GAPS IN TEACHING SPIRITUALITY IN UNDERGRADUATE MEDICAL EDUCATION

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ABSTRACT: In this paper I attempt to point out some of the gaps in Canadian undergraduate medical education as it is practiced at the present time due to our Canadian lack of recognition of the importance of the spiritual component in disease processes and their healing. My methodological approach to this topic is to attempt to review contemporary practice of the teaching of spirituality in Canadian medical schools.

In order to accomplish my task of reviewing the teaching of spirituality in medical education, I initially contacted the librarians of both the Canadian Medical Association and The College of Family Physicians of Canada. It proved particularly difficult since the literature these librarians made available to me appeared to be mainly American and there is practically nothing comparable on the Canadian side. Both the American literature on spirituality in medical teaching, and the Canadian literature where it existed, were new to me. My hope was to find out what teaching on spirituality in medical practice occurred in Canada. However my initial review of the literature, facilitated especially by the Canadian Medical Association's librarian, resulted in primarily references to American studies. While our two countries have many similarities, there are certainly outstanding differences, one of which is the general population's attitude towards religion. While the Americans are in general a religious people the Canadians appear to be generally less so. In both countries, however, researchers in this area avoid the term religion, preferring the somewhat nebulous term "spirituality". But this term needs to be 'unpacked' for any particular audience. Also, when referring to the effects of 'spiritual' intervention what is actually often referred to ought to be termed religiosity.

RESUMÉ: Dans cet article, je souhaite attirer l'attention sur certaines lacunes que présente l'enseignement des études médicales dans le premier cycle au Canada, telles qu'elles sont enseignées actuellement. Ceci vient du fait que le Canada ne reconnaît pas l'importance de la spiritualité, en tant que composante spirituelle, dans les processus pathologiques et dans la guérison. Ma démarche méthodologique ici pour aborder le sujet, sera d'essayer de revoir les méthodes qui sont appliquées aujourd'hui pour enseigner la spiritualité dans les facultés de médecine canadiennes.

Avant de commencer mon travail, j'ai tout d'abord pris contact avec les bibliothécaires de l'Association médicale canadienne et du Collège des généralistes canadiens. Cela s'est révélé particulièrement difficile dans la mesure où la documentation que les bibliothécaires pouvaient trouver sur le sujet était, selon moi, principalement américaine et qu'il n'y avait pratiquement aucune documentation comparable du côté canadien. Que ce soit la documentation américaine ou la documentation canadienne (là on pouvait la trouver) sur la spiritualité dans les études médicales, toutes deux m'étaient nouvelles. Je souhaitais trouver la façon dont l'enseignement de la spiritualité dans les études médicales au Canada, se présentait. Toutefois, ma première constatation en analysant la documentation apportée spécialement par la bibliothécaire de l'Association médicale canadienne, fut que les références étaient essentiellement tirées d'études américaines. Alors que nos deux pays ont beaucoup de points en commun, des divergences existent dont la position générale de la population face à la religion. Tandis que les Américains sont, en général, des gens religieux, les Canadiens, eux, le sont en général moins. En revanche, dans les deux pays les chercheurs évitent d'employer dans ce domaine le terme *religion,* lui préférant le terme quelque peu nébuleux de *spiritualité*. Afin que tout public comprenne ce terme, il faudra pourtant le

« déballer » de même que lorsqu'on fait référence aux effets causés par un facteur *spirituel* qui est en fait souvent religieux et qui doit être appelé par un terme religieux.

The American Context

According to one contemporary American author the meaning of spirituality over the last century has moved away from its traditional meaning towards the view that "spirituality [is]broadly a search for meaning, purpose and connectedness" (Puchalski, 2014, p.10). Another such author refers to spirituality as "relationship centred care" (Koenig, 2008). This latter notion is one that I personally prefer as a practicing family physician especially when it is thought of as care for the whole person. In the United States Puchalski suggests it is one of the hopes of medical training that physicians are thus trained to practice relationship centred care, understood as care of the whole person. This can be further viewed as 'compassionate presence,' a domain unique to spirituality and health. This is considered critical to effective patient care (Puchalski, 2014, pp. 10-12). When this is translated into medical education, this involves a number of steps including taking a spiritual history, ethical aspects of spirituality, religion and health and the impact of spiritual and religious beliefs on healthcare decision making (Luchetti, 2014, p.4). Brown Medical School, for example, offers a 17-hour elective on such an approach that was evaluated via pre-and post course questionnaires evaluating the resulting knowledge and skills. As Luchetti notes that according to Ananadarajah and Mitchell (2007) who studied this activity at Brown students were able to improve: their knowledge about the evidence regarding spirituality in healthcare, the clinical evidence available, the role of chaplains, how to approach patient care and how to recognize spiritual distress. Furthermore, students noted that the course was an opportunity for self-reflection (Lucchetti 2011, p. 6). Furthermore such medical courses in spirituality seemed to be easily implemented and well accepted by students (Luchetti , 2011, p. 9). In the United States the broad area of psychiatry as it appears in medical schools appears to be particularly interested in this area. Learning objectives created by psychiatrists, again according to Luchetti, include the following: religion and spirituality in mental health, interviewing and assessing patients' religious/spiritual practices, beliefs and attitudes and religion/ spirituality in human development. (Luchetti, 2011, p.10).

The Canadian Context

My initial review, as mentioned above, using the Canadian Medical Association librarian, was conspicuous for its absence of Canadian data. I thus did a second search, using the College of Family Physicians of Canada's librarian, asking for specifically Canadian references. The next section will try to give a sense of what that search unearthed.

In 1998 the World Health Organization (WHO) stated that a strictly biomedical view of patients will no longer suffice for health care, given the mounting evidence of the value of spirituality and spiritual well-being to overall health and quality of life (Hartung, 2012).

Canadian medical education has not responded to this, preferring instead to unpack spirituality into its psychosocial components. According to one author, Hartung, the World Health Organization's stance, with the exception of Canada, has been echoed by numerous medical accreditation agencies and professional associations that now require patients' spiritual needs to be addressed by a physician (Hartung, 2012: p. 78). The Royal College of Physicians and Surgeons of Canada, however, that sets the standards in Canada, as outlined in the CanMEDS competency framework appears to ignore the WHO directive and does not specifically address spirituality. For instance, the word spirituality is not used in the official documents in Canada as it is in the United States and Great Britain. In fact, the literature is sparse to non-existent with respect to spirituality in undergraduate curriculum in Canada (Hartung, 2012: p. 78). While we do have in Canada a movement towards reconciling the biomedical model with a more holistic one through the introduction of medical humanities courses, teaching medical humanities also lags behind American schools. According to some authors, of whom Hartung is perhaps a leading example, there is an important connection between spirituality and health. In particular Spiritual well-being promotes better immune function, is a major determinant of quality of life in patients with cancer, helps patients cope with illness, improves energy level in the chronically ill, improves patient perceptions of quality of care, and can be an important coping resource (Hartung, 2012: p. 79). Rather than attribute these findings to the importance of the recognition of spirituality in the context of health care in Canada CanMEDS competencies required of Canadian physicians includes psychosocial skills, such as the expression of empathy, compassion, trustworthiness, effective listening and respect for diversity. These important skills appear to be related to the spiritual component in healing as was suggested strongly in a multicultural study of roughly 25 spiritual healers by myself and a number of other physicians, a nurse and educators of spiritual healers in which I took a leading role (Sawa 2009). Interestingly these skills were often found in the context of an explicit belief both by the spiritual healer and the patients in the importance of the intervention of or the relationship with a higher power, sometimes, but not always seen as the Judaeo-Christian God. In some ways, this is parallel to the looking to a higher power in the 12 step process commonly used in the treatment of alcoholics or other addictions. I will not detail that study here but have included a number of references to it in the literature. (See the references under Sawa, Sawa et al and Winchester et al in the bibliography.) This does suggest that if Canadian medical education ever moves in the direction of recognizing spirituality that it also ought to be unafraid to acknowledge the importance of the belief in a higher power for the healing of many patients. A major gap in the Canadian medical curriculum is this explicit recognition of the relationship between a person's spirituality and their health. The most recent Canadian survey in this regard that appears in the literature was in 2003, a good 10 years ago. Luchetti (2011) notes this as follows: Grabovec (Grabovec and Ganesan 2003), carried out a survey of training available to Canadian residents in psychiatry. At that time, most Canadian programs offered minimal instruction on issues regarding the interface of religion, spirituality and psychiatry. According to the authors, "a lecture series focusing on religious and spiritual issues is needed to address this apparent gap in curricula across

the country". This seems to be a rather weak suggestion given the size of the gap. There is at present no curriculum on spirituality and health in Canadian medical schools either for medical students or as opportunities for the development of such competencies for medical practice. There is, of course, a political reality in relation to medical curriculum in Canada. Canadian deans of medicine have much power in the medical education system. The system is a hierarchy, not a democracy. In a survey conducted to gain an insight into the deans' thinking on the topic, it was found that some deans are uncomfortable with the traditional meaning of spirituality. Not surprisingly, so are some students and physicians. One would not think that this would be enough to justify the removal of traditional meanings to reduce discomfort in our secularized society. My personal experience in medical education suggests that some deans of medicine may allow their discomfort with religion to bias them to discard spirituality as if it were simply religion, something which is unacceptable to them. I tend to view this as a biased position, and fear that, given the authority of medical authorities, fear that it might prejudice students and physicians from seeking to learn about and integrate spirituality into their practice. This is clearly not the intention of the World Health Organization cited above. One of the approaches suggested in for example the Canadian Medical Association Journal to fill the gap in teaching spirituality is to teach the humanities in medical humanities courses (CMAJ 2013). This can also be seen as a biased position. Pulcaski, an American, and perhaps the most respected leader in this area, suggests that Canada might have moved along the same trajectory (as the USA) if a survey of Canadian medical deans had not elicited a lukewarm response…I think that some deans see it as religion only and are suspicious" Of course, spirituality is so much broader and in spite of our materials that state that, there is some resistance-we had that in this country (USA) too…it's important to separate religion from spirituality and to understand the extent to which attending to a patient's spiritual needs is an "integral" element in providing good health care, says Aschenbrener. "It's part of caring for the whole person, its not something separate that's sitting off to the side some place and therefore in a separate course. Rather, it's something that needs to be integrated with care for the whole patient." "You want it to be a part of the physician's approach to the patient, not something separate that they think about once and a while," she adds (CMAJ, 2013: p. E36). As mentioned above, in the United States the importance of spirituality in medical care and medical teaching is much farther along in its application. For instance, again according to Puchalski, the importance of compassion is now a part of American Code of Medical Ethics. As she notes: The American Medical Association developed a Code of Medical Ethics stating that physicians should provide competent care based on respect and compassion-values that many would consider core to spirituality(Puchalski, 2014: p. 11). Canada has not followed this lead by the Americans as nothing comparable appears in Canadian documents relating to medical ethics. Puchalski followed this up by pointing out that: The American College of Physicians noted that physicians should extend their care for those with serious medical illness by attending not only to their physical pain but also to their psychosocial, existential, or spiritual suffering. In 2004, the field of palliative care cited spiritual, religious, and existential issues as a required domain of care. The joint commission on Accreditation of Healthcare Organizations recognized the importance of spirituality to patients (14) and eventually required that patient's spiritual issues be addressed (15). These standards and

guidelines for attending to patient suffering and for recognizing spirituality as part of holistic health, healing, and wellness provided the impetus to train physicians who could implement them(Puchalski, 2014: p. 11). Again, there is Canadian silence on these topics. There is much to be said about the difficulties, of course, of producing a medical curriculum that does justice to the complicated nature of the spiritual experiences of patients and of their needs to be understood by their physicians who treat them. Let me finish by relating the story of a patient of mine, whom I have seen for a number of years. He has read this paper and is happy with its contents. The fact that he is a Mountie adds to his credibility. This clinical encounter is from my patient notes: Here was the initial encounter: Yesterday I saw a 35-year-old Mountie whom I have been seeing since June of 2010. He was put on an antidepressant called cipralex, then a second antidepressant, imipramine on July 13, 2013. The 'force' doctor forced him to go back to work, leading to his depression. He was put on a third antidepressant, then Effexor. He continued to be very depressed until Sept 3. He saw a psychiatrist who tried three more antidepressants. In December another antidepressant was tried. He was in therapy until March 2011. His mood was still down. On April 6 he reported to me that he was still "hallucinating." He had "visions," His therapist had told him not to be concerned. "Oh, know, they're not real." He also had apparitions of a girl with a painted face twice. He would have 3-5 apparitions a week. He said he was really going through a rough point at that time. He felt the apparitions were there to tell him that he was going to be all right. On April 6 he disclosed that his dead grandfather was also visiting him. On April 20th he came to see me for a counselling appointment. He told me about a case where a man blew off his head in front of him. The Mountie felt he had pushed him too hard and thus he was responsible for the man's actions. He was having vivid memories. On May 18th he said the man with the blown off face was visiting him and taunting him beside his bed. This was a very upsetting recurrent vision. The Mountie said he was investigating the man for sexual assault of his niece. On June 11 the apparitions were continuing. I provided him some material on psi phenomena, which helped to normalize his experience, and he found this helpful. His cousin continued to appear, smiling and comforting him. On September 9th, 2011 he disclosed that he had been having second apparitions of an angry bodiless face of a lady. She was 'like in the Exorcist.' She made faces at him. On Jan 31, 2014, he stated that he is sure there is life after death. My grandfather and cousin were looking after me. He saw the man with half missing face about 10 times, his grandfather and cousin 15-20 times. They were smiling and comforting. His cousin's face radiated light, always smiling. At the time he had PTSD and he was afraid he was going crazy. He was scared to tell me about apparitions. The appearances were "so real" and he could interact with them. He wanted to know how you could discern if they were hallucinations vs. interaction with spirit. He said that if I had discounted his experience this would have affected our relationship and he isn't sure that he would have come to see me again. He would have felt judged and would have withdrawn sharing with me. He said he is not a religious person, just ordinary. He grew up Catholic He holds a mixture of religions. He told me last week that he continues to have apparitions. As mentioned he has been assessed by psychiatrists and psychologists. None of them suggest that he is not fully sane and competent. He just happens to have abnormal experiences that

may well have been causally related to his work as a Mountie but that are plausibly experiences of a spiritual kind.

Conclusion

This clinical encounter illustrates the importance of listening respectfully and not being judgmental. Just listening to his story as a physician or counselor may be considered a spiritual intervention. 'Entering into his world' by compassionate presence is certainly a spiritual intervention. This suggests to me as a family physician that our next generation of physicians need to be acquainted with the possible spiritual dimension in the health of the patients they may come into a clinical relationship with. And this in turn means that we have to take spirituality in relation to health seriously in Canadian medical schools. In addition to difficulties in finding common meaning with the word, "spirituality" we also have gaps in what is left out of our definition. Mystical experiences in the major religions are not accounted for. Nor are paranormal phenomena, such as found in this case of the Mountie. Yet, paranormal experiences are part of my practice of medicine (Sawa 2011). Christian spirituality has a long history of mystical experience (Thurston 1952) (Greeley 1975). How are we to help these mentally sound patients who experience paranormal phenomena (Sawa 2010, Sawa 2011)if we do not listen openly to their stories and grant them that they are real, at least for them, and treat them with respect and compassion rather than pre-judgment. How can we refine our research if we disregard this sort of data as not legitimate spiritual experience? And how can we bring spirituality into the Canadian medical curriculum unless we actually do reasonable justice to the variety of things we put in the spiritual realm today that bear a family resemblance to one another?

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