- ➢ Small group discussion and sharing

Enhancing Early Clinical Exposure

- ➢ Lack of early clinical exposure
- ➢ Experiential: meeting and talking with real patients, vignettes, videos,
- ➢ Integrate into existing Ethics sessions
- ➢ Integrate into existing Clinical Skills sessions
- ➢ Clinical role models; their stories
- ➢ Clerkship experience
- ➢ Patient-centered competencies

Questioning the Priorities of the Curriculum

- ➢ Admissions process
- ➢ Discomfort of teachers
- ➢ University image – innovative, pt-centered, learner-centered

Appendix F: Teacher Consent Form

Spiritualité et formation médicale : Qu'en disent les étudiants? Qu'en disent les enseignants?

Chercheuse principale : Dre Sharon Nur Hatcher, Professeure agrégée, Département de médecine de famille, Faculté de Médecine et des Sciences de la Santé de l'Université de Sherbrooke

Programme d'étude : Maîtrise en Sciences Cliniques, Department of Family Medicine of the University of Western Ontario, London, Ontario

Co-chercheurs: Dre Moira Stewart, University of Western Ontario, Dr Hassan Soubhi, Université de Sherbrooke

Madame,
Monsieur,

Nous vous invitons à participer à la recherche en titre. Les objectifs de ce projet de recherche sont les suivants :
* Explorer comment les étudiants et les enseignants en médecine perçoivent la spiritualité ainsi que son rôle dans le soin des patients.
* Regarder quelles activités pédagogiques pourraient aider les étudiants en médecine à intégrer et utiliser la spiritualité dans leur pratique professionnelle future.

En quoi consiste la participation au projet?

Votre participation à l'étude implique que vous participiez, sur une période de une heure, à une entrevue individuelle. Cette entrevue sera animée par la chercheuse principale Dre Sharon Hatcher afin de mieux documenter et connaître vos perceptions par rapport à la formation médicale dans le domaine de la spiritualité en médecine. Vous serez guidés dans ces entrevues par une série de questions que Dre Hatcher va vous poser et vous serez appelé à donner votre opinion sur ces questions. Ces séances feront l'objet d'un enregistrement audio qui sera par la suite retranscrit.

Les seuls inconvénients liés à votre participation sont le temps consacré à la recherche, soit environ une heure. Il est possible que vous ressentiez un malaise par rapport à certaines questions qui vous seront posées. Si c'est le cas, vous êtes libre de refuser de répondre à toute question et au besoin, nous pourrons vous référer à des ressources appropriées (les services de relation d'aide, incluant psychologue et travailleur social, déjà en place au sein de votre institution).

Votre participation implique également que vous complétiez une fiche signalétique, c'est-à-dire un court questionnaire contenant des renseignements démographiques mais sans que votre nom n'y figure.

Qu'est-ce que la chercheuse fera avec les données recueillies?

Pour protéger votre identité et votre vie privée, vous ne serez pas identifié par votre nom. Les enregistrements audio des entrevues seront retranscrits et ne seront pas identifiés par les noms des participants; un code numérique sera utilisé à la place. Toutes les données recueillies dans ce projet seront strictement protégées et seuls les chercheurs impliqués dans ce projet y auront accès. Les chercheurs impliqués dans ce projet sont Dre Sharon Hatcher, étudiante à la maitrise en sciences cliniques à l'University of Western Ontario, Dre Moira Stewart, directrice de recherche de Dre Sharon Hatcher et co-chercheure dans ce projet, et Dr Hassan Soubhi, co-chercheur dans ce projet. Les co-chercheurs participent à la conception de l'étude, à la collecte des données, aux analyses et à la rédaction des publications issues de cette recherche. Tous les renseignements personnels qui vous concernent seront codés et conservés sous clé. Les informations découlant de l'étude seront confinées dans un rapport de recherche et un certain nombre de publications pourra en découler. Les résultats de cette étude feront également l'objet de présentations dans des congrès scientifiques. En aucun cas, des renseignements personnels permettant votre identification ne seront inclus dans un rapport ou une publication. Les données brutes seront conservées sous clé pendant une durée de cinq ans, soit jusqu'en 2015 et seront ensuite détruites en préservant la confidentialité.

Est-il obligatoire de participer?

Non. La participation à cette étude se fait sur une base volontaire. Vous êtes entièrement **libre de participer ou non**, et de vous retirer en tout temps sans avoir à motiver votre décision ni à subir de préjudice de quelque nature que ce soit.

Y a-t-il des risques, inconvénients ou bénéfices?

Au-delà des risques et inconvénients mentionnés jusqu'ici [malaise par rapport à certaines thématiques abordées, inconvénient de temps ou de déplacement], les chercheuses et chercheurs considèrent que les risques possibles sont minimaux. La contribution à l'avancement des connaissances au sujet de la spiritualité en médecine sont les bénéfices indirects prévus. Aucune compensation d'ordre monétaire ne sera accordée et tout sera fait pour faciliter votre participation en organisant la rencontre selon votre disponibilité et selon l'endroit de votre choix. La durée de l'entrevue sera limitée à un temps maximal de une heure en une seule séance.

Que faire si j'ai des questions concernant le projet?

Si vous avez des questions concernant ce projet de recherche, n'hésitez pas à communiquer avec moi aux coordonnées indiquées ci-dessous.

Signature :   *Date :*

Dre Sharon Nur Hatcher
Chercheuse responsable du projet de recherche

J'ai lu et compris le document d'information au sujet du projet « Spiritualité et formation médicale : Qu'en disent les étudiants? Qu'en disent les enseignants? » *. J'ai compris les conditions, les risques et les bienfaits de ma participation. J'ai obtenu des réponses aux questions que je me posais au sujet de ce projet. J'accepte librement de participer à ce projet de recherche.*

☐   *J'accepte de participer à l'entrevue*

Signature :

Nom :

Date :

S.V.P. Signez les deux copies.
Conservez une copie et remettez l'autre à la chercheuse.

Ce projet a été revu et approuvé par le comité d'éthique de la recherche Éducation et sciences sociales, de l'Université de Sherbrooke. Cette démarche vise à assurer la protection des participantes et participants. Si vous avez des questions sur les aspects éthiques de ce projet (consentement à participer, confidentialité, etc.), n'hésitez pas à communiquer avec M. André Balleux, président de ce comité.

Appendix G : Teacher Interview Guide

1. **Comment les enseignants en médecine perçoivent-ils la spiritualité?**

   Que signifie le terme 'spiritualité' pour vous?

   Avez-vous eu des expériences en lien avec la spiritualité (dans votre propre vie ou chez d'autres autour de vous?)

   Y a-t-il, selon vous, des bénéfices à la spiritualité? Si oui, lesquels?

   Y a-t-il des inconvénients? Si oui, lesquels?

2. **Comment les enseignants en médecine perçoivent-ils le rôle de la spiritualité dans le soin des patients?**

   Que pensez-vous est le rôle de la spiritualité dans le vécu des patients? Dans le soin des patients? Dans la relation médecin-patient?

   Pensez-vous que la spiritualité affecte le développement de certaines maladies? La guérison de certaines maladies?

   Avez-vous souvenir d'une expérience clinique où la spiritualité a été importante? Indiquez en quoi elle a été importante?

3. **Quelles activités pédagogiques peuvent aider les étudiants à intégrer et utiliser la spiritualité dans leur pratique professionnelle future?**

   Quels souvenirs reliés à la spiritualité gardez-vous de votre formation médicale?

   Dans votre formation, avez-vous souvenir d'une expérience clinique ou d'un événement que vous pensez avoir été un point tournant dans votre perception de la spiritualité?

   Selon vous, quelles sont les barrières à l'intégration de la spiritualité dans la formation médicale? Quels sont les facilitateurs?

   À votre avis, quelles activités pédagogiques pourraient aider à intégrer la spiritualité dans la formation médicale préclinique? Dans la formation médicale clinique?

   Quelles autres recommandations feriez-vous pour l'intégration de la spiritualité dans la formation médicale?

   Question ajoutée :

   Dans quelle mesure parlez-vous de spiritualité avec vos collègues?

Teacher Interview Guide (English Version)

1. **How do medical teachers perceive spirituality?**

   What does the term 'spirituality' mean to you?

   Have you had experiences related to spirituality (in your own life or in others' around you)?

   According to you, are there benefits to spirituality? If yes, what are they?

   Are there drawbacks? If yes, what are they?

2. **How do medical teachers perceive the role of spirituality in patient care?**

   What do you think is the role of spirituality in what patients experience? In patient care? In the doctor-patient relationship?

   Do you think that spirituality affects the development of certain diseases? The healing of certain diseases?

   Do you remember a clinical experience where spirituality was important? In what way was it important?

3. **What educational activities can assist students to integrate and apply spirituality to their future professional practice?**

   What memories related to spirituality do you have of your medical training?

   In your training, do you remember a clinical experience or event that you feel was a turning point in your perception of spirituality?

   According to you, what are the barriers to integrating spirituality in medical education? What are the facilitators?

   In your opinion, what educational activities would help integrate spirituality in preclinical medical training? In clinical medical training?

   What additional recommendations would you make for the integration of spirituality in medical education?

   Added question:

   To what extent do you talk about spirituality with your colleagues?

Appendix H: List of Themes 1 – Teachers

Participants as Persons

Inner:

- Values
- Beliefs
- Searching for meaning (of existence, of events)
- Metacognition, self-awareness, understanding
- Feelings, emotions (both + and -), subconscious, intangible
- Personal, alone (+: courage to stand up for one's beliefs or values; -: isolation)
- Questioning (+: defining one's beliefs; -: crisis of faith)
- Outlook on life
- Outlook on death

Outer/Others:

- Connection
- Deeper relationship: listening, welcoming, helping, influencing, accompanying
- Specific people: family, friends (+: bonding; -: conflict)
- The world, the planet
- Nature
- Actions, behaviour (+: can reflect spirituality; -: can be an escape from)
- Community, society (+: making a contribution, common values, respect of others' beliefs; -: differences, division, extremism)

Transcendant/Greater:

- Belief in God (or not), Creator
- Powerful force(s), Energy
- Connection with the Universe, small part of a greater whole
- Destiny, fate
- Another taking responsibility (+: alleviate guilt, sense of helplessness; -: crutch, cop-out)
- Reaching for a higher level
- Receiving help (from above), assistance in times of difficulty

Spirituality as a Journey:

- Childhood beliefs and practices: break from, return to
- Defining and refining one's own beliefs
- Personal growth and maturation (becoming a better person), aging, wisdom
- Facing and getting through life's difficulties
- Crisis, turning-points, suffering
- Confronting death, finality

Spirituality and Religion:

- ➢ Different from Religion
- ➢ Spirituality includes Religion, but larger
- ➢ Spirituality without Religion
- ➢ Spirituality in everyone, natural
- ➢ Spirituality can be cultivated, taken care of
- ➢ Spirituality like psychology, philosophy,... but more
- ➢ Religion as a negative aspect of spirituality

Diverse Practices:

- ➢ Prayer
- ➢ Meditation
- ➢ Reading
- ➢ Writing
- ➢ Reflection
- ➢ Discussing, sharing with others
- ➢ Going out in nature
- ➢ Art
- ➢ Groups: prayer group, discussion group, Balint group, support group
- ➢ Mentorship (role-model, priest)
- ➢ Faith activities, retreats, conferences
- ➢ Going to church, mass, rituals
- ➢ Teaching, talking to children, catechism

Qualities/Manifestations of Spirituality in the Person:

- ➢ Serenity, peacefulness, calmness
- ➢ Hope, optimism, positive thinking
- ➢ Openness, tolerance, acceptance of others, non-judgemental attitude
- ➢ Contentment, gratitude, thankfulness
- ➢ Rigidity, closed-mindedness

Participants as Physicians

Limitations of Science in Medicine:

- ➢ Limits of treatment
- ➢ Sense of physician helplessness
- ➢ Reality of death
- ➢ Illness awakens spirituality
- ➢ Unexplained events (miracles, cures, dreams, coincidences, premonitions, psychosomatic illness)

The Doctor-Patient Relationship as a Spiritual Experience:

- ➤ Connecting, communing, bonding with the person
- ➤ Searching for meaning of illness, suffering
- ➤ Asking
- ➤ Listening
- ➤ Welcoming ("*accueil*")
- ➤ Receiving confidences
- ➤ Giving comfort, reassurance, hope
- ➤ Openness towards and respect of patient's spirituality
- ➤ Accompanying
- ➤ Expressing emotion
- ➤ Taking time with patient
- ➤ Reflecting with patient
- ➤ Helping patient cope with illness
- ➤ Breakthroughs with difficult patients
- ➤ Solving problems together (decisions about treatment, end of life care, calling upon resources like priest, native healer)
- ➤ Praying for patient, with patient, to deceased patient
- ➤ Learning from, influencing each other
- ➤ Bonding with other patient caregivers

Talking with Patients about Spirituality: Not frequent, not easy

Issues:

- ➤ Kind of health problem (facilitators: serious illness, chronic illness, mental illness)
- ➤ End of life care and decision-making (facilitator)
- ➤ Setting (facilitators: hospital care, home care)
- ➤ Patient of different culture than physician
- ➤ Ethical boundaries (facilitator: physicians willing to take risks; barrier: fear of imposing one's beliefs, overstepping boundaries)
- ➤ Patient's beliefs (facilitator: wanting to take them into account; barrier: wanting to respect them)
- ➤ Level of physician comfort with the realm of spirituality
- ➤ Reaction of others (positive or negative)
- ➤ Time (facilitator: willingness to take the time; barrier: lack of time)

Talking with Colleagues about Spirituality in Patient Care : Not frequent, not easy

Issues:

- ➤ Type of practice (facilitators: palliative care, care of the elderly)
- ➤ Personal affinity (one on one sharing)
- ➤ Necessity (case discussion, patient transfer)
- ➤ Medical culture (often a barrier)
- ➤ Reaction of others (positive or negative)
- ➤ Beliefs of others (barrier: wanting to respect them, not confront them)

> ➤ Role in conflict resolution

Participants as Teachers

Facilitators:

- ➤ Progressive introduction into curriculum
- ➤ Not compulsory
- ➤ No exams
- ➤ Reflective
- ➤ Integrated with current curricular activities
- ➤ Room for student initiative (consult with them)
- ➤ Room for teacher initiative (telling stories about patients, use of the humanities, the arts)
- ➤ Small group discussions
- ➤ Role models in clinical setting
- ➤ Make use of clinical opportunities, teachable moments
- ➤ Importance of mentorship
- ➤ Use past experience of introducing something new in curriculum (examples: ethics, public health)
- ➤ Getting students in touch with reality of patients (witnessing, listening, talking, hearing their stories, community involvement)
- ➤ Getting students in touch with reality of physicians (experiences, emotions, suffering)
- ➤ Gettings students in touch with their own spirituality
- ➤ Link with training in residency: critical clinical years

Barriers:

- ➤ Religion is taboo
- ➤ Naming spirituality itself
- ➤ Loaded curriculum/lack of time
- ➤ Discomfort of teachers
- ➤ Challenges of faculty development
- ➤ Opposition of certain faculty
- ➤ Immaturity of students
- ➤ Lack of interest of students
- ➤ Lack of religiosity in students
- ➤ Performance pressures (students rather study)
- ➤ Clinical service pressures
- ➤ Hidden curriculum (valuing scientific expertise at the expense of other competencies necessary for patient care)
- ➤ Medical culture and institutions slow to change
- ➤ Accreditation

Appendix I: List of Themes 2 – Teachers

Participants as Persons and Physicians

Spirituality as Three Dimensions of Relationship...

Inward: deeply personal

- ➢ Fostered by Introspection, Reflection
- ➢ Related to Emotions
- ➢ Defining Values and Beliefs: Spirituality different from Religion
                                  For some, Spirituality includes Religion but larger
- ➢ Spirituality in everyone, natural

Outward:

- ➢ Individual actions (need to care for others)
- ➢ Connection with others, with patients
- ➢ Deeper relationship with others, with patients
- ➢ Effect of patients on the physician
- ➢ **Difficulties**: Spirituality lived with family, children, friends (can be conflict)
                Community (rigidity can lead to extremism)

Upward:

- ➢ Relationship with something greater: Receiving assistance in times of difficulty
                                  Another taking responsibility (+: alleviate guilt, sense of helplessness; -: crutch, cop-out)
- ➢ **Different conceptions**: Belief in God (or not), powerful Force(s), Destiny

Spirituality can be cultivated: Spiritual Practices

 Personal:

- ➢ Prayer
- ➢ Meditation
- ➢ Reading
- ➢ Writing

With others:

- ➢ Discussing, sharing with others

- ➤ Groups: prayer group, discussion group, Balint group, support group
- ➤ Spiritual counsellor (priest, healer, therapist)
- ➤ Faith activities, retreats, conferences
- ➤ Rituals, ceremonies

Spirituality as a Journey...

Personal:

- ➤ Childhood beliefs and practices: break from, return to
- ➤ Period of Questioning (+: defining one's beliefs; -: crisis of faith)
- ➤ Searching for meaning of life events
- ➤ Dealing with crisis and difficulties
- ➤ Dealing with illness
- ➤ Confronting death

Professional:

Limitations of Science in Medicine:

- ➤ Limits of treatment
- ➤ Sense of physician helplessness
- ➤ Psychosomatic illness
- ➤ Unexplained events (miracles, cures, dreams, coincidences, premonitions)

Talking about Spirituality: Not frequent, not easy

Facilitators:

- ➤ Kind of health problem (serious illness, chronic illness, mental illness)
- ➤ Care of the elderly
- ➤ End of life care and decision-making
- ➤ Setting (hospital care, home care)
- ➤ **With all the above:** Interdisciplinary teams, case discussions and transfers

Issues with patients:

- ➤ Patient's beliefs (wanting to take them into account)
- ➤ Ethical boundaries and decision-making (physicians willing to take risks)
- ➤ Time (facilitator: willingness to take the time; barrier: lack of time)
- ➤ Level of physician comfort with the realm of spirituality

Issues with colleagues:

- ➤ Medical culture (often a barrier)

> ➢ Personal affinity
> ➢ Reaction of others (positive or negative)

Participants as Teachers

Go Slow Approach…

> ➢ Progressive introduction into curriculum
> ➢ Not compulsory
> ➢ No exams
> ➢ Integrated with current curricular activities
> ➢ Use past experience of introducing something new in curriculum (examples: ethics, public health)

Barriers:

> ➢ Naming spirituality itself: Religion is taboo
>
>   Medical culture, hidden curriculum
> ➢ Loaded curriculum/lack of time/performance pressures
> ➢ Discomfort of students: Better in residency? - critical clinical years
> ➢ Discomfort of teachers/challenges of faculty development

Facilitators: coherent with dimensions of spirituality

Turning Inward:

> ➢ Reflective
> ➢ Getting students in touch with their own spirituality

Turning Outward:

> ➢ Getting students in touch with reality of patients (witnessing, listening, talking, hearing their stories)
> ➢ Room for teacher initiative (telling stories about patients, use of the humanities, the arts)
> ➢ Awareness of diversity of patient beliefs

The Journey:

> ➢ Mentorship: Accompanying students in their growth and maturation
> ➢ Getting students in touch with reality of physicians (experiences, emotions, suffering)
> ➢ Role models in the clinical setting

Importance of sharing:

> ➢ Small group discussions

Appendix J: Teacher Stories of Unexplained Events

« I had an elderly patient, who came to see me and who, at a certain time, developed jaundice and after investigation and all that, we discovered that she had cancer and she was a patient with whom I got along very well and we had certain discussions. So eventually, the family did not want me to tell her that she had cancer. I had difficulty with that, she became sicker and sicker and she couldn't come and see me anymore, she lived in a rural area. So I had the pleasure to go visit her in her country home and at one point (they had put her bed in the living room because she couldn't go up the stairs anymore), I sat with her and she told me: 'Now, I would like you to tell me what's going on'... With her, I was able to tell her: 'Listen, your family was a bit afraid if I told you - you have a terminal illness.' She asked me a bunch of questions, if she had much time to live, so we were able to have a discussion, to know really heart to heart things that were so important, and I think that both of us felt so close from that discussion. Finally, once I gave her all the information, she told me: 'Thank you so much, I am so happy that you were honest with me.' I told her that I was there to accompany her and here we have the extramural hospital, so nurses do everything they can to accompany the sick. So maybe 3 or 4 weeks later, I was dreaming at night, I was dreaming and in my dream I was in a chair, a rocking chair and I had a baby in my arms and the baby was in distress, but I knew that the baby was her, in my dream, it was her even if physically it did not look like her, it was clear, it was clear to me that it was her and she was in great, great distress. She was crying and I felt that distress, I was mothering her, I was consoling her and I was saying: 'Look, it's going to be OK, you'll see, you'll be OK.' And as I was talking to her, it's as if she was lifted out of my arms and was going up to the sky. I was telling her: 'You'll see, it's going to be OK, you must not worry, don't be afraid you'll see.' While I was saying that, inside myself, I felt this kind of serenity, the absence of everything, of anxiety, of everything, and it's as if it was a peace, a serenity that I have never felt in my life, awake or even asleep. At that moment, the telephone rang, it was 3:00 am, and the nurse told me that she had died.»

« It happened to me once before when I was in my clerkship. I was taking care of a patient who… had something special, a vulnerability that I connected with. I remember it still, imagine - it's been 30 years! ... Something connected with regard to, I don't know, I thought he was nice, I thought he was pitiful. In those days, as a medical clerk, we could go home for the holidays. I went home and again, during the night (and I remember it was New Year's Eve), I dreamt that that man had died. I don't recall exactly what the dream was, but when I went back, I checked and he had died, that man.»

« My brother had a friend who had an extremely severe obsessive compulsive disorder, extremely severe. In fact, he was a man in his thirties who could not hold a paying job. He still lived with his parents, he could hardly go out. It was like two years that he'd been followed in psychiatry, I think they didn't really know much more what they could still offer him. My brother and I decided to start praying for this young guy. In one month, he started doing better and today this young guy has now moved out on his own, he lives in another city, he has a paying job. Lots of people would say that it was coincidence; I

think that he had been two years with the same treatment, it did not work. We started to pray for him, and then, he got out of it. In my opinion, there was something there. So I think, I think that prayer may have affected the course of his illness.»

« My mother had many complications, she almost died many times, she hemorrhaged, her hemoglobin was 75, it was hell and then, they gave her a transfusion. When she arrived, they asked her level of care; day 1 in the ER, a major infection, 40 degree fever, we had to determine her level of care... it was clear she did not want to be resuscitated and all that. And then the discussion..., she was very sick, if she presents a VT [ventricular tachycardia], do we reverse her? [Dr] was saying: there are reversible things, does she want it [the treatment] or not? So then, I discussed this with my mother and she was telling me: 'If I have something and it takes a pretty simple intervention and I come back to how I was before, I want it, I think I want it,' In the course of things when the time came (the transfusions, when she entered intensive care), it was an even grayer zone and... each time, they asked the question. When I arrived, she told me: 'Do you know what happened to me? I missed a good chance to let myself go and now I think I've missed my chance... it's very difficult.' She felt extremely troubled by each of those decisions. At one point, Mom said: 'I could not refuse the transfusions, because it's still not clear to me that it's not a suicide and I don't know what I'm allowed to do and what I'm not allowed to do.' She had said in the past that she hoped to never find herself in long-term care, but her autonomy in the last six months was a constant loss, subtle, and it was borderline for an apartment on her own. And now, with all her complications, she was experiencing new after effects and she was able to anticipate that the next step would be long-term care. When she got a little stronger, and she explained to me after, she said: 'You know when you hemorrhage, you don't have a lot of energy eh, you have to fight to stay alive and it's as if my brain, it was not clear what was going on in there. And when I felt a bit better, then I was able to tell myself: oh now, there's an important question to address.' Miracles happened in this story, some kind of small magical moments: her neighbourhood mechanic passed by her door with his brother who was a priest and they came in to see her, it just happened like that. And then, she asked her questions and [the priest] told me: 'Your mother has just passed an important stage; she has clarified what she is allowed to do to not lose her place in heaven.' When I arrived, it was clear, she said: 'I can decide today that with the course of my life (she suffered from rheumatoid arthritis), that I have suffered for 30 years, my illness, my evolution, that I can decide that it's enough and I can, myself, make that decision. It's not euthanasia, it's just that I can choose to stop treatment and to let nature take its course and that's what I've asked for.'»

« We had a very spiritual discussion on who we were, who we were as souls, as persons. It rained, it was windy, it squalled like we would say in my parts, it hailed, we were outside and we stayed five hours talking. During this discussion she told me that she had been to see a tarot-card fortune teller and this fortune-teller had told her that a very, very, very, very close friend would die. So spontaneously I said: 'I hope it's not [ ], the friend we have in common.' And she said: "No, I think she was talking about me, but she didn't dare tell me.' She told me really where she was in her process, in her life, in her career, in her relationships. And that she found that she had had a very good life and that if it was her she was talking about, she was OK with that. She told me: 'If I ever have an accident,

if you are in the ER, I want you to promise me that you would not resuscitate me, no matter what the situation'... She brought me and introduced me to her parents, her brothers, her sisters. To each person she introduced me to: 'Look at him closely, he is a significant person, he is important to me'... Six months later, they were in an accident, they hit a moose and I was on duty at the ER. It was a small hospital, everyone knew each other, the janitor who lived in the area called me to tell me: 'I don't know who it is, it's our common friend's car and one is resuscitating the other, they are coming... Exactly, when they arrived, she [her partner] was trying to resuscitate her; both my arms fell and I was saying 'She doesn't want this'... They had been resuscitating her for 20 minutes, she was bleeding from both ears, she had a fracture at the base of the skull, she had a cervical fracture... And finally her heart started again, but she never breathed on her own probably because of the cervical fracture, but at one point, her heart started again and I was like: 'Stop, stop.' I didn't want her heart to start again because I was telling myself: 'She won't get out of this. She, she did not want to see herself as a vegetable or on a machine.' Finally, when we stopped, it was 3:00AM, who went to inform her family? It was me.»

« So the story is this: it's an old man, 75 years old, his wife dies from a long illness, he is very attached to her… During his wife's illness, we find he has renal cancer, we operate his kidney, and he's referred a few months later for lung metastases. There's no good chemotherapy for renal cancer. The lung metastases are proven, I do the biopsy: of renal origin, 3-4 metastases. I have him seen in hemato-oncology. Ah the treatments are not great, the man doesn't want them. I say: 'Thank you sir, I'll see you again in my office in 3 months.' I see him again and he says: 'I'm not doing too badly.' I don't do X-rays, I say come back in 3 months. I do X-rays (he comes back 3 months later), no metastases on the X-ray and I have the CD with me. I find that amazing, it's the only miracle I've seen. And I saw him again last week, it's been two and a half years, he's doing really well. I ask him: 'Sir, to what do you attribute the fact that you have been cured from the metastases?' He says: 'My wife told me that I would heal if I was not so sad, now I am less sad, and I have healed. My wife left with it.' It's the only miracle I have witnessed in my life.»

« I'm thinking of my mother's friend who died recently... She has just died, but listen, over ten years ago she had breast cancer, you know the inflammatory CAs that happen and you tell yourself: they only have a couple of months, that's it, it's over. Shit, she survived that. She healed that breast cancer. She was surely very spiritual, but a firm believer, a church-goer and really there were people who prayed for her and she prayed. So it was her way of life, but she had that attitude of saying: so there I have that, but the rest of my body is OK. I did not interact with her a lot, I did not see her a lot, I heard a lot through my mother, but I already knew her quite well. Listen, she was followed in Montreal, Dr. [ ] in Montreal brought her everywhere to conferences, people talked about her everywhere because they said: I don't believe it, she lives, she's still alive. No one believed it; everyone was convinced that she would die. No one ever told her because obviously, we have to leave it open to doubt and all that, and she would always say: 'I told you so, I knew it, I knew that it would go well. So see, I followed your recommendations, I took care of myself.' and then she would say: 'I put the good Lord in

there and everything went well.' Even [my physician husband] and I, we said: [she] survived that cancer, it's impossible... and now she is dead from a second cancer, stomach cancer!»

« I have a friend, who I consider a very spiritual person, who last summer..., he announced that he had colon cancer, with metastases to the liver, and the mass was so big that it was inoperable. He told himself: not afraid of dying at all, that's not the question, I'm not afraid of dying, but I will do what I have to; take care of myself, start to eat right... He took his cancer treatment in a very, I would say, Zen way, very spiritual, by being 'go with the flow', it's OK. At one point we were convinced that we would lose him, we would go see him at the hospital and he was dying. He was there and looking at us and was saying: 'Hey, wake up, I'm going, it's OK but you, you're not OK.' It was striking, people would say: 'Oh my God'. We, we only wanted to shake him and say: 'Hey, fight' and all that. He would say: 'No, no, no, and no'... When we all said: 'OK, it's OK, now, we are ready, you can go' and all that, he relaxed and said: 'We'll see tomorrow'. Progressively, he started getting better, getting better. In fact..., the first chemotherapy hadn't worked; the tumors had grown. The second chemotherapy did not work and at one point he asked: I want to try the second one again and he told himself: it's going to work. It worked. The tumors completely regressed, so much that at the level of his liver, when they went in to see, the surgeon said that there was a little something the size of a grain of sand, necrotic, that there was nothing there anymore; he still took out a part of the liver. In the colon, the big mass had shrunk; it was now tiny, very small. And yesterday, he came over to my place and he just had his colostomy removed and he doesn't have anything left, no more recurrence, he is considered... well anyway, cured – when it will have been two years. But he has the attitude of: no, it's healed, it's OK, and he has decided to carry on for another while. It was very spiritual, the accompanying... And when, at one point, he saw us let go and all that, he was able to calm down and say: 'OK, let's try again, it's gonna work this time.' It worked. Is it coincidence? It was the same chemo that he had a second time. So personally I believe; I am convinced of that.»

Appendix K : Specific Educational Activities Suggested by Teachers
For Undergraduate Curriculum

- Review of certain problem-based learning cases to include patient deaths, medical error, patient beliefs and values, spirituality
- Integrate spirituality in ethics sessions
- Participation of students in clinical ethics committee (simulated or real)
- Integrate spirituality in sessions on lifestyle change
- Integrate spirituality in curriculum on professionalism
- Sessions on multiculturalism
- Sessions on aboriginal culture and spirituality
- Sessions on aspects of different religions related to health care
- Patient accounts related to illness experience, suffering, coping with chronic and serious illness (in person, on video)
- Students meeting and talking with dying patients about life and death
- Clinical skills session on talking to patients about spirituality, taking a spiritual history
- Integrate spirituality in clinical skills sessions on patient-centered approach
- Integrate spirituality into clinical reasoning integration sessions
- Student discussion groups about personal values, spirituality, religion
- Reading/Internet/References about spirituality
- Reflective activity within clinical immersion experiences in first and second year
- Reflective portfolio during clinical training/rotations
- Integrate spirituality in certain clinical rotations (palliative care, geriatrics, family medicine)
- Direct observation (via one-way mirror)

Curriculum Vitae

Name:	Sharon Nur Hatcher
Post-Secondary Education and Degrees:	University of Ottawa Ottawa, Ontario, Canada 1980-1984 M.D. McGill University Montreal, Quebec, Canada 1984-1986 CCFP
Titles:	Associate Dean Faculty of Medicine and Health Sciences University of Sherbrooke Associate Dean Université du Québec à Chicoutimi Director Saguenay Medical Program Director of University Teaching Chicoutimi Health and Social Services Centre Faculty Advisor First Nations and Inuit Medical Training Program of Quebec
Honours and Awards:	« Prix de reconnaissance » Department of Family Medicine University of Sherbrooke 2004 Georges Lachapelle Scholarship University of Western Ontario 2007-2008, 2008-2009, 2009-2010, 2010-2011, 2011-2012, 2012-2013, 2013-2014 University of Sherbrooke Department of Family Medicine Research Fund 2011

«Prix d'excellence catégorie mission universitaire»
Centre de santé et de services sociaux de Chicoutimi
2011

Certificate of Merit
Canadian Association of Medical Education
2013

Publications:

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