

Transcendence, religion and spirituality in medicine

Medical students' point of view

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Abstract

To explore how medical students—the doctors of tomorrow—reflect upon meeting the spiritual needs of their patients, and whether they have reflected on their own religious or spiritual beliefs, or not. The study also investigates to what extent the students feel comfortable with addressing spiritual issues in their patient care, and whether they feel this is beyond their role as medical doctors.

A self-administered questionnaire was developed. The survey was administered in teaching classes at the medical university of Vienna. One thousand four hundred (836 women and 564 men) students responded, laying the foundation for a thorough statistical analysis.

59.5% of the students had reflected on their own belief concepts, 21.9% consider themselves religious, and 20.1% see themselves as spiritual individuals. 75.6% of the students agreed with the statement that religious conviction/spirituality might have an effect on how cancer patients cope. 85.9% would consider talking with their patients about religious/spiritual issues if patients wish to do so. 86.3% would involve chaplains if they feel it is necessary.

The results of this study suggest that future doctors want to see the patient in a wider scope than the bio-psycho-social one, by including the meta-dimension of transcendence.

Abbreviations: AMS = Austrian medical students, R/S = religiosity/spirituality.

Keywords: medical students, religion, spiritual care, spirituality, transcendence

1. Introduction

Awareness of religiosity and spirituality has grown immensely within the field of medicine in recent years. There is a new and heightened awareness of transcendence, religiosity and spirituality as part of human life, both in illness and health. Spirituality concerns the search for transcendent meaning,^[1] whereas religion is belief in a defined transcendent power.^[2] Religious and/or spiritual conviction has been proven to be an important resource in coping with disease.^[3] Patients report their own religious/spiritual convictions as meaningful sources for dealing with cancer.^[4,5] Addressing the spiritual needs of patients is associated with an improved quality of life,^[6–8] reduced pain levels,^[9] and higher existential well-being.^[7] Neglecting the issues of religiosity and spirituality (R/S) in medical care has been linked to poorer ratings of quality of care and satisfaction with medical care.^[10,11]

Patients report that talking about religious/spiritual questions are important for them in dealing with their illnesses, and most of them want to do so with their physician.^[12] One study shows that 94% of patients with a self-reported R/S agreed that if they became seriously ill, they would want their medical doctor to ask them about their religious/spiritual beliefs, and even 45% of the patients who disclaim R/S beliefs agreed.^[13] The integration of issues concerning R/S in medical care is important not only for patients in their clinical context, but also for doctors and nurses who find this integration meaningful.^[14,15]

Nevertheless, many physicians describe a lack of knowledge of how to address religious and spiritual issues.^[16] Thus, over 75% of American medical universities have included spiritual care in their medical curriculum.^[17] Students are taught about the need to incorporate awareness of spirituality, and cultural beliefs and practices, into their clinical work.^[18] However, in German speaking countries, like Germany, some medical universities offer elective courses in spiritual care. Austrian medical universities, however, do not offer teaching on this subject at all. There is also little knowledge, about how physicians and medical students evaluate the integration of R/S in medical care in Europe. This present study wants to investigate Austrian medical students' (AMS) attitudes towards spiritual care, and particularly its relevance to their future profession. This study, therefore, explores the personal convictions of the students as well as their own personal reflections about whether or not they would feel comfortable integrating these themes into their future patient care.

2. Methods

This study was conducted at the Medical University of Vienna, Austria and was approved by the data protection committee and

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the ethics committee of the Medical University of Vienna. In a cross-sectional survey, a self-administered anonymous questionnaire was used to collect information about the attitudes of AMS (years 1–4) towards R/S in medicine.

2.1. Data collection tool

Participants completed a self-administered anonymous questionnaire, which was tested first in a pilot study in 2011 with 350 students at the Medical University of Vienna.^[19] As there are no comparable studies, we chose to use this self-administered questionnaire focusing on our research interest. The survey comprised of 4 questions addressing information about birth year, sex, year of study, and purpose specialization. Ten multiple-choice questions regarding spiritual/religious issues in medical students' lives and work were also included. Items are scored on a 5-point Likert-type scale: (0) strongly disagree, (1) disagree, (2) uncertain, (3) agree, (4) strongly agree.

2.2. Statistical analysis

We used descriptive statistics to describe the range of responses. For categorical variables, the descriptive statistics are marked as numbers and percentages. To explore subtheme relationships we used Spearman correlations. The differences between man and woman participants were analyzed using *t* test and chi-squared tests of independence. Statistical analyses were performed using IBM Statistical Package for the Social Sciences (SPSS) Version 22.0 for windows. All statistical tests were two-tailed with alpha set at 0.05.

3. Results

3.1. Sample

A total of 1400 AMS, 59.7% women and 40.3% men, participated in this cross-sectional study. Participation was optional and anonymous. In teaching classes at the medical university of Vienna, students (year 1–4) were randomly asked to fill in the questionnaire. There were no inclusive/exclusive criteria. All students who were willing to participate and were present on the day of the study were included, giving a response rate of 100%. Of the 1400 AMS, 333 students were in their first year, 248 in their second, 393 in their third, and 426 in their fourth year of study.

3.2. Medical students' religiosity/spirituality

Self-rated R/S was assessed by asking: "Do you consider yourself a religious person?" and "Do you consider yourself a spiritual person?" Students reported their R/S by using a rating scale from 0 (strongly disagree) to 4 (strongly agree). For the purpose of this study, a student was considered to be religious/spiritual if he or she agreed or strongly agreed with the respective question. According to this, 21.9% of the students would consider themselves to be religious, 15.5% uncertain, and 62.7% did not agree or strongly disagreed. When they were asked about their spirituality, 20.1% agreed or strongly agreed to being spiritual, 22.4% were uncertain, and 57.5% did not agree or strongly disagreed to being spiritual.

The differences in the self-rated R/S of the students (year 1 till 4) are shown in Fig. 1. When it comes to the self-reported religiosity/spirituality there are differences according to which

year of their studies the students are in—first and the fourth year students reported the highest rate for R/S.

3.3. Reflected personal belief-concepts

59.5% of medical students in our study had reflected on their own belief-concepts. Additionally, the belief that R/S could be a resource for cancer patients had a significant positive correlation $r=0.30$ ($P=0.000$). That means that medical students who have reflected their own belief concepts agreed stronger to this statement. Also the openness to talk with their patients about R/S themes $r=0.16$ ($P=0.000$) and to involve hospital chaplaincy $r=0.15$ ($P=0.000$) were positive correlated with the students' reflected belief-concept. On the other hand, feeling uncomfortable to speak about R/S is significantly negatively correlated to that reflected belief concept $r=-0.14$ ($P=0.000$).

3.4. Spiritual care—a sex issue?

Sex differences are shown in Table 1. When the questionnaires for woman and man students were compared *t* test were significant for all questions, except for 3.

This means, that man and woman students answered on average significantly different on the questions. Concerning whether or not the student had reflected on his/her own belief concepts, and regarding the feeling of being uncomfortable to talk with patients or someone about R/S issues, the man students agreed stronger than the woman students.

3.5. Talking about religious/spiritual matters

Most of the AMS who participated in this survey (85.9%) would speak about R/S with their patients when it is the patient's wish. Without patients requesting it, 35.7% would talk about R/S with their patients. The majority of the medical students have no difficulty talking about R/S themes in the clinical context. 12.1% of medical students agreed/strongly agreed with the statement about feeling uncomfortable talking about R/S with their patients, and 6.9% of the students would also feel uncomfortable talking with anyone about these themes. Regarding the students' own R/S, the results show that medical students with an R/S feel less uncomfortable talking about R/S with their patients.

3.6. R/S in clinical practice

In the clinical context, 13.7% of the students report that the R/S of a patient belongs in the patient's medical history. When it comes to seeing the patient's R/S as something that enables them to cope, 75.6% of the medical students agreed that religious conviction/spirituality might have an effect on how cancer patients cope. And, 86.3% of the AMS would involve a chaplain when they felt that this was important for the patient.

3.7. Whose role?

Fig. 2 shows the medical students' opinions of who they consider to be a suitable dialogue partner for the patient on questions and issues concerning R/S (multiple answers were possible). Most students consider it to be the role of the chaplain (94.7%), 90% consider it to be the role of the partner, 85.2% consider it to be the role of close friends, 52.7% consider it to be the role of nurses, and 55% consider it to be the role of physicians. Finally, 46.6% consider it to be the role of everyone mentioned above, and 1% consider it to be the responsibility of none of the above mentioned people.

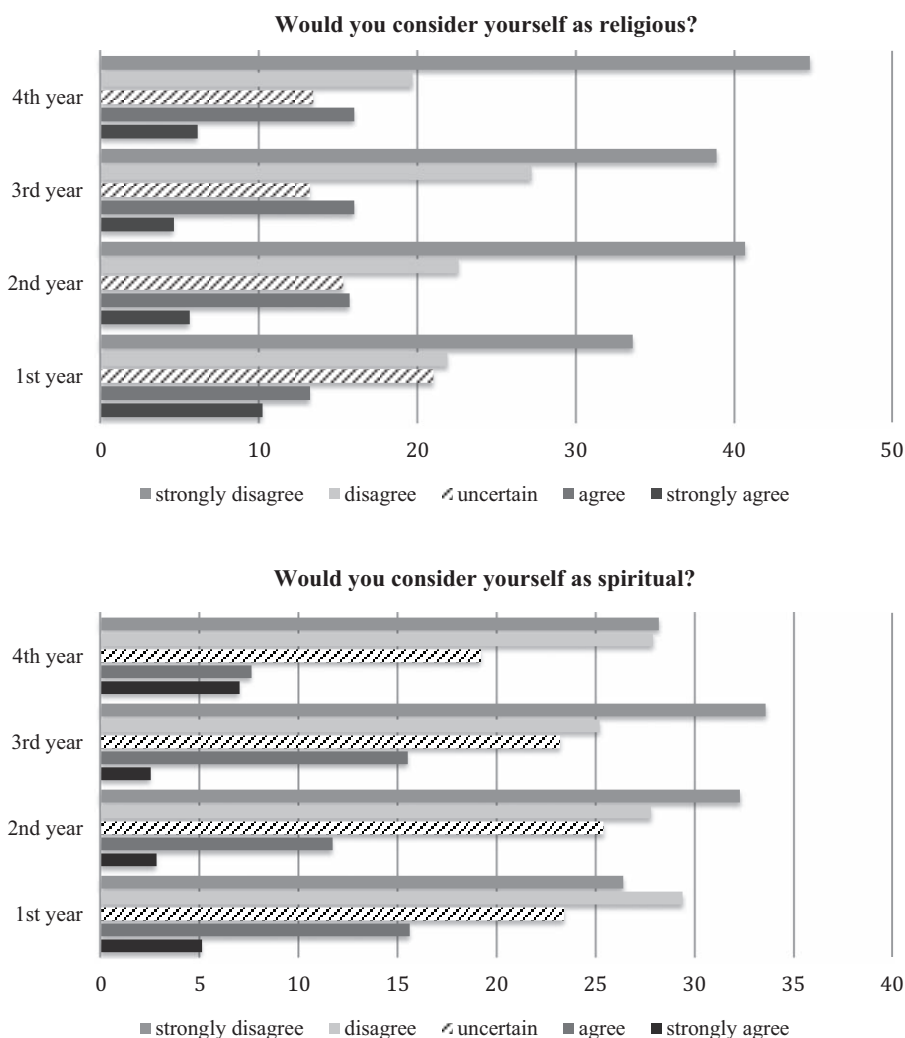


Figure 1. Austrian medical students' religiosity and spirituality.

4. Discussion

To our knowledge this is the first study to examine medical students' attitudes towards R/S in medicine in a German-speaking country. Exploring the attitudes of medical students may enrich the understanding and practice of religious/spiritual R/S issues in the clinical setting.

4.1. Openness

Our study demonstrates that when it comes to R/S themes, the majority of AMS show a generous openness to these themes in the clinical context. Numerous studies show that this kind of openness is of great value for patients, and strengthens meaningful patient–doctor relationships. By including the spiritual dimension in the bio-psycho-social model, physicians practice patient-centered compassionate and holistic care which brings them back to the roots of medicine.^[20] Patients report a desire for more frequent in-depth discussions about religious issues,^[21] and a need for understanding, compassion, and hope.^[12] Furthermore, in a literature review of 54 studies, the majority of the studies (30/38) confirm that most patients, at least in some circumstances, found it appropriate to be asked about their R/S needs by their physician.^[22] Most AMS in this present

study (85.9%) would discuss R/S matters with their patients, as long as the patient requested it. Similar findings were described in a study among US practicing physicians, where 91% found it appropriate to discuss R/S issues if the patient brings it up.^[23] Lucchetti et al^[24] found that most Brazilian medical students wanted to address these issues (58%), but nearly half said they were not prepared to do so.

Facing a serious or life threatening illness raises a number of existential questions concerning meaning, value, belonging etc.^[25] Neglecting these questions is like leaving the patient alone in his/her hour of greatest need.^[26] Therefore, it is important to support and accompany the patients on this existential search, even though physicians do not have the answers.^[20]

4.2. Resources

In psychotherapy, cancer patients show a need to express themselves and seek support on an emotional level, but also have a variety of other needs associated with the disease.^[27]

Almost all AMS (75.6%) believe that the patients' R/S might be a resource for coping with cancer. Similar to our findings, Brazilian and UK medical students agreed that spirituality has a

Table 1**Sex differences in Austrian medical students.**

	Man (n = 564)	Woman (n = 836)	P
Would you consider yourself as a spiritual person?	1.34	1.20	0.04*
Would you consider yourself as a religious person?	1.24	1.52	<0.01**
I have reflected my own belief-concept	2.51	2.42	0.67
Do you think R/S could help cancer patients coping with their illness?	2.90	3.05	<0.01**
Would you talk with your patient about R/S convictions?			
Would you talk with your patients about R/S convictions, when they ask for it?	1.97	2.11	0.02*
I would involve a chaplain in my treatment when I feel it is necessary	3.19	3.38	<0.01**
	3.27	3.44	<0.01**
I don't feel comfortable to talk with my patients about R/S issues	1.45	1.35	0.83
I don't feel comfortable to talk with someone about R/S issues	0.82	0.80	0.69
I don't know why I should talk about R/S with someone	1.19	1.04	0.03*
Should the patients' R/S be a part of the medical history?	1.15	0.99	0.02*

The participants answered on a 5-point Likert scale (0 = strongly disagree, 1 = disagree, 2 = uncertain, 3 = agree, 4 = strongly agree).

* Significant at $P < 0.05$.

** Significant at $P \leq 0.01$.

positive impact on health,^[24,28] US physicians likewise mentioned that R/S helps patients to cope.^[29] And indeed, studies have shown that cancer patients indicate R/S as important in their cancer experience and as a source of strength and comfort.^[30,31] By neglecting these issues, physicians might miss an important resource in the patient's coping mechanism.^[26,32]

4.3. Whose role?

Research indicates that patients have spiritual needs, and these needs become transparent for patients, clinicians, and family members.^[33,34] But who should address these needs in the clinical context? In our study, the majority of AMS hold on to the traditional roles and believe that chaplains (94.7%), partners (90%), and close friends (85.2%) are the perfect dialogue partners for these concerns. Studies with oncology nurses and clinicians have shown the same picture: almost all of them agreed that this is the role of the hospital chaplaincy and the spiritual community of the patients.^[35] The study of Kristeller et al.^[36] also found that oncology nurses and clinicians felt primarily responsible for the spiritual distress of their own patients, even though they see it as a low priority. The AMS in this study said it should be the role of physicians (55%) and nurses (52.7%). These results have implications for medical training. As for now, there is no training in spiritual care in the medical education in Austria. All in all, this is poorly dealt with in most European countries compared with the training in the US.

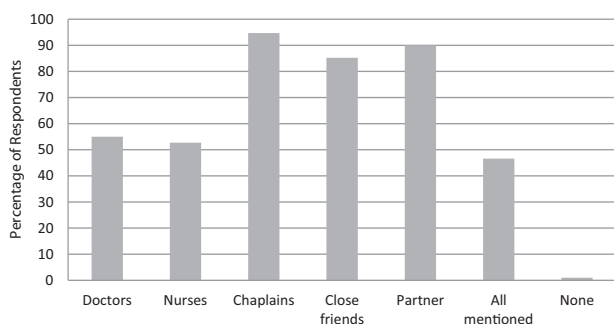


Figure 2. Students' opinions about who they consider to be the dialogue-partner in R/S issues. R/S = religiosity/spirituality.

Medical students should be trained to become valuable listeners to their patients' existential, religious/spiritual questions, and both the patients and future doctors would benefit from this. Including adequate training in spiritual care in the medical curriculum may strengthen the awareness and respect of the patients R/S. It would also help the medical students to develop a person-centered view of medical care in the midst of the daily routine and make them suitable dialogue partners in R/S themes.

Nearly half of the AMS agreed that R/S issues are the responsibility of people in all the roles mentioned. This underlines the importance of a team approach to holistic care.^[37] In a holistic team approach every member of the clinical team has their own specialty and expertise, and together, all the members can ensure the care of the patient in the domains of their bio-psycho-social-spiritual needs.^[20,32] This team approach also permits physicians to have limits concerning R/S issues, and to be aware of when and how to include the other members of the team.^[38,39] This permits and strengthens the interdisciplinary approach in the care of patients as whole persons.^[40] By not primarily referring dying patients to the chaplaincy,^[41] clinicians also include the R/S resources for the living.

So, what is the physician's role? Even though studies have shown that patients have a need to talk with their physician about R/S themes, this does not imply that it is a doctor's obligation. Physicians should be open and listen to R/S concerns in a professional, respectful, supportive, and caring way.^[1,42-45]

4.4. Medical students own reflected religiosity and spirituality

Research confirms that the R/S of the physician influences clinical decisions as well as the doctor-patient relationship.^[46] Almost a quarter of AMS in this study agreed or strongly agreed to being religious (21.9%) or spiritual (20.1%). In a study with Harvard medical students, it was found that the R/S beliefs of the students improved their relationship with their team and also improved their work-life balance. In addition, it was found that it reduced their emotional stress when they had to deal with the suffering of patients, and that R/S beliefs can strengthen their hidden curriculum attitudes. On the other hand, the R/S students report more often than other students, identity struggles, increased self-doubt, and insecurity about their medical knowledge.^[47] In our study, we also found that more than half (59.5%) of the AMS had reflected on their own belief systems. For a better doctor-patient

relationship concerning R/S matters, it is not the doctor's belief per se that is important, but physicians can better understand their patients, their beliefs, and points of view, when they have worked through their own thoughts and feelings about R/S matters.^[48] Illness raises questions of a universal nature and questions of a transcendent nature concerning meaning, value, and relationships: spiritual questions. How physicians answer these questions for themselves will affect to what degree they are able to help patients in their spiritual struggles. Physicians who have taken these questions seriously for themselves will not trivialize or dismiss them when faced with a patient who is struggling.^[48] This also emphasizes the importance of training that strengthens the doctors personal-professional competence.^[49] Thus, training in spiritual care allows students to identify spiritual distress and spiritual well-being in patients as well as in themselves, thereby creating an avenue of compassionate caregiving.^[45,50,51]

4.5. Limitations and strength

The present study has several limitations. First, using a self-administered questionnaire makes it difficult to compare it with other studies. Second, our questionnaire did not have open questions to explore more about the individual views about R/S in clinical practice. It also would be interesting to know if students have ever been confronted with these matters, and what they would need to be confident and prepared in these situations. For the purpose of a largest possible participation, we designed a shorter questionnaire that ensured a greater willingness to participate.

Another limitation or possible weakness is that our questionnaire focused on R/S issues for cancer patients, and the results might have been different if the focus were on another patient group.

Although research has identified that spiritual needs and R/S coping are important for cancer patients, this does not imply that spiritual needs and R/S coping is important exclusively for cancer patients and palliative care.^[52,53] In a bio-psycho-social-spiritual model R/S is seen as part of the whole human being. Another limitation of the study is the fact that we only asked 1st through 4th grade medical students. If we had included the students in the last years, in which they primarily work with patients, the results might have been different. Finally, another limitation is the lack of a follow-up study that would have made it possible to see whether the students' attitudes would change over the years of studying.

In spite of these limitations, the present study has a number of strengths. This is the first study in a German speaking country looking at the attitudes of medical students concerning R/S in clinical settings. This study, therefore, contributes to a base for further research. As the study was conducted with a large number of participants (1400) it can be said to be very informative. Finally, these results may open doors for including a curriculum of spiritual care in medical education.

5. Conclusions

Research acknowledges that R/S can no longer be ignored in the medical context. Our study confirms the openness of medical students towards patients' R/S. The study provides a snapshot of the attitudes of medical students about incorporating R/S into their future medical practices.

It is novel in demonstrating that AMS believe that R/S might be a resource for patients and that they are open to discussing these themes with them, regardless of their own R/S.

Given the importance of R/S matters in a holistic care approach, in addition to the openness of AMS to including R/S matters in their future practices, the stage is set for incorporating spiritual care into the Austrian medical curriculum. Students also embrace an interdisciplinary team approach by including chaplaincy in their patient care. The results of this study highlight a willingness to integrate the spiritual dimension in patient-centered care. Puchalski notes that "the doctor of the 21st century will be both a highly skilled diagnostician and technician and a compassionate caregiver who respects all dimensions of patients' life."^[46] This also reflects the author's belief.

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