Spirituality and Health Care Education in Family Medicine Residency Programs

Dana E. King, MD; Jeremy Crisp

Background: Increasing interest in the role of spirituality in clinical care has begun to affect educational programs. This study evaluated the current status of training in spirituality and health care in family medicine residency programs. Methods: We surveyed 138 randomly selected US family medicine residencies regarding their spirituality and health care curriculum. A response rate of 73% (101/138) was obtained. Results: Almost all (92%) of program directors said spirituality teaching was important, but only 31% of programs have a specific curriculum (average: 6 hours) to guide the spirituality and health care teaching of their residents. The most common factor correlated with having a spirituality curriculum and perceived effective education efforts (which occurred in 84% of programs with a structured curriculum) was the presence of faculty members with specific interest, expertise, or training in spirituality and health education. Conclusions: Residency programs with trained/expert faculty are more likely to have structured spirituality and health care teaching.

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Spirituality is not a new theme in the healing process. From the ancient Greeks’ healing temples of Aesculapius, to modern research on prayer and medicine, spirituality continues to play an important role in the discussion of physician-patient interaction.

The influence of spirituality in the role of healing is being increasingly recognized as important to patients. Studies show that 77% of patients believe that physicians should consider their spiritual needs, and 73% of patients believe they should tell their physicians about their religious beliefs. Gallup polls continue to reveal that as many as 95% of Americans believe in God, and 61% of Americans find religion to be an important part of their daily life. McCord and colleagues have documented that 83% of outpatients want physicians to ask about spiritual beliefs in at least some circumstances. Despite such striking evidence of the importance of spirituality, patients report that only 10% to 20% of their physicians discuss religion or spirituality with them.

Many educational programs have responded to this growing body of literature by developing curricula to teach future family physicians how to address this issue with their patients. More than 50 medical schools currently offer courses in spirituality and medicine, but to date, only psychiatry residency programs require training at the postgraduate level on how to deal with patients’ religious concerns. Some family medicine residency programs have begun to provide training on attitudes, knowledge, and skills in spirituality. The extent and nature of spirituality teaching in family medicine residency programs, however, is not known.

The Accreditation Council for Graduate Medical Education (ACGME) does not require a specific curriculum in spirituality in family medicine programs, but the American Academy of Family Physicians (AAFP) has published AAFP Recommended Core Educational Guidelines on Medical Ethics (AAFP reprint no. 279, revised June 2003). These guidelines include how to deal with certain spiritual issues in patients, including the belief systems of the patient and family, and “... an understanding of cultural, social, and religious customs and beliefs that differ from his or her own.” The Society of Teachers of Family Medicine (STFM) has a Group on Spirituality, but neither the Society nor the group has developed curriculum guidelines to assist family medicine educators in their spirituality teaching efforts.

The survey reported here was conducted to (1) determine the extent and nature of teaching on spirituality and health being taught in family medicine residency programs, (2) identify perceived facilitators and barriers to spirituality education, and (3) determine preferred methods of curriculum dissemination.
Methods

The study was reviewed and granted an exempt status by the Medical University of South Carolina Institutional Review Board. The study was conducted between June and August 2004. Of the 466 US family medicine residencies listed in the AAFP’s ACGME-accredited Residency Programs in Family Practice, 150 were randomly selected to participate in the study. The number of programs surveyed was chosen to accommodate the summer research fellowship schedule.

Programs were contacted and questions were directed to the program director or designee. In many cases, the designee was the faculty member(s) identified as responsible for the program’s spirituality education. Respondents were asked if they preferred to receive the survey by e-mail, fax, or telephone, and the survey was provided in that manner.

An introductory letter describing the purpose of the study accompanied the survey. A reminder letter was sent to nonrespondents 2 weeks following the first contact. Respondents also had the option to complete the survey via a confidential on-line form.

Survey Instrument

A member of the STFM Group on Spirituality developed the 15-item survey in cooperation with the other members of the group. The survey used two open-ended questions to gather information on the perceived facilitators of and barriers to spirituality teaching in the program. Responses to the open-ended questions were grouped by the authors and reviewed for agreement in classification. Most survey items used a 4-point Likert scale (4=strongly agree, 3=agree, 2=disagree, 1=strongly disagree) to measure respondents’ level of agreement with the nine statements listed in Table 1. The survey also asked respondents to select from multiple-choice items to indicate where and how spirituality is taught (eg, seminars, hospital rounds, etc), the number of hours taught per year, and their own participation in activities related to attending STFM conferences or other training. Three additional questions were asked regarding the university affiliation, size, and urban/rural location of the program.

Data Analysis

Survey answers were entered into a Microsoft Excel file and analyzed using SAS software. Descriptive analyses were returned initially. Chi square and t tests were performed to compare groups with and without a spirituality curriculum. ANOVA was used to compare responses on survey items by program type. Likert-type items were analyzed as an interval scale and as dichotomous responses combining strongly agree with agree and strongly disagree with disagree. Responses to open-ended questions were listed and grouped into similar categories once the responses were reviewed.

The authors reviewed and agreed on category designations.

Results

We could not contact 12 of the 150 programs because of incorrect information, lack of forwarding information, or inability to make contact with the program before project deadlines. Thus, 138 programs were successfully contacted, and 101 (73%) provided responses to the survey. Most responses were received from residency directors, while other responses were received from faculty members or administrative personnel designated by the residency director.

The residencies that did respond averaged 24 residents per program, or eight residents per year. Evaluation of programs’ demographic information and affiliation indicated that while more responding programs were urban (45%), suburban (35%) and rural (20%) programs were also well represented. Program types of respondents were representative of all residency programs: university (26%), community (47%), university-affiliated community (22%), and military (5%).

Perceived Importance, Faculty Interest, and Presence of a Spirituality Curriculum

Almost all (92%) of respondents reported that spirituality and religion (as it relates to health) are important topics for family medicine residency training. A smaller majority of respondents (57%) considered it an important component of their residency education program, but only 31% of programs have a specific curriculum to guide the spirituality and religion teaching of their residents.

When asked about faculty expertise on this subject, 67% of programs reported having faculty with special interest, expertise, or training in spirituality and religion/health issues. Of the programs that reported having a specific curriculum, 84% have faculty with special interest, expertise, or training, compared to 32% having experienced faculty in programs without a curriculum (P=.01 by chi square). The type of training seen among faculty varied among conferences, STFM seminars, fellowship training, and degree in theology or seminary. The most common of these training types was special conferences. Program location (P=.69 by Anova), program affiliation (P=.32), and program size (P=.56) did not have a significant role association with the prevalence of programs with curricula.

Teaching Objectives, Methods, and Goals of Spirituality and Religion Education

More than half (86%) of the respondents reported using the current AAFP Core Educational Guidelines on Medical Ethics to guide their spirituality teaching efforts. Seventy-seven percent of programs agreed that the goal of their spirituality and religion teaching is to equip
residents to address relevant spiritual and religious issues in the medical care of their patients. Only 5% use the textbook *Faith, Spirituality, and Medicine: Toward the Making of the Healing Practitioner* (Haworth Press 2000). Most programs integrate their spirituality teaching into lectures (67%), while almost half of programs report teaching spirituality during clinical precepting (49%) and inpatient rounds (44%). Spirituality teaching is also reported during participation in electives such as mission trips and other block rotations. The estimated number of hours devoted to spirituality varied from 0–40 hours per year for all 3 years of residency training, and the average was 6 hours.

**Facilitators of Spirituality Education**

The respondents reported a variety of factors that facilitated the teaching of spirituality and religion. A total of 106 factors were listed, usually with one- or two-word answers, which we grouped into five categories. The most common facilitating factor was the presence of supportive or trained personnel (39%), followed closely by positive attitudes toward the subject (38%). Other categories of facilitators included program-related facilitators such as pastoral care, curriculum, research, or hospice agreements (19%); hospital resources (2%); and formal institutional affiliations (2%).

**Obstacles to Teaching Spirituality**

Just over half (52%) of all reporting programs agreed or strongly agreed that lack of time is a significant barrier to their spirituality and religion education efforts, and 31% said lack of qualified personnel is a significant barrier. Barriers listed in the free response section of the survey included time (34%), attitude (eg, fear/discomfort with the subject) (32%), lack of priority (14%), and lack of personnel available (12%).

**Methods Used in Teaching**

A variety of teaching methods/settings were used by programs with structured curriculum in spirituality. The most common method used was lecture teaching, used by 67% of programs with curricula, followed by precepting (49%), inpatient rounds (44%), chaplain rounds (25%), and seminars (18%).

**Discussion**

This survey was intended to provide information regarding the current state of spirituality and health care education in family medicine residencies. Almost all residency program directors agree that spirituality education is an important aspect of family medicine residency training, but only about one third of programs have a structured spirituality curricula/curriculum in place. The greatest facilitating factor mentioned by

### Table 1

<table>
<thead>
<tr>
<th>Responses to Survey Statements*</th>
<th>Percentage of Respondents in Each Response Category</th>
</tr>
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<tbody>
<tr>
<td>Spirituality/religion (as it relates to health) is an important topic for family medicine residency training.</td>
<td>SD 7 D 65 A 27</td>
</tr>
<tr>
<td>Spirituality/religion (as it relates to health) is an important component of our residency education program.</td>
<td>SD 7 D 49 A 4</td>
</tr>
<tr>
<td>We have effective evaluation of our spirituality/religion teaching.</td>
<td>SD 14 D 68 A 15 S 3</td>
</tr>
<tr>
<td>Lack of time is a significant barrier to effective spirituality/religion education at our program.</td>
<td>SD 4 D 44 A 8 S 8</td>
</tr>
<tr>
<td>We use the current (1997) AAFP Core Educational Guidelines on Medical Ethics in our teaching.</td>
<td>SD 3 D 16 A 64 S 12</td>
</tr>
<tr>
<td>Lack of qualified personnel is a significant barrier to effective spirituality/religion education at our program.</td>
<td>SD 10 D 59 A 29 S 1</td>
</tr>
<tr>
<td>We use the textbook, &quot;Faith, Spirituality, and Medicine: Toward the Making of the Healing Practitioner (Haworth Press 2000) to guide our teaching.</td>
<td>SD 16 D 68 A 5 S 0</td>
</tr>
<tr>
<td>We have a specific curriculum to guide the spirituality/religion teaching of our residents.</td>
<td>SD 8 D 62 A 29 S 2</td>
</tr>
<tr>
<td>The goal of our spirituality/religion education is to equip our residents to address relevant spiritual/religious issues in the medical care of their patients.</td>
<td>SD 0 D 20 A 68 S 9</td>
</tr>
</tbody>
</table>

* Likert-type scale where SD=strongly disagree, D=disagree, A=agree, and SA=strongly agree

Data is reported as percent responding to the following choices: 1=strongly disagree, 2=disagree, 3=agree, 4=strongly agree.
established programs was the presence of a faculty member with special interest, expertise, or training in spirituality and religion. In some programs this was a physician, while in other programs it was a hospital chaplain or behavioral scientist. Programs without an established curriculum were significantly less likely to have a trained faculty member available. These results are consistent with previous surveys of practicing physicians, who cited lack of training in spirituality and health as the reason for their lack of integrating spiritual discussions into practice.10

Two barriers seem to be prevalent in the attempt to incorporate spirituality teaching into a family medicine residency curriculum: time and attitude. Residents and faculty alike must approach the subject of spirituality and residency curriculum: time and attitude. Residents and faculty alike must approach the subject of spirituality and health education have been found in pediatric faculty and residents.13 However, there is no official resource or guide on how to establish such a curriculum for family medicine residencies. The STFM Group on Spirituality has conducted several faculty development seminars at recent STFM meetings, but diffusion of the basic fundamentals of this topic has been slow.

Despite the challenges of using a scientific approach to addressing spiritual issues,14 the time seems right for STFM and other leading family medicine organizations to address spirituality education and offer guidance to programs that wish to incorporate such teaching into their residency. The Association of American Medical Colleges has already begun to address this need and has published guidelines on dealing with religious and spiritual issues at the end of life.15 At least one medical school has instituted a spirituality curriculum and demonstrated improved knowledge, spiritual history-taking skill, and improved attitudes toward addressing spiritual issues in the clinical context;11 more such studies need to be done.

This survey has some limitations. Data were collected from a random sample of programs, representing roughly 22% of existing programs. While the response rate was good (73%), not all residency programs have had an opportunity to respond, and our respondents, though chosen at random, may be atypical in some way. Second, many programs were unable to identify an individual responsible for spirituality education. This raises the possibility that responses may not always have come from the individual at the program who was the most knowledgeable about the program’s spirituality teaching. Third, programs may have exaggerated their current curriculum offerings, despite the anonymity of their responses.

In spite of these limitations, this survey provides information that should be useful to residency organizations, educational groups, and residency program directors. Our results have identified key factors in promoting and expanding appropriate teaching of spirituality and health care, namely having trained faculty available to teach, prioritizing time, and encouraging positive attitudes toward the subject. Model curriculum guides and outlines of the important principles in spirituality and health care education have been proposed9,10,17 and evaluated.11,18 The development of more-specific curriculum guidelines, sponsored by official family medicine educational organizations, may assist in the effort to make learning how to deal with patients’ spiritual issues a universal component of family medicine residency training.

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REFERENCES

The Family Medicine Residency Program at Scripps Mercy Hospital Chula Vista trains family medicine physicians to provide comprehensive medical care, with a curriculum that emphasizes community medicine. Scripps partnerships with local community health programs allow residents to focus on medically underserved communities, particularly those along the California and Baja border regions. Our GME program is small but close-knit, with ample opportunities to make a difference in the community while gaining valuable hands-on experience. Residents complete rotations in numerous inpatient and outpatient settings.

Dana E. King, Jeremy Crisp. BACKGROUND Increasing interest in the role of spirituality in clinical care has begun to affect educational programs. This study evaluated the current status of training in spirituality and health care in family medicine residency programs. METHODS We surveyed 138 randomly selected US family medicine residencies regarding their spirituality education. The Jackson Memorial Hospital Family Medicine Residency Program exists for two reasons: to provide superior education and training for family medicine residents and to give patients the best possible medical care. The family medicine program is proud to be part of the multicultural, community-focused, innovative, encouraging environment found at this residency program. The goal is to provide the broad-based medical training that is essential for family physicians to develop their skills and become lifelong learners. It is strongly felt that having qualified primary care doctors committed to the well-being of patients, their families, and the community at large, is essential in today’s ever-changing world of medicine.