Is it Time to More Fully Address Teaching Religion and Spirituality in Medicine?

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About a century ago, Sir William Osler, one of the most distinguished physicians of the day, observed that "Nothing in life is more wonderful than faith . . . . Faith has always been an essential factor in the practice of medicine" (1). Doctors and patients shared this belief in faith, and much more. Doctors and patients lived alongside each other, sent their children to the same schools, and worshiped at the same religious institutions.

But even as Osler wrote those words, the medical world was rapidly changing, becoming more self-consciously based on science. The microbiological revolution enabled physicians to claim to know the cause of an ever-increasing number of diseases; at the same time, new diagnostic and procedural tools enabled physicians to see deep within the body. Rather than being cared for at home, seriously ill patients were admitted to a hospital. Science became an almost unquestioned source of authority. Physicians started seeing patients less as social beings with families and faith being essential parts of their lives, and more as collections of malfunctioning organs defined by microscopic pathology and bacteriologic culture (2). As the medical gaze shifted from without to within, physicians saw religion as having less relevance to medical care.

Although physicians' attitudes may have changed, religious and spiritual beliefs remained pervasive among our patients. Today, approximately 90% of Americans believe in God or a higher power (3). Furthermore, 53% of Americans consider religion to be "very important" in their lives (4). Because religious commitment is intrinsically connected to cultural, mental, spiritual, and societal aspects of wellness, many patients believe that any authentic approach to health care ought to engage their religious commitments.

Yet, physicians infrequently discuss religion and spirituality with their patients, notwithstanding the ubiquity of religious beliefs and despite the data showing that religion and spirituality are associated with positive health outcomes. The closest most physicians come to discussing religion is to refer patients to chaplains (5). But this is not what our patients want. Our patients want their physicians to be aware of their religious and spiritual beliefs (6).

Why don't physicians talk with patients about their spiritual beliefs? As we have incorporated ever more science into clinical practice, perhaps we have tended to ignore those parts of medicine that give a person meaning. Those parts are not in the vocabulary of science. Although the Accreditation Council for Graduate Medical Education (ACGME) competencies state that "the entrustable learner is comfortable with some ambiguity" (7), physicians avoid what cannot be accurately measured. Our current system leaves little room for mystery.

One barrier to obtaining a spiritual history is lack of training in discussing religion and spirituality (5). This training also is missing in the hidden curriculum. Most students (78%) said their instructors had never or rarely addressed religion and spirituality with patients (8).

Medical education associations have made recommendations to address this failing. A 1999 Association of American Medical Colleges (AAMC) report defined a core set of "spiritual competencies" that learners should acquire during their medical education. They noted that "spirituality" is "expressed in an individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism and the arts" (9). Spirituality involves sacred matters and may have individual, group, or communal expression. "Religion" is a subset of spirituality and has been seen as a personal or institutionalized set of religious attitudes, beliefs, and practices. The AAMC called for medical schools to educate students on matters related to the spirituality of patients and themselves, and on the impact that this may have on the care of patients (9).

In addition, the Liaison Committee on Medical Education (LCME) provides a framework for incorporating a spirituality curriculum into undergraduate medical education. The LCME mandates that medical school curricula include instruction regarding "the manner in which people of diverse cultures and belief systems perceive health and illness" and how to understand the "basic principles of culturally competent health care" to be able to "provide effective care in a multidimensional and diverse society" (10).

Although the guidance provided by the ACGME, AAMC, and LCME is important, if we want to make a difference, learners must not only hear about the importance of incorporating religion and spirituality into patient care in the classroom, but they must see this consistently practiced by attending physicians.

In some ways, the spiritual history parallels that of the sexual history. For years, the sexual history was considered "off limits" in the clinical encounter, perhaps because it was too private a subject or not relevant for most medical providers, or perhaps because providers were uncomfortable talking about a diverse range of sexual behaviors. We now believe that sexual health is an integral component of overall health. The spiritual history is also important. Indeed, it may be the "last taboo" of the medical history needed to care for our patients.

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Spirituality may seem an unlikely topic for academic discourse. We pass judgment on our fellow faculty members primarily on the basis of the quality (and quantity) of their scientific research. As education-minded physicians have increasingly sought to have medical education seen as an appropriate topic for scholarly study and academic rewards, they have tried to place their work within the trappings of quantitative science. That sort of systematic, quantitative approach (even in work labeled as "qualitative" research) may be ill-suited to a topic such as religion—a topic based on, well, faith. And faith, as Osler acknowledged, falls outside of the scientific model. Perhaps we ought simply to get to know our patients as human beings, whatever their system of beliefs. Perhaps we ought simply to give them the space to speak, and listen to them, absent guidelines, or checklists, or—dare we say it—scientific analysis. Perhaps that would be one way to bring us closer to understanding, and truly caring for, our patients as they wish to be cared for. We believe the time is now to more fully address teaching religion and spirituality in medicine.

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