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Letters to the Editor

Reply to letter to the editor
Réponse à votre lettre à l'éditeur

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We appreciate Dr. Chaikof's feedback[1] and this opportunity to address his concerns and suggestions. Given his focus on the patient case itself, rather than the research results published by CMEJ, the authors of the case prepared this response.

A core element of patient centered care, as defined by the Institute of Medicine, is providing care that respects patients' preferences and uses patients' values to guide clinical decisions.[2] Indeed, the fear of stereotyping or offending our students is one of the issues that may cause medical educators to pause, rather than move forward, with creating a curriculum that embraces discussions of religion and spirituality as an important part of patient centered care. Unfortunately, this may be the same fear that prohibits physicians from comfortably discussing religion and spirituality with their patients. It would then seem that to truly practice patient centered care we need to be comfortable to explore, as Dr Chaikoff discusses, "the richness and complexity" of our patient's religious identity, not only at end of life or tense difficult situations, but also on a routine basis. In our own reviews of checklists used during standardized patient encounters we noted that religion and spirituality were an often-neglected part of the social history. Allowing students to practice discussing religion and spirituality in a low-stress, standardized patient scenario may add to their comfort and reinforce its importance in patients' everyday lives. Thus, we decided to create a sensitizing, formative activity that would encompass a social history in an outpatient visit, where the scenario would have the focus on religion and spirituality to encourage students to move past their discomfort. This exercise was specifically designed not to be a highly charged medical or ethical dilemma. We wanted the students to feel safe to discuss religion and spirituality, and, in this scenario, not doing so would be to miss the patient's story.

We entered into this activity with a little fear. We recognized that spirituality and religious traditions are deeply personal and that we might offend some students. We certainly did not want to reinforce stereotypes or misrepresent traditions. To that end, we invited the community Rabbi to give us feedback, both to ensure that the scenario we had created

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appropriately reflected the traditions of the faith and to make changes if he felt it was stereotyping or offensive. Secondly, this learning activity was an information gathering encounter, designed to practice previously learned emotion-handling skills, active listening skills, and the components of a social history, including the FICA model of gathering spiritual information. In addition, students were instructed to ask clear, open-ended questions, free from assumptions, and allow the patient to freely discuss all components of her lifestyle including the current stress of her family relationships, religion, and spirituality. A non-judgmental interviewing approach is crucial when exploring the social history. The debrief session explored empathically how important the faith and participation in her faith community was to our patient and to understand she was worried about her daughter's future as a member of the community. Given the students' assignment to take a focused social history, patient centered care emphasizes that students should refrain from assessing the validity of the concern or trying to "fix" the problem.

After receiving Dr. Chaikof's letter, we self-reflected on the concerns he raised. Unconsciously, we may have reinforced a stereotype. We wrote the scenario as a mother who loves her daughter and is worried about how her marriage will impact the family traditions. Some of our students may have seen her as intolerant, overbearing, and hysterical. If so, they would have missed learning the essence of patient centered care. Additionally, there is an opportunity for us to consider the intersection of teaching a patient centered curriculum in the context of a student centered education. As faculty, becoming aware of our implicit biases requires intensive, frequent self-reflection and the courage to change. We could think about adding self-reflection exercises for faculty after sensitive topic standardized patient encounters in the future. We are all just learning and trying to move forward, yet we should not ultimately graduate doctors who are afraid to address this very important part of a patient's life. Our fear should not stop us from trying to give students the skills they need to deliver truly excellent patient centered care. Neither should it stop our students from discussing religion and spirituality with patients.

References

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